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### Abstract

This thesis is an illuminative evaluation of the Drinking Choices Project, a health education programme based in the North East of England. The data for the evaluation was gathered by using participant observation.

The instructional system, the Drinking Choices Manual, is a five-day teaching plan which includes alcohol knowledge, health education skills and an examination of the attitudes appropriate for health educators in the alcohol field. It was written by Ina Simnett, Linda Wright and Martin Evans. All of the materials are presented in a framework of participatory learning.

A pyramid model was designed for the dissemination of the programme; the first people trained were Health Education Officers (HEOs) from the District Health Authorities in the northern region. Courses were run throughout the region, in the first instance for HEOs to be trained to use the Drinking Choices Manual and then, following through the pyramid, the HEOs trained other professionals who trained other colleagues who then used the Drinking Choices materials with their clients.

The Introduction to this report describes the initial development and background of the project and the Health Education Council, (which is the Funding body).

The thesis is in three parts, the first of which consists of reviews of the literature in the three major aspects of the project:

- Research Methodology
- Alcohol use and abuse
- Participatory learning methods.

The second part begins with a description of the culture of the HEO so as to understand the organisational system in which the innovation took place; then the progress through the pyramid of dissemination is described, along with a detailed examination of the Manual itself and an investigation into obstacles encountered in implementing the Project.

Part III examines positive aspects of the project, including a variety of outcomes and spin-offs which resulted. In Chapters VIII and IX conclusions and recommendations are presented; in Chapter X, which was written six months after the project ended, the Steps to Successful Change are outlined, followed by an epilogue, appendices, and bibliography.

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**An Illuminative Evaluation  
of an Alcohol Education Project**

**Donna V. Brandes**

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**A thesis submitted for the award  
of the degree of  
Doctor of Philosophy of the  
University of Durham**

**School of Education  
1985**



**-1, MAY 1985**

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### Acknowledgements

I offer my appreciation and grateful thanks for the help given me in the conduct of this research, to a considerable number of people; more than the usual number due to the collaborative nature of this evaluation project.

First and foremost, to Professor Frank Coffield for his rigorous and generous supervision of the project and the thesis, and for his creative ideas throughout the time we worked together.

To Jane Randell of the Health Education Council for her guidance and encouragement.

To the writers of Drinking Choices, Ina Simnett, Linda Wright and Martin Evans for their continued participation, consultation and help; and, in particular, to Dr. Simnett who has been very supportive and has generously offered her ideas throughout the project.

To Kathleen Meacham and Aileen Jones, the successive project secretaries, without whose assistance this thesis would not have been produced, and to Mrs. Annemarie Rule, whose typing expertise and positive attitude made rewriting a pleasure (almost).

To the Health Education Officers of the North East region for their continued willingness to be interviewed and consulted over three years, and to contribute to the project in so many various ways. I also wish to acknowledge that all of the Health Education Officers in the region were willing to have their names used in this report; the absence of these names is not meant to deprive them of well deserved appreciation but is because of my protective attitude toward them. They are at the core of this endeavour.

To my colleagues in the School of Education, especially

John McGuinness, Pat Allatt and Anne Saunders for their support and advice.

To my family and friends, who accepted my deep involvement in the project to the exclusion of many of my customary activities and supported me in completing it: particularly Eva Ross, Anne Joynes, Diane Howard, Tom Adams, Dorothy and David Neave, and Viyog and Premlok, and most especially to Sudhiro.

## INTRODUCTION

### Background to the Project

The Health Education Council (HEC) is one of those rather interesting birds known as a QUANGO: A Quasi-Autonomous-Non-Governmental Organisation.

It was established by the Government in 1968 with the purpose of planning and promoting Health Education at a national level. This followed a recommendation from the Cohen Committee (1964) which stated that the aims of health education are "to do more than provide information. It must also seek to influence people to act on the advice and information given, and must seek to counteract pressures which are inimical to health."

Four main types of programmes for health education are listed in the Cohen Report:

- "(i) specific action (e.g., vaccination and immunisation);
- (ii) habit- or attitude-changing (e.g., avoidance of over-eating; attitude to mental illness);
- (iii) support for community action (e.g., clean air, fluoridation);
- (iv) education which leads patients to know when to consult their doctors, especially at the early stage of serious disease."

The report also listed many subjects which were deemed worthy of being given priority for health educators:

- motherhood
- dental health
- mental health
- prevention of illness and accidents in industry
- footwear
- cancer detection
- food hygiene
- noise prevention
- pollution
- eating
- smoking
- habits such as alcoholism and others

The Cohen Committee also spelled out the recommendation that:

"The Government should establish a strong Central Board in England and Wales which would promote a climate of opinion generally favourable to health education, develop 'blanket' programmes of education on selected priority subjects, securing support from all possible national sources, commercial and voluntary as well as medical and assist local authorities and other agencies in the conduct of programmes locally. It would foster the training of specialist Health Educators: promote the training in health education of doctors, nurses, teachers and dentists; and evaluate the results achieved by health education."  
(p. 1)

Similar recommendations can be seen in the earlier published Constitution of the World Health Organisation (1946) which stated:

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

"Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."

In its annual report, (1982-83) the HEC listed ten major aims; which I have summarised:

1. initiate and support programmes of health education
2. educate and train health educators
3. provide health education materials and teaching aids
4. sponsor research and surveys to provide data on health education, and from them establish priorities for action
5. evaluate effectiveness of health education activities
6. serve as a national resource for information and advice on health education
7. cooperate with government, local authorities and educational establishments in developing health education
8. make necessary representations to government

9. promote public use of caring services
10. cooperate and share information with other health education bodies.

The project which is the subject of this thesis is part of a major regional alcohol campaign in the North East which embodies all of the above aims, but since it involves an evaluation of an educational innovation, it particularly applies to numbers 4 and 5. The HEC considers research into and evaluation of, health education programmes as one of its most important aims, and in 1982-83 had approximately thirty research projects in operation.

The HEC, then, is a quasi-independent organisation; in fact it is a registered, limited company which is given charitable status and empowered "to initiate and support national and local programmes and campaigns of health education, etc. ... " (UEC, 1982).

The Council itself is the body which makes policy and major decisions; it has twenty members, and these are appointed by the Secretary of State for Social Services in England and by his or her counterparts in Wales, and Northern Ireland. The senior staff within the organisation comprises six on the management team and eleven other officers. This staff is supported by assistants, secretaries and other services, approximately 80 in all.

More than 80% of the annual budget of approximately £10,000,000 derives from the DHSS in England, the Welsh Office, and the DHSS in Northern Ireland; the rest comes from local authorities, and from sales of publications and films.

Its "quasi-autonomous" status stems from the fact that much of its financial support comes from the national budget, through the Department of Health and Social Security (DHSS), and there are strong links between the two organisations. HEC also has links with more

than a hundred other health promoting or protecting organisations.

#### Health Education Officers

This report is so intertwined<sup>o</sup> with the functions and activities of Health Education Officers (HEOs) that they will have a chapter to themselves (Chapter IV). Briefly, they work for the regional health authorities, and are responsible for carrying out education and training in the subjects listed in the Cohen Report.

#### The Development of the North East Alcohol Education Campaign

In 1974 the HEC initiated an alcohol education campaign for the North East of England, in the area covered by Tyne Tees Television; this area roughly coincides with eight area health authorities, most of whom had Health Education Officers in posts at that time. At the same time the North East Council on Alcoholism (NECA) was organised, with the assistance of HEC, to deal with public responses to the campaign, and to offer services to problem drinkers; a director, a secretary, and later a deputy director, were provided. An Alcohol Education Campaign Working Party was established in the region.

The pilot programme of the media campaign included posters, leaflets and television commercials, all of which presented messages suggesting that people with drink problems should seek early help and advice. The aims of the campaign were (Centre For Mass Communications Research, 1982):

1. To increase public and professional awareness of alcohol and its problems
2. To establish the feasibility of health education about alcohol and its problems



The pilot programme encountered some problems: initial difficulties arose with the administration of the project, and distribution of the pamphlets and posters did not always occur in time to coincide with the television commercials. The most overwhelming problem was the lack of counselling or support facilities for members of the public who responded to the campaign. NECA was deluged with requests for help, (an estimated 900 in three months); no specialist counselling services existed for people with alcohol problems, and most medical help was limited to traditional GP or psychiatric treatment. The campaign came under criticism from HEOs and alcohol workers in the region for encouraging the public to identify drink problems and providing only very inadequate services to deal with them.

Between 1974 and 1977, NECA began to set up voluntary counselling services and training courses throughout the region. Because of the problems encountered in 1974, the HEC and North East regional medical officers felt that any further campaign should be aimed at promoting sensible drinking habits in the general public (referred to in the trade as "primary prevention", as opposed to "secondary prevention", which refers to dealing with people with drink problems). From that time on the campaign focussed on sensible drinking rather than on problems. HEC in London continued to plan such a campaign, and in June 1977 an introductory meeting was held in Newcastle, at which it was agreed to launch the campaign that autumn, with a budget of £175,000, most of which would be used for television commercials. The rest of the money would be spent on activities in the region, such as meetings, establishing some support services, and also evaluation. A regional co-ordinating group was established which represented the HEC, plus Health

Education, Community Medicine, Education, Probation, and Social Services. The Teachers' Advisory Council on Alcohol and Drug Education (TACADE) was to assist the co-ordinating group in presenting seminars and short training courses for the professional people involved. (A list of all abbreviations is included in the Appendix.)

The media publicity and the training programmes and seminars for counsellors were continued throughout 1977 and 1978 and HEOs in the region were given a special three-day training in effective ways of supporting the campaign. (This is a very brief over-view of the many activities which were being carried on in the North East throughout this period.)

The regional co-ordinating group kept finding that whatever activities they originated, responsibility for carrying them out always fell back on them. "There was an urgent need to transfer expertise, knowledge and skills to others who could then act as educators during activities promoted by the campaign." (Drinking Choices Manual, p. 2.)

In 1979 the regional working party asked three HEOs to plan a module which could be used to train multi-disciplinary groups as alcohol educators; thus began the Drinking Choices project, the subject of this report.

#### The Drinking Choices Project

The alcohol module is a training package which includes the Drinking Choices Manual (DCM), and the dissemination plan for running courses to train people in the use of the manual. It was designed by a group of three Area Health Education Officers (AHEOs) in the North East, with the help of Martin Evans, Director of TACADE.

It was (and is) being used to support field health educators such as probation officers, social workers, community policemen, teachers, youth workers, psychiatrists, nurses, health visitors and others as they learned about the use and abuse of alcohol, and about changing attitudes and behaviour. The basic learning method used in the module was participatory learning which I define briefly here as transferring the responsibility for learning from the lecturer to the group. Two pilot courses using DCM were run, in Spring/Summer 1981, in Northumberland and Cleveland. Martin Evans informally evaluated the pilot project in discussions with Ina Simmet and Linda Wright, and then joined them in rewriting the manual; it was printed and ready for the first regional training of key tutors in Autumn 1981.

The HEC supplied the funding for a three-year research project to be conducted at Durham University under the supervision of Professor Frank Coffield. Its major aims were:

- (a) to assess the effects of the module and to see how well it met the aims stated in the manual, which are included later in this chapter (p. 15);
- (b) to evaluate the use of the participatory approach;
- (c) to facilitate the dissemination of the module throughout the Northern region, and to assess its strengths and weaknesses and revise it before a national dissemination was undertaken.

I was appointed as Director of the project in July of 1981. I began the action research immediately by meeting the HEOs and other key people with whom I would be working, and by reading about health education and about alcohol.

In September of 1981 I approached Professor Coffield, and he

agreed to supervise the Ph.D., and the University then agreed to accept the project. I was appointed as a Research Fellow in the School of Education as of January, 1982. The project was funded by HEC at a cost of £38,000.

Part of the research was evaluation of the module with a view to applying this approach to other aspects of health education in the promotion of a community-based and holistic approach to health education. The evaluator was also acting as facilitator in the training and development of HEOs and others as key tutors who used the module within their own locality. The form of evaluation used was illuminative evaluation (Parlett, 1981) and the main research methodology was that of participant observation. The aim was to disseminate the module through four levels of a pyramid which is presented diagrammatically below (Figs. 1 and 2), see pp. 13 and 14.

In the autumn of 1981 the first regional Drinking Choices training course was held for HEOs from each Area Health Authority in the Tyne Tees region: Newcastle, Northumberland, Durham, Cleveland, North and South Tyneside, Gateshead and Sunderland. In autumn 1982 the second training course took place and this time it included a new group of HEOs, youth leaders, members of regional Councils on Alcoholism and other professionals from the North East as well as from Lancashire, Cumbria and North Yorkshire. The author attended the first and facilitated the second regional training.

PYRAMID I

Dissemination Plans for DCM

Level I

Sep. '81-Feb '82  
(7 districts  
represented

Alcohol Project is

initiated by Regional Sub-Committee  
for alcohol campaign

Initial Training Course for Health Education Officers

Northumberland Durham Newcastle Cleveland N. & S. Tyneside  
Sunderland Gateshead

Level II

Series A: Jun. '82-Jun. '83  
Series B: Dec. '82-Dec. '83

H.E.O.s train other trainers

Professional colleagues: nurses, tutors, other HEOs  
workers in the Health Service, etc.

Level III

Trainers use the module with professional  
colleagues and clients

Courses are organised for social workers, probation officers, educators,  
nurses, youth and community workers

Level IV

Trainers use the module with members of the general public

Courses will be offered and advertised throughout the North East to members of  
the public, schools, adult education, clinics, hospitals etc. as well as  
informal contact of professionals with members of the general public

PYRAMID II

Dissemination Plans for DCM

Level 1

Oct. '82-Mar. '83  
(9 areas represented)

Level 2

Feb. '83-Jan. '84

Level 3

Dec. '82-Jan. '84

Level 4

Dec. '82-  
Jan. '84

Second Training Course for HEOs and Other Professionals

Northumberland Sunderland Lancashire Gateshead  
N. Yorks Cleveland Durham Newcastle E. Cumbria

Trainers from Level 1 train other Professionals

Various Course Members use the Module in Different Ways

Any of the above Course Members have Contact with Clients

### General Aims of the Module, as Stated in the Manual, Drinking Choices

"On completion of the course, participants will:-

1. Hold the attitude that education can be an effective means of prevention.
2. Have confidence in their ability as alcohol educators.
3. Take action by educating their clients about alcohol.
4. Be able to use and apply their previous experience, training and knowledge to alcohol education.
5. Be able to see the needs of the whole person in relation to their life situation and identify the way alcohol fits into this picture.
6. Be able to apply educational strategies to alcohol problems at primary, secondary and tertiary levels of prevention.
7. Have knowledge about the development of an individual's drinking behaviour and how it is influenced by social, legal, cultural, economic, psychological and genetic factors.
8. Have knowledge of the influence on drinking patterns in our society of cultural, economic, fiscal, legal and educational factors.
9. Have knowledge about the biochemical and pharmacological properties of alcohol and its part in the host-agent-environment system.
10. Be aware of, and understand, current theories about alcohol use and abuse."

### The Steering Committee for the Project

In autumn of 1981, as the project and evaluation began, the committee was selected and appointed by the HEC and the writers to oversee the dissemination and evaluation of DCM. It consisted of:

Mr. Tom Bailey; HEO, Durham (secretary  
to the committee)

Mr. Martin Evans; Director of TACADE

Ms. Jane Randell; Education and Training  
Division, HEC

Dr. Ina Simnett; AHEO for Northumberland  
(at the time)

Mrs. Linda Wright; DHEO for Cleveland  
(at the time)

Also present at the committee meetings were Professor Frank Coffield, academic supervisor to the evaluation and Mrs. Donna Brandes, facilitator/evaluator of the project.

#### Purposes of Evaluation

The regional working party had many aims in having this project evaluated; the first one being to see whether DCM did work in developing a network of alcohol educators and to find out what improvements or refinements were necessary.

Furthermore, it is felt by HEOs that they have an ethical responsibility to carry out effective activities which relate to the needs of their clients, so it is customary procedure to evaluate new educational materials as they are introduced.

The writers of the manual also wanted to assess the efficacy of their product, and the working party wanted to indicate to HEC that their funding of the project was a worthwhile investment.

It was hoped by all concerned that the project would contribute to the body of knowledge in health education and that HEOs and other professionals would see that the methods employed worked with their clients and that educators would use the manual extensively. It was also intended that any member of the community would be able to see him/herself as an unofficial alcohol educator, using the



alcohol information with friends and relatives.

In addition to this thesis on evaluation, the HEC has requested a short 16 page publication consisting of a description of DGM and how it can best be disseminated and put to use. This pamphlet would be distributed to local authorities and HE units throughout the UK.

### Description of Thesis

#### Part One

The first chapter is a brief review of the literature on research methodologies and evaluation along with a discussion of the choice of participant observation and illuminative evaluation as the methodologies to be used in this project.

Chapter Two examines current thinking about use and abuse of alcohol and how this is affected by the political environment.

In Chapter Three the participatory learning approach will be examined in the light of current writings about effective adult education, since the manual is primarily intended for teaching professionals.

#### Part Two

Chapter Four, The Culture of the HEO, provides the transition from the reviews of the literature into the main body of the thesis, and consists of a visit to the world of the HEO, which describes the particular features of an unusual occupation.

Chapters Five, Six and Seven, respectively, describe the progress of dissemination through the pyramids, the strengths and

weaknesses of the manual itself and how people responded to it, and the obstacles encountered in the project, as well as some negative results.

Chapter Eight records the positive results of DCM, including some unexpected and tangential results, which we call spin-offs.

### Part Three

In Chapter Nine we draw some conclusions from all the data, summarising what we have learned about DCM, and offering some recommendations about its future development.

Chapter Ten explores the subject of innovation.

The thesis ends with the epilogue, bibliography, the appendix, and a sigh of relief.

## Part One

This section of the thesis comprises the background information necessary to understand the project, as well as reviews of the literature on the three major aspects of the project:

research methodology

alcohol

participatory learning

## CHAPTER I

### SELECTING AN APPROPRIATE RESEARCH DESIGN

"The practice of genuinely educational research would transform the world in the course of studying it."

Torbert (1981)

#### Defining the Problems

The practical problems for the writers of the Drinking Choices Manual (DCM) were: how to create an increased and ever-increasing number of alcohol educators in the North East, how to raise public awareness about alcohol, and how to encourage sensible drinking.

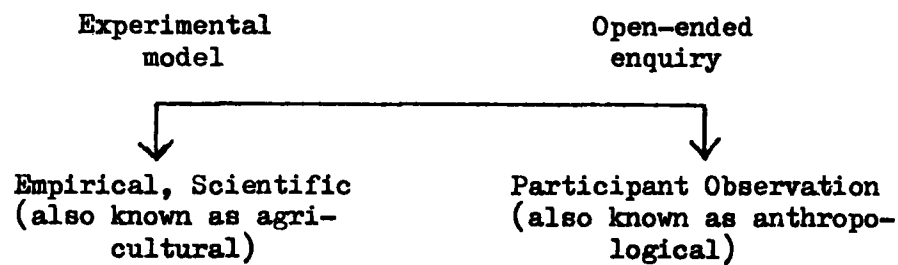
The broad problem assigned to me by the Health Education Council (HEC) was to understand the effects of the DCM on all four levels of the pyramid.

The research problem is a task of educational evaluation: stated very briefly, how far does the DCM, in the context of its dissemination programme, achieve its own stated objectives, and what happens in the process?

#### The Debate on Research Methodology

Research methodology in education, and in the social sciences generally, has been changing very rapidly in recent years: there are now many different models available and one of the tasks of the researcher is to identify the one which is most appropriate to the particular problem and circumstances of the research project. Not all of these available methodologies will be considered here, since

that investigation would not be appropriate. To simplify the procedure of comparing possible research paradigms, we will examine two styles at opposite ends of a continuum, knowing that there are many other models which fall between the two (Nisbet, 1980):



The purpose of both models is to structure, and make sense of, whatever data is collected in order to allow the researcher to formulate justifiable conclusions; as will be seen later they have many other aspects in common.

### The Scientific Method

The scientific method involves isolating observable phenomena from which a clear hypothesis can be constructed. Something occurs, the scientist notices it, and seeks to explain it. He does his reasoning in advance. He makes an educated guess, based on past experience and past theories, but also using his "creative intuition" (Popper in Magee, 1973). This guess is usually called a hypothesis and it needs to be operationalised, that is, it must be translated into a form in which it can be tested. The experimenter identifies a dependent variable, one that he does not directly control but which is carefully defined; the dependent variable is then subjected to systematic changes, called independent variables, to measure the effects of those changes. Thus an

experiment is devised to test the hypothesis and, as a result of the evidence gained from the experiment, the hypothesis can be refuted or verified.

Karl Popper has proposed (Magee, 1973) "that we formulate our theories as unambiguously as we can, so as to expose them as clearly as possible to refutation". This suggests a courageous element to experimentation. For example, if a researcher were seeking to prove that all zebras have stripes, she would not be content with the relatively easy solution of finding thousands of examples of striped zebras (or horses wearing pyjamas). She would be searching at the same time for an animal which fulfilled all of the other definitions of 'zebraness' and which did not have stripes, thus making systematic attempts to refute her original theory; this is called falsification.

Thanks to Popper and others, it has been recognised that a good theory should contain the means for its own destruction: it should be possible to disprove it. Popper admired Einstein, who, having formulated an original theory based on highly creative and controversial predictions, then exposed it to refutation until it was corroborated. Even then Einstein did not consider the theory complete or final. However, the theory did hold at the time, having been put to critical tests. This approach to understanding the natural world has been called the hypothetico-deductive method. When performed in the manner of Einstein or Popper, it can provide the scientist with broad opportunities for the growth and evolution of his theories. This approach is widely accredited because of its successful use in the physical sciences.

The science of statistics has provided a structure which allows the logical and mathematical analysis of a number of variables;

the recent introduction of computer technology has greatly facilitated and expanded these analytical capabilities.

In current usage, the experimental method is still frequently the most appropriate for large-scale research or for the gathering of data which can be studied and transferred or replicated in other geographical, educational or sociological areas.

### The New Paradigm

The new paradigm provides many specific research models, which have differences between them; the factor which unites them is a much closer relationship between the researcher and the researched than is usual in the experimental method. The knowledge and learning occur through a collaboration, a mutual process which involves taking personal risks. The researcher is often immersed in a new culture, a new language, and active participation in previously unfamiliar events. She cannot do this and remain unobserved; a degree of self-disclosure is required. She becomes an insider to the culture, and at the same time remains an outsider.

Furthermore, as Reason and Rowan (1982, p. 489) state:

"Research can never be neutral. It is always supporting or questioning social forces, both by its content and its method. It has effects or side-effects, and these benefit or harm people."

Researcher and researched, in the new paradigm, discuss and explore these issues together. Risks regarding confidentiality face everyone involved. The process is based on getting to know each other, rather than on "neutral observing". Likes and dislikes, taste and preferences, agreements and conflicts are not set aside, but brought to awareness to be dealt with in ways which it is hoped

may be acceptable to both parties. Conflicts are negotiated.

The new paradigm usually involves an open-ended enquiry, characterised by unpredictable discoveries. The task of evaluation is in part an exploration, and in part an investigation. The research problem is defined in broad terms with an unlimited number of uncontrolled and uncontrollable variables. Guesses and hypotheses are made, tested and re-formulated along the way; the data are continually analysed and examined for new findings. Observation is done with the knowledge and co-operation of the observed. The first observations are descriptive, providing an overview. Although the focus is narrowed as the observation proceeds, and eventually certain factors are selected for final study, the descriptive observations continue until the project ends (Spradley, 1980, p. 33).

#### The Two Methodologies Contrasted

Nisbet's continuum (1980) symbolises the debate between the traditionalist and the 'new paradigmist' which has been alive in the literature of the social sciences since the 1960s. Let us examine the salient characteristics of the two extremes, side by side

Scientific	Anthropological
1. A way of thinking associated with most natural scientists	1. A way of thinking associated with some social scientists
2. Systematic	2. Relatively unstructured
3. Reductionist	3. Holistic
4. Restricted	4. Open-ended
5. Not based in a specific theory	5. Set in a theoretical framework



Scientific	Anthropological
6. Objectives are fixed, not variable	6. Objectives are reordered, redefined, revised during the process of evaluation
7. Researcher reasons in advance and charts the course of study	7. Researcher focusses and re-focusses the study as events unfold
8. Tests hypotheses	8. Generates and questions hypotheses
9. Quantitative information is sought; anecdotal or subjective information is disregarded	9. Qualitative information is sought along with informal quantitative data; weight is assigned to it by the evaluator, and it is built into the formative context of the study
10. Investigators observe, and isolate phenomena, formulate hypotheses, test hypotheses, quantify results	10. Investigators go through a cycle of observation, further inquiry, explanation, further observation, and so on
11. Concentrates on reliability	11. Emphasis on validity
12. Selecting a sample is a problem	12. Sample is mainly self-selecting (volunteers)
13. Uses statistics and tests as evidence	13. Uses accounts and records of behaviour as evidence
14. Atypical results are rarely studied in detail	14. Atypical results are of special interest
15. Researcher collaborates and compares evidence with other scientists	15. Researcher collaborates with subjects
16. Relationship between researcher and subject is not a key factor	16. Relationship is a significant factor
17. Researcher tries to minimise impact on subject	17. Researcher interacts with and has varying degrees of impact on subject (and vice-versa)
18. Predicts outcomes, measures results	18. Follows events, interprets, explains and describes

Scientific	Anthropological
19. Replicability is considered necessary	19. Replication is usually not undertaken
20. Ignores context (e.g. political, socioeconomic)	20. Sensitive to context
21. Objectivity permits publication	21. Publication raises problems of ethics and confidentiality
22. Suitable for large-scale research	22. Suitable for small-scale research

Modelled on tables produced by Harré (1982), Coffield (1982), and on points from Parlett and Hamilton (1972).

From the foregoing, one can see that the debate is not about a black and white issue; impassioned arguments on each side are available in the literature, but it is the comparison which interests us here.

"There is no one royal road to truth in the social sciences ... All methods have their strengths and weaknesses and all are, in varying degrees, messy and unsatisfactory because life is messy and unsatisfactory." (Coffield et al., 1980, p. 16)

Harré and Secord (1972, p. 2) state that research in the social sciences is in a period of transition between the two methodologies, or as they put it, " ... out of the deserts of methodological positivism and into the pursuit of real science", and again they advocate (op. cit., p. 6) " ... the treating of people for scientific purposes as if they were human beings". It would seem from looking at the wealth of material to support both sides of this issue that the transition is well under way, and is accompanied by and parallel to the growing fields of humanistic education and

psychology, which have also shown rapid development in these directions in the past three decades. The literature on evaluation closely parallels that on research methodology; that is, a number of researchers have moved within the field of evaluation from experimental methods to a more informal anthropological approach.

The new traditions are being codified and structured in various fields. Reason and Rowan (1982) have compiled a volume of writings on the new paradigm and the authors come from widely diversified professional backgrounds including, among others:

Medicine (Heron)

Psychology (Allport, Reinharz)

Mental Health (Rosen)

Management Consultancy (Reason and Rowan)

Philosophy (Harre)

Education (Parlett)

There is room in the social sciences for the debate to continue and to allow for personal preferences on the part of the researcher or the funding body. The choice for this project was made in 1981 at the outset of the research; the methodology selected was illuminative evaluation, using participant observation. The philosophical and practical reasons for the choice will be explored in the following pages.

#### Philosophical Base

The first task was to select a research methodology which would meet the aims of the research project and the peculiar circumstances of its own design, as well as match the philosophical values of the writers, the funding agency and the evaluator.

Bannister and Fransella (1971, p. 11) point out that humans are

enquirers by nature and that their enquiries can lead them either in positive or negative directions:

"Currently there is a demand from many psychologists that their subject should become more 'Humanistic'. This is comical in one sense - it is as if sailors suddenly decided they ought to take an interest in ships - but necessary in another. A variety of vanities have diverted psychologists from concern with whole men. A craving to be seen as scientists has led them to favour a model of miniscule man. Only thus could they justify mimicking the procedures of the natural sciences in such a concretistic manner."

When we examine the arguments against using the experimental method with human beings, the philosophical objections seem to subsume all the practical ones. Essentially the new paradigmists are saying we have to approach a person as a human being:

"This is different from the modal way in which we approach physical objects, i.e. manipulating them to see what happens, taking them apart, etc. If you do this to human beings you won't get to know them. They won't want you to know them. They won't let you know them." (Maslow, 1966, p. 7)

Harre and Secord (1972, p. 31) argue that

"empirical research on persons involves a subtle, developing interdependence between propositional knowledge, practical knowledge and experiential knowledge ... This knowledge of persons is most adequate when ... researcher and subject are presenting each other in a relationship of reciprocal and open enquiry ... "

This indicates that in addition to evaluative skills the researcher must possess interpersonal skills.

A joint committee on standards of evaluation was set up in the United States to establish acceptable guidelines for evaluating educational programmes: in their manual (1981, p. 86) they state: "Evaluators should respect human dignity and worth in their interaction with other persons associated with an evaluation". And, further, under Guidelines, evaluators should "Make every effort to

understand the cultural and social values of the participants ... " and "Maintain good communication about the evaluation with participants ... "

### Matching the Evaluation to the Programme

The initiators of the project felt that it was necessary to find a type of evaluation which would be congruent with the educational process, namely participatory learning, which was used throughout the project; the educational method is described in Chapter III. They felt that it was vital to the project that everyone would be seen as co-teachers, co-learners, and co-evaluators; this would not be possible using a more traditional research methodology.

This was a key factor not only in the choice of research design but in the selection and appointment of the facilitator/evaluator: I was appointed because of my experience in humanistic education and participatory learning, and training in group work skills. Upon my appointment, it was suggested to me by Jane Randell and the Steering Committee for this project that I should seek a supervisor for the Ph.D. who would understand and encourage the use of the anthropological model. They felt that this would provide the funding body (HEC) with the information about the DCM and the alcohol module which would be needed for the purposes of evaluation, and would accomplish this in a context of seeing and treating people as human beings rather than as a source of statistics.

### Practical Issues

Along with the theoretical bases for our choice, there were many practical considerations: in this particular project there was

an unavoidable and urgent time factor to consider. I was appointed in July of 1981 to begin work on the project in September, and so entered 'in medias res' at the stage where a pilot project had been completed and the first group of HEOs were about to begin their training in the use of DCM. The involvement of the University of Durham did not begin until January 1982, even further into the midst of the programme.

In February 1983 an informal interview was conducted with Linda Wright, District HEO for South Tees, who is also one of the writers of the Manual. She gave additional reasons, summarised below, for the initial choice of an action research design:

The facilitator/evaluator would be feeding back continually to the writers of the DCM information which would enable them to revise the written material. This information would be invaluable in aiding the writers to update the Manual regularly during 1982 and 1983 and to produce a final version to be published in 1983. For these purposes, a pre-test/post-test model would have had a disadvantage, in that the writers would have had to wait two years before results of any kind became available. It was therefore the intention of the HEC to have the facilitator/evaluator proceed relatively quickly through the training of the HEOs and implementation of the Drinking Choices courses, the use of the materials by professionals and their clients, obtaining at all times the accounts of all those people as to the usefulness of the resources, i.e. constructing a formative evaluation of the process as it was happening.

It seemed desirable at the time (1981) to produce a "naturalistic observation which would provide a good source of insight and a basis

for generating ... theories." (Tuckman, 1978)

The information obtained from running courses and conducting interviews was intended to be used immediately for revision purposes and also to be used in continuous assessment and re-assessment of the directions in which the project ought to proceed. Furthermore, the proposed project included an enormous number of variables: the political/economic climate, the reorganisation of the NHS, regrading of HEO's posts, the interests of various staff members in the HEC, the personal characteristics and managerial styles of the HEOs, the eight varied communities participating, the various models of course work to be used, the time allocated for each individual course, and many more.

This project fits into the category of a case study, in that it is an analysis of a single programme. It is both formative and summative evaluation, in that it was designed to improve the programme while it was being developed, and it will also present some final conclusions and recommendations about the DCM which will relate to all participants in the innovation.

Since the purpose of the evaluation of this project is primarily to provide the HEC with information about the effectiveness of the DCM, it fits neatly into Parlett's (Reason and Rowan, 1982, p. 219) description of illuminative evaluation:

"The basic emphasis of this approach is on interpreting, in each study, a variety of educational practices, participants' experiences, institutional procedures, and management problems in ways that are recognisable and useful to those for whom the study is made. The illuminative evaluator contributes to decision-making by providing information, comment, and analysis designed to increase knowledge and understanding of the programme under review. Illuminative evaluation is characterised by flexible methodology that capitalises on available resources and opportunities, and draws upon different techniques to fit the total circumstances of each study."

This study was 'purpose-built' for the HEC; the aims and objectives being agreed upon through extensive negotiations with Jane Randell of HEC, who is the member of the Steering Committee primarily responsible for the project. It is open-ended to allow the researcher to take each new development into account.

The frame of reference of an evaluation in the new paradigm is negotiated with those commissioning the study, in this case Jane Randell and the Steering Committee. We developed, and are still developing right up to the final draft of this thesis, the questions we wanted to ask:

"... there are no fixed evaluation procedures and the exact purposes of each study are unique to that setting and to the particular policy discussions into which the report will be fed."

(Parlett, op.cit., p. 221)

So we could give this thesis the title 'A formative, summative, illuminative, participant-observational, anthropological, ethnographic evaluation', but we will not.

### Illuminative Evaluation in General

#### Basic characteristics

Illuminative evaluation almost has a personality of its own. It is characterised, according to Parlett and Dearden, by honesty, common sense, pragmatism and a sense of professional responsibility. It has its own Golden Rule:

"Investigators should not investigate others in ways they would not like themselves to be investigated."  
(op.cit., p. 34)

Further guidelines are offered which reinforce the idea that people should feel enriched by being involved in the research and should not feel ignored. Respect must be given to participants. They should



not feel under pressure to participate and should have every opportunity to express themselves. The researcher must avoid collusion and over-involvement and her understanding should incorporate many different points of view.

Illuminative evaluation uses naturalistic field conditions as opposed to rigorous laboratory conditions and there is little use of quantitative measurement procedures; this is acceptable since the method is concerned with describing and explaining, not with measuring or predicting. The evaluation examines the way in which a programme develops and how it is influenced by wider social contexts.

As Parlett and Dearden comment, (op. cit., p. 46:)

"The evaluator's task is not to come down definitively in favour of or against the particular innovative scheme being studied, but rather to elucidate and clarify a number of related issues that have to do with the operation of the scheme in practice, its philosophy, its perceived advantages and disadvantages and its intended and unintended consequences. It aims to provide information and insight for a wide audience of interested parties."

### Participant Observation

One of the methods chosen for this evaluation is Participant Observation. This is not a single method, nor even an eclectic one, but rather what Shostrom (1977) calls a "creative synthesis", that is, a combination of various broad strategies developed and internalised by the researcher.

Each new paradigm writer seems to have coined his/her own phrase to describe the methodology. This reflects the early stage of any new paradigm, in which there may be a lack of clarity or of conceptual agreement. Terms which have been used are as follows:

democratic evaluation  
ethnography  
collaborative enquiry  
heuristic research  
dialectical research

dialogical research  
action research  
experiential research  
ethogeny  
grounded theory

and more.

My personal preference is 'participant observation'. It is a methodology which is intentionally unstructured and which uses:

"observation  
interviewing and re-interviewing the same people  
document analysis  
self-analysis (of the researcher)  
participation"

(McCall and Simmons, 1969)

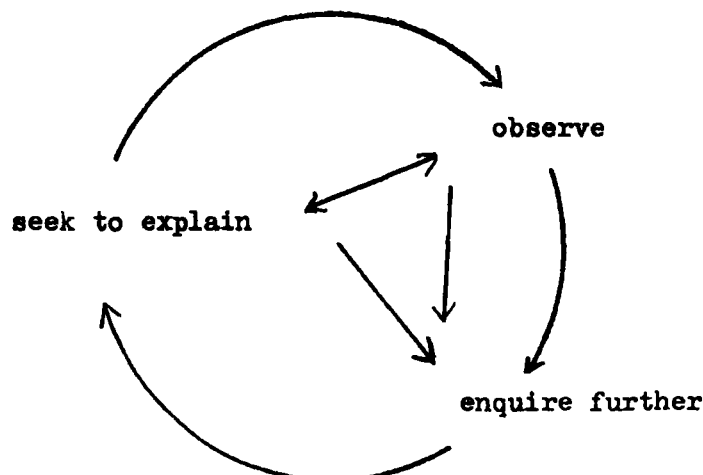
It also harnesses the creativity and imagination of both the observer and the observed. As Parlett and Dearden say (1977, p. 13) " ... no method (with its own built-in limitations) is used, exclusively or in isolation; different techniques are combined to throw light on a common problem."

### Gathering Information

An evaluation of this sort cannot be charted in advance. It involves three stages in which the researcher must:

- (a) observe
- (b) enquire further
- (c) seek to explain

This progression is not linear but circular and repeats itself in this manner:



In this way different sets of information are obtained. Observation and documentation hold a central place in the study and arise from the researcher's attendance at conferences, meetings, discussions, events and interviews; the researcher is engaged at all times in gathering the views of participants and in understanding their behaviour, language patterns and customs.

Parlett further states that " central to an understanding of illuminative evaluation are two concepts: the 'instructional system' and the 'learning milieu'." (op.cit., p. 14)

#### The Instructional System in This Project

In this evaluation the instructional system is the manual. The manual has been briefly described in the Introduction and it will be explained further in Chapter VI. At this point it is necessary to say only that this educational programme assumes a different format every time it is taught. This is because of the pyramid model which has already been explained and also because of the student-centred learning approach. The manual was designed to be adapted to each new learning situation.

#### The Learning Milieu

The learning milieu is defined (Parlett and Dearden, 1977, p. 14) as "the social-psychological and material environment in which teachers (HEOs in this case) and students (course members) work together." So in this example we are dealing not with one learning milieu but with a complex variety. Each course or mini-course is a special case in terms of milieu, whether on level 1, where key tutors are trained in the use of the whole manual, or on level 4 where, for example, a few patients in a hospital ward may be taught

to use the Drinker's Diary.

Questions posed by the writers of the manual, for the evaluator  
(Produced in the Steering Committee, June, 1982)

Are the objectives of the training courses met?

Does the training appear adequate and appropriate for what it is asking the HEOs and other professionals to do?

How do the HEOs and other course members feel about their effectiveness and efficiency for carrying out the tasks? What problem do the professional people perceive related to the tasks?

Can they apply the skills learnt during this training to other in-service courses/activities?

Have the attitudes of the course members towards alcohol changed?

What courses (how many and when and of what sort) do the HEOs and other professionals run?

Self-image of HEOs - do they feel adequate/confident as trainers?

What are the perceptions of HEOs, clients and the Facilitator of courses run, and of the manual?

Apart from running courses, is there anything else HEOs or others are intending to do as a consequence of this project?

Clients' perceptions of themselves - do they identify themselves as being alcohol educators?

Comments on the role of the facilitator, e.g.  
which roles are most important

- evaluating the training?
- continuing to support and

- train the HEOs and others?
- evaluating the HEOs and others  
and what they do?

How does DCM fit into a wider social context?

Whatever other comments and recommendations the facilitator/  
evaluator cares to make at the end of the project.

### Initial Stages in this Particular Evaluation

#### The Contract with the Funding Body

- (a) By July 1981 the pilot project was completed.
- (b) Also in July 1981, HEC appointed me in an interview  
with Jane Randell.
- (c) The contract stated that:
  - (i) I was to facilitate and evaluate the project at  
the same time.
  - (ii) I was to complete a Ph.D. with the project report  
as the thesis. This was to be supplemented by  
a short HEC publication on DCM.
  - (iii) I was to find an appropriate supervisor and a  
University in which to base the project.
  - (iv) I was to develop a research methodology and to ask  
questions appropriate for a formative evaluation.
  - (v) I was to report at regular intervals to the  
Steering Committee.
  - (vi) It was made clear to me at the initial interviews  
that I was to have a free hand in all details, large  
and small, regarding the facilitation and evaluation  
of the project. On the other hand, I was expected  
to consult closely with the Steering Committee.

This was in addition to the requirement to report to the Steering Committee; I was expected to keep in touch and not to make major decisions alone, but also not to feel that I needed to run to them with every little question.

- (vii) I was to start with two days a week part-time work. This was later raised to three days a week and finally to full-time work.

(d) The unstated contract:

- (i) Much of this developed as the project advanced. It was not all in existence at the beginning; it became clearer to me as I went along.
- (ii) I was chosen by the Steering Committee as a friendly party and a good deal of trust was invested in me. I am on the same wavelength as the writers regarding participatory learning and the approach taken in the Drinking Choices Manual.
- (iii) There was no built-in protection against possible conflict between me and the Steering Committee. It was all based on mutual trust, and in the end this proved satisfactory.
- (iv) Political issues could be mentioned but should not be stressed as they are unchangeable within the scope of this project.
- (v) Professor Coffield's degree of involvement had to be determined. He was not a member of the Steering Committee but was invited to all the meetings after April 1982, and attended most of them. Jane Randell was instrumental in supporting us when the demands for supervision went beyond that normally extended to a Ph.D. candidate of "at least once per term". About half-way through the project, the contract was changed to two hours of supervision

per fortnight, with the accompanying preparation time for both of us.

- (vi) I was never questioned or challenged about my use of time. Various people expressed concern that I was "doing too much", but at no time did any member of the Steering Committee ever question my various educational activities. Not only did they see my involvement in participatory learning in the wider educational field as being beneficial to the project, they also seemed to feel that anything which increased my own understanding would be reflected in the project. This also applies to any activities at Durham University which I performed in my capacity as research fellow.

#### Selecting the Sample of Interviewees

It would have been impossible to interview and re-interview every person involved with this project as there were over four hundred of them. Therefore, it was necessary to select an appropriate sample. Certain people were self-selecting because they were key people; this classification includes the writers of the manual (Martin Evans, Ina Simnett and Linda Wright) and the representative of the funding body, Jane Randell; in other words the Steering Committee. The Committee included two other members as well, Tom Bailey, an HEO from Durham who served as secretary, and later Ray Duffell, the DHEO from Northumberland who was added to replace Linda Wright when she went to Australia in 1984. Professor Coffield and I both attended all Steering Committee meetings, and acted as links with the University.

There was another category of key people from the alcohol workers in the region:

Peter Rørstad, Director of the North East  
Council on Alcoholism

Barbara Howe, The Deputy Director of NECA

Tony Ford, Alcohol Development Officer  
from Northumberland

Dr. Anthony Thorley, Director of the regional  
alcohol and drug treatment unit.

The next category comprised all of the HEOs from the first regional training. Among this number, certain ones were destined to become closer to me because of good personal relationships or because of involvement in various sub-projects, such as planning the third regional training, or because we ran courses together.

There was also an element of mutual choice; I began to develop a feeling that certain people enjoyed being interviewed repeatedly, collaborating in the data gathering and writing. I also had a sense of which interviewees were most productive for me to consult. There were certain ones who definitely did not want to talk to me, either for reasons of their own which I did not discover, or because they did not enjoy it or because I concluded that they did not provide much extra information. Although I made consistent efforts to obtain the much needed negative feedback from these people, I did not feel that I had the right to insist that people talk to me; if I met too much resistance, after two or three attempts, I gave up on that person and chose another.

The final category is the sample selected by me. My supervisor and I agreed that two course members from each course, or circa 20, would provide a fair sample when taken in addition to all of the above. The question was how were they to be selected? We developed a set of criteria. First there was to be a balance of men and women, and of various ages. We considered many other



possible criteria, one of which was people's willingness to be interviewed and to continue to collaborate. Although no-one refused, I had to trust my own instincts as to which people would continue to make themselves available to me. While observing on the courses I made a point of noticing which people seemed to be most comfortable in being able to give both negative and positive criticisms. We felt that these people would be most useful in the interviewing process. Finally, we decided that what was needed was a cross-section of people from various professions so that we would have the widest range of responses to DCM. So the sample was stratified according to sex, age, willingness to contribute and professional background.

Between 1981-1984 I interviewed sixty people:

23 people - more than five times

20 people - three to five times

12 people - one to three times

5 people - one time only

a total of about 200 formal interviews.

Arranging these interviews, of course, represents a large investment of time making telephone calls, and about 5,000 miles of travelling. Others in the sample phoned me at various times to report interesting developments, and there was an extensive correspondence between various people involved in the project, as well as informal meetings, social gatherings and unexpected visits.

#### Ensuring Validity in Qualitative Data

All of the information collected in this project falls into the category of qualitative data (i.e., information consisting of facts and interpretations presented in narrative rather than

numerical form). Care must be taken to avoid mistaken conclusions resulting from false interpretations or lack of cross-checking or other inappropriate methods of analysis. In order to avoid the pitfall of thinking that qualitative data analysis can be accomplished solely on an intuitive level, the interpretation of data must be as rigorous as it would be using a scientific method; the differences would be in the amount and nature of interaction and communication between researcher and researched about emerging conclusions. (Joint Committee on Standards, 1981, p. 133)

As in all research, the central question to be addressed is the validity of the responses given by the participants, and various controls have been introduced to increase the objectivity of these responses. Parlett addresses the question of validity in qualitative research in this manner: (1977, p. 18)

"Behind such questions lies a basic but erroneous assumption: that forms of research exist which are immune to prejudice, experimenter bias and human error. This is not so. Any research studied requires skilled human judgments and is thus vulnerable. Even in evaluation studies that handle automatically processed numerical data, judgement is necessary at every stage: in the choice of samples; in the construction or selection of tests; in deciding conditions of administration; in selecting the mode of statistical treatment (e.g. whether or not to use factor analysis); in the relative weight given to different results; and, particularly in the selection and presentation of findings in reports.

When the investigator abandons the agricultural-botany paradigm his role is necessarily redefined. The use of interpretative human insight and skills is, indeed, encouraged rather than discouraged. The illuminative evaluator thus joins a diverse group of specialists (e.g., psychiatrists, social anthropologists and historians), by whom this is taken for granted. In each of these fields the research worker has to weigh and sift a complex array of human evidence and draw conclusions from it."

We tried to build in some insurance against our own assumptions and other pitfalls by taking the following steps:

- (a) Frequent communication with the writers of the manual and representatives of the funding body, as well as others involved in courses or in the alcohol field.
- (b) Using the formative aspect of the report by checking conclusions and findings with the Steering Committee and others, throughout the whole period of the project.
- (c) Cross-checking with various interviewees, to see whether their interpretations of events match with each other, and with their own previous statements. Some people were interviewed as many as fifteen times; everyone in the sample was interviewed at least twice, (except for five people who were only interviewed once, due to, e.g. moving away, changing jobs).
- (d) Having various academic and professional people read the report at several stages of its development, to look for mistakes and omissions, or places where we may have jumped to mistaken conclusions.
- (e) Combing through interview transcripts, participants' course evaluations, and other reports, for comments.
- (f) Engaging in a careful 'soak', (immersion in the data), where all data which had been gathered was studied, sentence by sentence, and categorized so that patterns emerged. The soak is meant to 'speak' to the researcher, who is meant to be 'listening', not searching. Ideas and conclusions should arise from being grounded in the data. (Glaser and Strauss, 1967)

- (g) Checking official records and documents such as statistical analyses of drinking patterns, to compare what various informants say about the same issue.
- (h) All written work on the thesis and various kinds of interim reports, Steering Committee reports, and newsletters were carefully read and challenged by the project supervisor.

In this style of evaluation, the impact of the researcher on the research is not discounted but is considered with all the other factors. This becomes all the more important when the evaluator is also the facilitator of the project. This dual role has added another dimension to the relationships I have established with people involved in the project; all of us, when collaborating, were examining on many different levels how the work was going and thus determining ways to make it work better. Issues to do with the dichotomy of roles will be discussed in detail in Chapters Eight and Ten.

#### Words of Wisdom

Of all the advice and words of wisdom I received while working on this chapter, one phrase which has been helpful to me in wading through the wealth (not to say plethora) of material to select the information I wanted to use, came from Dr. Peter Reason

"Never Read or Write Anything Boring".

In July of 1984, we shall see whether the methodology selected was the most appropriate, and whether Dr. Reason's advice was followed.

## CHAPTER II

What is it?

It gives people pleasure.

It provides one of Britain's favourite recreational pastimes.

A little is good for you; too much can kill you.

The media claim it has magical powers.

It's more ancient than Homer, with lots of new developments.

Doctors say it causes disease.

Educators say it is an education priority.

Social Scientists call it a multi-faceted social problem.

It costs money; it is a major source of revenue for the Government.

It can damage every part of the body, the purse and the home, marriages, children and unborn babies.

It's fun.

It's a life style, a behaviour problem, an epidemic.

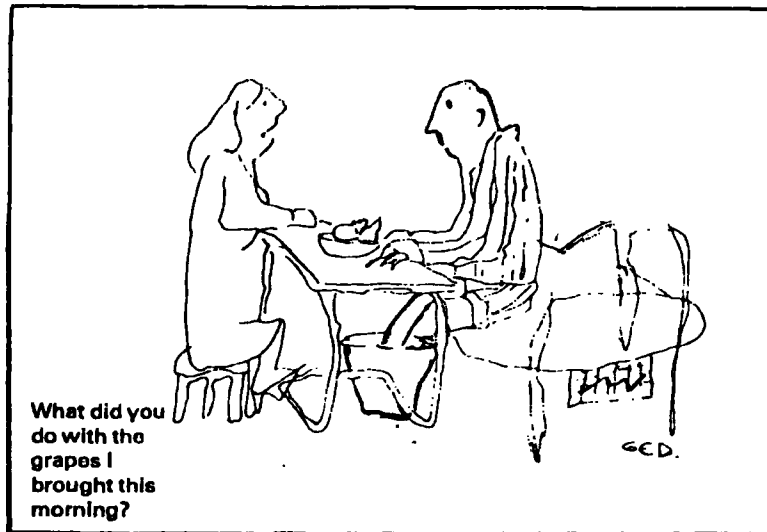
Legislators are tearing their wigs about it.

Some people want to ban it from Britain altogether.

Others are willing to put up with it ... but not on Sundays.

## CHAPTER II

### ALCOHOL: A REVIEW OF CURRENT ASPECTS OF DRINKING



(See 1, below)

#### Introduction

##### A Force for Good and Evil

No-one knows when alcohol was first imbibed by people. Certainly it is an ancient beverage; one source of evidence on this score is the Bible:

"Go thy way, eat thy bread with joy, and drink thy wine with a merry heart ... "

Ecclesiastes: 9

- 1) Apologies to the reader for not providing references for the cartoons in this thesis; some of them were collected and given to me by various HEOs and friends during the three years of the project, without the dates and sources attached. They seemed too juicy to omit .....

The use of alcohol for religious ritual is part of the Judeo/Christian tradition, and drinking alcoholic beverages 'just for fun' is also a matter of ancient record:

"Wine can of their wits the wise beguile,  
Make the sage frolic, and the serious smile."

Homer, The Odyssey

In fact, a survey of literature, whether fiction or non-fiction, indicates that:

"Since the beginning of recorded history, people have used easily accessible substances such as wine, marijuana, opium, mescaline, coffee, tea, cocoa leaves and tobacco, to 'get high' - to make themselves feel good, or at least better."

(Steiner, 1979, p. 15)

In one society the use of a substance may be unquestioned; in another its use may be considered deviant. In the US, the UK, Europe and South America, alcohol and tobacco, tea and coffee are widely used. In Moslem countries alcohol has been forbidden but the use of hashish by certain groups is condoned. Sherlock Holmes could inject himself with cocaine and this was considered a mild eccentricity in Victorian England. Opium was freely used in the Far East and imported here during the 19th century.

As Glatt says:

"... attitudes towards those who misuse alcohol have varied widely and wildly over the ages; 3000 years ago a Spartan king decreed that drunkards' legs be cut off; 1000 years later a Roman lawyer urged that such drinkers be treated as sick people (a recommendation largely forgotten during the subsequent 2000 years, and again rejected by some in our days).

(Glatt, 1982, p. 1)

Alcohol is also a popular substance because it is so easy to produce in different parts of the world. Easterners can ferment it from rice, the French, Italians and Californians from grapes,

the Scottish and English from malt and barley, and so on. (Plant, 1979).

Alcohol provides harmless pleasure for many people, and in some cases is mildly beneficial to health and well-being. Drinking, as enjoyed in moderation by most members of society, is not surrounded by problems; it can enhance hospitality and ease loneliness or tension, without negative effects. It can also be enjoyed and celebrated as one of the great achievements of mankind, by gourmets, and connoisseurs all over the world. Also, of those in the population who do suffer the adverse effects of heavy drinking, many change their jobs, marital or social situations, or personal habits, and bring about their own rehabilitation. However "alcohol is a drug which can produce dependency, and is misused tragically by a minority of those who drink it" (Royal College of Psychiatrists, 1974).





Certain countries have contradictory attitudes about alcohol consumption, characterised by, on the one hand, permissiveness in legislation and tolerance towards drinking as a social habit, and on the other hand by moral criticism of alcoholism; Scotland and Ireland are examples of these (DCM, 1981, p. 93). Others, such as Spain and Portugal, have similar contradictions, while France in the past has been most permissive towards heavy drinking. This has changed in recent years with Government campaigns to reduce the level of alcoholism (Grant and Gwinner, 1979).

The origins of the licensing laws in Britain lie in the Vagrancy Acts of 1495, which were initially and principally intended to prevent labourers from moving about the country, and so breaking their remaining feudal ties by seeking gainful employment. Subsequently legislation has been concerned with the control of groups in public places.

In these Acts we find the first restrictive legislation:

"Two Justices of the Peace may reject ale-selling in any place, and take security from sellers of ale for their good behaviour."

1495 Act against Vagrancy  
and Beggars (Dorn, 1983, p. 11)

The modern advertising media promise us enjoyment, relaxation, business prowess, sexual magnetism and social success if we choose the right drink; on the other hand, the Government is now finding it necessary to warn us about such advertisements.

I enclose examples of two advertisements: one from a slick popular magazine, and the other, intended to counteract advertisements like the first one, from the HEC's Tyne-Tees Alcohol Campaign (see pp. 49 and 50).



## How to succeed in business without really trying.

It's a well accepted principle of business that people  
are more receptive to new ideas after a good meal.

And a lot of the credit for that belongs to Martini.  
Martini has a subtle, dry, crisp taste that's really  
unique.

A taste that can put almost anybody in a better frame  
of mind.

So if you want to be a success in business, just remember  
this one important word: Martini.

Martini & Rossi use only carefully selected wines  
and herbs in the world's most beautiful drink.



**The right one  
just by itself**



# Stick to your two or three pints two or three times a week.



**Why spoil a  
good thing?**



**The Health Education Council**  
Helping you to better health

If you'd like more facts and information  
about drink and drinking, contact  
N.E.C.A., Mrs Hester, Elms Park  
Barnsley, South Yorkshire S11 8AA  
Tel: Barnsley 320107  
or 22 Belle Vue Lane, Muddlesley, Rye, East Sussex TN4 2PS. Tel: Muddlesley 898111

There is also a bewildering array of contradictions in the press about whether there is an alcohol problem in Great Britain at all; some say it is epidemic in proportion while others deny the problem exists (see p. 52).

Below are given some samples of these seeming anomalies in the same newspaper over a five month span; the dichotomy reflects the conflicting political undercurrents awash in the world of alcohol. "The Brewers' Society - who ought to know" versus the "sort of game the DHSS was playing" v "the BMA ... " and so on.

This project acknowledges, and has as a basic assumption, that a problem does exist regarding the use and abuse of alcohol in England today. Alcohol is a highly controversial, sensitive topic which concerns government, industry, big business, and the NHS, among others. This chapter will discuss medical and social approaches to the problem, the government's current activities regarding alcohol abuse, and a few of the complex political issues which determine this interest. Out of this will be drawn some implications for Health Education.

#### The General Picture in the UK

One source of apparently reliable information about alcohol in the UK is the Bruun Report. The origins, non-publication and contents of this report are extensively, in some cases bitterly, debated in the press.

"In May 1979 the Central Policy Review Staff (think-tank) produced a report 'Alcohol Policies', which has not yet been released by the Government. Despite this it was published earlier this year by the sociology department at Stockholm University as part of a research project called 'Studies in

## DOCTORS CHIDED ON DRINK

By DAVID FLETCHER  
Health Services Correspondent

AS many as 30 per cent of men admitted to casualty, general medical, and orthopaedic departments in hospitals are found to be physically dependent on alcohol or problem drinkers, Mr Fisher, the Parliamentary Secretary for Health, stated yesterday.

He told a symposium on alcoholism called by the British Medical Association that many patients who consulted their family doctors were, unknown to the doctor, also problem drinkers.

"But despite the fact that they are likely to attend his surgery more frequently than others, roughly in only one in ten will the problem be identified."

There was an urgent need for doctors to be aware of the extent of alcoholism and to respond not just to the consequences of their drinking but to the drinking itself.

OF ALL the pressure groups at work in the country, the one which tries to discredit alcohol and blame it for all our ills works furthest from the public eye. These people work behind the scenes—I suspect a cell of them at quite a high level in the Department of Health and Social Security—whispering in the ear of newspaper editors and Government Ministers that we are suffering an epidemic of drunkenness.

Whoever these people are, they clearly nobbled Labour's last Downing Street Think Tank whose report, wisely shelved by Mrs Thatcher, was unexpectedly published last week in the *Daily Mirror*.

All of its figures are out of date, in any case—according to the Brewers Society, who ought to know, our drinking has slumped in the last two years. But even for 1978 its figures are misleading. According to the Addiction Research Foundation of Toronto, which has no particular axe to grind, we not only drink less than most countries but have far fewer alcoholics.

(Sunday Telegraph, 5 December, 1982)

# AUBERON WAUGH'S COLUMN

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## SUNDAY TELEGRAPH

April 24, 1983

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TWO YEARS AGO there was a tremendous scare, emanating from the Department of Health and Social Security, that Britain was suffering from an epidemic of alcoholism. Respectable newspapers which should have known better accepted Ministerial briefings uncritically.

When I investigated the matter at some length, I found it was a pack of lies. Incidence of alcoholism in Britain was less than a quarter of the figure for France, less than a third of that for Italy, less than half that for West Germany. One wondered what sort of game the DHSS was playing.

Earlier this month London Weekend Television, using the Chief Medical Officer of the DHSS as its source, announced that an epidemic of venereal disease was almost out of control in London. This puzzled me, too, as World Health Organisation figures show that VD in Britain is running at about one-tenth of the US rate per 1,000 inhabitants, less than a quarter the rates for Canada, Denmark, Norway and Sweden, half the rates for Australia and West Germany. The WHO uses DHSS statistics.

Now a letter in the *Times* from a Harley Street doctor reveals that the Chief Medical Officer had not read his own figures correctly. There has been no increase. New cases of gonorrhoea have decreased since 1971, and cases of syphilis are running at less than a fifth of the 1940s norm.

The police are now to be given draconian powers of entry against an alleged increase in drunken driving. I wonder what new powers the Government will demand to combat this non-existent epidemic of VD.

Swedish Alcohol Policies'. In his introduction the Projektledare (or boss), Professor Kettil Bruun, considered it was important 'to underline the international perspective, especially for increasing our understanding concerning obstacles to alcohol policies and for locating new ideas in the field' ... despite the fact that this was '... a confidential report which originates from the United Kingdom, which has not been made available either to the public or to the scientific community'."

(British Medical Journal,  
Vol.285, No.3, 1982, pp.638-39)

"Many people who are concerned in this country with public health aspects of alcoholism looked forward to the publication of this report with sharp expectation. Quite a few of those who are active in this field were at an earlier stage consulted by members of the Review Staff, and had commented on the keenness and intelligence of the questioning. There was very special interest in the benefits of what might be deemed an 'independent review': people from outside the usual specialist circle were taking a fresh and unbiased look at alcohol and alcoholism in society ... Here, we hoped, would be the sort of report for which we had all been waiting ... We are still waiting. The report has never been published.

'Mr. Soley asked the Prime Minister if she will publish the work of the Central Policy Review Staff on alcohol policy in the United Kingdom.

The Prime Minister: No.'

Thus the relevant parliamentary exchange as reported in Hansard - a matter of manifest health importance disposed of with one curtly negative word, and reasons for refusal to publish not stated."

(British Journal of Addiction,  
Vol.77, 1982, pp.113-17)

"The document has been leaked several times since completion in 1979 ... Since its most recent exposure in the Daily Mirror on 29th November (1982) it has become a major national issue ... While it is still classified as 'confidential' in this country, a version claiming to be a full facsimile ... was

openly published in April (1982) by the Sociologiska Institutionen at Stockholm University."

(Health Services Journal,  
24.12.1982, p.3)

## Around the Churches



# New bid to publish alcoholism report

TYNESIDE churchfolk are spearheading a new move to secure publication of a Parliamentary Commission report on alcoholism which — an embarrassing secret, perhaps? — is gathering dust in some Whitehall pigeon-hole.

When the last Parliament was dissolved, M.P.s were trying to have the report released under an early-day motion for which 100 Members' signatures are necessary.

One argument in the case for publication was that the gist of the report had already been aired unofficially in Sweden, so, why

not here? With dissolution, the demand automatically went by the board.

Now, with Mrs. Thatcher re-installed, that early-day motion idea is being revived; indeed, has taken fresh impetus from a conference on alcoholism which the Newcastle Methodist District's Social Responsibility Committee organised at Gateshead three weeks ago.

The delegates, including social and health workers, teachers and parents as well as churchfolk, were all urged to lobby their M.P.s again, demanding the report's publication.

One of the prime movers, the Rev. Brian Shackleton, of St. Mark's, Gateshead,

said: "This is not just an anti-alcohol move; nor a Methodist anti-drink thing which, as such, might only antagonise some M.P.s and others.

"It is simply an attempt to get all the facts in a vital public debate involving society as a whole."

Mrs. Jean Taylor, lay secretary of the Social Responsibility Committee said: "The suspicion is that the Government are not keen to publish the Commission report because of their vested interest in excise revenue from drink.

"Alcoholism on the other hand is a growth industry in this country. The human cost of it is shattering."

(Newcastle Chronicle,  
1st July, 1983)

The Bruun report agrees with statements made earlier in this chapter that the great majority of people use alcohol sensibly and in some ways to their benefit; however the costs of alcohol abuse in terms of loss of industrial productivity,



health care, crime and accidents are rising. Following the Road Safety Act of 1967, breath tests were introduced; however, throughout England and Wales the level of drink/driving offences was three times greater in 1978 than in 1967 (NECA, 1982).



The press, the other media, the various alcohol publications, the Brewers' Society magazine and many other sources provide statistics and recommendations about alcohol consumption and policy. The Bruun report (1982) states that in 1978, UK consumers spent £7½ billion on alcohol, approximately 8% of all consumer expenditure. (Some more recent statistics, quoted in the Brewers' Society magazine and in the press, see below, put the consumer cost at £12 million.)

## £12,000m SPENT ON ALCOHOL

By JOHN PETTY  
Commercial Correspondent  
GOVERNMENT statisticians have under-estimated spending on wines and spirits by about £400 million a year, it was claimed yesterday by the stock brokers, Wood Mackenzie, after a year-long study of the market.

"Drinkers spent well over £12,000 million on alcohol last year," said Michelle Proud, the analyst who led the research. "The Government will tell you over half of it went on beer, bought mostly in the pubs. But we have found that more of it went on spirits and wines than the official figures show."

The basis on which Government experts make their estimates is about to be changed. Customs and Excise figures are precise on what is drawn from bond, but they can hide a vast amount at the point of sale.

For instance, scotch costing about £7 a bottle in a supermarket may be sold at £20 a bottle in pubs when dispensed in individual nips.

### Top seller

Spending on whisky, the top-selling spirit, totalled £1,445 million last year with three-fifths of it sold in bars, said Wood Mackenzie. But spending on wine actually overtook whisky last year.

Cider sales are racing ahead, up from £90 million in 1976 to £262 million last year.

In spirits, the top 10 brands account for half the total sales. Brands selling more than a million cases a year were led by Bell's whisky at 2,650 cases, Teacher's whisky at 1,820,000, Smirnoff vodka at 1,760,000, Gordon's gin at 1,740,000, and the Famous Grouse scotch at 1,060,000 cases.

Tea remains the favourite drink at 167 litres per head a year, followed by beer at 111 litres, milk 65 litres and coffee 50 litres, but all are declining, said Wood Mackenzie.

Fizzy soft drinks take just over 35 litres per head a year, with other soft drinks at 375 litres and pure fruit juice at 95 litres.

Wine amounts to almost 8½ litres a head per year, of which more than 5 litres is light table wine. Cider totals about 4½ litres per head and spirits about 4 litres. The survey has been done as part of a new subscription-service to the trade and runs to 400 pages, including forecasts for the future.

(Daily Telegraph, June 14, 1983)

The favourite national social pastime appears to be going out for a drink. The Government has a large investment in this form of consumption, since in 1978, it brought in £2,000,000,000 in net revenue (See Fig. II.1, p. 84).

### Drink and Social Class

It is also interesting to consider how drinking habits and customs relate to social class in Britain.

"Surveys suggest that the taking of alcohol is widespread in our society. More than 90% of adults and over three-quarters of young people claim to have drunk or to drink.

... drinking at home declines across the social classes from three-quarters of social class I to one quarter of social class V ... While similar percentages of all social classes visit public houses to drink, consumption in clubs is more frequent among the working classes, and in restaurants and hotels among the middle classes ... "

(Reid, 1981, pp.276-77)

Roman (1974, p.121), mentions some factors less widely considered in the research literature and general conversation - the amount of privacy over which a person has territorial control, at home and at work, physical visibility to others, degree of independence of job performance - among others. One other factor which might be mentioned is the degree of likelihood of 'getting caught' at heavy drinking, that is the measure of probability of being noticed, being labelled, or having drinking activities affecting the lives of other people surrounding the drinker. An analysis of these factors leads him to the conclusion that "Successful deviant drinking is more likely as one's status in a work organisation rises ... one more opportunity structure wherein the rich have more chances and more freedom than the poor."

### Agencies and Departments

In central Government alone there are 16 departments with direct policy interests in alcohol production, sale and

consumption. To list a few:

Customs & Excise  
DHSS  
Employment  
Home Office  
Trade  
Transport  
Treasury and nine more with minor policy interests.

Locally, responsibilities in this area are held by the health and social service authorities, the police and the courts. The above refers to statutory agencies; the report further lists public organisations concerned with alcohol:

Alcohol Concern  
Alcoholics Anonymous (AA)  
Brewers' Society  
HEC  
Local councils on Alcoholism  
Medical Council on Alcoholism  
National Council on Alcoholism  
Temperance organisations and more.

#### The Problem in the North East of England

In 1978 the DHSS commissioned a survey to identify patterns of alcohol consumption in England and Wales. Two thousand adults were interviewed at home, using questionnaires, about their consumption of alcohol over the previous seven days. The DHSS was concerned because over the preceding twenty years there had been a steady increase in the number of people reported to be affected by problems related to excessive drinking.

According to the DHSS study, in 1978 the North ranked third, after London and the North West, in the following categories:

Death from liver cirrhosis  
Admission to mental hospitals with primary diagnosis of alcoholism  
Drunkenness convictions  
Proportion of people identified as heavy drinkers

According to statistics from the North East Council on Alcoholism (Wilson, 1982), the average weekly consumption of alcoholic drinks by drinkers in the North East is higher than anywhere in England and Wales; an interesting point is that beer accounts for 93% of this consumption, as compared with 66% of the total consumption in the South East and East Anglia.

Also, on each separate drinking occasion, men consume more in the North East than anywhere else in the country; on average 5.6 drinks per occasion. People tend to see themselves as lighter drinkers than they really are and, in the above-mentioned DHSS survey, most of the people identified by the survey as being heavy drinkers did not consider themselves heavy drinkers. (This label is defined by the DHSS and by the Royal College of Psychiatrists as drinking more than 50 units per week.) According to this definition, 18% of men and 2% of women in the North East are heavy drinkers.

The statistics below, from the Family Expenditure Survey (1981), show that families in the North spend more on alcohol than anywhere else in England except the Greater London area, and considerably more than the average for the UK.

#### REGIONAL EXPENDITURE

Expenditure of selected regions for the two-year period 1980-81

All households

	North	East Midlands	Greater London	United Kingdom
Average weekly household expenditure				
Alcoholic drink	6.47	4.89 (lowest)	(6.48)	5.71 (national average)

### Cultural and Historical Setting for Drinking in the North East

Statistics aside, there is a wealth of reference in fiction to the Northern Drinking Man. From A Place in England by Melvyn Bragg, we have this description of a Cumbrian Drinker:

"Dido would drink steadily from now until ten-thirty by which time he would have taken in about fifteen or sixteen pints of mild and bitter. There were many men who drank seven or eight pints every night of the week: some drank more: all drank more on Saturdays. Dido would take at least a dozen every night he came in which was most nights in winter and summer, fewer in spring and autumn."

and another extract from the same page, (p. 16) with a further insight about Dido:

"Joseph pulled himself a half of bitter, as much to make sure of its quality as to enjoy the drink. He drank so little nowadays. Yet, strangely, though he had been so much among beer - he still thought there was still in it something grand. Drunks, he had noticed, except stupid drunks who piddled out their feelings like bladderless pups, drunks were treated with respect even when they lost all control. And those who drank deeply like Dido - and held it, they had a position which they were conscious to maintain."

In Class, Culture and Community, Bill Williamson describes the life of his grandfather and the culture of a North Eastern pit village, Throckley in Northumberland, at the turn of the century. He states that drinking was the main escape route from working class routine for his grandfather and his friends; drinking was controlled, not boisterous, and (as in Bragg's description) it was important to be able to hold a large quantity of alcohol without becoming insensible.

Drinking was also highly ritualised, and the grandfather liked, when going to drink at the club, to dress up in his best clothes to

enhance his dignity. The grandmother supported her husband in this by keeping him smart for his drinking expeditions.

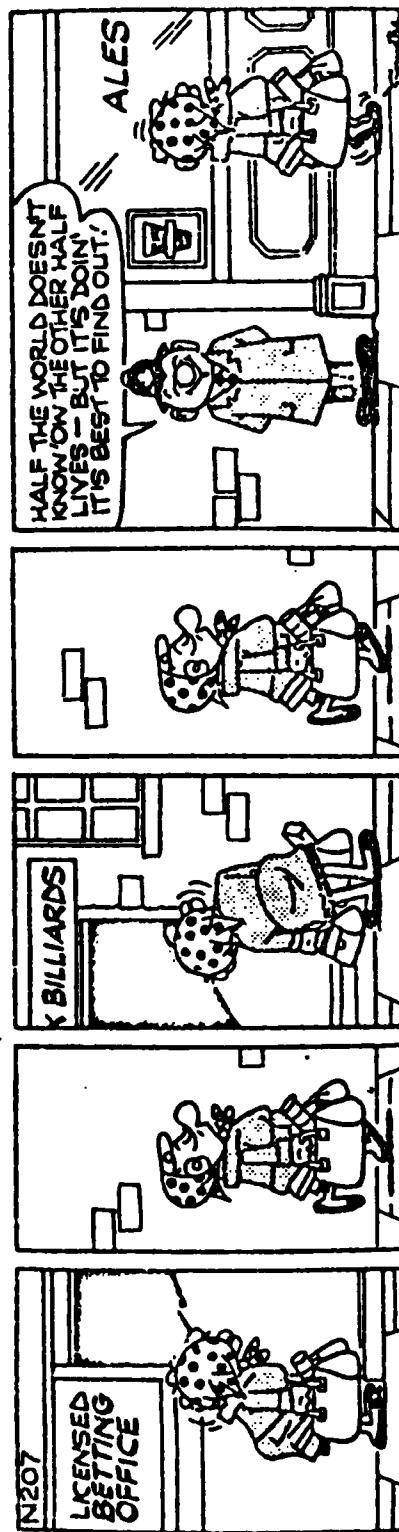
On a deeper level, Williamson talks about the attitudes formed by living in a Northern pit village. The work of the miners is dangerous; fatal accidents and serious illnesses are very common. Boys start work in the pits at the age of eleven or younger. Literature and films abound with images of the girls and women waiting at home, not breathing easily until the lads and men come back, or standing at the head of the pit waiting for news of the latest disaster. According to Williamson, the result of this type of work is a philosophy of hedonism and fatalism ... life is short, hazardous, unpredictable, and events are not in our control. Death is always close, and people are powerless against the whims of Fate; there is no use in worrying. Money is scarce, simple pleasures such as gardening, singing, and drinking with friends are all there is to look forward to.

Perhaps one could speculate that the same fatalistic attitudes attend two other industries which are traditional in the North; shipbuilding, which presents hazards and uncertainties about reliable employment, and fishing, which in Northern seas is another extremely dangerous and risky occupation.

Today another factor presents itself: the North East suffers the highest rate of Unemployment in the UK, with the one exception of Northern Ireland; this may further reduce a sense of security or responsibility. Just one example which will be considered later in depth in Chapter VII, is that of the young offenders in Northumberland. They talk of holding no hope of

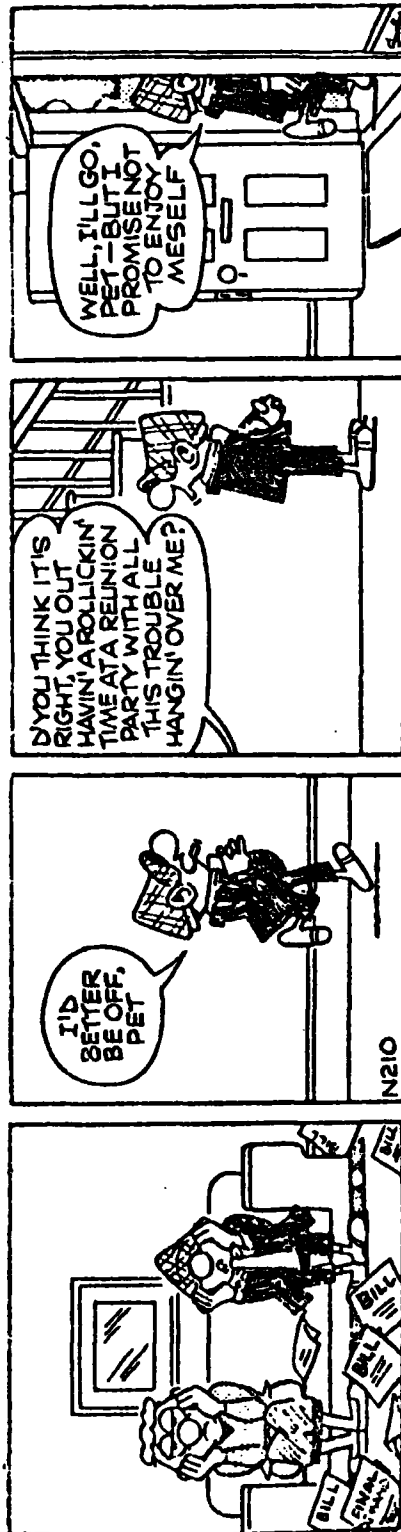
ever getting a job, of having nothing to do, and of having no money ... perhaps a fatalistic philosophy and a love for drinking could be considered appropriate and rational coping strategies in their circumstances.

Andy Capp is the archetypal Northern drinking man, so popular that fans from each different city claim that he originated there, saying: "Everyone knows he's from Newcastle!" - "Don't be daft, he's from Hartlepool!" His creator, Reg Smythe, describes him thus: "He always buys something for Flo (for Christmas) of course. She did rather well out of him last year - a new whitewash brush, a six pack of beer (the kind he drinks) and a Racing Form Annual, which he said he might borrow occasionally." (Smythe, 1982, p.1)

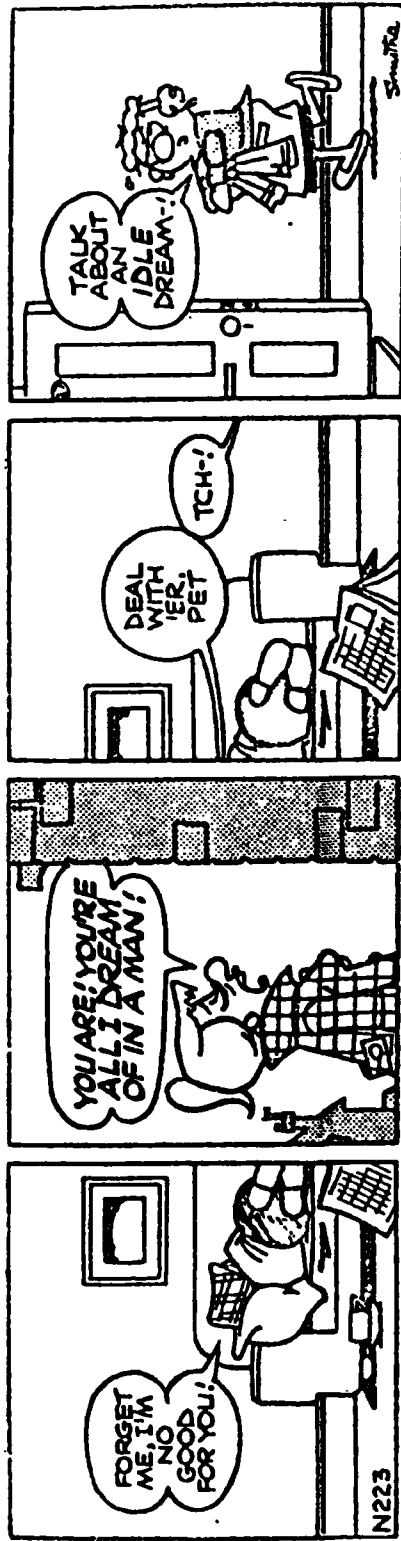




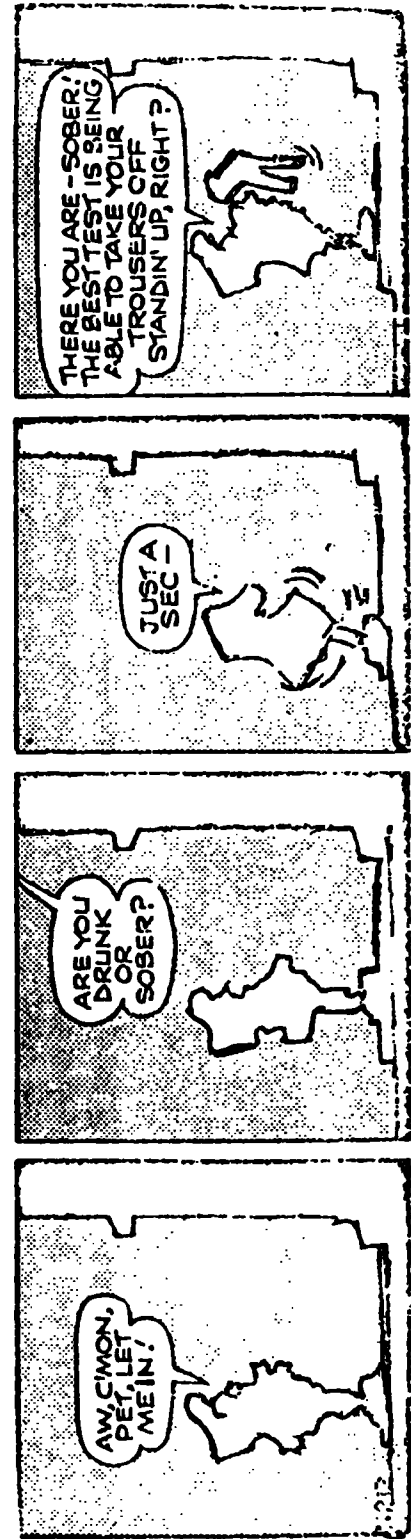
One could call him a Male Chauvinistic Pig - but he is fiercely loyal, in his way,  
to both his wife, and his girlfriend .....



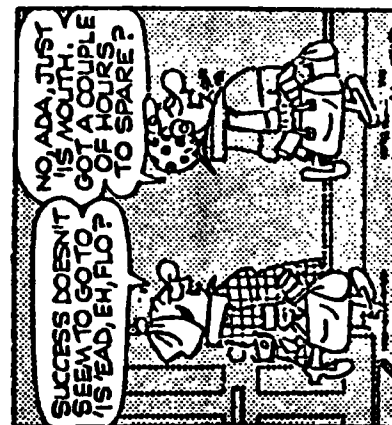
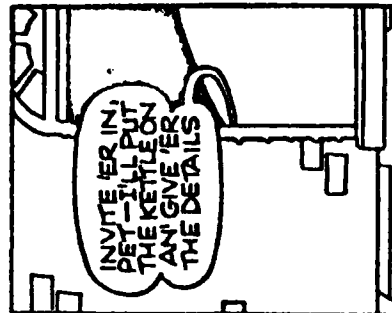
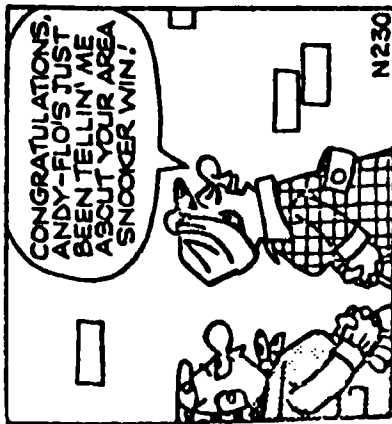
and get away with it!



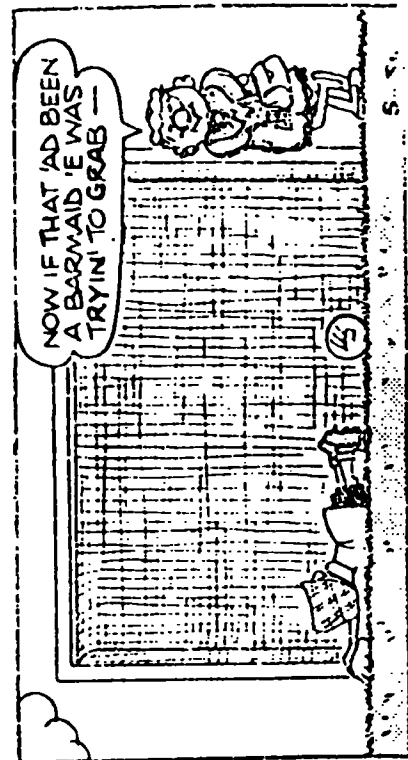
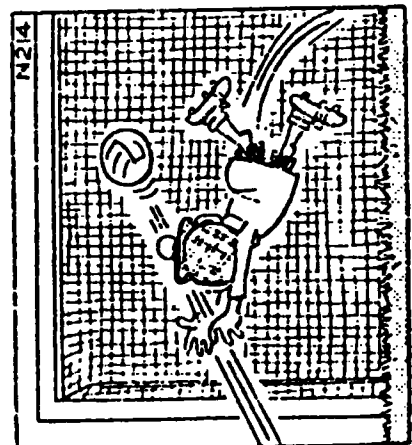
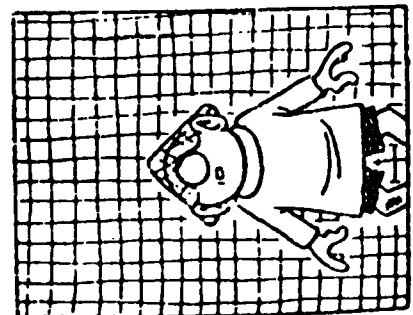
He can hold an enormous amount of beer and has a penchant for coming home late.



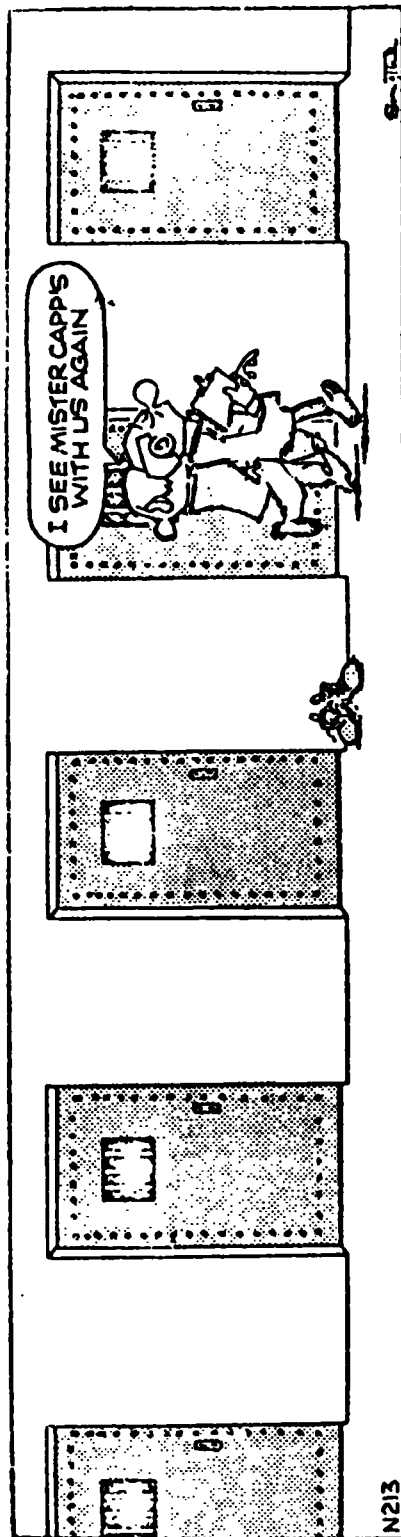
He's a Betting Man, a Racing Man, a Snooker Man, a Darts Man ..... and  
a great talker

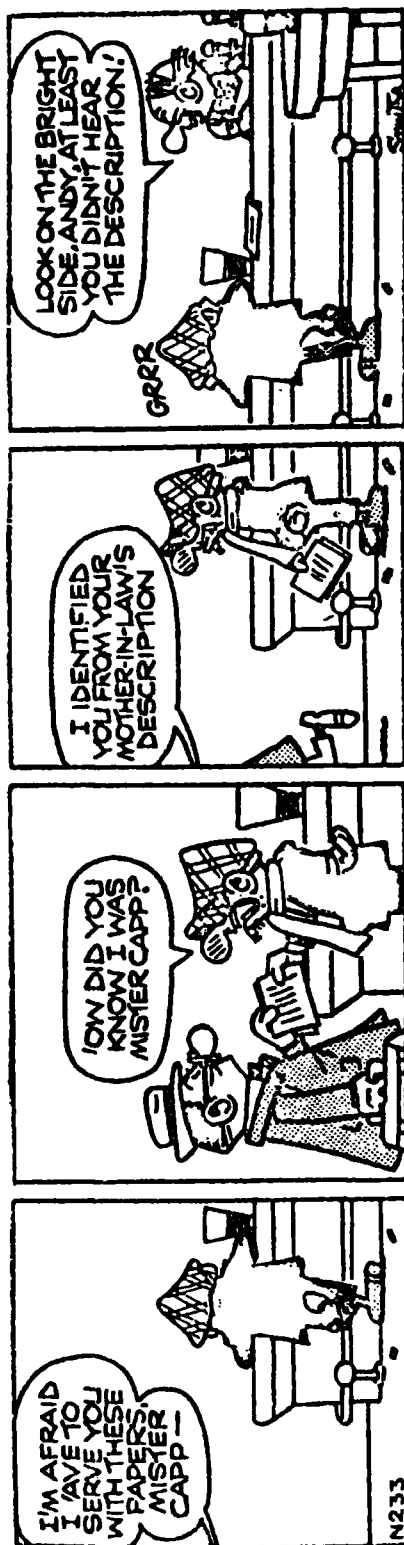


an amateur footballer .....



..... notorious with the police, the rent collector and other authority figures .....

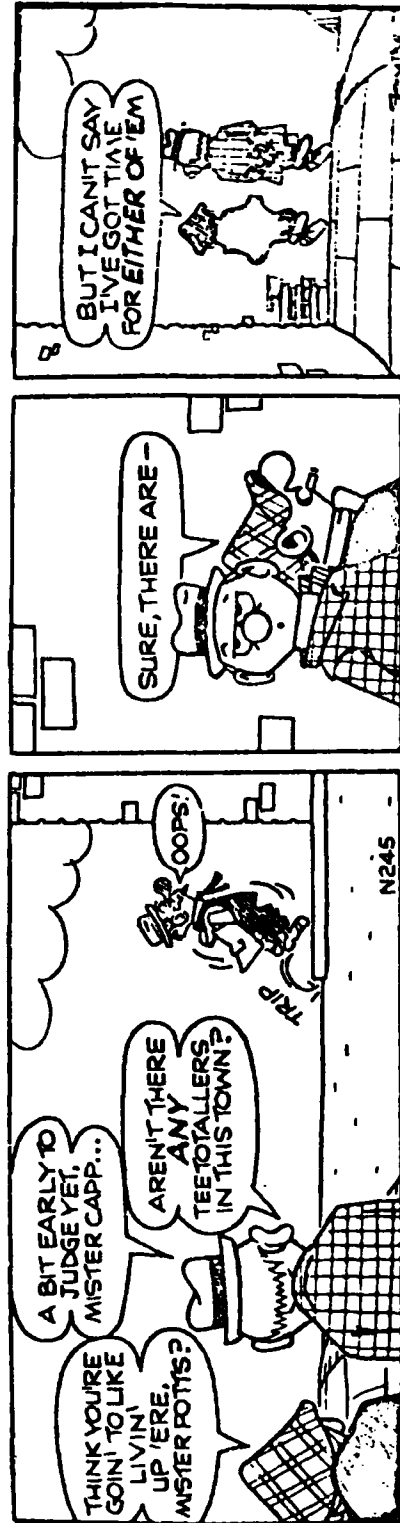




As for Flo, she's long-suffering ..... and she looks after him.



Above all, his dress (cloth cap) and his drinking and betting habits, (neatly represented in his punful name) are said by the proud citizens who reinforce his popularity year after year to place him firmly in the North East.



In a survey published as Workless (Marsden, 1982), interviewers spoke (informally) to a range of unemployed people across Great Britain; their comparisons of the North East to other areas may shed some light on this aspect of the problem. One feature that they noted (in common with Williamson) was the loyalty to the community, the disinclination to move elsewhere, no matter how severe the local unemployment situation might be. The social lives of Northeastern families seemed to comprise a set of overlapping and often interchangeable, networks of neighbours, fellow workers or non-workers, relatives, close family and friends. The members of these rich networks help each other, spend leisure time together and buy drinks for each other. The working men say to their workless mates, "Here, get yourself a jar." The wives support each other in doing the cleaning, shopping and other chores. Social life still centres on the working men's club. Williamson expands on the theme of working men's clubs, which were formed in 1862 by aristocratic philanthropists who wished to reform and increase the respectability of the working classes, keeping them away from the rowdy public houses by supplying a better type of entertainment. An unemployed middle-aged man in the Workless survey commented: "They take nearly £4,500 a week in that bar". Bar profits are distributed to club members (working or workless) in the form of free beer.

#### The Search for Causes

Since the cause of alcohol problems is, put simplistically, excessive drinking, the first question people tend to ask is:

"Why Do People Drink?" and the second question is "Why Do They Drink Too Much?"

Some of the reasons why people enjoy an alcoholic beverage have already been mentioned. An interesting experiment took place at one of the DCM courses in 1982; a group member suggested that we generate two lists, one about reasons for joining in sports of various kinds, and one about reasons for drinking. The two lists were almost exactly the same, the only difference being the fitness factor in sport, and consisted of the following reasons, among others:

time away from the home  
seeing my friends  
relaxing after work  
encouraging social contact and communication  
makes me feel better about myself  
and many more.

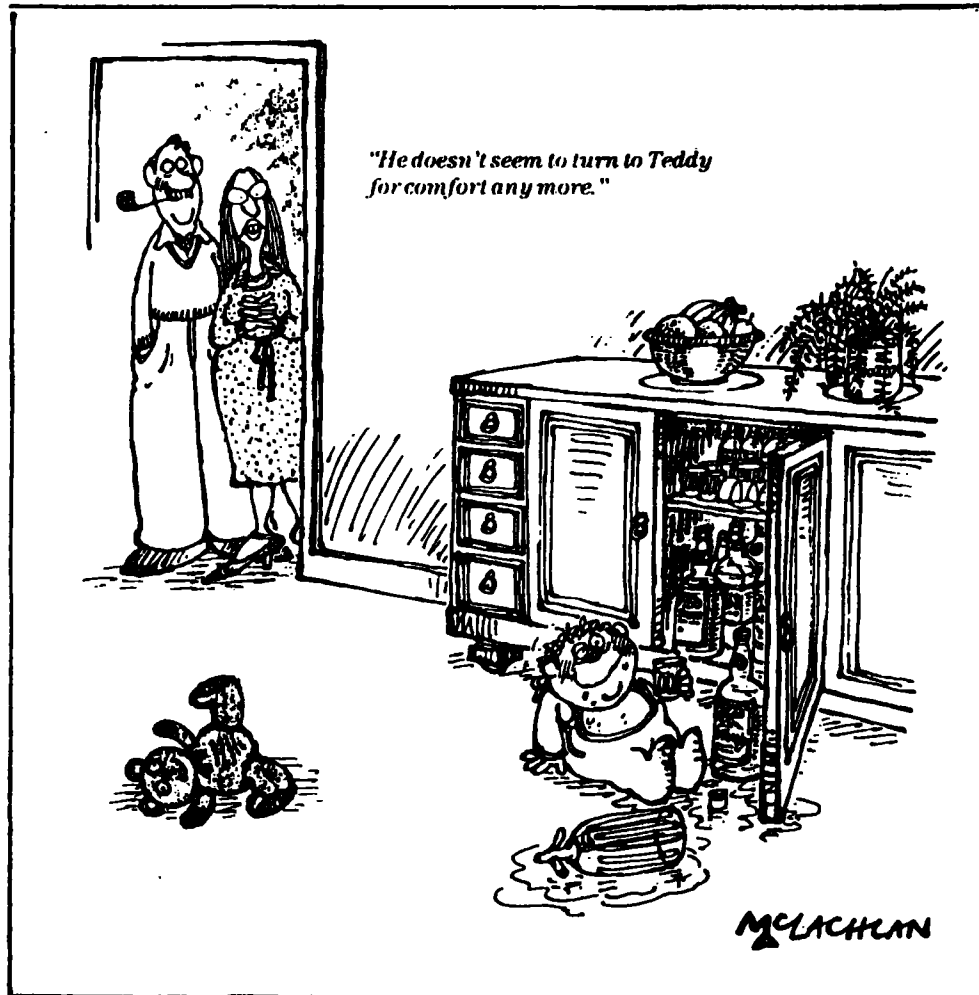
All these can be positive, and even beneficial, in moderation.

In the literature on alcohol there is a great deal of speculation about the reasons for the transition from such healthy conditions to the dangers of excess. One common factor seems to be that alcohol represents a response to the various kinds of stress which may affect an individual. An unsatisfactory home life or marriage, a lack of self-esteem, loneliness, depression, overwork, poor health, unemployment, poverty, emotional upset, and many hundreds more are listed as causes of excessive drinking. The problem with this approach is that when everything is listed as a cause, then nothing is.

Some sociologists do not think it worthwhile to see problems in terms of causality. In The Deviant Imagination (1975) Geoffrey Pearson pointed out, from his experience as a social worker, that there is "no immediate solution to social problems"



(nor an immediate cause). "The theory and research do not touch the clients' unhappiness."



Pearson further stated in his disoussion of deviance that "how and why men do other than they are supposed to do, and how other men think of this disorderly conduct is also a study of how things might be other than they are ... " He said it is a case of "cultural relativism; all men are, from some points of view 'deviant', but also from other points of view, 'normal'."

How did Andy Capp get to be the way he is? There is a structure of tradition which is the framework for Andy Capp and

for Bill Williamson's more respectable grandfather from Throckley; Andy has been slotted into this framework, and has made the standard cultural adaptations and used the standard coping strategies such as football, mildly criminal activities, (like avoiding the rent collector), political viewpoints, and family ties. From this viewpoint, class is like a mirror. In its reflection a man can recognise himself and others and the recognition is instant. Small clues - talk, dress, accent, gait - are all that is needed to recognise a much larger pattern. Us and Them can be sharply defined. Common experience, shared anxieties and hopes are at the base of class (Williamson, 1982, pp. 6 and 7).

These frameworks are also based on tradition, rather than on current causality; people who break away from the structure, who take an exit route into, say, higher education or upward mobility, are the exception.

One could name an enormous number of possible causes for the cultural framework that exists, and for its characteristics in today's society: the present government, unemployment, the weather in the North East, the closure of many of the local pits; then these factors would have to be traced back in turn, to their causes. Rather than attempting this possibly fruitless task, Williamson suggests, as do some other sociologists, that ... "To understand people from Throckley - or anywhere else - it is essential to grasp the totality of their way of life and the meanings which attach to their actions and to the social institutions which are the framework of those actions" (p. 9).

Saint Exupery's Little Prince visited a planet inhabited by

a drunkard.

"Why do you drink?" asked the Little Prince.

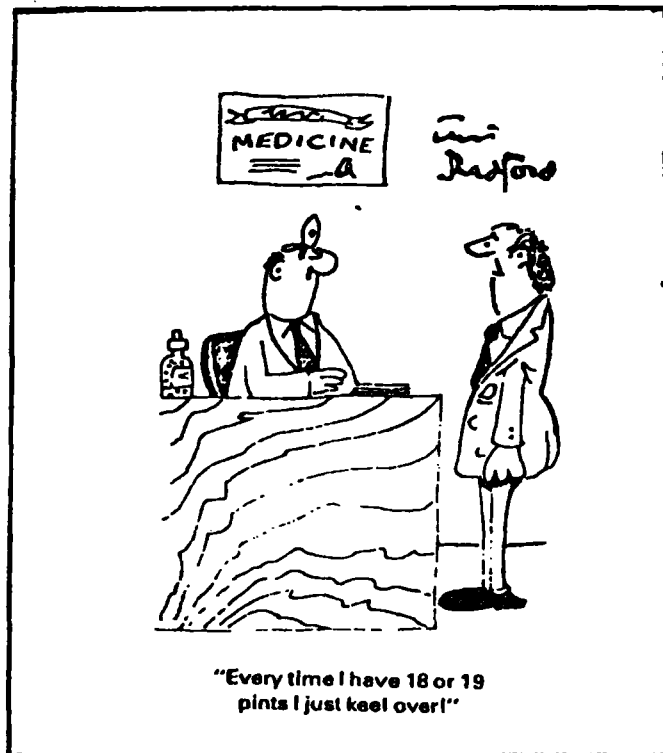
"To forget", answered the Drunkard.

"To forget What?"

"To forget that I am a Drunkard". .....

This is a very brief summary of very complex systems of thinking about why people drink. In the North East, pub life and club life are very popular forms of social intercourse; other places of entertainment, such as community centres, cinemas, theatres, and sports centres, frequently have bars available. A Geordie who was interviewed on 'Northern Life' (Tyne-Tees TV) during a programme about alcohol produced a sentiment we have heard many times during this project:

"Life wouldn't be worth living if I could not drink."



## Attitudes to the Misuse of Alcohol

Once again we are confronted with a debate in the literature; there are many distinct models for approaching alcohol abuse, and they fit on the continuum below:

<u>Medical Model</u>	<u>Holistic or Societal Model</u>
(AA Model)	(Health Education Model)

There are many choices in between, including:

sociological  
psychoanalytical  
psychological  
and behavioural models,

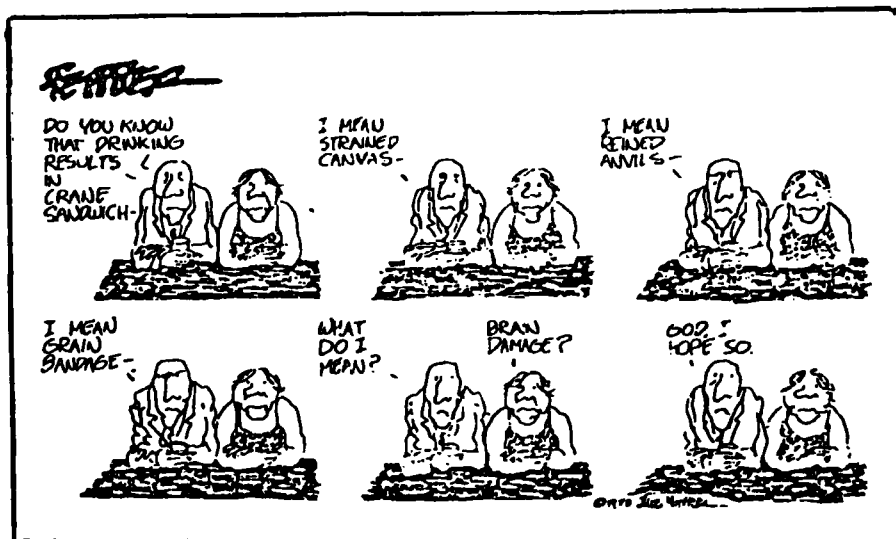
each of which includes features of both extremes on the continuum, so that they are points along the scale, but without a clear position on it.

It is not surprising that a medical model has been developed, nor that treatment has been the doctor's province; the negative effects on the body caused by alcohol misuse are horrific; in fact there is no part of the body that is excluded from harmful effect.

In a lecture at Newcastle's Freeman Hospital, Dr. Bernard Brown spoke of the medical aspects of alcohol (Brown, 14th June, 1983). He produced evidence to the effect that alcohol abuse contributes to, among others:

Bronchitis	Epilepsy
Various Carcinomas	Cerebella degeneration
Hepatitis	Pancreatitis
Cirrhosis of liver	Hypogonadism

Dr. Brown described the various ways in which, if the liver is damaged, as it is by prolonged heavy drinking, it cannot perform its usual function of filtering poison from the bloodstream, and these toxic substances can 'back up' in various parts of the body.



A common danger, but one not widely known to the public, is that of varices. These are swellings, similar to varicose veins in the leg, in which blood builds up; they can burst or have slow leaks. In Newcastle recently, according to Dr. Brown, a young man died when a varice on his navel burst as he was walking down the street, and he bled to death very quickly.

Psychiatric illnesses also were mentioned by Dr. Brown, including:

- Alcoholic dementia
- Delirium Tremens
- Korsakov's disease (permanent long-term memory defect)
- Depression

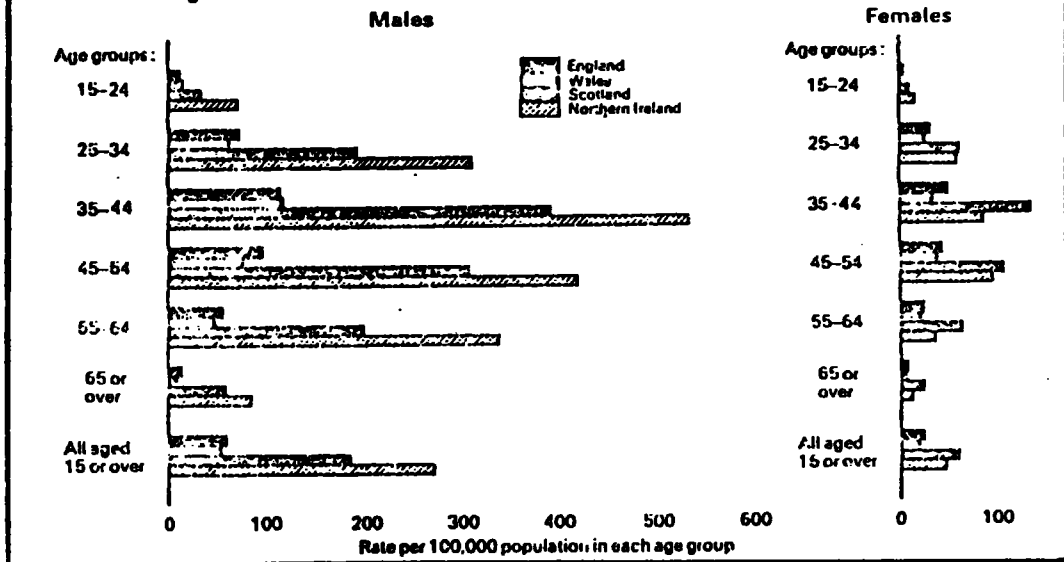
The following page from Social Trends shows the statistics for mental illness related to alcohol, with relative figures for gender and age groups.

## 7: HEALTH AND PERSONAL SOCIAL SERVICES

Some indications of the misuse of alcohol are shown in Chart 7.10. The rate of alcohol-related admissions to mental illness hospitals and units for men was more than twice that for women in 1981, compared with a ratio of 4 to 1 in 1971. For both sexes and in all countries, except for women in Wales, the rate was highest in 1981

in the 35 to 44 age group; in 1971 the rate had been highest in the 45 to 54 age group. In general the rates for women aged 15 or over tended to be higher in 1981 than in 1980, while those for men aged 15 or over tended to be lower.

**Chart 7.10 Alcohol misuse—admissions<sup>1</sup> to mental illness hospitals and units: by sex and age, 1981**



All admissions with a primary diagnosis of alcoholic psychosis, alcohol dependence syndrome, or non-dependent abuse of alcohol. (Social Trends, 1984)

Kendell (BMJ, 1982) has made the interesting speculation that "if ethanol (alcohol) was a newly synthesised substance, the Committee on Safety of Medicines would almost certainly not allow it to be administered to human beings".

Jellinek's work, The Disease Concept of Alcoholism (1960), is widely quoted in the literature. He classified the various species of 'alcoholism' in a system not relevant to describe in detail here. He said the definition of alcoholism as a disease is a highly controversial subject, and that is certainly borne out in

a search of the literature. Jellinek argues (p. 12):

"A disease is what the medical profession recognises as such. The fact that they are not able to explain the nature of a condition does not constitute proof that it is not an illness ... Physicians know what belongs in their realm ... the medical profession has officially accepted alcoholism as an illness, and through this fact alone alcoholism becomes an illness, whether a part of the lay public likes it or not, and even if a minority of the medical profession is disinclined to accept the idea."

The disease concept offers hope to professionals: a disease can be labelled and understood. To the alcoholic, this concept can provide sympathetic attitudes among friends and relatives, and a comforting belief that help must come from outside himself.

The Medical Model considers that there is a progressive disease called 'alcoholism'; some of the literature refers to it as "a chronic disease manifested by repeated ... drinking so as to cause injury to the drinker's health or his social or economic functioning" (Cameron, 1975). In other sources it is described as "an addiction to ethyl alcohol" (Keller, 1975). Freud (1925), in the psychoanalytical model, considers fixations or over-indulgence at the oral stage of childhood to be the underlying causes of excessive drinking, and the mood changes of the alcoholic as representing regression to childhood. The World Health Organisation's Expert Committee described it in 1952 as a form of deviance from the social norms of the community, and later, in a further report in 1974, called it a state of dependence or addiction.

Depending on the degree of optimism expressed by the person writing and his/her vested interests, it is variously described as

"untreatable" or "treatable only by total abstinence". The American Medical Association, not surprisingly, considered it a disease of epidemic proportions (Davies, 1979).

When considering the Medical Model, it seems necessary to include the approach used by Alcoholics Anonymous (AA), an organisation founded in America in 1935, which currently has branches throughout the UK and Europe. Alcoholism is seen by AA as a disease and total abstinence is put forward as the only cure; the person who is ill with this disease is supported by others who have been 'cured', by family members who are treated along with him, and by the Christian-based tenet of the organisation; "the path to abstinence is spiritual growth" (Seixas, 1982).

In searching through the literature, one notices that the proponents of the different models tend to be very vehement in upholding their views, and ruling out other approaches. Furthermore, each one refers to his perspective as if it were indisputable fact, so that the various contributors to the debate are flatly contradicting each other, leaving the searcher wandering back and forth along the continuum. The topic is extremely controversial, and emotive; there seems to be no consensus, nor is one likely in the near future because professional empires are at stake.

What the two ends of the continuum in the literature have in common is an agreement that the disease or problem comprises many associated problems and is very resistant to change. Further, they seem to agree that the alcoholic is not a criminal and so deserves attention rather than punishment (Cameron, 1975). But, as Fajardo states (1975), "There is no agreement in the scientific world about the phenomenon known as alcoholism, 'drinking problem', chemical



dependency, or alcohol addiction ... The United States Supreme Court determined ... that the disease label was still open to scientific question." Once again the deciding factors seem to be attitude, experience, and preference on the part of professionals.

Moving over for a view from the holistic end of the continuum, Dr. Anthony Thorley, Consultant Psychiatrist and Director of Parkwood House, the regional Alcohol and Drug Clinic for the North East, has written (Thorley, 1981, p. 2):

"It is no longer useful to consider alcoholism as a single disease entity with a well-defined prognosis. The inadequacy of a narrow view of alcoholism has been reflected in the medical profession's failure to provide effective treatment. It is more effective to develop the less dogmatically constrained concept of problem drinking ... "

Dr. Claude Steiner, who is an American Psychotherapist and author, has argued (1979, p. 27):

"If alcoholism is not a disease, then what is it? I believe that the simplest and yet most valid definition of alcoholism is that it is a very bad habit ... Not all alcoholics are the same, and they become alcoholic in different ways and for different reasons."

Thomas Szasz, in an article entitled "Bad Habits are not Diseases", (1972) makes some stringent points against the Medical Model, which have been summarised below:

- "A. Every person has the ability to injure or kill himself; this represents freedom of action. In a free society this ought not to be considered a crime or a disease, although it may be disapproved of or considered immoral.
- B. Every person is also capable of injuring others, under the influence of alcohol or not. He ought not to be free to do this, nor to disavow responsibility for his actions on the grounds of illness.
- C. It is one thing to say that a person is not

responsible for being an alcoholic - this implies that he should not be punished for his habit. It is another proposition to say that he is not responsible for the 'interpersonal, occupational, economic and legal consequences of his actions; this would give the drinker an excuse for injuring others ... Drinking to excess may cause illness, but in itself is not a disease. Excessive drinking is a habit ... " (p. 76)

Another argument for a broader model is that a plan of action often needs to include not only the drinker but his or her family to ensure a greater chance of success, since they are usually significant factors in the behaviour patterns of the problem drinker.

Furthermore, the doctor is only one source of help; the problem drinker may require assistance in finding coping strategies other than drink. He may need help from a social worker, a counsellor, or a psychologist.

Many workers in the alcohol field recommend a very broad-based approach:

"What is important is a counselling approach that sustains crisis-level anxiety with respect to the drinking, but which reduces anxiety and fosters hope with respect to finding alternative, less self-defeating ways of coping with life's problems."  
(Finlay, 1979, p. 61)

"In recent years the walls of the disease theory of alcoholism have been collapsing all around" (Heather and Robertson, 1981, p.1). These two Scottish doctors argued against the disease concept on the grounds that the condition of alcoholism is reversible, that people have been known to resume normal drinking.

"Thus alcoholism does not betoken an irreversible disease, but a reversible behavioural disorder ... Therefore, in our view, continued support for the disease perspective can only retard the development in theory and research of new and improved ways of changing the drinking behaviour of those who so request."

And again, R.D. Kendell (1979, 1.21) states,  
"Unfortunately, our new knowledge is making it increasingly clear that most of the assumptions of the 'disease model' are unjustified and act as a barrier to a more intelligent and effective approach to the problem." (This is in spite of his acknowledgement, earlier in the article, that the model had the benefits of removing blame and punishment from the alcoholic, and creating more humane public attitudes.)

The HEC, the funding body for this project, supports the societal model end of the continuum. Although alcoholism was formerly thought of by HEC as a disease, now it is seen to have many dimensions. It is conceptualised as being at the extreme end of the drinking continuum, so that it arises out of normal drinking, rather than being a separate entity (Grant and Gwinner, 1979). This stance allows the HEC to address itself to all drinkers, not just those with problems.

This approach also reflects a general trend in the literature. Medical, legal and social opinions and attitudes about alcohol have definitely, if slowly, been changing over the last few decades. Essentially the change involves a lessening of the judgmental, critical, moralistic frowning upon the alcoholic and the recognition that the alcoholic can be helped with various kinds of attention to the social and emotional aspects of his/her dependency. Whether the alcoholic is seen as suffering from a disease, an addiction or a drinking problem, there is a much more sympathetic

attitude in general toward the person's plight (Kaplan and Sadock, 1975).

### Political Issues Surrounding Alcohol

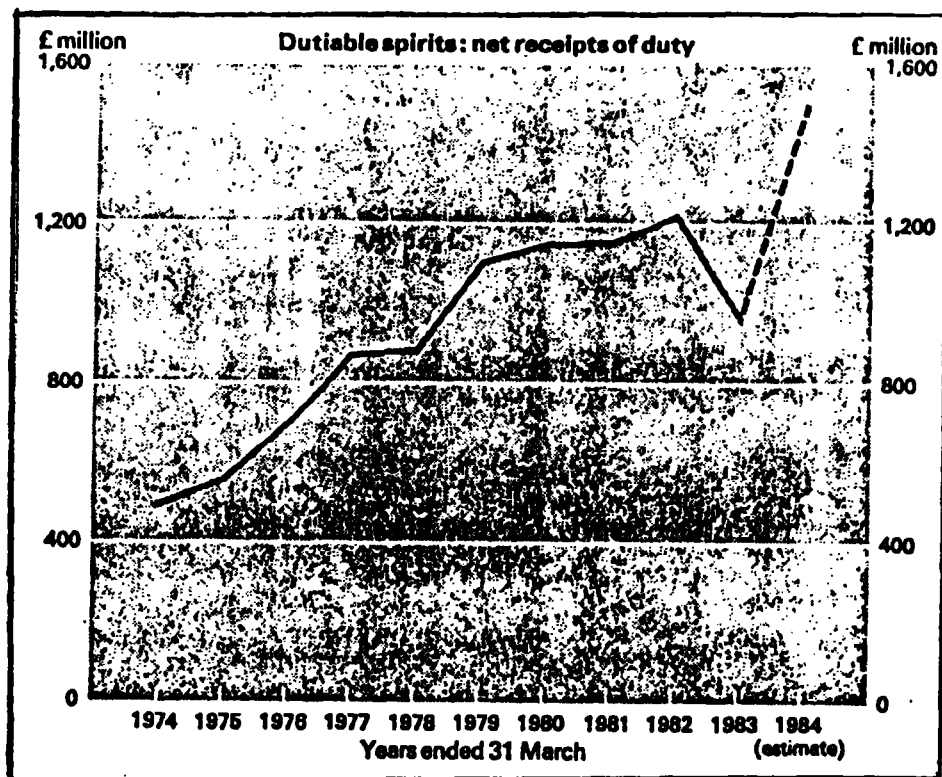
If it is true that a generally more sympathetic attitude towards people with alcohol problems exists, then we must briefly consider some political issues in order to discover what prevents effective measures being taken against alcohol abuse.

Any Government is pulled in many different directions by the interests and demands put upon it by different groups. Until the pressures to do something effective about alcohol abuse are greater than the pressures not to do something, then it is easier to maintain the status quo.

This is illustrated by a consideration of the economics of alcohol mentioned earlier in this chapter. Revenue from alcohol and employment in drink-related industries, coupled with the strong lobby of the drinks industry in Parliament, are overwhelmingly aligned against positive action. (See Fig. II.1, p. 84.)

(Source: H.M. Customs and Excise and Brewers' Society)

(a) The amount of VAT is estimated from the total expenditure on each of these drinks, as given in Tables E1 and E2.  
(b) VAT on Cider and Perry is included within the VAT figure for Wine.



On the other hand, there is the cost:

#### Problems related to Drinking (Summarised)

Alcohol misuse is estimated as costing the country between £500 million and £700 million a year (at November 1977 prices). This cost includes:

1. Loss of output by employees due to sickness, absenteeism, reduced efficiency at work, unemployment and premature death.
2. Cost of providing Health and Social Services related to illness, child abuse and neglect, marital disharmony, where alcohol is a factor.
3. Cost of accidents including road traffic accidents, home accidents and industrial accidents where alcohol is involved.
4. Cost of judiciary, probation and prison services related to drunkenness, offences, drink/driving offences and other criminal offences where alcohol is a factor.

(DHSS, 1978)

Compare the revenues, and the social costs of alcohol abuse, with the expenditure on preventive measures in the UK in 1979:

National Health Education Campaign on Alcohol	£17,600
Don't Drink and Drive Campaign	£1,317,800

This reflects the overall situation that economic considerations appear to be given more weight by the Government than health and social considerations.

However, the tax revenue from alcohol is a powerful incentive to any Government to continue with present policies. The force of public opinion and popular mythology also seems to support a do-nothing policy:

"The working man must have his drink."

Some of our sample have speculated that it may be useful to the Government to have the public remain unaware of the extent of damage caused by alcohol. Otherwise one of the means of social control would be removed. The physiological effects of alcohol in impairing judgment mean that a populace which is 'under the influence' is not likely to be taking informed political action. This may apply equally to trade unions as to the Government, in that they also may find it advantageous not to promote awareness in their members. In the North East in the past the unions have not been active in promoting industrial alcohol policies. In fact such policies seem to be notable by their almost complete absence.

In contrast to the powerful, well-informed, well-organised forces of the drinks industry, we have the relatively weak and disorganised lobby for change represented by the educators, researchers and treatment-orientated professionals. This disarray

is further complicated by the fact that the agencies for change do not agree on a common philosophy or approach. The temperance and total abstinence organisations are not usually supported by the above-mentioned professionals, who espouse a moderate 'sensible drinking' approach, although some doctors do believe that total abstinence is the only cure for alcoholism. The move away from the medical model and thus from this form of treatment has already been noted. The funders of this project dispute the medical model and support an informed public attitude towards drink as well as responsible Government action. But, as an expert in alcoholic education, (one of our sample) remarked at a recent interview: "We are up against very clever, powerful political people who have much more experience in lobbying than we do."

A more subtle aspect of this situation is that health education is often used in such a way that the current Government at any given time can be publicly seen to be taking a great interest and positive action. Thus 'drop in the bucket' funds are provided, for instance, for this research project (£38,000). The project is producing ideas for future training and preventive measures which will undoubtedly be costly. Whatever government is in power is likely to say that it can not afford such programmes and at the same time offload the blame for lack of progress onto the health education agencies. Alcohol education can thus be used as a scapegoat for failure by the Government to take any real positive action towards developing a national alcohol policy.

In the face of all these complex issues, regional and national alcohol field workers often get the feeling that "Nobody Up There" cares that much about public health; this feeling has been voiced



in many of the interviews held during this project. According to one health education professional, the major brewers are a strong lobby to any government, because of the revenue they produce, and the Brewers' Society puts forward the view that it would be wrong to limit the pleasures of the working man.

However, my own search through the Brewers' Society literature has not uncovered such statements; the society, as far as I can see, is pushing for companies to educate staff and workers about alcohol, and to encourage sensible drinking practices, and also workable management policies to deal with drinking problems. In fact, the Brewers' Society literature bears close resemblance to some sections of DCM. The Society is a trade association which makes annual grants of over £40,000 to the National, Medical and Scottish Councils on Alcoholism for purposes of research and education about the effects of alcohol, as well as other grants to academic and medical researchers. It is difficult to determine whether this is just window-dressing to impress the alcohol education factions or whether it represents a sincere effort on the part of the Brewers to reduce the dangers of alcohol misuse.

As Richard Smith points out (1982, p. 1394):

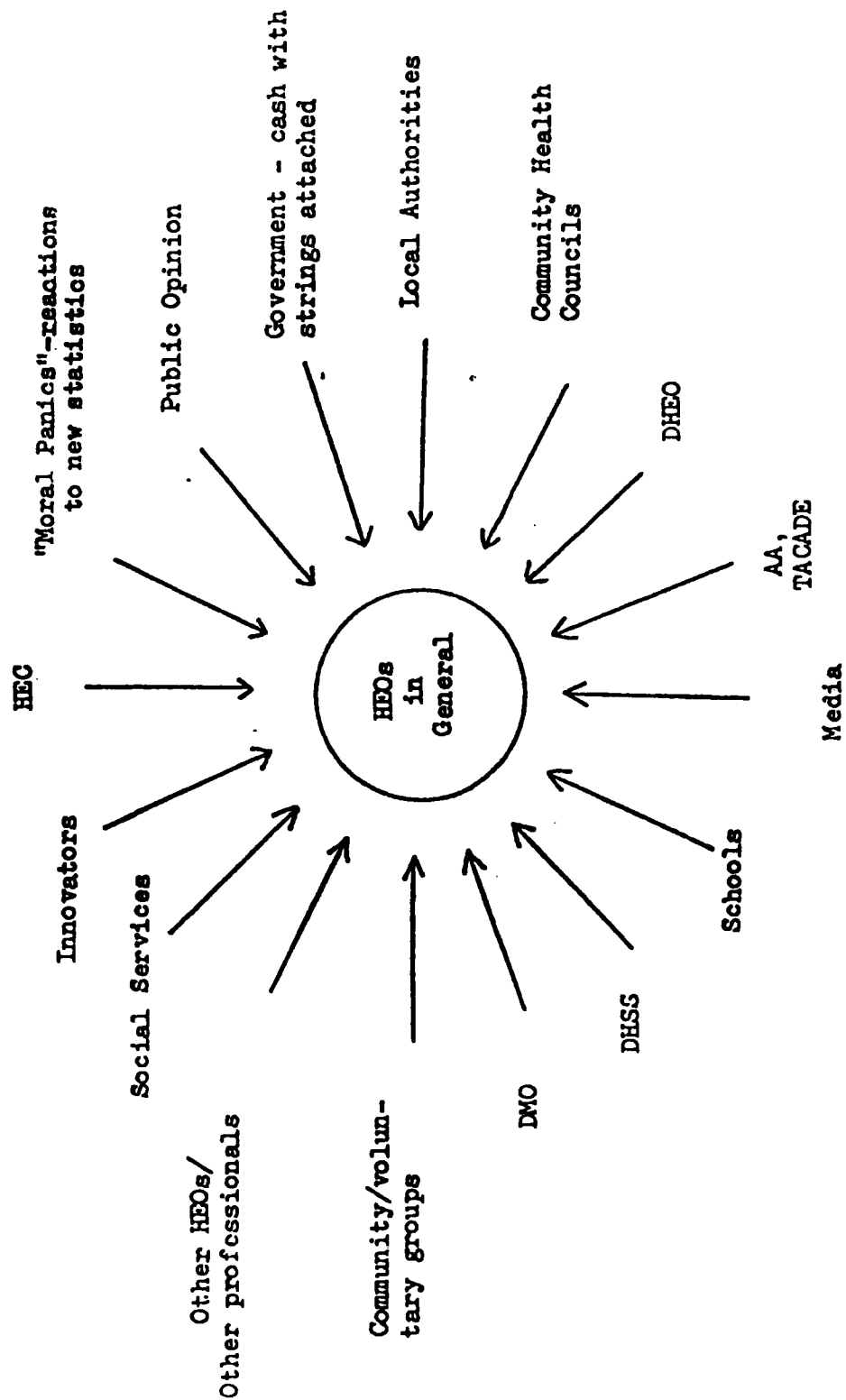
"Just as with action on smoking, what is really needed is a Government committed to reducing the harm and which acts in a co-ordinated way to achieve that end. But political action will be neither easy nor a panacea. There is formidable opposition to any political measures designed to cut consumption."

Richard Smith added that "The Government is piggy in the middle between the might of the drinks trade and the relative ineffectiveness of the present anti-alcohol lobby in the Government".

A look at the following charts, which emanated from discussions

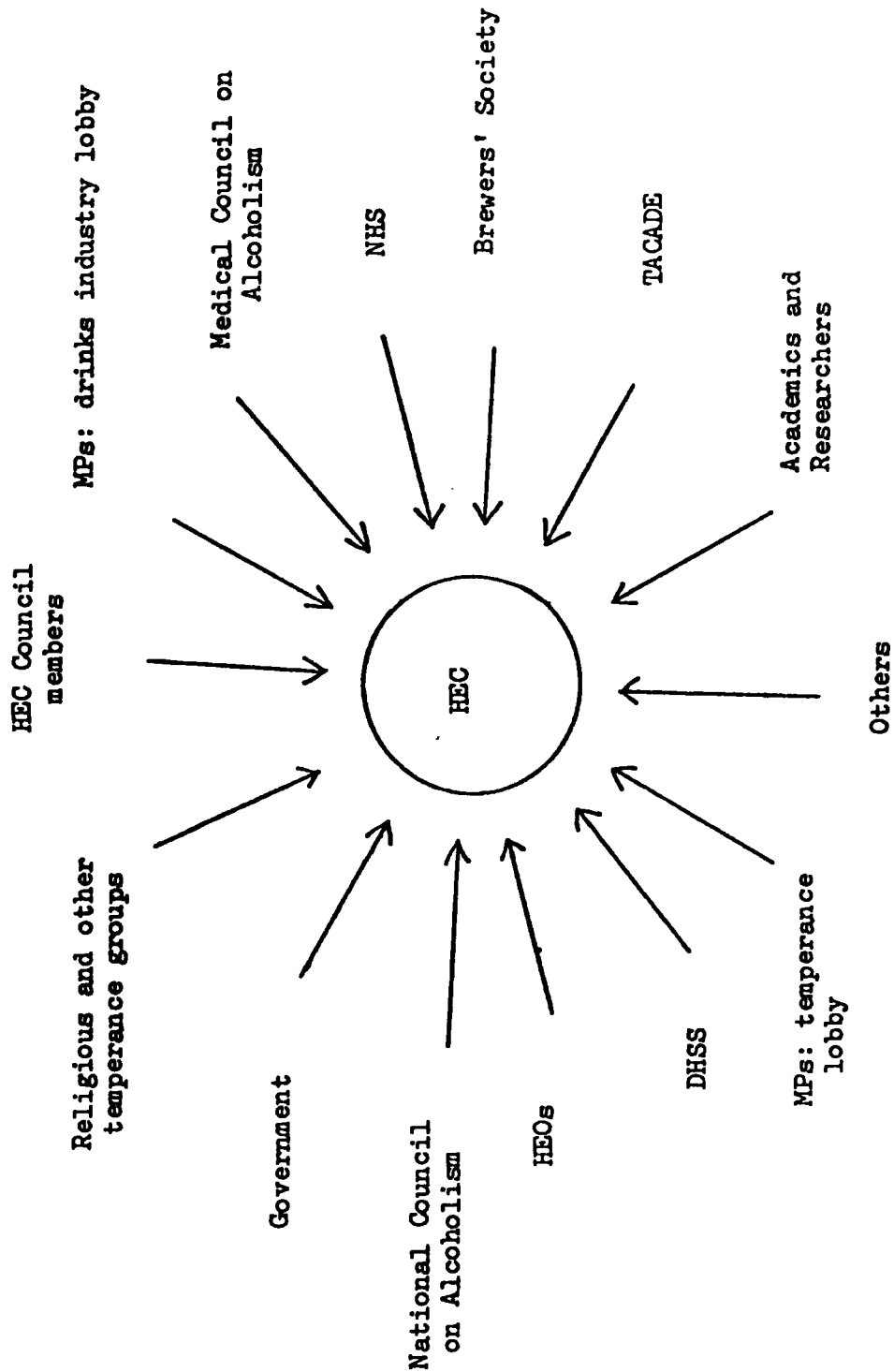
Possible Sources of Pressure on HEOs  
(to work on Alcohol Education, or not)

(Fig. II.ii)



Possible Sources of Pressure  
on HEC

Fig. II.111



with HEOs on various occasions, will give some clues as to how they themselves see the possible sources of pressure to make things happen or not happen in this struggle. (See Figs. II.ii and II.iii, pp. 89 and 90).

#### Some Conclusions about Positive Change

The Minister of Health, in 1977, set up a body called the Advisory Committee on Alcoholism, which published a report known as 'The Kessel Report', and a sub-group on Prevention also published some conclusions and recommendations. This sub-group took the view that there was no reason to interfere with those who enjoy moderate drinking without harming themselves or others in any way and pointed out that an attempt to do so in America (Prohibition) met with disastrous effects.

The sub-group stated that among the most effective means of coping with the problem would be to work to influence social attitudes towards alcohol, and this they deemed to be

"a prime task for health education ...  
Such education should make the case for moderation, insist on the individual's right to decide for himself and not to be swayed into untoward drinking patterns by the influence of others."

(Trethowen, 1977, p. 96)

To support this view, and not to undermine their own suggestions, they further recommend that licensing laws should not be extended, nor drinking ages be lowered, and that the present laws should be better enforced. Industrial policies should be developed and monitored. Major health education programmes should be directed at adults and young people, aimed at encouraging moderate

drinking, discouraging harmful and excessive drinking habits, and promoting early identification of drink problems. The public should be given more information, including accurate statistics and knowledge about the cost of alcohol abuse to society so that it can reach a realistic position for voting on licence or tax reforms. The Government should encourage this kind of education, and support it by maintaining existing controls on prices and availability of alcohol.

To refer back to the Swedish report, their recommendations were very similar to those of the sub-group (in fact the sub-group is one of the sources of their report), but there are some further ideas worth mentioning here.

The Government ought to be concerned about the trends in misuse, and there are some areas in which it could act immediately. The Government would first have to realise and then publicly admit that the cost to this country of alcohol abuse cannot be measured in monetary terms alone and that the revenue from alcohol is heavily outweighed by the health costs (Braun, 1981).

The report suggests that the action should balance social and economic interests and should use the greatest care and caution, as well as sustained effort, to bring about change in public attitudes about alcohol.

The Government should "adopt as an objective that per capita consumption of alcohol in the UK should not increase"; it should seek to formulate all its policies on alcohol so as to reach that objective.

Specifically addressing itself to Health Education, the report points out that this is not an easy option, and that it

cannot work on its own, but must be backed with other associated measures. There is no one right solution, nor with such a complex problem, any possibility of a quick one. Education will have to be part of a very long-term strategy for alleviating the alcohol-related problems of this society; however, it is seen to be an integral part of such an effort. More thought should be given to alcohol education so that it has greater coherence and purpose; the Government should clarify how they are going to co-ordinate and rationalise spending on all existing projects.

Since this project is primarily concerned with alcohol education, which places it on the prevention side of the problem, we will give only brief mention here to responses to drinking problems which already exist. The Swedish Report indicated that services cannot now cope with the amount of treatment needed, and will never be able to. Needs of criminal offenders and others with drinking problems are not being met; training for staff in these services is under-developed. People with drink problems can be helped by a wide range of people, including doctors, psychiatrists, social workers, probation officers, police, the courts; the spectrum of facilities for accomplishing this must be increased. Industry should develop suitable and effective policies regarding the use of alcohol by employees.

Having visited several alcohol clinics in America and Britain, I have noted that the present trend seems to include a many-faceted assault on the complex problems of an alcohol abuser. For example, Parkwood House in Newcastle, which seems to be generally regarded as a model clinic, uses a team of workers including psychiatrists, a consultant psychiatrist, a nurse training officer,

## When industry can help fight alcoholism

**T**HE second World Conference on Alcoholism and other Addictions opens in London tomorrow, and on Thursday industrial programmes are to be discussed. "While on the one hand alcoholism continues to increase all over the world—not just in the West—one encouraging factor is that there is less stigma attached to the illness," says Dr Max Glatt, one of the speakers at the conference. "This means that problem drinkers are coming forward for help and treatment at earlier stages, which is vitally important."

Industry could play its part in the prevention of alcoholism, he says, by being more aware of the problem. Employers could encourage problem drinkers among their staff to come forward voluntarily for help, and they could keep their jobs open for them. The illness should be diagnosed at the second "prodromal" phase, when someone has memory lapses or when it becomes second nature to arrange appointments so that they "don't clash with opening times."

To curb the alarming rise in drinking among increasingly

younger age groups, Dr Glatt advocates counter-action to advertising which glamourises alcohol. "Alcohol has always been part and parcel of the social fabric of our society, and has become even more so. But it has also become a domesticated drug which affects the central nervous system. We should have objective education programmes about this."

(Sunday Telegraph, February 27, 1983)

an occupational therapist, a social worker and an array of other nurses and doctors. Staff and clients explore together the client's case history, so as to become familiar with the family, plus social and personal factors which have contributed to the problem. The client is encouraged to be very active in his/her own process, and all goals are negotiated with, and agreed on, by the patient. The assessment continues throughout the treatment and includes medical examinations. The approach does not rely on any single method, but includes a variety of behavioural, therapeutic, groupwork, counselling, social work and medical techniques. In-patient and out-patient treatments are used where needed, as well as day care.

In America the multi-pronged attack on the problem is also used, and one of the clinics I visited (Highland Park Hospital, Highland Park, Illinois) was in the process of building an ultra-modern alcohol clinic which would include the latest in medical, therapeutic, counselling, social work and recreational facilities for patients who would either visit regularly or live in the hospital. Education about alcohol is carried out by all members of staff in both of these clinics; they have already been receiving and updating their own training as alcohol educators, and the Drinking Choices Manual has been in use in both places.

#### Some Concluding Remarks

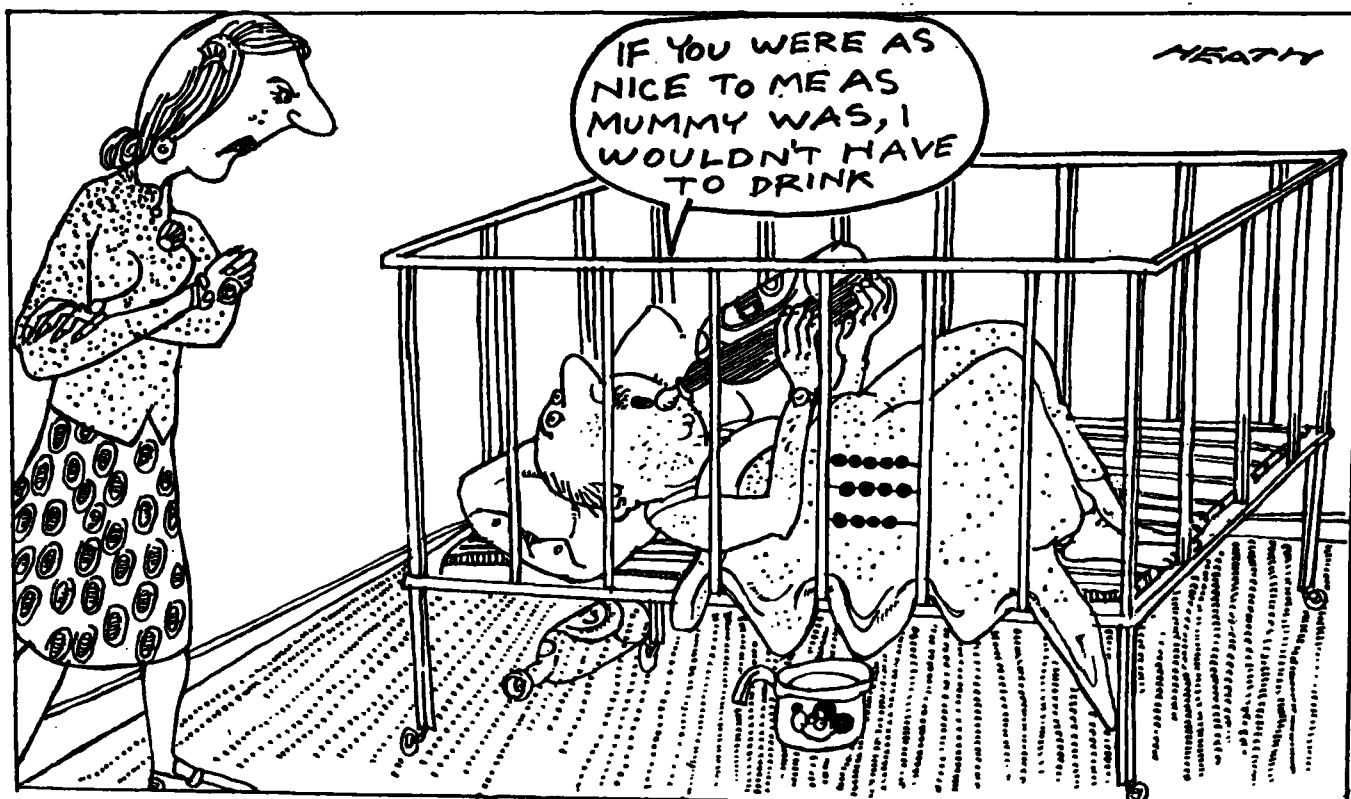
An article which has had a great deal of mention in the literature, 'Alcoholism: a Medical or a Political Problem?' by R.E. Kendell (British Medical Journal, Vol. 284, 1979, p. 52) sums up the issues so effectively that an extended quote is



being included here:

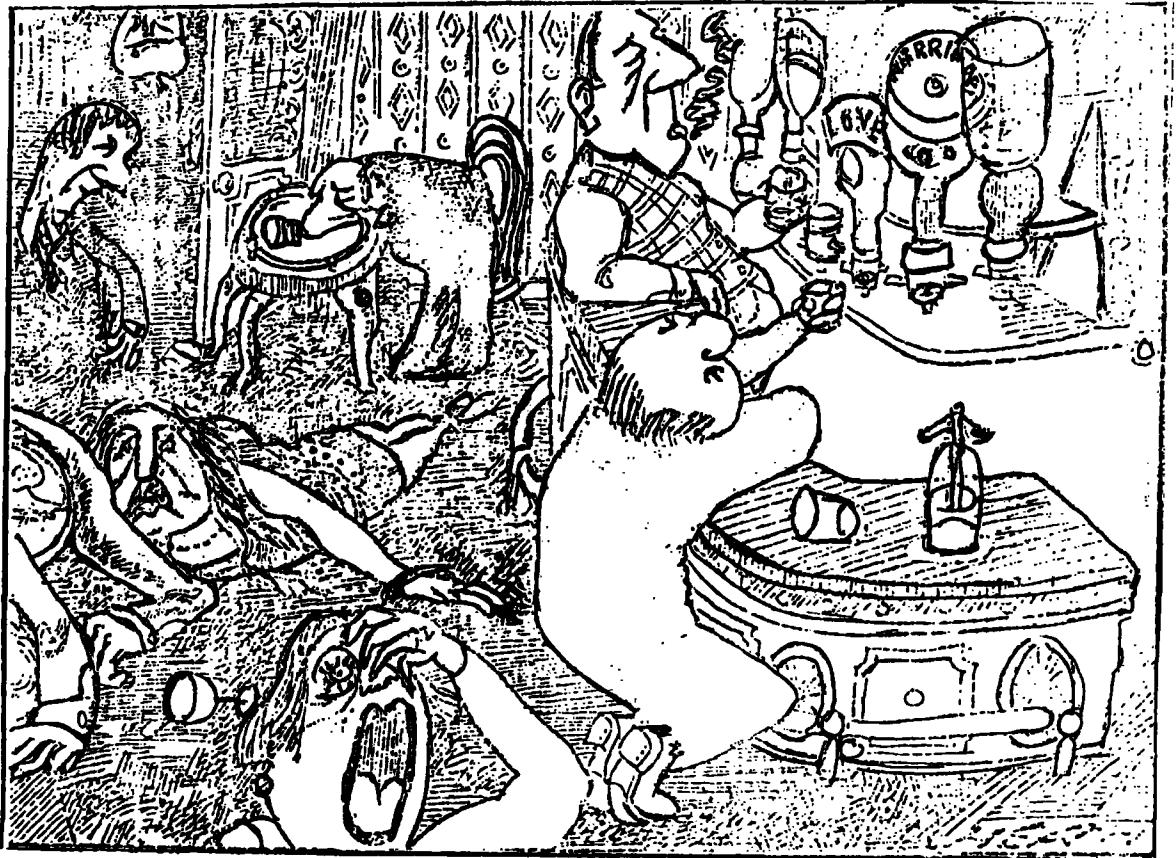
"The medical treatment of alcoholism is of limited efficacy, as is the treatment of most of its secondary consequences. The same is probably true of the counselling methods used by social workers and voluntary organisations. Above all, there is no realistic prospect of any of the caring professions, individually or corporately, being able to cope effectively with the disability and sufferings caused by alcohol abuse in the foreseeable future, even if the human and material resources available to them were to be greatly increased.

It is precisely because alcohol gives so much pleasure to so many people as well as causing so much harm that any decision to restrict consumption has to be a political one. Only society as a whole can decide how much damage and suffering it is prepared to tolerate for the sake of how much enjoyment. But the appropriate decision can be made only in the light of an adequate knowledge of the facts, and a major government-financed campaign lasting for a decade or more will be needed to achieve this: to convince the man in the street that it is dangerous to drink more than, say, 80 g of alcohol a day and to teach him how many grams there are in a pint of beer or a double whisky."



But in spite of these difficulties, it would be wrong (in this writer's opinion) to consider health education a 'dead duck'. There is currently tremendous public interest in health, as witness the growth of the slimming industry, diet fads, fun runs, growing public disapproval of smoking, the rise of vegetarianism, etc.

This project is one minor representation of an optimistic idea that the recommendations of the Bruun report and the other major voices in the alcohol field can be implemented.



### CHAPTER III

#### THE USE OF PARTICIPATORY LEARNING IN DCM

##### Introduction

In this chapter I hope to demonstrate that all of the components of this project were designed to be congruent; the formative evaluation, the holistic non-medical approach to alcohol education, and the choice of participatory learning methods, were all intended to form a consistent whole. The choice of a project facilitator/evaluator with training and experience in humanistic teaching was a deliberate one and matches the underlying philosophy and methodology of this project. Parlett describes the role of the evaluator as follows:

"Illuminative evaluation thus concentrates on the information-gathering rather than the decision-making component of evaluation. The task is to provide a comprehensive understanding of the complex reality (or realities) surrounding the program: in short, to 'illuminate'. The crucial figures in the working of an innovation - learners and teachers - become his chief preoccupation. The evaluator concentrates on 'process' within the learning milieu, rather than on 'outcomes' derived from a specification of the instructional system. Observation, linked with discussion and background inquiry enable him to develop an informed account of the innovation in operation." (1977, pp. 24 and 25)

This attention to "process" is also a feature of humanistic education.

To give the reader a better understanding of this particular innovation, the bias behind it ought to be openly stated. The

writers of the manual prefer participatory learning to didactic methods; since they incorporated them in the manual it would be foolish as well as hypocritical to pretend otherwise.

In this chapter it will be demonstrated that the instructional system devised by the writers of DCM reflects the principles of participatory learning, thus making the bias towards these methods unmistakably clear.

We will show that HEOs and other professionals have valid reasons for resisting the change to these approaches, and explore the factors which make the transition so difficult.

We will then turn to the debate in the literature, which is a lively and ancient one. We will begin by setting forth the philosophy behind student-centred learning, then look at some arguments against it and some answers to those arguments; the aim is to understand both sides of the debate. In the broader context of educational philosophy, no-one will have the last word, since the pendulum of current thinking tends to swing back and forth, probably at least slightly behind economic, social and political trends. In the context of health education, however, the structure of DCM reflects the present views of its authors, and they will be given the last word in this chapter.

#### The Instructional System: What DCM Contains

The DCM is designed as a five-day course. (For practical reasons, the teaching sometimes takes place not in a five-day block, but over two weekends, ten afternoons, etc.) A distinctive feature of DCM is that it contains material and instructions for the group leader and also a section of student materials and

handouts. Every course participant receives a copy of the manual to ensure that all the factual material and necessary references for further reading will continue to be accessible. Other information is given in the form of films, charts, posters and pamphlets. Becoming informed about the use and abuse of alcohol requires a range of understanding that includes:

- physical effects
- psychological aspects of use and abuse
- cultural indices
- the social, legal, political, and  
economic environment
- personal experience

The design of the manual is such that learning in these fields is achieved through a series of individual and group activities. This necessitates some use of participatory learning methods. I shall briefly describe five main examples:

- (i) Rounds - Course members and facilitators sit in a circle, and are requested to participate by making a statement, in turn, on a given topic (for example, "My first experience with alcohol as a child was ...").

The ground rules are:

No interruptions

Everyone listens

Permission is given, clearly and emphatically,

not to participate. Anyone may simply say

"Pass". This is an extremely important option.

The aim is to give each person an opportunity to speak and be listened to in such a way that their response is seen to be valued by the group. The intent is also to demonstrate that no one is being forced to participate.

- (ii) Brainstorming - This is a means of generating and collecting ideas from group members. A topic is given, such as "Why Do People Drink?". Contributions are recorded unsystematically, quickly and publicly

without censorship or evaluation. Ideas can later be analysed, categorised, or selected, by the group for any further purpose.

Again, it is demonstrated that everyone can, but no-one has to, participate, that all contributions will be accepted, and that the group is the source of ideas and information.

- (iii) Games - A wide variety of games is used; some are knowledge-based, and some are intended to enable the sharing of experiences. The TACADE card game, "A Tour of Knowledge", is an example of the former; alcohol facts appear on cards in question/answer form, enabling group members to test their own level of knowledge. The Values Continuum is an example of the latter; members arrange themselves along an imaginary line which represents a range of opinion on a topic such as "Alcohol legislation ought to be changed/remain the same". Each person states their reasons for being in the position they have chosen. The aim is to encourage group members to explore their own values and to accept the fact that the values of others may be different; others may strongly disagree with what they thought to be unassailable truths.

- (iv) Feedback - When an activity or experience has been completed, the leader asks the group to report back, in order to find out:

what they learned;

what they felt about it;

whether it was complete or needed more time;

perhaps, what they would like to do next.

This feedback can be obtained by doing a Round or simply by asking for comments.

The aim is for the leader to involve the group by hearing their responses and accepting them, and to be seen to be heeding the wishes and needs of the



group members. This is an example of 'paying attention to process'; the leader and the group are noticing what is happening, as it happens, and exploring their feelings about the group and its activities.

- (v) Role Play - A number of these are used. One of the most relevant is "The Karpman Triangle", in which participants experience being in the roles of Victim, Persecutor and Rescuer in a family problem which concerns alcohol. It is important for the participants to realise that they themselves sometimes become caught up in these roles, and to develop strategies for communicating about the negative interactions and eventually stopping them.

Other components of the course do not necessarily require an experiential approach. For example:

- (a) Research Projects - Group members research and report back on various topics related to alcohol; the group members are demonstrating their ability to gather information and share it.
- (b) Use of Visual Aids - Films, slides, posters and pamphlets are used throughout the course, mostly as a stimulus to discussion.
- (c) Group Discussions - Discussions could be claimed to be participatory activities and are often seen by educators as examples of 'involving the students'. However they can be, and are, used in a didactic manner when the teacher has pre-decided all the 'Right Answers' and has formulated the desired outcomes of the discussion. This is referred to in Bligh (1972) as "controlled discussion" as opposed to "free discussion".

In this activity, as in all of the others in the manual, a wide range of teaching approaches were used by the various HEOs in the project.

In general terms, the continuum of style has as its extremes:

Completely Didactic (Leader- and Manual- directed)	—————	Completely Client-centred (Group directed)
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The past training and tradition of teaching styles of HEOs are important factors in understanding their varied responses.

#### A Tradition of Didactic Methods

Many HEOs come from backgrounds of either nursing or education. Both these disciplines have traditionally relied on didactic methods. Health educators tend to carry on using those methods for a complex variety of reasons, one being that the Health Education Certificate course and Diploma course, which in many cases is their most recent educational experience, are largely knowledge-based. Another reason is that they are often called in by other professionals to serve as 'outside experts'. For example, a teacher in a comprehensive school may ask an HEO to come and lecture to her pupils about alcohol and drug use and abuse. This visit may comprise one or two hour-long sessions in which the HEO is expected to impart a large body of information, and the pupils are expected to absorb this knowledge. So the HEO often shows a film, conducts a brief discussion, and then leaves a pile of pamphlets and some posters.

This often seems to be the best and most effective approach for imparting facts under such circumstances.



"The lecture has long been under attack as a teaching strategy. It remains a valuable method of achieving certain categories of objectives and its value can be enhanced by appropriate use of audio-visual techniques. It is difficult in some circumstances to separate the apparent benefits of giving and receiving lectures from the existence of the structure in which they are given. It has been shown for instance that a structured programme is more successful than an unstructured one, whatever the strategies selected within that structure, and the easiest strategy to pre-plan is a lecture."

(Freeling and Barry, 1982, p. 72)

Some of the HEOs involved in this project have stated that they still find the didactic methods safe, natural, comfortable and appropriate. One of the aspects of these methods is that they are subject-centred. Hargreaves (1982) has described the subject-centred teacher:

"The teacher's authority ultimately rests in the authority of his subject. For such a teacher his subject expertise is absolutely central to his identity. He thinks of himself not as a teacher, but as a mathematics teacher, or a history teacher and so on." (*ibid.* p. 195)

The adult-educator may easily fit into the 'expert' role and the HEO, in particular, may find the subject-centred approach most relevant to her one-off sessions. If the lesson or lecture goes badly, there is at least the feeling that some information has been imparted, and some materials left behind. "I did as much as I could under the circumstances." As Bennett (1976, p. 46) puts it, "It is probably no exaggeration to say that with a more formal structure somebody is almost certain to learn something along the way." If it goes well, the lecture may appear very slick and impressive and the expert image is enhanced.

Media campaigns have been features of health education work

within our community; in fact the health education officers' function has sometimes originated from a media campaign. Their task has been to back up a campaign by giving information to the public in the form of pamphlets and posters, and to do this without any specialised training.

This function has left a legacy of didacticism, and a model of pouring necessary information into empty vessels. When HEOs go into schools, colleges and other educational settings, they slot into the time allocations, curriculum context, spatial arrangements (tiered lecture halls and formal classroom organisation) and into the expectations of pupils, students and staff. We live in a hierarchical society, organised so that those who know tell those who do not know, and thereby maintain and enhance their own status.

"Teachers are qualified in their subjects; they know; and they are not satisfied until they have told their pupils what they know. In the jargon of the educationists this is the 'transmission' model of teaching: the function of the teacher is to impart knowledge to (in this respect) ignorant pupils, and the most obvious way in which to achieve this is by telling."

(Hargreaves, 1982, p. 200)

The most obvious way is not always the most effective nor the way in which knowledge will be deemed relevant and will be retained by the learner.

Furthermore, as Bligh says in What's the Use of Lectures? (p. 50),

"Although it is sometimes believed that the lecture method can fulfil three kinds of functions (referring to information giving, promoting thought, and changing attitudes), the available evidence suggests that it can only effectively achieve one - the students' acquisition of information. The lecturer should only use methods that can fulfil

his objectives. It is therefore suggested that new teachers should use the lecture primarily for this purpose. If they wish to achieve other objectives, they should use other methods wherever possible."

#### An Alternative Approach

"I shall only ask him, and not teach him, and he shall share the inquiry with me: and do you watch and see if you find me telling or explaining anything to him, instead of eliciting his opinion." (Socrates, c. 400 BC)

Socrates call it inquiry.

Dewey writes about it in Experience and Education (1938).

Carl Rogers describes it as Student-Centred Learning (1965).

In the literature on education it is frequently referred to as progressive (Bennett, 1976).

George Brown calls it Confluent Education (1976).

Knowles speaks of Andragogy (1970).

At the University of Massachusetts, they call it Humanistic Education (Weinstein, 1970)

In Britain it is sometimes referred to as Participatory Learning.

There are certain common themes which connect all of these ideas.

"If one attempts to formulate the philosophy of education implicit in the practices of the new education, we may, I think, discover certain common principles amid the variety of progressive schools now existing. To imposition from above is opposed expression and cultivation of individuality; to external discipline is opposed free

activity; to learning from texts and teachers, learning through experience; to acquisition of isolated skills and techniques by drill is opposed acquisition of them as means of attaining ends which make direct vital appeal; to preparation for a more or less remote future is opposed making the most of all the opportunities of present life; to static aims and materials is opposed acquaintance with a changing world."

(Dewey, 1938, p. 223)

Bennett has contrasted the two approaches in the following way:

Progressive	Traditional
1. Integrated subject matter	1. Separate subject matter
2. Teacher as guide to educational experience	2. Teacher as distributor of knowledge
3. Active pupil role	3. Passive pupil role
4. Pupils participate in curriculum planning	4. Pupils have no say in curriculum planning
5. Learning predominantly by discovery techniques	5. Accent on memory, practice and rote
6. External rewards and punishments not necessary, i.e. intrinsic motivation	6. External rewards used, e.g. grades, i.e. extrinsic motivation
7. Not too concerned with conventional academic standards	7. Concerned with academic standards
8. Little testing	8. Regular testing
9. Accent on cooperative group work	9. Accent on competition
10. Teaching not confined to classroom base	10. Teaching confined to classroom base
11. Accent on creative expression	11. Little emphasis on creative expression

(Bennett, 1976, p. 38)

Perhaps a closer look at some of the main principles of student-centred learning will be helpful.

A. The learner has full responsibility for her own learning

"I know I cannot teach anyone anything, I can only provide an environment in which he can learn."

(Rogers, 1965, p. 389)

The leader/teacher acts as a facilitator and a resource-person.

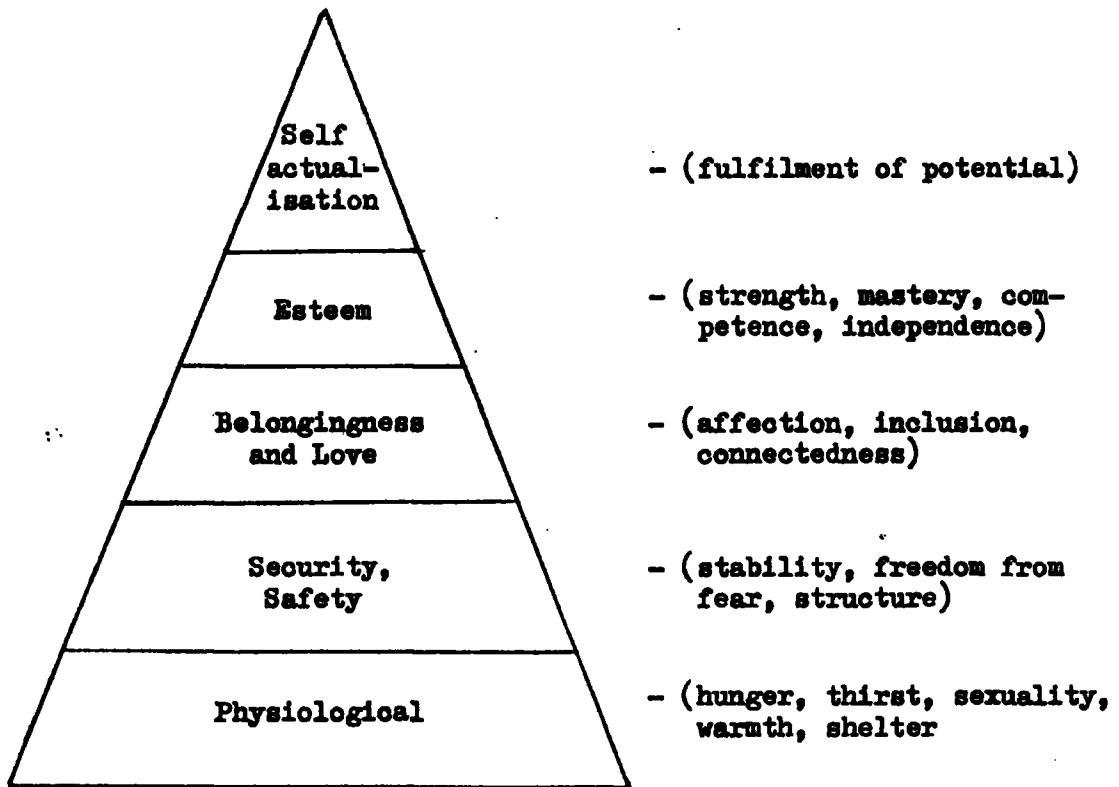
The students are responsible for choosing and planning the curriculum, or at least they participate in the choosing.

Learning is self-initiated, often involves the processes of inquiry and discovery; the learner is also responsible for evaluating the results.

B. The subject matter has relevance and meaning for the learner

Partly this can be accomplished by having the students choose their curriculum; in adult education, without exams and required syllabuses, there is little problem in achieving this, as the major limiting factors would be the title of the course, the previous experience of the students, and their stated needs. Activities can be designed so that all of those factors are taken into account. "Learning which is meaningful and relevant depends partly on what is taught, and partly on how it is taught" (Weinstein, 1970, p. 21). Much of the learning process is aimed at helping the learners to identify, clarify, and deal with their own concerns. If this is true in a classroom or course, there is little difficulty with problems of student motivation. In Maslow's terms (1970), their needs are being met.

General needs of human beings were arranged by Maslow in a hierarchy of importance (starting at the base of the pyramid:



If the physical needs are not being met, the person will not be motivated to satisfy the 'higher' needs; those will be seen as unattainable. In adult education the students' hunger or thirst are not included in the responsibilities of the teacher. All of the higher needs are considered to be included and the student-centred approach demands that the teacher involve the students in such a way that all the needs are being met to some degree at least. As Maslow (1970, pp. 80-95) said, "Gratification ... releases the organism from the domination of a relatively more physiological need, permitting thereby the emergence of other more social goals ... The healthy person is one whose basic needs have been met so that he is principally motivated by his needs to actualize his highest potentialities."

Maslow is not without his critics: Jahoda, for instance, writes:

"The idea that the hierarchy of human needs, established by Maslow (1958/70) and now often used in planning to ameliorate the poverty in the third world - beginning with the need for food and shelter and culminating in the need for self-actualisation - corresponds to a temporal sequence of what the underprivileged want from life, is psychologically mistaken and politically ultimately reactionary, according full human stature to only a small elite.

(1982, p. 20)

However, I believe that this statement not only does not detract from Maslow's views, but actually reinforces them. Maslow is not talking about catering to an elite portion of society, in fact what he is saying is that we ought to create a 'good' society, in which everyone can get what she wants, as well as what she needs. I believe that Maslow would agree with what Jahoda says, because although he was an optimist, and although he created a new language in which to talk about his ideas, he did not look out at the world from a politically naive position; he worked with the poverty stricken, with drug addicts, and with people labelled by others as psychopaths, and still he said: In principle, everyone can become self-actualized. If everyone does not, it is because something has happened to gum up the process." (1976, p. 220).

In any case, he is included here because his concept of self-actualization is part of the vocabulary of Health Educators, and thus is related to DCM.

As Postman and Weingartner (1969, p. 31) put it:

"Good learners seem to know what is relevant to their survival and what is not. They are apt to resent being told that something is 'good for them to know' ... "

The humanistic teachers enters into a dialogue with the students in which their needs, as related to the topic at hand, are uncovered and stated.

"The most important single factor influencing learning is what the learner already knows. Ascertain this and teach him accordingly."

(Ausubel, 1968, p. 171)

C. Involvement and participation are necessary for learning

"In fact, learning is the human activity which least needs manipulation by others. Most learning is not the result of instruction. It is rather the result of unhampered participation in a meaningful setting. Most people learn best by being 'with it', yet school makes them identify their personal cognitive growth with elaborate planning and manipulation."

(Illich, 1971, p. 44)

The constraints of the punishment/reward system of teaching, so familiar to most teachers and learners, do not apply when the learner is personally involved. The rewards of working through a process together and finding new questions or answers on the other side are exciting in themselves. Intrinsic rewards are derived from the fun of learning, of discovering, of challenging or questioning, of becoming competent in new areas.

Praise and blame or negative criticism from the teacher are also out of place in this new context; the learner is as involved in evaluating as she is in planning and participating.

If the learner is fully involved, he does not have to seek outside approval, in fact, as Hargreaves points out below, approval-seeking behaviour negates 'unhampered participation'.

"I want to suggest, then, that the majority of pupils become addicted to the teacher's approval during the process of formal schooling. When they learn, it tends to be as a means of



obtaining approval rather than as an end in itself. Indeed, paradoxically, the pupils' desire to obtain approval may subvert the learning process. Approval-seeking may become a substitute for learning ... If it is true that the pupils' concern to obtain approval and to avoid disapproval leads them to respond in ways which inhibit learning, then we must ask ourselves to what extent does learning require approval from the teacher? It is certainly true that enormous amounts of childhood learning are associated with the bestowal of approval by socializing agents, especially the parents. Approval in its various forms is without doubt one of the most common sources of reward and one of the most basic elements of childhood socialization. Yet even if approval is essential in this respect, it does not necessarily follow that it is an essential or desirable tool in the promotion of classroom learning. Human beings can learn without approval, and if our earlier analysis bears any truth, then learning based on teacher approval may be undesirable in the classroom ... The question is (rather) whether we can reduce and minimize approval giving in the classroom and what effect this might have on the learning process."

(1972, pp. 200-201)

Neill discusses the same issue in relation to compelling a child's attention:

"When we consider a child's natural interest in things, we begin to realize the dangers of both rewards and punishment. Rewards and punishment tend to pressure a child into interest. But true interest is the life force of the whole personality, and such interest is completely spontaneous. It is possible to compel attention, for attention is an act of consciousness. It is possible to be attentive to an outline on the blackboard and at the same time to be interested in pirates. Though one can compel attention, one cannot compel interest. No man can force me to be interested in, say, collecting stamps; nor can I compel myself to be interested in stamps. Yet both rewards and punishment attempt to compel interest."

(1962, p. 17)

These statements as can be seen above in Neill's reference to himself, can also be equally applicable to adults. In fact, the

sort of lively true interest that he describes is what is really meant by participation. When everyone in the learning group is awake, alert, interacting and yet acting individually, there is involvement. The dialogue between all of the learners and teachers is one of the sources of excitement.

"Finally, one of the most crucial ways in which a culture provides aid in intellectual growth is through a dialogue between the more experienced and the less experienced, providing a means for the internalization of dialogue in thought. The courtesy of conversation may be the major ingredient in the courtesy of teaching."

(Bruner, 1971, p. 123)

#### D. The relationship between learners

The dialogue itself is not enough, nor is the interaction; the quality of that interaction is also crucial. Rogers (1961, pp. 39-40) describes the helping relationship as one in which "at least one of the parties has the interest of promoting the growth, development, maturity, improved functioning, improved coping with life, of the other". This is parallel to one of the goals of health education which pertains to enabling people to make their own choices.

The person in the helping role may have advantages of experience, position, or advanced knowledge over the learner, but one of the aims of working together would be to equalize the relationship. The way that the helper talks, listens, and is in the relationship consistently gives the learner the message: "You are in charge of yourself in this relationship".

#### E. The teacher becomes a facilitator and resource person

Neville Bennett (1976, p. 160) argues that

" ... to teach well informally is more difficult than to teach well formally. It requires a special sort of teacher to use informal methods effectively - one who is dedicated, highly organised, able to plan ahead and willing to spend a great deal of extra time in preparatory work."

Indeed, the participative approach will require of the teacher some qualities and skills which perhaps may differ from those demanded by didactic methods. She must have a degree of sensitivity and perception in order to clarify and identify student needs. She will need to be capable of divergent thinking and considerable resourcefulness to find the materials requested by students, which will not be predictable in advance. Tact, skill, humour, and a willingness to take risks, are needed to facilitate interpersonal communication in a participatory setting. But the most essential requirement is a willingness on the part of the teacher to share himself without imposing. All of his expertise, knowledge, attitudes, training, are the resources he has to offer the student, and they must be offered in a context of availability not of insistence; the student may freely accept or reject the offerings (Rogers, 1961). The reverse of this is not true, however, in regard to offerings; in this approach the cliché phrase "all contributions will be gratefully accepted" is adopted by the teacher as a matter of policy. The students' contributions, and the students themselves, are accepted in an atmosphere of unconditional positive regard, and are individually and collectively valued. Some contributions will be viewed as being more useful or pertinent at a certain time; all are acknowledged in a positive manner.

The phrase "unconditional positive regard" is Rogers' way of saying that the teacher prizes the student in a total way, not a

conditional one, an "outgoing positive feeling without reservation, without evaluation" (1961, p. 385). In an atmosphere where the teacher displays this behaviour, it is usually reciprocated by the students and this tends to enhance their self-esteem and productivity. "In a learning environment characterised by open communication and trust, a teacher should be able to use resources to illuminate what ... people know and feel" (Neeson, 1983, p. 49).

F. The learner sees himself differently as a result of the learning experience

The outcome of this method of learning is intended to be, not only enhanced knowledge, but also changes in all the learners.

Rogers suggests (1965, p. 280) that the learning process which takes place in psychotherapy could be adapted to apply to education:

"The learner comes to see himself differently ...  
He becomes more self-confident and self-directing  
He becomes more the person he would like to be  
He behaves in a more mature fashion  
He adopts more realistic goals for himself  
He changes his maladjustive behaviour, even such a long-established one as chronic alcoholism (author's emphasis)  
He becomes more open to the evidence, both to what is going on outside himself, ... and inside himself."

Broader Context

To take a wider view of health education without assuming it is a panacea for society's ills, let us consider a general statement from Knowles about adult education (1970, p. 33):

"A strong case can be made for the proposition that the greatest danger to the survival of civilization today is not atomic warfare, not environmental pollution, not the population explosion, not the depletion of natural resources, and not any of the other contemporary crises, but the underlying cause of them all - the

accelerating obsolescence of man. The evidence is mounting that man's ability to cope with his changing world is lagging farther and farther behind the changing world. The only hope now seems to be a crash programme to retool the present generation of adults with the competencies required to function adequately in a condition of perpetual change. This is the deep end - the awesome challenge - presented to the adult educator by modern society."

Health education, and DCM in particular, are aimed at providing people with the tools to live productively and with vitality in a changing society, and I would agree it is an awesome challenge, but for me the fact that the task is not easy is also what makes the work exciting.

#### The Implementation of these Methods in DCM

The opportunity for learners to participate, experiment, experience and grow is built into DCM. The exercises and the activities and the strategies recommended to the group leaders all aim at producing an atmosphere of openness and trust. The course is not intended to stop at raising levels of knowledge about alcohol (DCM 1981, p. 4).

In the stated aims, DCM mentions attitudes and confidence as well as information. All of the activities are designed to say to the learners, either subtly or directly, "We (the group) value your contributions; we accept your contributions, although we may disagree."

#### Some Major Points in the Debate: Didactic v. Participatory Methods

One of the most common arguments against inquiry methods is that they require learners to 'reinvent the wheel'; some kinds of

knowledge are proven and tested and it is a waste of time to discover them again. "A school is ... a place where the massed wisdom of the ages is passed from one generation to the next, and where youngsters are taught to think in a logical and systematic fashion" (Rafferty, 1969, p. 70).

Rhodes Boyson puts it even more strongly in one of the 'Black Papers' (1969, p. 161):

"Discovery methods though useful in stimulating the mind are dangerous if people grow up thinking that they can in their life-time discover what it has taken 10,000 years of human history to achieve. Men are arrogant to believe that this can be achieved for its only result would be to revive the dark ages. People must learn the theorems of Euclid and the grammar of a foreign language. Traditional methods of study are generally short cuts to knowledge. Many new methods have been introduced as experiment for experiment's sake and to help bored teachers, not bored children."

Proponents of participatory methods do not claim that the massed wisdom of the ages should be ignored nor that a student in a progressive learning environment would not come across Euclid in his reading; it is the way in which this happens that is being questioned. Phrases like "People must learn" and "Youngsters are taught to think ... " are translated into "people may decide to learn when they see that a piece of learning is relevant", and "people learn to think things through for themselves." The idea is that the learner will be exploring the wisdom that has been passed down, when it is relevant to his own present needs, when it fits into the framework of what he wants to know. The teacher or group leader is there to provide resources when they are relevant, i.e., when the student has discovered the need for them. However, as an equal member of the group, the leader can also offer suggestions or introduce new ideas when she feels it is

appropriate.

Participatory activities, to an extent, do away with what Glasser (1969) calls the certainty principle, the idea that there is a right and wrong answer to every question. This raises another major objection, which is often stated as: "But there are right answers. Paris is the capital of France, and Tokyo is not." The answer to the objection lies in the basic aims: what is it we want the student to take away with him? If it is simply, and only, the right answer, then we can give it to him, or someone else can state it, and he can remember it as long as he needs it, and reproduce it on an exam or repeat it in his own lectures. In student-centred learning the aim is to equip the student to find out for himself what the capital of France is, and to be able to find out the answers to such questions, to understand the difference between the "knowledge that" and the "knowledge how", and furthermore to ask and to explore questions like "What makes Paris uniquely French and Tokyo uniquely Japanese?"

One of my own favourite maxims, which did not surface in the search through the literature is "A good teachers soon renders herself obsolete". This is a source of some discomfort to people making the initial transition to this way of thinking. A new type of reward has to emerge for the teacher; she will learn that she is valued for her skills as a resource person and facilitator, rather than as a giver of knowledge.

Bennett's argument, quoted earlier, about the higher degree of dedication required of an informal teacher, is frequently used against participatory methods. As he puts it (1976, p. 161) "How many teachers do we have who could meet these specifications?"

Bantock in the Black Papers (1969, p. 116) was also concerned with whether or not teachers could handle such approaches competently:

"... used incompetently ... they are probably more disastrous to learning than an exclusive reliance on the old formal methods. These methods, with their permissive atmosphere, in the hands of incompetent teachers are enervating and time wasting."

I would reply that in the hands of an incompetent teacher, any method would be boring and unproductive. However, what Bantock says is worth noting; it is true that there are not many teachers who have achieved competence in the new methods, as the necessary skills and practice are seldom offered in their training. Should we then discard the new methods, or should we produce a greater number of teachers who are capable of using them effectively? Obviously, we of the DCM project prefer the latter course of action.

It is true that new skills are difficult to master; for the teacher, it may mean changing old assumptions and former attitudes, and developing strategies which are different from the familiar, comfortable ones to which he is accustomed. Far from being a drawback, this can be considered an advantageous feature of using new methodologies, if the teacher is stimulated and excited by the prospect of his own personal growth, which can either be constrained and limited, or extended each day that he is teaching. Stenhouse (1981) points out that if the teacher is a learner each day of his classroom life, his growth, both intellectual and emotional, can be stimulated; he can even rejoice in being overtaken and passed by the growth of his students, because he has provided a positive environment for learning.

"A good classroom, by this criterion, is one in which things are learned every day which the teacher did not previously know" (p. 37).



Stenhouse also says (op. cit., p. 25) that the teacher should not be expected to accomplish all this on his own:

"Cooperative and well-organised effort is needed, and teachers working cooperatively together have the same right and need as other professionals - such as doctors or engineers - to have access to consultancy and to draw on research."

A related argument is that the participatory approach is reliant upon a charismatic teacher in order to work successfully. The idea is that an ordinary person cannot be trained, or cannot learn through experience, to be skilled in this sort of interaction; that a good teacher has something special which is innate - the 'born not made' argument. As Peters (1959, p. 16) says:

"Nevertheless there is something distinctive about the charismatic leader which he shares in an exaggerated form with other 'natural' leaders who exercise authority in virtue of personal claims and personal characteristics ... because he is a special sort of person."

The nature of participatory learning depends upon mutual respect between teacher and learner; this sort of respect does not depend only on expertise, it depends upon human interaction characterised by trust and high regard. Neither is it dependent on the charisma of the leader, but rather upon that leader's skill in communication, and this can be learned; in fact DCM consists partly of practice in communication skills. It is of prime importance that the leader addresses the group with respect and an attitude of interest and caring, and that the leader and the group listen to each other. This is related to the principles of andragogy (peer-teaching) outlined by Knowles (1970) and one of the statements he makes seems extremely relevant here:

"The behavior of the teacher probably influences the character of the learning climate more than any other single factor; however, the teacher conveys in many ways whether his attitude is one of interest in and respect for the students or whether he sees them essentially as receiving sets for his transmissions of wisdom. The teacher who takes the time and trouble to get to know his students individually and who calls them by name (especially by first name) obviously conveys the first set of attitudes. But probably the behaviour that most explicitly demonstrates that a teacher really cares about a student and respects his contribution is the act of really listening to what the student says" (p. 41).

For these reasons, DCM includes a section on Active Listening, in which everyone in the group, including the leader, learns to listen to others accurately, and, temporarily at least, without judgement.

Charisma is a distinct advantage in most professions, but it is a gift, and ought to be regarded as a bonus, whereas the skills discussed above can be classed as necessities, and can be learned.

Another negative point frequently raised is that the progressive methods create suspicion and cynicism among the teacher's colleagues. This has been apparent in some cases in the DCM project. Anxiety has been expressed by some HEOs who felt that their course members would feel suspicious, uncomfortable and foolish in an unstructured learning environment. Also some HEOs who did not attend DCM courses, evidenced cynicism regarding the potential success of the group-work methods being implemented by their colleagues.

This point ought not to be regarded lightly, it is of serious concern to teachers, most of whom care very deeply about what their colleagues think of them.

"Teachers naturally make judgements on the professional competencies of their colleagues, but they are rarely discussed openly ... Reputations are common knowledge but they are transmitted sotto voce in the channels of staff gossip ... Relations between colleagues in school are characterized by sensitivities in matters of competence ... "

(Hargreaves, 1982, p. 205)

An innovator who dismisses these concerns will find himself facing increased resistance to his innovations. Part of the training for future use of an innovative programme such as DCM ought to be in developing skills which would equip HEOs (or teachers, or other professionals) to talk with people who are suspicious. Cynicism can be overcome with communication if the communication is a genuine two-way exchange of understanding. Cynics are sometimes speaking out of fear or misapprehension; they needed to be heard and answered, or sometimes just heard. Another way of dealing with cynicism is to point to successes, as in the following letter from a teacher who was involved in participatory learning during an M.A. course at Durham University in 1983.

" ... The response from my classes to the Waiting Game and to 'Confluent Education' in general has been fascinating to observe. The initial suspicion and general 'this isn't English' attitude has given way to cooperation, enthusiasm and genuine discussion (as opposed to a rather fake question/answer routine). Interestingly, although I've spent less time 'teaching' them than the rest of our Department, one member of staff did comment on the large amount of work they seemed to get through. They seem to work together much better and actually said that they enjoy English rather than endure it! ...

I think I'm winning my 'battle' with the new approach - mainly because the children and their work is my best advert and other classes are beginning to enquire of their chums what it is that they are actually doing!"

As for anxieties expressed by course members, the trainer or

leader can listen to these and accept them. Holt says (1972, p. 89):

"It might be helpful if we feel comfortable doing it, to say to the students that we understand their scepticism and suspicion, and the reasons for it, and are sympathetic rather than hurt or angry."

The leader can also point out that not only can anyone refrain from participating, they can also choose when training others, to use only methods with which they themselves feel comfortable. Some may choose to use traditional methods of presentation, and the leader ought not to have an investment in anyone's "conversion".

As Wilkinson asks in "Are You Fit to Train Others?":

"Do you harmonise with your trainees? What can be more damaging to producing good results than a leader quite out of harmony with his trainees? He cannot understand them; they don't understand him. The successful training manager must strike a note of harmony with those who look to him for guidance."

(1984, p. 30)

This does not mean that the leader can never express her opinions, just that she also listens to the ideas and worries of the course members, and takes time to explore and clarify problems until they feel satisfied.

An issue which causes some educators a considerable amount of anxiety is that progressive education often seems to be synonymous with permissiveness; we quoted a similar concern of Bantock's earlier in this chapter. Teachers imagine scenes of wild chaos, uproar and confusion. As Glasser (1969, p. 200) points out:

"For most students who have not done well in school, permissiveness is destructive. Ultimately it generates antagonism and ridicule toward those who unrealistically administer without rules."

Permissiveness is a very unpopular word with humanistic educators; they throw away the word permission, and substitute responsibility. This is especially true in adult education: who are we to give permission, or indeed to take away responsibility, from the students? Glasser goes on to say (loc. cit.):

"Responsibility is not a one-way street. Reasonable rules are part of a thoughtful, problem-solving education ... Teachers have the responsibility to make education relevant and interesting; students have the responsibility to attend class, to study, and to learn."

In fact, the ground rules are just as firm in a progressive learning milieu as in a traditional one. The differences are in who makes the rules, how they are implemented, and in the kinds of rules there are. They are generated by students and teacher, (or group leader, or lecturer) together, and they refer to a way of working together so that everyone has opportunities to participate or not, to be heard, to make choices about the curriculum, to pay attention to each other's needs. The ground rules are negotiable, and are used as foundations, or reminders, not as sanctions.

If the teacher cannot assume the 'fountain of all knowledge' or expert stance, the students will not respect him; so goes another fear that teachers sometimes express. The idea of saying "I don't know" in response to a student's question is anathema to some teachers, who feel very uncomfortable if they are not in possession of all the facts related to a subject they are presenting. This sort of incompleteness is referred to by some of the HEOs, among others, as poor or sloppy teaching.

Abercrombie, writing about group teaching in higher education, states:

"We assumed that one of the main aims of education should be that of encouraging autonomous learning, and that consequently the relationship between teacher and pupil needs to be that of cooperators exploring knowledge (rather than that of givers and passive receivers of information) ... "

(1979, p. 46)

In the first instance, i.e., the first three levels of the dissemination pyramids, DCM courses are in-service training courses and are attended by adults. These people come from a broad range of social and educational settings; they have had considerable experience of life and work (and, perhaps of alcohol problems). In their work, which in some cases includes training their colleagues to use DCM, they will engage in relationships with other people who are also more than blank pages on which to write. The skills of using one's own experience as a learning resource and facilitating others to do the same, are better learned by modelling; interpersonal skills in experiential learning ought to be practised experientially, even while cognitive theory is being absorbed.

Research into the effectiveness of group work methods in learning has been carried out in Britain and in America in recent years, with varying results. The debate in the literature on this question is confusing in that evidence for and against these methods is so contradictory as to have the effect that the arguments cancel each other out. Some studies argue that bright pupils are better able to adapt to progressive methods, others seem to prove the opposite view. One way of looking at both sides of the question is expressed by McGregor (1960), in writing about management and motivation, and may also apply to theories of education.

Theory X assumes (among other assumptions) that:

"The average human being prefers to be directed, wishes to avoid responsibility, has relatively little ambition, wants security above all."  
(p. 39)

Theory Y's opposing assumption is that:

"The average human being learns, under proper conditions not only to accept but to seek responsibility."  
(p. 48)

DCM assumptions and Health Education assumptions are based on Theory Y, because the overall aim of health education, as practised by the HEC and the HEOs in this region, is to encourage people to take responsibility for being informed about good health practices, to look after themselves, and to make sensible choices regarding drinking, eating, smoking, and other health issues. It is not a parental attitude which says "We know what is best for you". It says, without condescension, "the choice is up to you". The writers of DCM feel that the style of presentation in the alcohol education courses should match this aim.

#### Appropriate Methods

The bias of DCM has been stated, and it is not an attempt to compromise to say that there is no single method of learning that is better than all the others; there are those which are most appropriate to particular tasks in particular contexts. The last word in this context is that DCM is an example of progressive adult education methods applied to health education in such a way that the model can be adapted to suit any learning milieu and any age group.

Although DCM rests on "Theory Y" assumptions, and embodies

Rogerian principles, it uses a wide variety of methods and media including: lectures, games, group discussion, individual and group research, films, posters, pamphlets, and sharing of feedback both verbally and visually. These are all intended to be used in a participatory framework, to be a series of learning experiences from which the group as a whole, and as individuals, draws conclusions and discusses ideas and opinions.

Faure (1970, p. 59), supports this combined approach:

"Instead of setting various methods against each other, it is more constructive to list the resources they offer and determine methodically the conditions in which each may be used to supplement the others ... Education suffers basically from the gap between its content and the living experience of its pupils, between the systems of values that it preaches and the goals set up by society, between its ancient curricula and the modernity of science. Link education to life, associate it with concrete goals, establish a close relationship between society and economy, invent or rediscover an education system that fits its surroundings - surely this is where the solution must be sought."

Cognitive and affective learning are also integrated in DCM; a body of knowledge regarding alcohol is incorporated in the manual, and one of the initial tasks of the group is to determine, with the help of the leader, which aspects of the knowledge and which skills are relevant to their work and personal needs. Time is allowed for discussion about the topic of alcohol and the feelings that are generated by the discussion.

This merging of cognitive and affective learning, which Brown (1976) calls "confluent education", is expanded by Parlett when he discusses the overall environment of learning, or "the learning milieu" (1972, p. 13):



"The learning milieu concept is necessary for analysing the interdependence of learning and teaching, and for relating the organisation and practices of instruction with the immediate and long-term responses of students. For instance, students' intellectual development cannot be understood in isolation but only within a particular school or college milieu. Equally, there are phenomena of crucial educational significance (such as boredom, interest, concentration, 'floundering' and intellectual dependency) that make nonsense of the traditional psychological distinction between 'cognitive' and 'affective' and which customarily arise as responses to the total learning milieu, not to single components of it. Students do not respond merely to presented content and to tasks assigned. Rather, they adapt to and work within the learning milieu taken as an interrelated whole. They pay close attention to 'hidden' as well as 'visible' curricula. Besides acquiring particular habits of studying, reading and responding, they also assimilate the conventions, beliefs and models of reality that are constantly and inevitably transmitted through the total teaching process."

#### But What About the System?

One seminal problem in introducing participatory methods has not yet been discussed in this chapter: no matter how committed teachers and HEOs may be, they are working within a system which is highly resistant to change, and in which they usually do not have the power to make decisions in favour of innovation. Even if they did, as Hargreaves says, the system needs changing both from below and from above.

"All the de-schoolers are advocating fundamental changes in Western society's culture and structure as well as in the educational system, and I think they are right when they suggest that there are urgent educational changes needed which cannot wait until other social and economic changes have paved the way. I think they are wrong in implying that massive educational reforms can be effected without at least a few major concomitant social and economic changes. Given the present power structure, we can expect few radical innovations

from Parliament, from the Department of Education and Science, from local Chief Education Officers and their Education Committees. Certainly if the reforms are to be made by teachers and are likely to affect them, then changes will be neither sudden nor dramatic. Piecemeal reform and slow, sparse innovation is the more likely development. Educational and social evils do go hand in hand, and we need a growing awareness of this combined with a willingness to attempt radical and speedy solutions."

(1972, p. 423)

This dilemma was reflected in the data which we collected on this project, and will appear at various stages in the next few chapters. At times it emerged as a major obstacle to progress. Especially in the following chapter about HEOs and their various points of conflict with each other and with the system, one can see that HEOs are often stuck within the active conservatism of a massive hierarchy. However, I would like to join Hargreaves in ending on a more optimistic note.

"I think there are two educational developments which give grounds for hope. The first is the experimental work going on in a few primary schools. At this stage a pupil would, in my own conception of voluntary schooling, be following a self-selected and self-directed course, exploring as few or as many aspects of life as he wishes. There would be no set curriculum; no class teaching of subjects; no attempts to 'integrate'; no age-grading; no streaming. The teacher would be a resource provider, offering help, advice, and encouragement to further exploration. A few primary schools come very close to this pattern now. The second is the changes that are occurring among the young generation of teachers ... In my view they will soon emerge as a potent force - there are already signs of such a burgeoning among the supporters of Rank and File within the National Union of Teachers. The teaching profession is nursing its own version of 'the alternative society' within its bosom, and before long it will sting."

(1972, p. 425)

Perhaps the HEOs in this region can offer another hopeful

element; at least they have had a chance to learn about an experiment with new methods, and they are working in the Health Education field which does provide a conceptual basis for moving toward 'the alternative society'.

In the analysis and interpretation of the data, which form the major portion of this report, the effects of participatory learning on course members and educators will be one of the important factors.

## Part Two

This section of the thesis comprises the nuts and bolts of the evaluation. The information in it has been gleaned, for the most part, from the interviews and written evaluations of the course members and HEOs, and from my own observation. There will be a good deal of anecdotal material and many comments from the facilitator/evaluator; this will mean a change to a more personal style of writing.

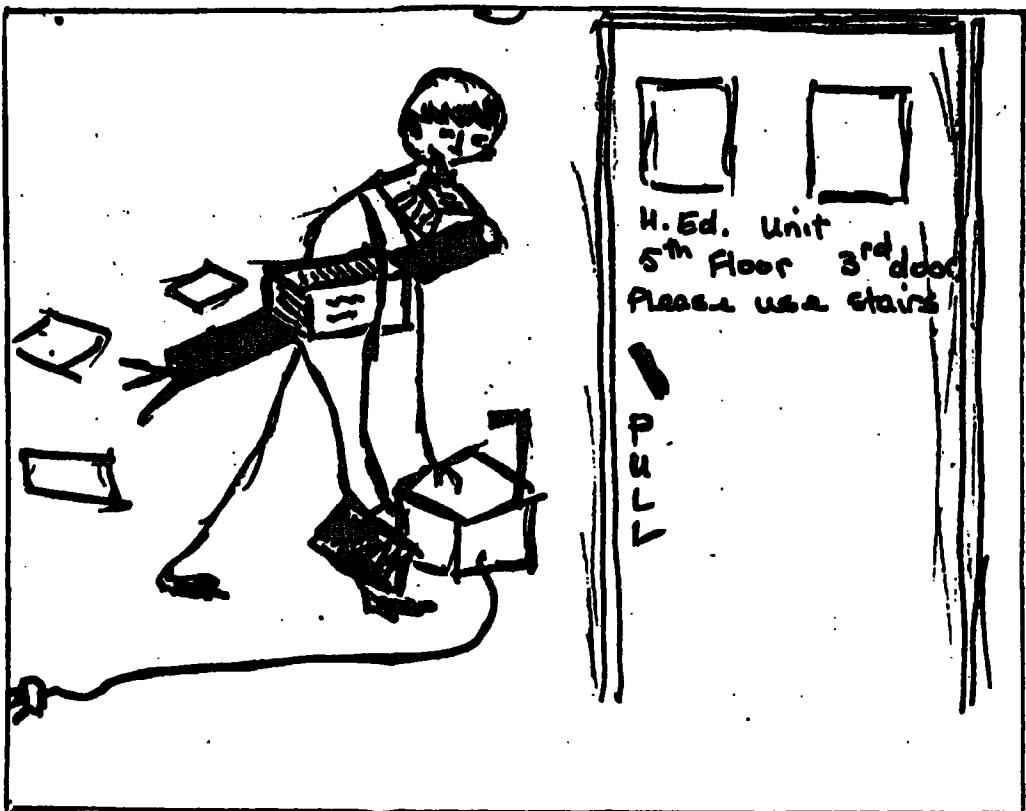
## THE CULTURE OF THE HEO

An Image of an HEO - Harry Edward Orr by Pauline Amos

The man I am about to introduce to you is aged 35 and has two children, two years apart of course. He is of average height, bent-backed, with abnormally long arms, of harassed appearance and in a constant hurry.

Ah! he has arrived. I can see him now, climbing out of his dirty red economical hatchback. He proceeds to unload and then struggles with a screen, which nips his fingers, an overhead projector, box of leaflets and battered briefcase. He stops to check his bilious green diary (next year it will be red) and then attempts to open the door with a calloused hip. The wind blows and some of the leaflets float away, the cord from the overhead projector unwinds and he is beginning to dribble on the keys that are in his mouth. He realises that this is a door you have to Pull. Good! Someone has let him in .....

Harry Edward Orr, ex-nurse, ex-teacher, and holder of numerous Mickey Mouse degrees, "This is your life" !



## CHAPTER IV

### THE CULTURE OF THE HEO

#### The Occupational Culture

##### Introduction:    What tribe is this, anyway?

It could be said that there is no such thing as "the culture of the HEO"; certainly they are a very individualistic, even idiosyncratic, professional group, widely separated by attitudes, training and background as well as by geography. There are a multitude of definitions of the word "culture"; how it is defined depends on who is interested in the concept at the time, an anthropologist, a sociologist, a psychologist, a lexicographer or perhaps a tourist. In the case of this project, since we have been investigating the impact of an educational innovation on an organisation within the National Health Service, we will use the term culture to refer to "... the learned beliefs, values and characteristic patterns of behaviour that exist within an organisation" (Margulies and Wallace, 1973, p. 44). In this context, I would argue that a culture does indeed exist in the field of health education, and that I am obliged to describe the culture of the local tribe so that its impact on this project, and the project's chances of success, can be assessed.

"... it would seem that any effort aimed at achieving organizational change needs to take into account the organizational culture, as an element that may be seen to influence innovation."  
(Marshall and McLean, 1983)

Thus it is the fact that the manual's writers had an understanding of the HEO which made it possible for DCM to be effective, and my understanding had to grow so that I would be a better facilitator.

By training, I cannot call myself an ethnographer, but as a result of being a participant observer for three years I claim for myself the title of the first temporary amateur ethnographer of the HEO in the North East. As Agar says, ethnography

"always involves long-term association with some group, to some extent in their own territory, with the purpose of learning from them their ways of doing things and viewing reality. In part, ethnography resembles the common image of 'social science' - questionnaires, tests, censuses, and so forth. But the ethnographer also eats with the group, works with them, relaxes with them, and hopefully comes to understand them. Meanwhile he personally struggles with the interference from his own ways of thinking, feeling, and acting". (1980, p. 6)

In ethnographic research, there is an emphasis on personal involvement in the community, and one of the serendipitous rewards is in finding new friends. In the three years that I have worked, eaten, relaxed and talked with HEOs, I have gained three close friends and several warm relationships. It is useful to have these kinds of informal contacts for evaluation purposes as well as for social benefits. A degree of trust is necessary between ethnographer and tribesperson if the student of the culture is going to glean information from gossip and offhand comments, to be a leaf on the organisational grapevine. Though these kinds of data must be treated delicately and confidentially, they are of vital importance to full understanding of the culture.

"In some organizations, one can identify at least two cultural systems, formal and informal. The formal culture may consist of idealized statements of what the values, beliefs, and behaviors of members should be. The informal culture may consist of these as they really are. All

organizations show this dichotomy, though in some one may be able to identify several informal cultures."

(Margulies and Wallace, op. cit., p. 45)

In this chapter we will see the "idealised statements of belief" in conflict with the conditions that really exist in the various aspects of the organisation.

My understanding of the occupational culture of the HEO is based on statements made by DHEOs and HEOs, on a close analysis of all interviews conducted, on my own observations and reading, and on discussions in our supervision sessions. I have made a point of seeking out new HEOs and ex-HEOs; both groups are able to view the culture from inside and out. Again and again in interviews and other conversations with these people, certain themes appear which help to define what an HEO is and does; this chapter will explore these themes.

### Is Health Education a Profession?

One of the many sources of controversy about HEOs and their work is the question of their professional status. They refer to themselves as professionals, and they are often engaged in training other professionals such as nurses, doctors, and dentists. Their work fits a dictionary definition of a profession: "... an employment not mechanical and requiring some degree of learning" (Chambers, 1972), but this definition is so wide as to be of little value. The job does not fit a more rigorous definition usually accepted by the medical and legal professions:

- "1. Full membership in a profession can only be permitted by an examining and supervisory body who issue a document to candidates who have successfully completed their training in order to qualify.



2. Continued membership is conditional on certain behaviour and competence.
  3. The professional body itself, and not the courts, can remove anyone deemed unfit to practise."
- (Hudson, 1973)

No such examining or certificating body exists in health education, in the teaching profession in England, nor in social work. Although a degree and a teaching qualification are needed for one to become a teacher in this country, there is no other control over entry to, or dismissal from the profession, nor an established standard of performance. Nurses require a qualification to enter into nursing. No qualification is required for entry into health education. However, some HEOs come from nursing backgrounds, and are accustomed to seeing themselves as professionals.

Hudson would describe their occupation as a "near profession", along with teaching; some HEOs are former teachers, who also see themselves as members of a profession, even though they could not match the above definition. Certainly the HEOs' work requires some degree of learning and is not mechanical, and many of them have either a professional or near-professional qualification. They tend not to see themselves as having a monopoly on expertise, knowledge or power; Drinking Choices is an example of how HEOs seek to break down barriers between professions, and to share knowledge or expertise with the aim of transferring it to clients. In a spirit of generosity we will use their chosen title in this report. The fact that HEOs do come from at least two widely differing professional backgrounds, and in some cases also from industry or business, will account for some of the conflicts we will be examining in this chapter.

The very fact that they do come from such diverse backgrounds also underlines the uncertainties about:

- (a) what knowledge is essential
- (b) what role they should play
- (c) their relationship with other professionals like doctors, who all have similar training.

" ... organizations that draw their personnel from two or more significantly different populations are likely to have different cultural systems."

(Margulies and Wallace, op. cit., p. 45)

### The Hierarchy

It may be useful to see how Health Education fits into the hierarchy of the NHS (Fig. IV.1, p. 138).

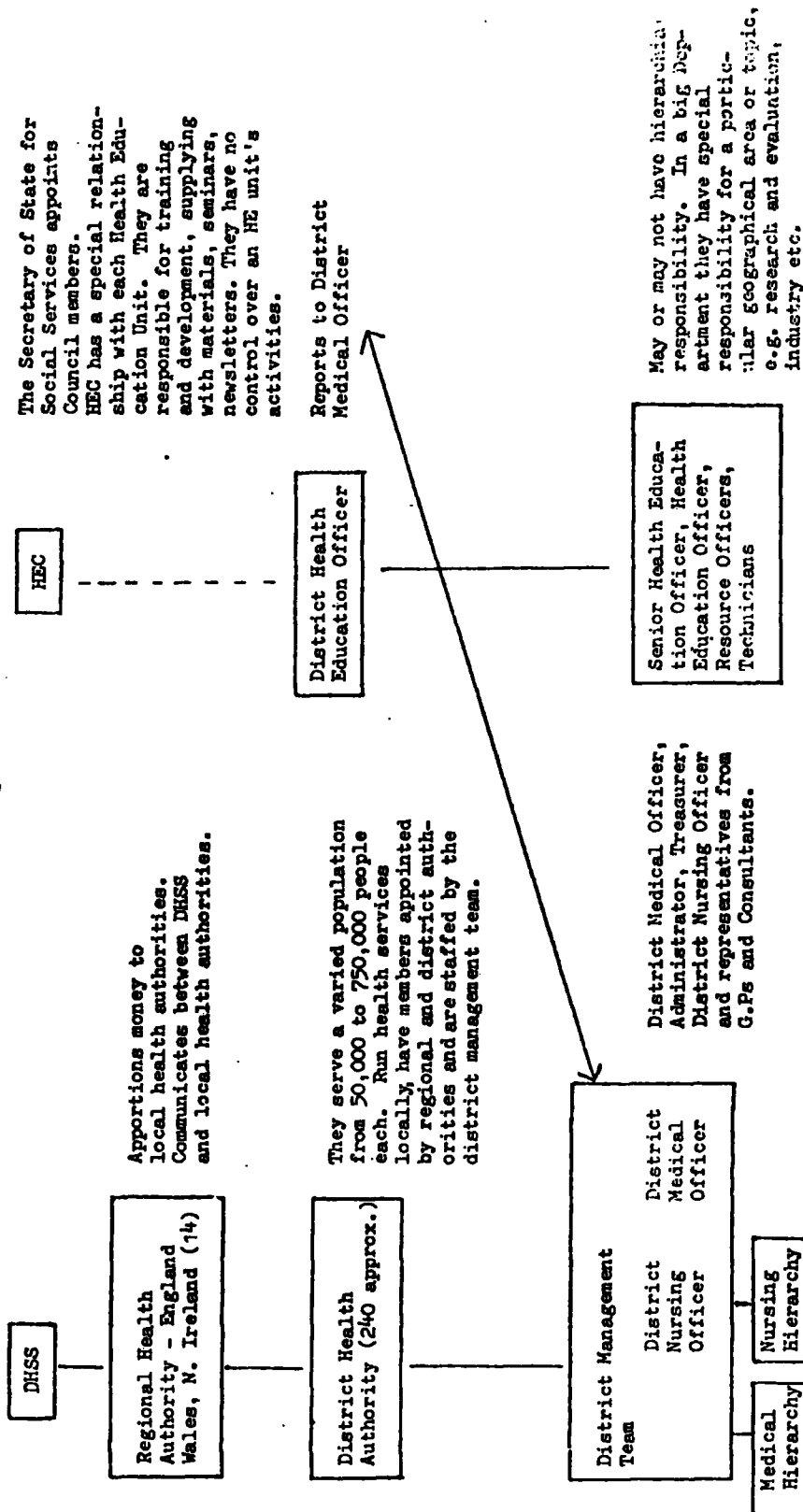
Examining this structure, one can see that the HEO is clearly a part of the health service, and responsible to a medical administration. Whenever the health service funding is cut by the government or the geographical boundaries are redefined, the HEO feels the reverberations.

Through the Education and Training (now called Professional Development) Division, the HEC overlooks and provides pre- and post-training for the Diploma and Certificate in Health Education, and further development for HE managers.

Although HEOs are likely to have been teachers, nurses, or health visitors in their previous jobs, in our own particular North East sample, of 27 HEOs, at least one came from business, one from industry, a few directly from their first degrees in college or university. Most of them have a specialised qualification, the Diploma in Health Education; this is part of the career structure

# HIERARCHICAL DIAGRAM

(Showing relationship of H.E. to Government)  
(Fig. IV 1)



outlined in the Kirby report (which will be further explained later in this chapter). Since it is the recommended training for an HEO, most of them have either completed it before they come into the post, or they are sent on it within eighteen months of appointment. It is a one year full-time course offered at Leeds University, and Bristol and South Bank Polytechnics.

The Certificate in Health Education is a day release course suitable for people such as nurses, dentists, teachers, and others who want to use Health Education in their jobs, and need some further training for that purpose. An HEO might have this certificate if she had achieved it as part of her professional training in a previous job; otherwise, it is not considered appropriate for HEOs, and it is usually taught, at least partly, by an HEO in conjunction with college staff.

In 1980, a working party of the National Staff Committee for Administrative and Clerical Staff produced a document called the Kirby Report, whose purpose was that "the needs of the population and the aims of the service are met" (Kirby, 1980, p. ii). This sentence is included here to emphasise a point made earlier, that the 'needs of the population' are intended to come before any other needs or purposes, (or at least, that is a stated aim of the DHSS). The aims referred to are subsumed under the Government's declared "commitment to the promotion of prevention and health education in its health policies" (op. cit.). The report states (p. 1):

"The Working Party's terms of reference were 'to identify the training needs of health education officers, to examine the range and nature of the existing training facilities, to assess the extent to which these facilities meet the present needs and to evolve proposals for their future promotion, organisation, oversight and development'."

"Kirby", as the document is called by HEOs, has not been implemented as a law, but is still widely used as the guideline for job descriptions, as laid out below (from the 1980 edition of Kirby).

"Job Description: The Formal Culture

Area (District) Health Education Officer

1. Although it is unlikely that any two posts of Area Health Education Officer will have precisely the same duties, this specimen job description describes, as the basis of good practice, the main substance of duties common to all such posts.
2. The extent to which an Area Health Education Officer would be able to undertake the duties must depend on the staffing and other resources available to him.

DHEOs are directly responsible to the District Medical Officer, and have management responsibility for Senior HEOs, HEOs, trainees, secretaries, technicians, and any other supporting staff. DHEOs are concerned with the following key tasks:

- Stimulating interest in and awareness of health education.
- Planning ahead for services.
- Consulting with professional colleagues in the community.
- Bidding for financial support.
- Monitoring, pre-testing and evaluating health education activities.
- Providing health education and training for a wide range of professionals.
- Arranging for supplies of aids, materials and literature.
- Using media appropriately to support national and local health education campaigns.
- Organising in-service training for HEOs, nurses, social workers, teachers, environmental health officers, doctors, dentists, and many others.
- Advising, consulting, managing, organising research and evaluation.

Specimen Job Description

Health Education Officer

1. This specimen is applicable to a service employing a full and adequate complement of health education staff. Certain tasks would change in a less than ideal staffing situation. There could be constraints, other than lack of full staffing, that would similarly

alter the contents of a health education officer's job description.

2. The organisation of health education in some areas might well result in higher graded officers specialising in certain areas, e.g. research and training.

#### General

The Health Education Officer will support the Area Health Education Officer in the latter's responsibility for promoting health education throughout the area; he will work under the general direction of the Area Health Education Officer and will be accountable to him. The Health Education Officer assists the Area Health Education Officer in providing an initiating, coordinating, advisory and enabling role for health educators. Technical, administrative, clerical and typing support will be provided from the general staffing resources of the service.

The HEOs' first stated task, then, is to support the DHEO in her activities. The job is further described as having five main functions:

- (i) Planning for health education and health care.
- (ii) Advising other health educators and other agencies on effective approaches to health education.
- (iii) Organising and participating in in-service training for other health professionals and trainee HEOs.
- (iv) Organising operational fieldwork, research and evaluation (of campaigns, and other programmes, posters, literature) audio visual aids.
- (v) Undertaking other tasks required by the DHEO."

It should be noted here that this last statement ((v) above) gives a great deal of control to the DHEO: if he stuck to the letter of Kirby's law, the DHEO could require the HEO to do any task he suggested, and the HEO would find it difficult to refuse. Power, therefore, is vested formally in the DHEO.

The District Medical Officer also influences the work done in the HE unit. One HEO told me about an example of this. In his district, the DMO considers the "Look After Yourself" (LAY) course to be one of the five top priorities for health education; it is a course offered to the public, usually ten sessions long,

emphasising selected health topics and including mild exercise. Since the DMO considered it important, this HEO is being sent on the tutor training course for LAY, and will probably be asked to offer it in his district. Like DHEOs, DMOs vary in their opinions about which are currently the most important topics.

#### Guiding Principles: The Semi-formal Culture

Some of the concepts which are the foundation of Health Education, the HEC, and the HEO, have already been described; people need to have the information about health topics so that they can make sensible decisions which will lead to positive health (not just the absence of disease). This is intended, according to all that I have learned during my sojourn in the culture, to be a caring, sharing, democratic attitude, not a paternalistic or bossy one. This seems to be a constant intention in the midst of many issues of individual differences, which are clustered around the question of what will be the best way to implement this philosophy.

#### Major Tension Between HE and HP

At present there is a trend in the health service to change the term Health Education to Health Promotion. Some HE units, are being changed to HP units, but with no change in job descriptions; some HEOs believe that this is meant to change their public image; it will make them look progressive. The dialogue among HEOs and DHEOs, variations of which I have recorded four times in one week, goes like this:

HEO 1: Health Promotion means positive health, not an absence of illness.

2: So does Health Education!

1: That's right, they both mean the same thing anyway.

2: No, but promotion means selling, advertising, bringing good health to public awareness.

1: All that is subsumed under health education.

3: I think promotion is wrong. Hitler was a health promoter, he forced the whole generation of German Youth into fitness. Promotion is for Hollywood agents and slick operators. I'm not going to spend my time and energy promoting fun runs and bicycle races. Education is where it's at.

4: I think you're all wrong. Who was it who said, Health Education is like a mobile, it just blows around in the wind, lots of committees making lots of changes, and nothing happens ..... ?

1: That's what I am saying!

2: No, you have all got the wrong end of the stick. Health Promotion means a clean environment, free transport to leisure centres with free admission to swimming baths. It means combating sexism and racial prejudice. It means getting involved politically. Picketing theatres and restaurants to designate no-smoking areas .....

1: Yeah, but look what happened in Bristol - an HEO is being threatened with prosecution for sending under-sixteens to buy cigarettes, just to prove the shops would sell to them. They did a lot in Bristol too, picketing theatrical productions which were advertised with funds from the tobacco industry. But Bristol is built on tobacco money - they'll have to stop.

2: No, you have all gone mad! Health Education is about choices, not about politics .....

and so on. In an attempt to make some sense out of all this, I



quote from part of the rationale behind the HE Diploma course:

" ... Health Educators support change by choice, not coercion. The principle of informed choice does not, of course, mean that the client is merely offered information about health risks and then left to make up his own mind about whether or not to take any notice of the facts provided. Sound educational practice would involve ensuring that any health information had been understood. The educationist would then arrange for clients to share and explore their beliefs and values in relation to the health information and discuss its implications for action.

Provide  
Information

Practise Decision  
Making

CLIENT  
CHOOSES  
FREELY

Explore and  
Clarify Relevant  
Beliefs and Values

It is worth noting in passing that evaluation of the effectiveness of the educational approach merely involved demonstrating that the client has a genuine understanding of the situation. No attempt would be made to devise attitude-change measures or look for 'healthy' behavioural outcomes." (Tones, 1983, p. 115)

The word 'choices' is a key word in the HEOs' vocabulary.

They see choice as a basic philosophical issue underlying their own personal effectiveness as well as the nature of their task.

A friendly HEO sent me an article (Mann, 1977) which contains the following quote:

**"Human Costs of Losing Choice**

We are only now beginning to recognize the exorbitant cost in human suffering of allowing exploitative social conditions to deprive certain groups of people of any meaningful control over their own lives. The most dramatic testimony to the importance of decisional choice for personal well-being is the evidence now emerging of how people react when they discover that all meaningful choice has been systematically stripped away from them. Such is the fate of a number of groups in Western society, particularly prisoners and the elderly."

For this particular HEO, and many others in the project, this

"importance of decisional choice for personal well-being" is what the job is about.

One source of frustration in putting the concept of choice into practice seems to be the feeling that "No-one up there cares". In the economic climate brought about by the present Government, the industries that HEOs look on as anti-health, (the main ones being tobacco, pharmaceutical, alcohol, sugar, and butter), are such influential political lobbyists and sources of revenue, that HEOs often feel there is little point in fighting them. For example, the HEC is able to spend £3,000,000 a year on anti-smoking campaigns; the tobacco industry spends £1,000,000,000 on advertising its wares. Yet the HEO is committed to letting people know the facts about the effects of excessive smoking, use of tranquilisers, drinking and sugar and fats in the diet.

"Of course it could be argued that the reason for the ineffectiveness of health education in closing social class gaps is due to the puny resources made available to prevention in an essentially curative-orientated NHS compared with the amounts spent on cigarette advertising and promotion. However it does not necessarily follow that a mere expansion of current health education activities without a change in methods used would make any difference."

(Hubley, 1979, p. 113)

Many HEOs are convinced that a non-directive community development approach is the best one to accomplish widespread changes in health practice, using some variation of the model below:

Stages in the thinking process leading to action by a group		
	Members of the Group	The Community worker (by asking questions)
Stage One	Vaguely dissatisfied but passive	Stimulates people to think why they are dissatisfied and with what

Stage Two	Now aware of certain needs	Stimulates people to think about what specific changes would result in these needs being met
Stage Three	Now aware of wanting changes of some specific kinds	Stimulates people to consider what they might do to bring such changes about by taking action themselves
Stage Four	Decide for, or against trying to meet some want for themselves	If necessary, stimulates people to consider how best they can organize themselves to do what they now want to do
Stage Five	Plan what to do and how they will do it	Stimulates people to consider and decide in detail just what to do, who will do it, and when and how they will do it
Stage Six	Act according to their planning	Stimulates people to think through any unforeseen difficulties or problems they may encounter in the course of what they do. (He may again need to help them work through each of the preceding five stages in deciding how to tackle each problem)
Stage Seven	Satisfied with the result of what they have achieved	Goes to another group or phase of the project

(Batten, 1967)

(The HEO would train and support the community worker.)

#### The Holistic v. Topical Issue

One further comment (for now) about basic HE issues. When I

first began interviewing local tribespeople, I was told very firmly, almost aggressively, by two of the older and more seasoned DHEOs that they did not have time to look at specialised topics such as alcohol, that Health Education is a holistic field and that it was unwise to jump on every trendy bandwagon. Some DHEOs feel that their time is better given to broader issues such as developing interdisciplinary links and organising community service teams. Others feel that although their work is holistic, one must seize the opportunities of the moment; when an alcohol campaign is mounted it is time to concentrate for a time on alcohol, while the money and resources are available. And others were extremely active in creating the opportunities of the moment, actually making the campaign happen. An interesting footnote is that the first two DHEOs described above did eventually link themselves, and their staff members, into the DC project.

In summing up what various DHEOs have said about this issue in interviews I have the impression that its source as an argument stems more from managerial style and personality of the individual DHEO than from more basic differences; the HEC seems to use both ways of working.

#### Autonomy and Constraints

The DHEO as manager engages staff, appraises their work, develops and supervises their training, is responsible for discipline, health and safety on the job, keeps records and controls the budget and performs any duties required by the District Medical Officer.

One implication of this broad range of managerial tasks, while not spelled out in the Kirby Report, is that the DHEO also grants,

(or does not grant) autonomy and responsibility to HEOs.

Thus, the degree of autonomy which any HEO experiences in the job depends upon the management style of the DHEO, and on the constraints of work in that particular unit; there are no laid-down organisational rules about it. Some DHEOs read all post that comes into the office, to keep themselves fully abreast of all that their staff are doing; and some also insist that all diaries are kept on the office desk. In those units also, many of the projects and in-service training are organised and delegated by the DHEO. Others leave the post and the accompanying tasks or responsibilities to the HEO herself, and the HEO is free to develop any topic or undertake any project, and the communication channels operate in the other direction: the HEO keeps the manager informed.

In a few units the HEO seems to be very active, while the DHEO stays very much in the background. However, autonomy, where it exists, operates within the framework of an agreed policy and programme, set out in writing and approved by the DMO and Regional Health Authority; in some units the HEOs are actively involved in the development of policy, plans and priorities.

The reader may remark that these differences among HEOs would be recognisable in a comparative study of other organisational groups, and I would agree. However, this organisational culture of the HEO is characterised by differences between units. This may be due in part to the lack of managerial training given to the new DHEOs. As Margulies and Wallace state (op. cit., p. 61):

"Obviously, one of the functions of the manager as a change agent is to display consistently and clearly ... the attributes he would like to see come about in the organization."

In the past, people newly promoted to managerial posts in HE have not always had the sorts of skills which make it possible to model such behaviour. In 1984, the HEC is beginning to fill this gap with courses in management training. Meanwhile, certainly one of the factors I have noticed is that some of the HEOs seem very frustrated at the lack of autonomy granted to them.

As Argyris puts it (1960, p. 263): " ... one of the most important needs of workers is to enlarge those areas of their lives in which their own decisions determine the outcome of their efforts."

However, I have noticed that while some HEOs resent strict managerial control, others seem to thrive under it. For as Argyris also says (1960, p. 266): " ... organizational efficiency increases if each unit has a single activity (or homogeneous set of activities) that is planned and directed by the leader."

Many DHEOs in this region do practise democratic management, and grant a large degree of autonomy to their staff; again the responses to various styles and qualities of management vary according to the circumstances and nature of the individual HEO.

Kirby states that each health education unit has a different set of constraints depending on the funding available in each district. In Spring of 1984 there are 420 HEOs, spread among 14 regions in England. Fifty per cent of these are comprised of three staff members or less, and fifty of them are one-person units.

One DHEO among our sample works alone in one room to serve an urban district of 160,000 people; he spends a great deal of time finding money for any project he wants to initiate. Incidentally, this man manages to accomplish a great deal alone, or rather by

making links with other people in the community. In another more prosperous district, a DHEO has as many as six or seven HEOs working as a team, with appropriate support staff. Most of the units in this region are somewhere between those two, with from three to five HEOs.

Each unit has a unique structure within the staff team; for example in one district the team is divided like this:

DHEO	HEO 1	HEO 2	HEO 3
Admin. and special topics	Health Services, nurse training	Schools and in-service	Industry, prisons

They have meetings to discuss all the work, and all join together in certain projects. Similar divisions occur in the other large units; in one or two-person units, priorities can cause problems; one or two HEOs cannot cover all the possible areas of work.

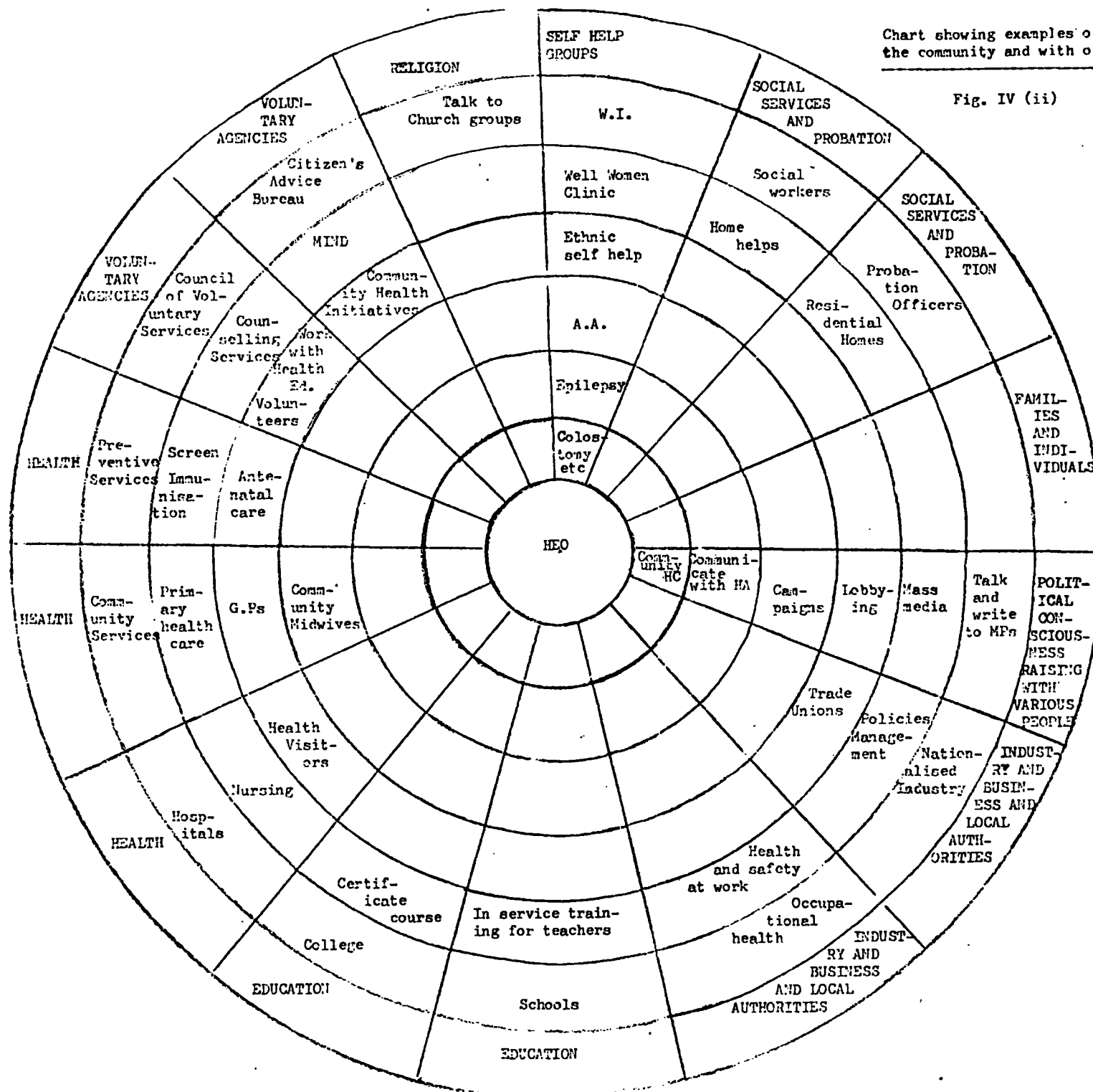
#### Links with Other Professions

The chart below (Fig. IV.ii, p. 151) is a representation of the connections between the HEO and other workers in the community. This picture of the network is oversimplified in that it does not describe other interdisciplinary links than those of the HEO.

This interaction has given the HEO the title "gatekeeper to the other professions" (coined at an HEO training meeting in 1984). As a corollary to being so closely linked to other workers, HEOs are inveterate committee goers, often serving on a number of different committees throughout a community: MIND, multi-racial projects, community development groups, training and educational programmes, hospital-based schemes. Committees can be productive and active; many of them are. Committee meetings can be

Chart showing examples of HEO's links with the community and with other professions

Fig. IV (ii)





stimulating and exciting; often they are frustrating, boring, competitive, waffley and maddening. The HEO could be assessed on his ability to tolerate committee meetings; he certainly attends a great number of them. Furthermore, and more importantly, HEOs could be trained in committee skills such as assertiveness, negotiating, and chairing meetings.

"Involvement in committees is essential if HEOs not only seek to change the public but also the bureaucracies and systems within which the public lives. Changing and educating the decision-makers may be as important or more important than changing the public, if we want an environment which makes healthy choices easier choices."

(Personal comment: Dr. Ina Simnett,  
May, 1984)

### Role Confusion

Now we come to a paradox: in spite of the Kirby Report, which has been summarised above from a 50 page document, and which outlines the HEO's role in considerable detail, some members of the culture seem to live in a perpetual state of mild identity crisis; one HEO said: "I feel that I am a juggler with dozens of balls in the air, and any minute a new one can fly in from the side". In fact, I have the impression that there are three kinds of HEOs (at least!): those who understand their role, or accept the Kirby description, those who do not think much about it, and those who wonder all the time who they are supposed to be and what they are meant to be doing. The first and second kind are self-explanatory, they are usually more task-orientated, and get on with the job.

The third type will need closer examination; why, in the light of Kirby's detailed job description should so many HEOs be

confused? There are several factors here that have emerged from analysis of their personal accounts of the culture.

They work in the NHS, but cannot count on continuing financial support from either the Government or the HEC. They often feel that their jobs are at risk. (In Chapter VIII, when we look at district reorganisation of the NHS, this factor will be developed further.)

The HEO could do some of the work of many other professions. She goes into schools and takes on a teaching role; goes into people's homes, as health visitors do; works in hospitals, as medical social workers do, to identify patients' educational needs; talks to young offenders along with probation officers. In industry, she may work alongside occupational nurses, management or employees. The boundaries between HEOs and other professionals are blurred.

These professionals see the HEOs as experts, and often invite them in for short talks or films on a topic such as nutrition. Many of the HEOs in this project see this as a mis-use of their resources, and would much prefer to do in-service training where they passed on skills and knowledge to the educators to enable them to become more expert in health education. They find one-off talks very unrewarding; no relationships are or could be developed with pupils or students, and there is no feedback or follow-up. This dislike is especially evident, since some of them had already developed an interest in participatory learning which has been re-awakened by DCM. Many of them now feel that with client-centred teaching methods they can help other people develop enough expertise, so that the HEO is only needed as a facilitator/resource person. The reactions of audiences are frequently hostile, as

they expect that the so-called expert has come to preach to them and tell them what they should and should not do. This very role of the expert is the niche where they are placed by other professionals and members of the public, and yet this is the one they want to avoid or give up.

Some social scientists do not find it useful to talk about roles or role confusion:

"In general, the theorizing about roles appears to us to be one of the most arid areas of sociological endeavour. It has started from inadequate ideas and built up mountains of qualifications and sub-qualifications. Role theory is an occupation which can keep a pedantic brain busy for years and even secure career advancement, but it tells us virtually nothing at all about the world we live in ... "

(Coulson and Riddell, 1980, p. 31)

The alternative view which is offered by the authors named above seems to provide a helpful answer to the HEOs' confusion:

"If, instead of talking about roles, we talk about the expectations held by specified groups as to the behaviour of people in certain positions, it makes it much easier to check the consequences of these expectations. It leads us away from the sort of mechanical idea of sociology that society 'creates', via social organization, sets of roles to which a person 'has to' conform, an idea which underlies the thinking of many sociologists. Definition in terms of expectations gives a much more flexible, dynamic model, in which people's behaviour in positions depends on an interaction between their own learned expectations and the pressures put upon them by others with possibly different expectations. It also depends on the power others have over them, an interaction which will be in constant conflicting change as power relationships change - in other words, a dialectical relationship."

(op. cit., p. 31)

## The HEO in Person: The Informal Culture

At a recent (March, 1984) DCM course I told people that I was writing this cultural description of the HEO. The following week I received the following letter from a young, politically active HEO; it seems to be an eloquent example of some of the role confusions and ideological issues which surround our tribe.

### "Some thoughts on the culture of the HEO

As many new HEOs are drawn into the profession from contact with creative or community/radical perspectives on health teaching, they tend to be of a radical disposition or at least open to persuasion that the status quo in the health service needs some revision.

One factor that seems to emerge here is that expected health behaviour of HEOs in terms of the classic physical health agenda items of smoking, drinking, etc., causes a certain amount of dissonance with behaviour, being not that which the thinly veiled 'educational' messages of the HEC and HE units push prescriptively out.

The dissonance is, however, resolved both by the adoption of a choices model but also more satisfyingly and comfortably by the progression towards a model of health behaviour which places responsibility with the social environment solely. One possible explanation of the increasingly radical shift in newer HEOs is in terms of defence mechanisms, as it could be argued that the radical value position of some HEOs leads them to adopt perspectives in advance of epidemiological or factual research and information. The hidden agenda then becomes social change.

As the visions of utopia offered by the social engineering are not things that are accessible to 'proof' or indeed 'refutation' it becomes valid to hold or advocate social change objectives though it must be made clear that this depends fundamentally on a value position ..... BUT efforts must be made to demonstrate how the present system of health education and provision of health service are based on value positions TOO and are not based on the mythological rock of scientific research.

Many HEOs are self-actualised - but what is more important is that they are, unlike the middle class, self-conscious of this and the processes that has brought or may bring this about. The attachment of this to certain value systems can generate responsibility without power (I mean here the institutional power not personal)

to effect change within the environment targeted for change to improve health.

The outcome of responsibility without power can be argued to be subversion or hidden agenda-setting as this would be the only model of change available to a radical HEO within an institution that prescribes the agendas and models of change that are deemed acceptable.

This can be seen also to foster cliques and 'bunker mentalities' amongst the profession who despite their personal power values and insight find themselves beleaguered.

Geographical separation also contributes to this and also accounts for the lack of orthodoxy, authority and consensus amongst the practitioners - though value divergence also accounts for the split consciousness of the profession as a whole.

N.B. Also professional journals do not reflect values and culture as with some other professions e.g. social workers. This is because they are 'provided' by, e.g. HEC who have set political agendas. The profession is not large enough to sustain alternative journals able to coalesce a coherent alternative perspective to the job but this may change."

(HEO, North West, 1984)

This letter gives a sample of the quality of the communication and trust achieved in this project, and is an example of how some HEOs see their job in a wider political context.

#### Varying Responses to the Job

When asked what they disliked about their culture, a group of fifteen HEOs produced the following list:

Not all HEOs agree all the time - lack of cohesiveness

Carrying projectors

Lack of professionalism

Coping with requests for leaflets and posters

Political overtones

Not being able to just go and do it, have to consult  
DHEO, and often others

Writing up

Mice (in connection with environmental health work,  
e.g. unhygienic restaurants)

So many hats (roles)

No-one up there cares

Speaking to large groups

Lack of guidance from HEC and Government

Lack of financial support

Overflowing in-trays

Expectations of clients

Committee Chairman with expectations

Working for NHS

Saying no

Being thought of as HEO

Ignorance of others of own role

Self-assessment

Big bureaucracies - small numbers of HEOs

Health v. cigarettes, and alcohol, drugs etc.

### Satisfactions

The same group of HEOs produced the following list of likes:

#### Best things about our job

Diversity

Variety

Meeting people

No two days are alike

Get to be a star in the media at times

Chance to be innovative

Interesting

Friendliness

Good relationships in region

Nice to see behaviour change

Self-motivation

Self-determination

Other HEOs' training activities

Get a good laugh

Flexibility of role

Talking

Working in Northern region  
Experiential learning  
What you are doing is valuable  
Being able to say yes  
Challenge  
Field workers' appreciation of you  
Self-fulfilment

Some HEOs say that a major cause of dissatisfaction is their lack of contact with the general public. This ties in with role confusion: are they supposed to work with clients or not? Mostly they are approached by other professionals for assistance or resources, and they say they do not see enough of ordinary members of the community, as they used to when they were teachers, health visitors or nurses in their previous incarnations. One implication of this is that without direct feedback from clients it is difficult to determine the educational needs of a particular community. Another factor is simply the lack of rewarding personal contact.

### Creating Opportunities

The problem mentioned earlier, the lack of direct contact with the public, has been ingeniously overcome by some HEOs. One (we will call him Robyn) was working in a prison in the North of this region, giving talks on contraception, alcohol, drugs and other topics suggested by the prison administrators. He discovered that a number of the men were interested in music. They had been writing Rock lyrics, and the local vicar was setting them to incongruous tunes. Robyn, being a Rock musician himself, now has the men playing the guitar and composing their own music.

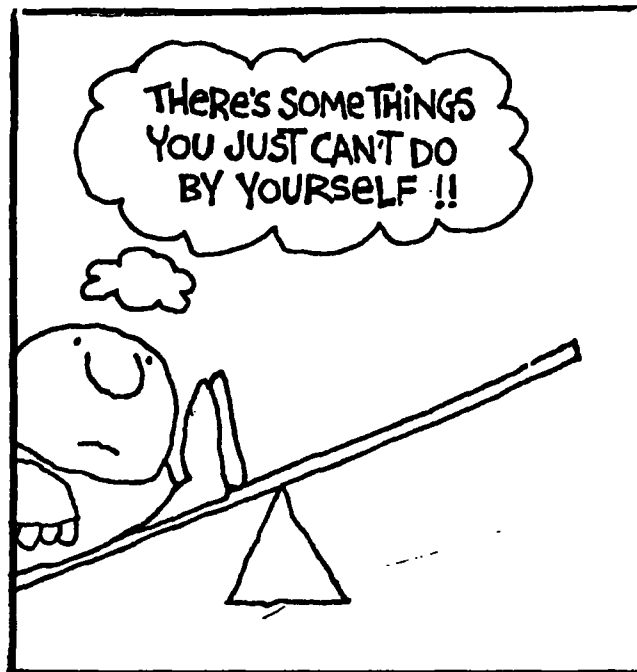
Robyn likes working at prisons for four reasons:

- (i) It is the acid test for innovations - groups at prisons will not stand any nonsense. They will not be polite, and if they do not like it, you will hear about it.
- (ii) He likes the prisoners and feels that when they return to the community they are considered as leaders by their peers simply because they have had the status of being in prison, so if their attitudes change, they can be powerful change agents themselves.
- (iii) Robyn noticed attitude changes in the prisoners from the beginning of his working with them to the end.
- (iv) Robyn has shown the prisoners' work to other people, who have come up with comments like, "Prisoners are real people".

Other HEOs create opportunities to work with school children on an extended basis, because they enjoy that more than in-service training for the teachers. Some may develop an interest in a particular topic and spend a lot of time over a period of months developing that theme. An example of this is the solitary DHEO who has put an unusual amount of time and energy into developing a community alcohol team, running a series of DC courses, sending professionals for training in alcohol counselling. When these are self-perpetuating he will turn more of his attention to the next topic of concern. Some HEOs have become involved with the Manpower Services Commission's Youth Training Schemes, providing materials, resources and training for the tutors. Still others enjoy direct personal involvement with



community development programmes, and Inner City or multi-racial projects.



### Variety

The HEO often has to do many different tasks in any one day; the reader might find it interesting to look at the following diary of an HEO's day, and, comparing it to his/her own job, look for possible sources of dissatisfaction and enjoyment. The following account, selected from ten others, seems to me to be fairly typical.

How I Spend my Average Working Day by Harry Edward Orr,

(HEO) 21st February, 1984

(True account, only names changed)

Time	What was I doing?	Where was I?	Who was I with?	Comments
8.00 a.m.	Getting car out - driving to work	Gosforth - North Shields	Alone	Listening to Neil Young on the Sony Walkman. Feeling O.K.
8.30 a.m.	Sitting at desk reading Minutes of last Society of HEO's meeting	Office	Joined by colleague and boss	Really disappointed by professional Minute taking
9.00 a.m.	Putting up leaflets for SR on Out-Patients. Talking to boss about 'World in Action' on 'fats'	Office - mine and bosses	Colleague	Thinking about what I need to do today.
9.30 a.m.	Sending photocopy of 'Smoking advice for diabetics' to Consultant. Letter to go with it.	Office	Colleague	I get to read the Life-skills Manuals doing this - good!
10.00 a.m.	Preparing timetable for Beamish III. The 'loo' - making coffee - switching on Radio 3	Office	Alone for a while	Thinking about p.m. and how to approach dietary teaching with the men-tally handicapped

10.30 a.m.	Still working on 'Daughter of Drinking Choices' or whatever it is called	Office	Alone - secretary popping in	Thinking a lot about Beamish III and how much is available - games, books etc.
11.00 a.m.	Finishing off timetable, writing it up ready for photo-copying	Office	"	
11.30 a.m.	Writing short note to friend in hospital	Office		Thinking I must pop in to see friend
12.00	Clothes off. Running 5 miles	North Shields Whitley Bay North Shields	Alone (friend has injury)	Good time (36 mins) Hard work
12.30 p.m.	Meeting with teacher re exercise and heart disease	Office	Alone then with teacher	Interesting fellow, he'll be back
1.00 p.m.	Wash & lunch	Back office!	Alone	It's always a rush at lunch time!!
1.30 p.m.	Out to Camperdown Adult Training Centre	Car	Alone	Neil Young on tape!
2.00 p.m.- 2.30 p.m.	Meeting with instructor re diet/slimming group for workers	Camperdown ATC	Instructor	Nice set up. Nice guy

3.15 p.m.	Driving back to North Shields Hospital	Car	Alone	Still Neil Young (and a little Bill Withers)
3.30 p.m.	Talking to friend in hospital	Hospital	Friend	Looks poorly, anxious. Deep vein thrombosis!! I'm worried
4.00 p.m.	Photocopying	Preston Hospital	2 secretaries	Why haven't we got one in the office?
4.45 p.m.	Chatting to boss and secretary	Office	Boss & secretary	It's nearly home time
5.00 p.m.	Driving home	Car	Alone	More Neil Young - it's a double L.P. Must get in touch with George Gandi!
5.30 p.m.	Putting car away at home	Home	Wife & daughters	Nice to be back
6.00 p.m.	Eating	Kitchen	"	Nice tea. Nice chat
6.30 p.m.	Filling in diary. Drinking tea. Chatting to wife.	"	"	

7.00 p.m.	Telephone, Tom & Jerry. Reading with daughter.	Kitchen & sitting room	Wife & daughters	Daughter's reading is coming on.
7.15 p.m.	Bathtime	Bathroom	"	It can be boring - but try to make it fun
8.00 p.m.	Putting daughter to bed late washing dishes	Bedroom Kitchen	Daughter Alone	I get to read some nice stories
8.30 p.m.	Chatting to wife. Sorting out papers, letters etc. 2nd visit to loo!	Kitchen	Wife	Thinking I've got work to do .....
9.00 p.m.	Watching Alias Smith and Jones	Sitting room	Wife	V. funny
9.30 p.m.	Etc. (Oops!)	"	"	Good play but ....
10.00 p.m.	Preparing sandwiches for tomorrow's lunch	Kitchen	Alone	Radio
10.30 p.m.	Watching TV and reading.	Sitting room	Wife	Tired
11.00 p.m.	Bed			

The reader may have noticed that this HEO is doing something about his own fitness.

A day like the one described by 'Harry Edward Orr' is full of changes in his modus operandi, and new challenges. One can see that Harry is experiencing a fair degree of freedom of choice, and is developing new tasks for himself. He saw his running as "hard work", and lunch time is "always a rush"; (some people rest at lunch time!). He is not stuck in one place behind a desk, and although there is a certain amount of paper to deal with, most of it consists of his own creative output as opposed to administrative tasks. He has made three professional contacts outside of the staff in his unit; two of them are new ones. He describes himself as tired at the end of the day; not surprising. He has had a great deal of mental, physical and social activity, and could be said to be enjoying variety, but the day could also be described as fragmented. The friend he visited in hospital and was worried about, was a course member in Harry's second DC course, a man who, as a result of DCM, changed jobs and went from being a care worker to being an alcohol counsellor. With Harry, he was organising a scheme to interview patients in that same hospital to discover drink-related problems, with a view to providing alcohol education and counselling to those patients. This sort of human contact, and resulting change in behaviour, is one of the rewards for the HEO.

I asked this HEO how much of his time is normally spent on alcohol-related topics; he replied, "About 20%. Most of my work is topic-based. Other topics that I now deal with are:

slimming/nutrition  
drugs, solvents  
the elderly  
dietary prevention of disease"



### Reflexive Nature of the Job

More than most other jobs, HE has a reflexive element, that is, the work HEOs do in helping others to choose healthy ways of living rebounds on to the HEOs themselves. The HEOs in the project seem to be as temperate and sensible in their eating, drinking and other health habits as they are recommending their public to be. I have heard them telling people to go to Slimming Class - they told me too. They are one group for whom you do not have to provide ashtrays, and a number of them go riding, running, swimming and hiking.

HEOs are human; they are not paragons of virtue, but their awareness-raising activities tend to raise their own awareness.

They are conscious of themselves as examples and as models; they believe that it would look very bad if they were seen to be smoking or intoxicated in public. They may smoke or drink to excess privately (some say secretly), but would not do so when running a course.



Along the same lines, some HEOs feel that their awareness improves their own mental health, that they would not be handling the stress of their job without their acquired knowledge of coping strategies. An example of this was described to me recently by an HEO who had changed jobs, left part of his family behind and moved from the North to the South. He found all these changes very stressful, and was experiencing tensions and especially a panicky feeling when driving. Because of his training and his heightened perceptions about mental health, and his communication skills he says he was able to:



- (i) realise that this was normal behaviour under stress.
- (ii) take effective control by practising deep breathing, slowing down the car and relaxing.
- (iii) know that the panic would go away soon; it always did.
- (iv) talk about it to me, and to others, which had the effect of calming and reassuring him.

By participating in projects like DCM, HEOs also become aware that communication skills and personal growth activities are as important for them as for their clients; many times I have heard Maslow's phrase "self-actualisation" used by HEOs to describe the ultimate goals of HE for themselves, their colleagues and for the public.

#### Other Aspects of the Culture

I see the following description as being lighthearted but meaningful. I told my colleagues that I was writing a chapter about the culture of the HEO, and asked them the question:

"How do you recognise an HEO when you see one?"

and

"What makes HEOs different from other professionals?"

The following section is a composite of what they said and what others say about them.

Like teachers, they are among the World's Great Talkers. Loquacious, discursive, they love to hold forth and to argue. Their work is of a controversial nature, always at least bordering on political issues, and often centrally involved in them. Thus there are bound to be major disputes reflecting different individual values, and organisational values. Still, when it is their turn to listen they are good at it.

## Language

"Every profession necessarily has its own terminology, without which its members cannot think or express themselves."

(Hudson, 1973, p. 17)

Jargon, as defined by Hudson, contains four essential elements:

- (i) It reflects a particular profession or occupation.
- (ii) It is pretentious, with only a small kernel of meaning.
- (iii) Used to convince people of importance.
- (iv) Deliberately or accidentally mystifying.

HEOs have an internal private language with which to converse together quickly and easily: in my experience they are not usually guilty of using excessive jargon when communicating with members of the public. However, they do have a fondness for initials which can seem obsessive at times.

### Script for an HEO dialogue in Acronymese

- HEO 1: Are you going to the HETI meeting in London?
- HEO 2: No, I've got an appointment with the DMO to discuss the new LAY and the DCM. He wants me to use them with YTS as part of NTI.
- 1: But the DMO is coming to talk to HEC about the new PHT in Notts., and we were told by our DHEO we have to be there.
- 2: Well, yes, but our CHC is eager to get their own LAY off the ground, and the next thing is the CAT, and we have to talk to the DHSS about what will happen to the RHA and the RMO, not to mention the rest of us, after reorganisation. I don't have time to go to London!
- 1: Besides, all of us are understaffed, only one HEU in the country is Up-to-Kirby, and that one is becoming an HPU any minute.

2: Yes, well..... Did I tell you we got a new OHP  
where the OHTs - P.L., you know!

In my opinion, HEOs do not talk like this in order to mystify, or to exclude the public, nor even to show off their own expertise; they do not use this language on courses, but only among themselves. I found myself doing it as well; not to be one of the crowd; it was easier, a convenient alternative to spelling it all out. Certainly the Health Education Officer immediately became an Aitchio. So, some jargon does have a useful function.

Aside from initials, there are many other terms peculiar to the job, some of which caused me some confusion at first, although they are not words used only by HEOs, because different HEOs define them in various ways, depending on political/philosophical stance. Some examples of these have been discussed earlier in this report:

- medical model
- holistic health
- health promotion v health education
- intervention
- alcoholism v alcohol related problems
- alcohol policy

#### Who is to Blame?

A phrase which has been in common usage in the health and social work fields is "victim-blaming". Again, this is a topic for much discussion among HEOs and represents the wide-ranging political differences in the tribe. It is related to the issues of self-responsibility and informed choice for the public.

Ryan describes this concept in Blaming the Victim (1971, p. 7):

"Blaming the Victim is, of course, quite different from old-fashioned conservative ideologies. The latter simply dismissed victims as inferior, genetically defective, or morally unfit; the emphasis is on the intrinsic, even hereditary, defect. The former shifts its emphasis to the environmental causation. The old-fashioned conservative could hold firmly to the belief that the oppressed and the victimized were born that way - "That way" being defective or inadequate in character or ability. The new ideology attributes defect and inadequacy to the malignant nature of poverty, injustice, slum life, and racial difficulties ...

As a result, there is a terrifying sameness in the programs that arise from this kind of analysis ... In health care, we develop new programs to provide health information (to correct the supposed ignorance of the poor) and to reach out and discover cases of untreated illness and disability (to compensate for their supposed unwillingness to seek treatment). Meanwhile, the gross inequities of our medical care delivery systems are left completely unchanged. As we might expect, the logical outcome of analyzing social problems in terms of the deficiencies of the victim is the development of programs aimed at correcting those deficiencies. The formula for action becomes extraordinarily simple: change the victim ..."

The victim-blaming concept is a source of great concern to some HEOs, particularly among the younger age group, who take their political awareness into their units and want to be working to change the systems which create inequalities of health care. Some other HEOs do not see these matters as part of their brief; opinions seem to range along the continuum below:

"Victim-blaming"

Everyone, regardless of economic or social status, is responsible for his own health. People could be healthy if they were informed and made the right choices.

System blaming

People cannot control their life circumstances in a vast system. Political changes must be made, and we are all responsible for this.

Argument itself may be healthy, as it may lead to consensus or finding ways to solve the dilemma. Following is a way suggested

to the HE diploma course:

#### "An Approach to Self Empowerment

From what has been said so far it would appear that health educators are faced with a dilemma. If they adopt an educational approach they might have to accept a role which involves the provision of good advice which will subsequently be ignored! Yet if they adopt a preventive approach they might have to resort to 'unethical' coercion and act as handmaidens to the medical model. On the other hand, the promotion of major social, political and economic change would appear a mammoth task involving either ineffectual posturing or commitment to degrees of subversive action. There may, however, be an alternative approach - an approach involving the pursuit of 'self empowerment'. The aim of such an approach would be to facilitate the kind of informed choice which was earlier considered an illusory goal. Four strategies would be involved. One of these would aim to promote beliefs and attitudes favourable to deferring present immediate reward for some future more substantial benefit - for instance abandoning over-eating for a promise of a healthier and longer middle and old age. A second strategy would attempt to increase 'internal locus of control'. In other words would challenge beliefs that life and health were controlled by fate or powerful people. This strategy would be complemented by an endeavour to enhance individual self esteem: an individual who values and respects himself is not only more likely to respond to an educational approach showing how to safeguard health, but will be more able to resist the various pressures which lead to unhealthy practices. It might, of course, be argued - and with some justification - that even a self empowered individual would be unable to have any impact on adverse social conditions and an oppressive environment. This may be true. However, the development of certain social skills - for example, assertiveness training - might enable the individual to challenge his environment and at the same time provide him with an experience of success which enhances self esteem and increases his belief in his capacity to control his life."

(Tones, 1983, p. 3)

At any rate, an outsider to the tribe has a language to learn and many difficult concepts to attempt to master, in the face of widely-varying explanations.

### The Controversial Nature of the Subject Matter

Whatever controversies may present themselves for endless discussions at meetings, lunches, chance encounters, one fact of HEO life has been inescapable: they love to argue. As we have mentioned before, the open-ended, political, individualised nature of the work almost demands it. Arguing is a challenge, and a form of recreation. Since I began my ethnographic study, there have not been many topics on which I could get agreement from the various HEOs I interviewed. They are contentious, some cynical, some idealistic, but almost all of them ready to challenge each other, and what is more, they see this tension as a healthy sign that they are free and able to be themselves. At the National Dissemination in March 1984, an HEO said, "One trait of HEOs is that they love to disagree". This comment brought vociferous disagreement from the group!

Having asked HEOs from every region about the reasons for all this arguing, I was not very surprised to find that they did not agree in their answers. Some of the explanations given:

- they come from different educational training backgrounds
- there is no orthodoxy to inherit
- it makes the job more exciting
- there is considerable difference in the times when various HEOs were trained: "My boss does not understand self-actualisation". (An HEO, 1984)
- arguing is all we can do, we have no real power
- all districts in the NHS are autonomous and badly linked
- people have been in the job varying lengths of time and with varying training

- they are scared to share and they are all different
- no one knows how to work to make the best changes in an inadequate and unequal health service (one area of general agreement)
- "disagreeing is a positive value, so HEO life is like a Mad Hatter's tea party - we like to display our independence." (An HEO, 1984)
- we all have different beliefs and political values

Perhaps some combination of these would serve as an explanation.

### Social Life

For many of the reasons given immediately above, there seems to be little social contact among our local HEOs, outside of the forum of the Society of HEOs and the various meetings and conferences. Except for these occasions, the job is contained within the hours 9 - to - 5 perhaps to a greater degree than in most professions. This is also caused by the fact that many HEOs in this region live far away from their units and from each other.

### Working Environment

The location of each unit is of course a factor in how each day is spent; one unit in the region is in a rural setting and necessitates a long drive to work and many long trips around the county. There is one unit all on its own in a mainly residential neighbourhood of Newcastle; another is above a shop in a commercial street. One is in a suite of offices in a large civic centre, one in a Social Services building in a downtown area. Four are located within hospitals. Obviously, the variation in ambience, and in the degree of comfort afforded, is very wide.

### Clothing

As the ethnographer of this tribe, I find myself longing for some colourful and unique costume or custom. Something with which to cry, "Aha, this defines the HEO at last!" But even in the question of plumage, the HEO remains difficult to define.

They do not have a tribal uniform or costume; as in other professions, there is the suit-and-tie or high-heels and smart-dresses group, and the blend-into-the-community, jeans-clad group. Of course as we saw in Harry's diary, there is also the track-suit-and-running-shoes crowd.

### Cooperation in the NE Region

"Relationships here are all very satisfactory because we've put the effort into making them that way." (Centre for Mass Communication Research, 1982, p. 73)

It is frequently said by this particular regional grouping of HEOs, and of them, that they have become a community, they are friendly, they share with each other in a spirit of cooperation. This, in spite of all the aforementioned differences and arguments, is one subject on which HEOs in the North East do agree. In my tribal investigations, I began to research this question by seeking out HEOs from other regions (at conferences and courses) and asking them how they get along with their colleagues. In other words, to see how other tribes compare to ours. In January - March of 1984, I interviewed a total of 24 HEOs from:

Buckinghamshire	Manchester (several districts)
London (various districts)	Devon
Merseyside	Cornwall
Humberside	Avon
Scotland	Yorkshire .....
Lincolnshire	

a fair cross-section of the 14 regions.



HEOs are probably not any different from other workers in that the enjoyment or unpleasantness of each day is coloured by the interaction with their colleagues; some people, in any profession, can simply be delightful or toxic to work with. My own impressions, and also reports from others, of the HEOs I have met around the country is that they can be territorially defensive and extremely sensitive to the pecking orders within the hierarchy. The links with other community organisations can be tenuous and fraught with interdisciplinary jealousies. Following are some quotes from these interviews; I shall not identify the regions from which they came, in order to protect the HEOs.

"In our county there are three Health Education Units. They know each other very well, and gather at coordinating meetings which are very serious and competitive. A lot of backbiting, gossip, 'This is how we do it in our district'. We never meet to have fun together. We certainly don't work together in a friendly and helpful manner.

You don't get the job unless you are vehement!"

(A DHEO in the North)

"I came in as an outsider; have done health education for seven years in another country. I did not work my way up and people resented it. Health Education here is not different from other countries, they have almost exactly the same interests and issues and programmes although the results of research would, of course, be different. There was no training for Health Education Officers in that country, no Health Education Council and no network. In England I feel that the training and the numbers in the profession are growing and expanding. But every HEO is supposed to be perfect and wonderful, they are scared to learn by making mistakes. Someone actually said, 'I am perfect at my job, I have set up this resource centre in the only way it can be.' The training makes it this way. I have to be a superstar. The DMO says, 'If we're going to pay you that much money, you have to offer us the earth'."

(A DHEO in the South)

"One of the problems of managers in health education is that they have a very broad brief. All of the world's problems are placed on the shoulders of 424 people. There is no data to work from and the managers have had very little training in management skills. They have been brought up with hierarchical and autocratic management styles. The older managers have got themselves back into a corner, they cannot admit there might be a better way to do things. Some districts have an outdated standard of practice with is very poor.

There are so many committee meetings, and they're all alike, boring and disagreeable. In the end, no one wants to go to yet another one, so we don't get together."

(An HEO in the North West)

"At the HEO seminar recently, I heard a lot of people were moaning about their bosses - right-wing, middle-aged thinking: our new HEO was appalled!"

(An HEO in the South East)

The general consensus among North East HEOs is that things are rather better in this region. Others from outside agree that they do have this reputation. This is one of the reasons given by the HEC for placing the alcohol campaign here in the first place.

"The level of cooperation between the health education departments and the area health authorities in the eight separate areas which were studied is most impressive, and it provides a good example of what may be achieved with good-will, regular communication and a determination to work together. It has been suggested by some that this cooperation was the result of the HEC campaign, but others believe it was there before the campaign, or would have happened in any case, and that the campaign has benefited from it. A researcher entering the field in 1981 could not possibly discover the truth of this. Still, it would appear that the recent phase of the campaign has clearly benefited from the good working relationships which exist in the region, and that this augurs very well for future progress."

(CMCR, 1982, p. 78)

They have a long history of working well together, for at least a decade. There were eight HE units in this region when the 1974 Alcohol Education Campaign began.

"The Tyne-Tees TV area had many advantages: good health authorities, cooperative local authorities, a population with variations in characteristics typical of the country as a whole and therefore accurately comparable with control areas, and the opening of the North East Council on Alcoholism with the availability of its Director to act as anchor man. Those same good reasons still apply ... We did not choose this area because the people ... have a bigger alcohol problem than people elsewhere ... the fact is, it ain't so. You are as typical in that respect as in others."

(CMCR, 1982, p. 10)

(Current statistics do not support this statement as they show the North of England consistently at or near the top of the scale in alcohol consumption (see Chapter II).)

DCM, it is generally agreed, has enhanced the relationships of HE workers in the NE, starting with the residential training course in 1981, through all the meetings and follow-up days. It has given a focus and direction to their work in the alcohol field, and a forum for discussion and planning, and has provided many occasions on which to meet and socialise.

Having asked the tribe members in the North East how they explain their unusually good relationship, I came to the conclusion that there were several factors. One is that there is a caring group of experienced and qualified DHEOs who have been in health education for a long time. They came from nursing or from health visiting or from academic fields with the necessary expertise. Some people also say that because the North East is more in a crisis situation with huge problems of unemployment, poverty and a harsh

climate, the HEOs realise they cannot work alone.

Many people say that people in the North are more friendly anyway; (certainly my own experiences in England seem to bear this out, although this does not constitute hard proof).

It seems that the main factor is that the working relationships have grown and improved over the last ten years at least, and that the local Society of HEOs has a history of cooperation. The presence of NECA as an active body in the region which also cooperates with HEOs in many ways, including the dissemination of DCM and the provision of alcohol counselling training, is another major factor.

#### Not Such a Bad Life .....

Those HEOs who enjoy their jobs say that the variety is exciting and the frequent switching of roles is stimulating. The contact with other professionals can be very rewarding. Some HEOs feel that this has been the outstanding bonus provided by DCM; as a direct result of running the alcohol education courses for multidisciplinary groups, they have strengthened their relationships with other HEOs, social workers, medical and industrial workers in the region, and these contacts will very likely continue to be fruitful in terms of alcohol teams and other collaboration.

#### Summary: What tribe did you say it was?

Perhaps it will be useful to review what we have learned about Harry Edward Orr, (or Henrietta Evelyn Orr, as she is just as likely to be a woman!)

She is to be found at her desk or in the field, working hard,

talking a lot, arguing about major and minor issues which often reflect the major splits in opinions and values in the organisation:

holistic v. topical approach to HE

autonomy v. constraints in the Unit

victim blaming - system blaming

health promotion v. health education

expert role v. trainer role of the HEO

responsibility v. power

likes and dislikes

keeping fit v. pleasurable habits

jargon v. technical language

With all this controversy, Harry Orr is still very busy doing many things other than talking; he is engaged in many projects and committee meetings, in planning and implementation of programmes. He is deeply involved in the life of the community.

This is not the end of our ethnographic visit to the North East HEO; he/she will be reappearing throughout this report. Without the HEO, there would not have been, and almost certainly will not be in the future, a DCM project.

DATA ON HEOs MARCH 1984

Number of HEOs	438
Number of Health Districts	207
Number of districts without any Health Education service	7
Number of districts being covered by another district Health Education service	31
Number of units offering a joint service to 2 districts	3
Number of units with only an officer in charge, but no other staff	51
Number of units with no OIC	7
Number of units, apart from OIC who have	
1 or 2 HEOs	80
3 or 4 HEOs	29
5 or more HEOs	10
Of all HEOs - 212 are female	76%
64 are male	27%
Of the OIC - 93 are female	45%
69 are male	37%

## CHAPTER V

### PROGRESS THROUGH THE PYRAMIDS

#### Introduction: Why the Pyramid Model Was Used

Some of the reasons for choosing this model of dissemination have already been mentioned in earlier chapters, but probably need reviewing. One of the purposes of the project was to create a greatly increased number of alcohol educators in the region in response to a need which was evidenced during the early stages of the alcohol campaign. The HEOs and the North East Council on Alcoholism were not able to cope with the numbers of people who responded to the campaign saying that they had drinking problems and needed help. This in itself made it evident that social workers, probation officers, nurses, doctors and health visitors in the region needed either initial training or refresher courses in alcohol knowledge and in skills for counselling or educating clients, and beginning to work with them.

Underlying that problem was the fact that HEOs were feeling frustrated by a persistent tendency on the part of other professionals to cast HEOs in the expert role and call them in for quick, "one off", lectures on alcohol abuse. Repeated efforts on the part of the HEOs to give up the expert role had been resisted, as discussed in Chapter IV. Thus the pyramid model was intended to overcome this resistance and made it possible for each person who needed the skills to see herself as an alcohol educator and to spread the

expertise to other colleagues or clients. At an even deeper level was the underlying idea: "A good teacher soon renders herself obsolete." The HEOs did not want to be constantly on call as alcohol experts and wanted that aspect of their work to phase out and become unnecessary.

One person, unless placed in an extremely influential position, can only have limited impact and cannot provide an effective way of promoting an innovation. The pyramid model, starting with 17 HEOs at the top, and with each of them planning to run courses for other professionals, provided a way of spreading the information and skills much more quickly and extensively.

#### Not a Miracle Cure

It may be prudent to remind ourselves at several points during this report that no one involved in this project considered that DCM would provide easy answers to alcohol abuse. No matter how enthusiastic people might become about DCM's actual and potential impact, it is at best an effective educational programme, and can be used as such in providing services for prevention and treatment of alcohol problems.

"The current state of treatment research suggests that heavy demands in the immediate future are likely to be placed on education. The task is to raise the overall level of understanding about alcohol and its effects, to enhance recognition of harmful drinking both in the mind of the sufferers and those whom they encounter and to reduce the stigma and misunderstanding which surround our knowledge of alcoholism."

(Grant and Ritson, 1983, p. 32)

In this context, we are considering DCM as an educational tool, and the pyramid as the way of implementing its use.

This chapter presents one of the essential aspects of the



evaluation, that is, how the pyramid model actually worked in practice and whether indeed there are now more alcohol educators in the region.

### Understanding the Pyramids

#### Level 1 of Pyramid I

I came into the project after the training model had been designed and invitations had already been issued for selected dates throughout the autumn of 1981 for the first regional training of HEOs. All of the HEOs and DHEOs in the District were included in the invitation and it was up to the DHEOs to decide which of their staff were coming. Seventeen HEOs came to the first three training days, which comprised a residential course at Beamish Hall in County Durham. This is where the codename Beamish I originated, and it became the shorthand term for the first regional training. The fact that it was a residential course meant that people mixed socially, at meals, at the bar, and on walks through the beautiful countryside surrounding the centre as well as on the training sessions. The dynamics of this particular group were of great interest to me as it was my first introduction to the culture of HEOs, except for some training in communication skills I had done with them some five years before. So, although I knew some of them already and a few of them quite well, I had very little understanding of them as an organisational group. They, however, knew each other very well and most of them had been working together for some years and had also, since 1979, been involved together in supporting the HEC/media campaign for alcohol education in the North East. The fact that they knew each other allowed them to behave in what I later

realised was their customary manner, that is, being competitive, argumentative, controversial and generally not unified, although friendly.

Moreover, as most group leaders realise, the better a group knows each other, the harder it is to take risks and to escape from preconceived notions of how each person traditionally behaves. Thus a group coming together for the first time has initial shyness and embarrassment to overcome and there is always the question of "what are people thinking of me", but a group in which the members already know each other very well has different kinds of barriers to break down.

An example of this in a later stage of the pyramid, was a group of social workers, all from one district. They found it extremely difficult to share their own experiences and feelings in the group for the following reasons:

- they knew each other well;
- they were worried about confidentiality;
- some managers were present and their staff said they felt threatened;
- they refused to do role play or games;
- open communication was slow to begin, only by the third day were they participating as a group.

The group leaders in the case of Beamish I were Martin Evans of TACADE and Antoinette Satow from the HEC who had worked together before and knew each other well and had designed another training package called Working with Groups. The approach used in Working with Groups emphasises an examination of the roles that individuals play in groups and how the life of the group develops, with attention to various theories about these processes. A lot of the work in the first three days consisted of introducing this particular

group to various theories of group dynamics and then allowing them to experience the ideas in practice. It was intended that the first three days, that is the residential section of the course, would not involve use of the Manual but would be the foundation for using group work skills throughout the rest of the course. Among the theories presented were those of Tuckman and Bion. This material was new to the HEOs and my impression was that they found it interesting, challenging and, in some instances, very difficult.

Having mentioned some of the disadvantages of the established network that existed in the region, I should mention that there were distinct advantages as well. The existence of lines of communication and long-standing working relationships made it possible for the courses using DCM to begin happening quickly after Beamish I was completed. The fact that the DHEOs were on the course meant that they were for the most part committed to participating in the dissemination and encouraging their staff to do so. DHEOs also were in a position to make the necessary links with social services, probation and the Health Service.

Following Beamish I, dates were chosen for six training days, which were to be non-residential and to occur on non-consecutive days over four months. Some of these training days had to be postponed due to extreme winter weather conditions which made crossing the region impossible. Thus it was late spring of 1982 when all nine days of training were completed, and, naturally, in between these widely spaced days, DHEOs and their staffs were involved in many other kinds of projects.

The switch to participatory learning methods was also particularly difficult for this group of HEOs, partly because of the

seniority of some of them, who had been using traditional methods throughout their previous experience, and partly because, in almost every case, previous training had been didactic. These two factors contributed to the personality of the Beamish I group and in retrospect I can see that they caused problems. I shall return to this point in Chapter VII.

At Beamish I, I was in an extremely complicated role with the following contradictory tasks to do:

- be a participant observer
- increase my own alcohol knowledge and skills as an alcohol educator
- get to know the group
- support Martin and Antoinette without interfering
- keep my own theories about group work, which were quite different from theirs, from getting in my way or confusing the course members
- repress my negative reactions when they arose, so as not to sabotage the group leaders
- offer consultation and advice when asked, without intruding
- evaluate the course
- build trust with the HEOs and begin the process of interviewing them
- begin to understand how an evaluation is done while being still in the initial stages of becoming a researcher for the first time
- write up or record everything that happened for three days
- begin to make relationships with HEC, HEOs, and DHEOs, and try to understand the organisational structure of the Health Service.

A difficult collection of tasks to undertake!

## Level 1, Beamish II

Before proceeding through Pyramid I, it may be useful to contrast the second session of regional training, which was considerably different from the first. By the autumn of 1982, Pyramid I had progressed so far that the Steering Committee felt it was time for Pyramid II to begin. By this time also, I was deeply involved as both project facilitator and evaluator, and relationships between me and the key tutors in the project were well established. Because of this, I was able to exert considerable influence over the design of Beamish II and in fact was invited to do so. I joined with Ina Simnett and Linda Wright in planning the second regional training course and it was made clear to me that I was expected to be the main facilitator. It was with some difficulty that I convinced the other two leaders that we should greatly increase the level of participation of the course members and that this would increase their confidence as alcohol educators. Both of the others had been committed as writers of the Manual to participatory methods. However, they had not had much experience of a completely client-centred approach and were doubtful how and whether it would work. In the end they decided to try it. We agreed to run the course together, I would take the lead in the sections of the course dealing with group work skills, and they would take the lead in the sections on alcohol knowledge and skills.

We began with a group work session in which some experiential activities were introduced and, growing out of those activities, some basic ground rules were established. This process is standard practice for client-centred work and although each group may establish some specific ground rules, there are others which almost every group tends to choose:

Everyone has the right to participate or not to participate.

All contributions are listened to and valued.

Structures are introduced, such as rounds, which give each person an opportunity to speak if he or she wants to.

The responsibility of the group is to support each other, and also to be honest in giving feedback.

The group is not working in terms of success or failure, nor does it expect praise or blame. We want to evaluate ourselves and each other with honesty.

Each group member has an equal right to negotiate for what he wants to happen.

Each group member is equally responsible for making effective learning possible.

Because of the manner in which the initial participatory activities are conducted, group members come to understand that certain behaviours are appropriate, such as listening carefully to what people say, giving people the right not to participate and that non-participation is not to be commented upon nor criticised. They also become aware that it is inappropriate, in a client-centred group, to discount or devalue group members' contributions. It may seem that this method of generating ground rules could be seen as a manipulative act on the part of the leader. However, the point is that any information which is brought out from the group ought to carry more weight than the same information if it were stated by the leader, which it is why it is the course members, and not the leader, who describe the ground rules. Moreover, the group leader can add suggestions for ground rules in an open manner, rather than subtly or covertly, so that she is offering guidance, and not manipulating.

The next step, once the ground rules have been agreed upon, is usually an agenda-setting exercise for either the course as a whole or the next section of the course. So the leaders at this point handed out the Manuals. Course members were given a chance to read through them quickly and we came back together to form small groups, one for each day of the 5-day teaching programme. These groups then separated to choose which activities they would include in their presentation of each day's work. The participants led the activities themselves, and thus they were able to try out their own leadership skills in what we hoped was a safe environment. Like their Beamish I counterparts, they found the group work interesting, challenging, and in some cases difficult.

The course was conducted in two 3-day sessions in the autumn of 1982, with the two blocks being only one month apart, and both being completely residential. These two factors were significant in producing a more cohesive group than that of the first regional training. Again the course was held at Beamish Hall, which provided us with the codename Beamish II.

Another major difference between the second pyramid and the first was the composition of the group. Beamish II included not only HEOs and DHEOs, but also clinical psychologists, psychiatric consultants, nurse trainers, alcohol field workers and youth workers. This was significant in that it made it much easier to establish ongoing activities involving a variety of professionals after the course was over, and also to enlist multi-disciplinary groups for courses at levels two and three. HEOs after Beamish I had to start by convincing professional people that DCM was a worthwhile course; this was much easier after Beamish II, with a group

of various professionals already having been through the training.

It also meant that there was a whole group of professionals in the region who could call on HEOs for cooperation and planning rather than just as experts in alcohol or other topics.

The geographical net was thrown wider as it now included Cumbria and North Yorkshire. The advantages of the group composition were that they had fewer preconceived ideas about each other since most of them did not know each other before the course. They were less hampered by embarrassment and competition and they were able to establish professional links when they returned to work. On the other hand, they were having to take risks with new people and being introduced to new ideas at the same time.

In comparing the two groups, I am not meaning to imply that people should not be trained with their close colleagues, but that the group leader be aware of the factors which may be operating. Since all three course leaders had participated in Beamish I but were now facilitating Beamish II, we were also working with the advantage of the previous experience. Nevertheless all of us felt, perhaps egotistically, that Beamish II course members developed a group identity more quickly than those from Beamish I, and that they benefited from presenting all of the alcohol education materials themselves.

#### Evaluation at Level One

A plan for evaluating the effectiveness of Beamish I was made in advance, but it did not consist of a written evaluation; when I was appointed, the writers and I agreed that I would conduct the evaluation by interviewing each HEO who was present at Beamish I.



In analysing the data collected from these interviews, it became clear that there was general agreement about several factors.

All the HEOs felt that they had increased their confidence and their skills as alcohol educators. They felt that they had made some significant attitude changes, in that they felt much more accepting of people with alcohol problems, and more aware of the variety of underlying problems surrounding a person who is drinking too much. They also felt that their alcohol knowledge had been updated and expanded, and they had had an opportunity to discuss ideas and information with other HEOs, and they had improved their relationships with each other.

One area about which there was disagreement was the warm-up exercises and the games which are incorporated into the Manual, and therefore which were included in the training course. Some people felt at the end that they still felt foolish when playing games, and disliked that feeling, while others felt that they now understood which activity they could use in warming up a group. Out of the comments made in the interviews, several improvements and revisions were made in the Manual; these will be presented in detail in Chapter VI. This is an example of the formative effect of this evaluation.

After Beamish II, I decided to change the evaluation method, so that all course members completed a written evaluation and a sample of four were chosen to be interviewed. Certain common themes emerged from compiling their responses. They all felt that they had gained more from the course than they expected. As one person said: "I anticipated a cold turkey sandwich and it developed into a feast". All but one person felt happier and more confident

in their role as alcohol educators. This one exception was an HEO who received a good deal of negative feedback about her style as a group leader. She was apparently addicted to lectures, and used a series of charts for demonstration. Most people felt that they had improved their teaching techniques and developed in their own personal growth, besides improving their skills as educators.

In this second group, the feelings about games and warm-up activities were much more positive, partly because of the client-centred approach adopted, and partly because the group leaders themselves were considerably more conversant with the use of games. This group was almost twice as big as the group at Beamish I, and yet they mentioned feeling close to each other and emphasised that one of the main sources of enjoyment was the warm, friendly feeling in the group.

### Level Two

Level Two of the Pyramid refers to any courses run by people who attended either Beamish I or Beamish II. By the spring of 1982, which was nine months into the project if we exclude the pilot courses, HEOs from Beamish I began running courses in Newcastle and South Tyneside. The two DHEOs in those areas were experienced in the job, with the necessary contacts in their communities, and were able to initiate courses without delay. Both these DHEOs ran multidisciplinary courses hoping to strengthen links between the professions and with the long-term intention to make it easier to start community alcohol teams.

By spring 1983, one year from the end of Beamish I and six months from the end of Beamish II, three districts had run three

courses or more, and all of the districts (except for one), represented at Beamish I had run at least one course. (Reasons for this will be discussed in Chapter VI under Obstacles.)

At Level 2 some HEOs joined with other professionals to run courses, some ran them on their own, some worked with other HEOs and some worked with me. Most of them seemed to prefer running multi-disciplinary courses for the following reasons:

These courses seemed to be less incestuous and competitive;

The HEOs could make new contacts with people they had not known before;

They could develop community alcohol teams or other less structured networks.

Also, by the spring of 1983, people from both Beamish I and Beamish II had attended follow-up days for further training. These were well attended with, in each case, more than half of the original course members being present.

There was a second district which was slow in beginning to run courses, and it so happened that in that district the DHEO had not been able to attend either Beamish I or II. As the evaluator, I felt that the regional training days were the mainspring for getting courses started at Level 2 and that attendance at those initial trainings was a key motivating factor.

One interesting exception to the usual pattern of progress through the pyramid occurred in a large metropolitan area. The HEO from that area who was able to attend Beamish I did not enjoy the course and did not initiate any courses at Level 2. However, the other two HEOs in that district, who had not attended the regional training, did begin running courses and, although they

had not been specifically trained in Drinking Choices, they overcame some initial difficulties as group leaders and learned how to do it as they went along. In spite of their later success, perhaps they would have been better off to have had the training, as they did receive a number of negative comments from course members on the first course they ran.

### Some Special Cases at Level 2

#### Parkwood House

Parkwood House is the regional treatment centre for people with alcohol and drug problems, set at St. Nicholas' Hospital in Newcastle. Keeping in mind that DCM is in most cases only indirectly concerned with treatment, it is important to note that at Parkwood they consider education to be part of the treatment. This is in line with both the medical model:

"... it is difficult for the early alcoholic, still with a responsible place in society, to admit to his condition. A very great advance that could be made in tackling the problem by public health methods would be the dissemination of factual information with sufficient force to displace harmful attitudes and to correct misconceptions."

(Kessel, 1965, p. 177)

and with the health education model:

"We envisage a domino effect in the spread of learning and skills from the writers of the manual, to the Health Education Officers, from them to the alcohol educators, and from the educators to their clients. Everyone ends up going through the same process and hopefully with the same skills. There are no experts; only helpers in the educational process. The skills are skills in everyday life related to alcohol and drinking; skills needed in friendship, family living, and inter-personal relationships in work situations."

(DCM, 1981, p. 5)

Parkwood House was the first case of a full in-service course, where the module was used with an entire staff team (except the director, who was excused on the grounds that he is internationally known as an alcohol expert and is a trained psychiatrist). All appointments in the clinic were cancelled for a week and all staff, including all the managers except the director, did attend the course full-time. The response to the course was extremely enthusiastic, both in terms of group work skills gained and in terms of alcohol knowledge, despite the fact that all the staff had had some alcohol training previously. I interviewed four people who attended this course. In every case the response was wholeheartedly positive, with very little negative comment. Since that time the course has been run in parts or in whole for nurses and other staff in the hospital where the clinic is based.

Having DCM used in this way in a clinical setting was an interesting test of the Manual and its ideas; these were acknowledged professionals, placing alcohol education as a high priority in their work, even though their work is mainly concerned with treatment. They felt that they had used it very successfully. They use a wide variety of approaches and treatment at Parkwood House, including counselling, work with families and patients, behavioural methods and, in some cases, drug therapy. At the time of writing, in May, 1984, about a year after their week-long course, the staff are still using Drinking Choices materials in various ways.

This seemed like a significant event to those of us following the progress of DCM. It meant that the people at Parkwood were now recognising that education is an important part of treatment for all clients, including their patients. This is in line with the rationale behind DCM.

### Otterburn Hall

The residential DCM course at Otterburn Hall was another special case. Like some of the courses mentioned earlier, it was run by two HEOs with me helping. (Perhaps this makes it level 1½?) The two HEOs had had a fairly negative experience running their first DCM course, earlier in the year. This was due to several factors:

- (a) They were inexperienced in participatory learning, so they tended (as they later realised) to talk too much and sound a bit "teacher-ish".
- (b) The group included two clergymen, a monk, a prison officer, two psychiatric charge nurses, a social worker and three teachers.
- (c) Because of inexperience, the leaders did not spend any time at the beginning of the course on introductory exercises so that the course members could get to know each other, perhaps build up some trust, and remove some of the initial barriers to communication that might have existed.
- (d) As can sometimes happen in a group, there were three people who liked to argue and hold forth at great length while other people became bored and restless.

The result of this was that the leaders were the target of a good deal of hostility and, ironically enough, the participants went out for lunch each day and came back having made a few too many bad Drinking Choices at the pub, and in no condition to go on, sensibly, with their alcohol course. Chaos reigned on the afternoon that I visited. Everyone was talking at once, and the group leaders were somewhat at a loss as to how to handle the situation; several people seemed quite drunk, and one was talking aggressively and wanting to argue every point.

The course members, just as much as their clients, come from communities where there are ambivalent social norms about drinking, and where they may be involved in heavy drinking with their colleagues at work, and where they themselves may have drinking problems. So perhaps the lunchtime drinking on this course was not an unusual phenomenon; with more time and increased expertise, it might well have been incorporated into the curriculum of the course. When it came to writing out evaluations, however, although some of the comments were flippant, and some were critical, people still were saying that they had gained a lot more in terms of alcohol knowledge than they expected at the beginning. (Not to mention experience!)

With all this in their recent memories, the Otterburn leaders were naturally inclined to want to make their second course much more tightly controlled. It was with great difficulty that I persuaded them that since I would be there the whole time, they could use the residential course as an opportunity to develop their participatory learning skills, and to run the course, as we termed it "à la Beamish II" (in a client-centred manner).

On the first evening we started with a session of group work, which went very well, according to the group. Then we asked them to move into planning/presenting groups, one for each of the five days of the course in the Manual. People joined groups 1 - 4, but no-one went to group 5 ..... No-one even noticed that it was non-existent. The two HEOs were beginning to panic and told me they would run Day 5 themselves. I said something like "Over my dead body .....", and they sank back into their chairs. A few minutes later, one of the group members noticed that the Day 5 corner was

empty. He remarked out loud that it would be good if one person from each of the other groups went into Day 5; it took approximately 30 seconds to accomplish this.

This incident is included here because it was a turning-point for those two HEOs; both of them, in a subsequent joint interview, attributed their conversion to participatory learning to that experience, and have since carried it farther than most of the others (more of this in Spin-offs, in Chapter VIII).

### YOPS

In the summer of 1982 another special case happened in the form of a training course for tutors on the Youth Opportunities Programme. This was a 5-day course and none of the course members intended to run training courses, a fact which was known in advance. All of them intended to use the course with their trainees so this was a case where Level 3 would be omitted from the pyramid. Course members and leaders felt that the course was enjoyable and effective. There was only one major difficulty and it is one which these same leaders had met before: course members elected to go to pubs at lunch-time and, in spite of having discussed the problems this could cause, came back in an alcohol-induced, sleepy condition.

One of the conclusions we have reached is that lunch on these courses ought to be provided in the place where the work is done and without the availability of alcohol, or the course structured in such a way that it does not encompass lunch time. It is interesting to speculate whether these same people customarily rendered themselves incapable of working in the afternoon or whether this was due to the fact that they saw themselves as being on holiday from work,



or they were threatened by the course, or to other reasons. Certainly, whatever the cause, the leaders found this a source of great frustration.

#### Level 1½

An HEO transferred to a similar job in another unit shortly after completing his own DCM training. He then returned to his former unit and joined with one of his colleagues to run a DCM which had been previously planned. The steering committee is in agreement that it would be good to encourage this kind of cross-district co-operation.

#### Level 2½

The reader will be able to understand how and why the pyramid model gets distorted if we describe Level, so called, 2½.

#### Special cases:

- (a) An HEO from Beamish II ran a course with a psychiatric social worker from a Sunderland Level 2 course. This was multi-disciplinary and very successful, partly due to the fact that, having both completed Drinking Choices, both also attended a group work skills course. This, in itself, was a special feature because the course was requested and organised by a DHEO who did not attend either Beamish I or Beamish II and later wished that she had been able to do so. The two group leaders and the course members evaluated the course together, deemed it to be very effective, and also held a follow-up day later, which was well attended.
- (b) An HEO from Beamish I ran a DCM course in Cleveland, with a clinical psychiatrist and a worker from Cleveland Council on Alcoholism, who had both attended

Beamish II. This particular collaboration has led to further instances of working together to plan self-help groups such as Drinkwatchers and Stop Smoking groups.

Level 3 - This would mean course members from Level 2 courses running DCM for other professionals.

The Pyramid breaks down here as far as running courses goes; i.e., no complete DCM courses were run at this level. There are several reasons for this:

- (a) When Level 2 courses were organised by HEOs or other professionals, the course organisers did not make it clear to professionals who were invited that they would be expected to become trainers of other colleagues as a result of attending DCM. Therefore many people came on the courses at Level 2 purely for their own benefit, which is acceptable, but which does not produce further trainers.
- (b) In many cases people who thought they were to run a course when they got back to their work-place were not allowed to do so. In some cases this is attributed to lack of time, e.g. two teachers who say they intend to use parts of DCM in a Liberal Studies VI Form course but who claim they do not have time to run the entire course. When they say to me that they do not have enough time, I often feel quite cynical about this; if it were a high priority, they would find ways to include the material. However, they often do not have enough power to change a timetable, or to convince managers that the timetable ought to be changed. Thus one of our conclusions is that key change agents ought to be included in Level 2 so that people, having done the course, have enough power to go back to work and include alcohol education in the timetable.

In other cases managers who sent employees on Drinking Choices with a view to having them run staff training courses have for some reason changed their minds or delayed the events. Possible reasons might be that it looks good for the company and is relatively easy and inexpensive to have one or two staff members attending such a course, but running the course on their own premises for other staff means a much bigger expenditure of time and money. Furthermore, if they took such action, managers might then be expected to develop further plans, such as implementing alcohol policies or providing counselling for people with alcohol problems. This is another reason why progress is sometimes blocked after a member of staff has been sent on a training course. There are a number of other examples of this kind of block.

- (c) An Environmental Health Officer in Cleveland fully intended, or so he thought, to run Drinking Choices for his staff. Management has not allotted the time for him to do this. He says he does not know why; this means that the decision was not explained to him by management and that he is not in a position to insist either on having the time allotted or on knowing reasons for refusal.
- (d) A Personnel Officer at a large brewery in Newcastle was told to attend the course as she would later be running modules for other personnel officers. When I first interviewed her, she was very enthusiastic and full of intentions about running Drinking Choices. She took me on a tour of the brewery and talked to me about the fact that each member of the work force received four free pints of beer per day, which they had to consume on the premises. She was very concerned about this as it meant that even the van drivers and lorry drivers were consuming their quota before and during work, not to mention the other

alcohol that they would be offered during the day as they called at pubs to make deliveries. She promised to get in touch with me if there were any developments about running courses.

However, the second time I phoned her for an interview about a year later, it took me over a week to reach her as she did not return any calls and I began to suspect that perhaps her plans had broken down. When I did reach her by phone and asked for an interview appointment, she said she would rather not because she had not been allowed to run any courses, much less encouraged to do so. The decision was not open to question and had not been explained. My feeling was that she did not want an interview because she felt quite angry about the situation, but did not feel free to say so.

- (e) An Occupational Nurse at British Telecom had a similar experience. In spite of the fact that she was one of the few people I have talked to who did not enjoy the course she attended, because she did not think the leaders were very experienced, she thought the Manual was very useful, and was fully intending to run a course for all the other occupational nurses in the region and perhaps even in the country. This never transpired and she was not told the reasons. She felt quite happy to talk to me and did not refuse an interview, but was discouraged that her plans to run courses had been thwarted. She could give me no reasons, except that she felt management did not see alcohol as a problem area, whereas she herself, in counselling employees, knew that many of them had alcohol-related problems. This provides us with another very important issue. Managers need to be made aware that alcohol is a potential problem area and that prevention of alcohol problems through education, training and counselling can save time and money in the long run.

- (f) People move away from a district or get promoted, transferred, or change jobs, or become ill or retire. We will consider these kinds of obstacles to progress in Chapter VII.

### Educating the Managers

So the breakdown of the Pyramid at Level 3 raises some very pertinent questions, the main one being, "How do we get managers involved in alcohol education?" Many of the blocks to dissemination seem to come from the top of the hierarchy in industry, in the NHS, and in local authorities. How can the HEOs focus more on educating the decision-makers at the top? How can we speed up the process which has been very slow so far, of encouraging managers to consider educational policies within their organisations so that people at all levels of a hierarchy have access to information about alcohol?

These questions will be considered in later chapters, along with some ideas about how they could be answered.

There is still hope for some Level 3 courses, for example in Sunderland in January 1984 course members from a Level 2½ course attended a follow-up day in which they decided to take their own action, since their respective managements were not very interested, and were each intending to run a Level 3 course, perhaps in various pairings, for interested colleagues.

Another major point is that the Level 3 courses can be considered to be outside the time-scale of the project. In other words they may well happen after the evaluation comes to an end in June, 1984.

Courses in other regions have been held in a slightly different context. Only people who will definitely become trainers have been invited to come on National Disseminations, and they are being made aware of our mistakes so that they can invite managers and potential trainers to come on Level 2. Therefore Level 3 is extremely likely to happen. This model will appear in this report as a recommendation for people who want to use the pyramid system for dissemination.

The writers of the Manual and the funding body were concerned about the breakdown at Level 3, and will be working to correct it, but the spread on Level 2 has been very wide and has, in terms of alcohol education, met the original aims.

Later in this report, under Results and Spin-offs, we will consider the national dissemination. For now, I would just like to mention that, within the time-scale of the project, at least three courses have been run which would constitute completely new pyramids, one in Devon, one in Liverpool and one in Ireland. Furthermore the first national dissemination has taken place which will constitute still another pyramid. The reasons for this will be explained under Spin-offs.

Many people at all levels of the existing pyramids are also using parts of Drinking Choices, both the teaching approach and some sections of the Manual, in a multitude of different settings.

Level 4 was originally intended to mean that people from Level 3, having attended a course, would go back and work with their own clients or pupils. As we have seen, Level 3 is often omitted from the pyramid. As a general rule, Level 1 people do not work with clients, either because they are in a position to be training

other educators or because their job only involves education and not treatment. Thus we can say that job description is a major issue in dissemination and ought to be considered by people planning to run Level 2 courses.

The following are some examples of use of DCM on Level 4:

- (a) Two charge nurses in a psychiatric hospital used the Manual to extract what they considered key alcohol facts and some exercises, such as the Drinker's Diary. They collated these to form a mini-manual of their own which they use with their patients, who are older males in an open ward. The nurses found their own version of DCM very useful and it was through them that I met my favourite client, George, about whom I shall write shortly, as he was the only Level 4 client with whom I established a positive relationship.
- (b) Having attended Drinking Choices in Cleveland, a probation ancillary and one of her colleagues ran a group for male offenders with drinking problems. She used some materials from DCM and added some of her own. She gave me copies of some of the materials she herself had developed and I passed these on to various DCM course members. She was pleased that the group had a high rate of attendance and that the men were enthusiastic. During the time the course was running, the men did improve their drinking behaviour. We cannot separate the effects of coming to a group every week with a supportive leader and a co-operative atmosphere from the direct effects of the materials in the Manual, and this indicates that the combination of Manual plus training is what proves to be effective, and this is what we set out to provide in the first place.

One very important conclusion from the evaluation is that out

of 60 people whom I have interviewed, 53 are using some part of Drinking Choices, either in a training capacity or with their clients.

The Drinking Choices materials have been percolating down through the levels and reaching Level 4 at least since the spring of 1982. However reaching clients has been one of the major difficulties for the evaluator for reasons which will be described in Chapter VII. The times when I did interview clients were extremely interesting and the description of one such meeting may add a human element to this report.

#### The Case of George and Bill

The closest client contact I established was with George (pseudonym), a patient in a psychiatric hospital. The charge nurse on his ward had attended DCM with two of his colleagues. This nurse - we will call him Bill - took a special interest in George and one of the reasons he introduced George to me was just for social reasons; I was somebody new who would also take special notice of this man and Bill thought that this would help George to feel better about himself. This is one reason why I received complete co-operation and encouragement from Bill.

George is 65, with a ruddy complexion and a handsome face which reflects his drinking career in a network of red capillaries, blood-shot eyes and slack skin. He has a slight speech impediment, due to brain damage from alcohol, and yet he is bright and lively. Unlike many of the patients on the ward, he goes out to work in the hospital every day; he is responsible for gathering soiled dressings from the surgical wards in the hospital, which he then



loads into a truck. He receives some spending money in exchange for this work. His mother is still living and he visits her occasionally in a home for the elderly. His favourite trip out of the ward is to visit his brother's family, who live nearby, and who always make him welcome at holiday times and seem to like to include him in their family activities once in a while. He leaves the hospital daily and goes into town to obtain the things he needs but, most of all, to go to the pub. It was obvious that he looked forward to my visits with great anticipation and he soon took to giving me a fatherly kiss on arrival and departure. He was very proud of the fact that he likes to read, and I sent him a copy of one of my books, which he read and enjoyed telling me about all his reactions to it. He also started writing to me and sending me cards and little presents. I began to feel that I was being very unfair to him as I knew that my own circumstances were such that I would not be willing to keep on visiting him once the evaluation was finished. I wrote to him and explained that I would only be coming once more and that I wished I had time to be a frequent visitor but that it would not be possible.

From the point of view of Drinking Choices and its effects on this particular client, most of the changes we noticed were due to Bill's efforts rather than any other factor. Bill made extracts from Drinking Choices and put together a small folder of alcohol information for those of his patients whom he thought were capable of participating in educational activities. He does individual sessions with these patients, where he talks about alcohol and its effects on the body and how the amount they are drinking can be monitored. Bill has cut down his own drinking and is quite proud

that he now always leaves a day or two between visits to the pub so that his liver can recover in between. He has gone on a diet and lost  $1\frac{1}{2}$  stones and is feeling generally more fit and healthy and he seems to attribute all this to his experience on the DCM course. He feels that the course will enhance his job prospects as he now has some specialist knowledge to offer a prospective employer. So the course had very good results for Bill as a participant, as well as for his client.

George is also proud of his progress resulting from Bill's DCM experience. He has cut down from drinking five pints a day to drinking five half-pints a day. He feels that he is much more concerned now about his health and much more aware of what alcohol does to it. He intends to cut down even further, or so he told me. He said that he now notices and criticises his mates in the pub when they drink too much and he passes on his knowledge about unit measures of alcohol and about what it does to the body. He says they "don't much like to hear it".

We can look upon this feedback as an example of using alcohol education as treatment and, as such, it is a positive result to record for DCM. However, I went away from the situation feeling that, if I had been willing and able to be a constant friend to George, or to provide him with other kinds of daily activities, this would have had an additional long-term effect, which would have been very desirable. Education by itself, obviously, is nowhere near enough.

#### The Young Offenders

As an example of activity at Level 4 resulting from Drinking

Choices, probation officers in Northumberland spoke to the local magistrates and convinced them to incorporate required attendance on Drinking Choices courses into sentences for young offenders with alcohol-related problems. This is not a new idea, as it has been happening in Coventry and other districts in this country; however it is new to Northumberland, and was instituted by probation officers who had just come from attending courses with the encouragement of the Alcohol Development Officer, who had attended Beamish II.

One of the men I interviewed has been haunting my memory. He is 28 years old, the same age as my younger son. He stood out from the others in the group because of his attractive appearance and his direct gaze. His wife works as a cleaner and her wages are subtracted from his unemployment benefits so that the amount she actually brings home adds up to £6. He spends his time doing a bit of gardening, keeping the house tidy, and walking the children to school each day. He goes for an occasional swim but this means a bus ride to the leisure centre and £1 to get in and the pool is so crowded that people are ejected after half an hour, so, although he enjoys it, he feels it is not really worth the money. It is cheaper and in some ways more interesting for him to spend the afternoon in the pub. His mates are there and the ones who are working buy him drinks. My own diffidence kept me from asking what offence he had committed. (The probation officer had told me that all of the men I talked to had committed alcohol-related offences.)

Another, younger, man told me he had just moved into his own small flat and told a similar story about how he spends his time. He told me about his budget; he pays his rent, sets money aside for bills, buys the minimum of food in order to survive and spends

the rest on drink. He could not stand living with his parents, but now he misses them and feels quite lonely.

Some of the younger lads, aged 18 to 20, told me that they all spend more on drink than they receive in unemployment benefit and they get this extra money from their sisters, mothers and girl friends who would rather see them going to the pub than lying around the house with nothing to do. They are in unanimous agreement about several factors:

Life would not be worth living if they could not drink.

Having Drinking Choices included in their probation order was good because they met in a group and talked about their activities and problems.

The alcohol knowledge was interesting but they "couldn't care less" what was happening to their bodies.

They liked coming to the group better than meeting their probation officer alone.

The probation officers also liked the group setting better. It was easier for everyone to talk and a positive group feeling was generated.

What can we conclude from these comments, at this early stage? We cannot tell as yet whether these particular clients will cut down on their drinking as a result of coming to the group. They liked coming however, and the fact that they were arriving regularly at the group, and building a comfortable relationship with the probation officers, may perhaps give the probation officers an opportunity to work with them in a more positive manner than usual.

One hopeful sign is that the magistrates in this district were willing to consider alternative methods of dealing with young offenders; this was the result of effective communication on the part of the probation officers who convinced them to try it, and

of the magistrates' willingness to give the plan a chance. The young offenders also seemed to see it as a positive option.

In order to ascertain whether the probation officers' plan really worked, we would have to come back in five years' time and see whether:

- (a) The magistrates were still assigning young offenders to attend groups.
- (b) The probation officers still preferred that way of working.
- (c) Young people were still attending groups.
- (d) The young people had changed their drinking patterns as they matured.

And even then, we would have to look at how, and if, their life circumstances had changed in the meantime.

So what can we say about it in June of 1984? Only that the plan is being tried out in Northumberland, and is being considered as a model in some other districts as a result of the communication set up by DCM. And that in Northumberland, the probation officers and their clients have an initial positive reaction.

#### The Cumbria Example

As a final example of how the pyramid model works, the following is a profile of the progress in one district, from the top of the second pyramid at Beamish II, to my final interview in October of 1983. Cumbria was not represented at Beamish I, because the former DHEO had just left for America and the new DHEO had just been appointed. This was not the most active district, nor was it the least active. One thing that was significant about this district was that it had very little intervention from me as

the facilitator/evaluator. I was not asked to run courses, nor did I interview course members; this is because of the geographical distance, or so I believe. Beyond the initial training I had two official interviews with the two key tutors in Cumbria. I also had some social contacts with them. The HEO attended all three of the follow-up days for Beamish II, and reported on his progress at those meetings, and was very actively involved in setting the agendas and participating in the activities. The DHEO, although she was not able to attend the follow-up days because of her other work commitments, encouraged the HEO to come and to keep in touch on her behalf.

The account that follows is a summary of some of the results of DCM in Cumbria.

November, 1982

Level 1: Six people from Cumbria attended Beamish II.

January, 1983

I attended a meeting in Carlisle of five of those people who were planning to work together on implementing DCM courses in their region. They outlined plans for a course for youth workers, interdisciplinary courses, work with staff of a day centre, etc. (and more).

Winter, 1983

Level 2: DCM course for youth workers

Multi-disciplinary group in Penrith

MSC Trainees' course

The HEO attended all three Beamish II  
follow-up days

Last interview, October, 1983

I visited Carlisle again, and interviewed the acting DHEO and another HEO. We discussed spin-offs:

Level 2½: Group work skills course for health visitors,  
(or 3) and for multi-disciplinary group.

DCM used on Health Education Certificate course.

Cumbria Health Education Unit now has a resource centre.

The HEOs interviewed felt that DCM, together with Working with Groups, had had a very great impact on their work. Everyone in the unit is now using participatory learning methods in all areas of their work.

Out of the original six who attended Beamish II, one has had a baby, so has been away from work. One has a new job in Aberdeen, and another has a new job in Dorset. This leaves three still in Cumbria. Future DCM courses are in the planning stage.

Level 4: Since January of 1984, I have been given many examples of use of DCM with clients, including several examples from Cumbria, e.g. one youth worker in W. Cumbria is using DC regularly with groups of young people.

The following comments are taken from course members' evaluations of the Cumbria course for youth workers in November, 1983; they were asked to complete two statements. At the beginning of the course, they wrote "What I want from this course is ... " and at the end, "What I gained from this course is ... " These are shown below as "Before" and "After".

### Before

Some helpful and practical ideas to help me try and tackle the problem of drinking which is being done by quite a number of my members (especially in the 13-14 age group).

### After

From a personal point of view the course made me think hard about my own attitude etc., to drinking. It was extremely interesting to hear other points of view. I feel more able now to talk to my youth club members and certainly would try some of the activities with them.

### Before

To establish the extent of the problem. To be able to recognise the problem before it arises to be able to tackle it either myself or through knowing the agencies etc., available.

### After

Several useful approaches for education in any subject. Awareness of resources and agencies (although it will require a lot of follow up on their functions.) Realisation or rather confirmation that the recognition and treatment is down to me, albeit that I can then bleed resources and agencies. On education though - a great help.

These are two examples out of twelve; the others were very similar, perhaps because they had already discussed their feedback in the group.

This tour through the Cumbrian pyramid provides an example of how the progress goes without much intervention from the facilitator/evaluator. By 'much intervention', I mean as much as the more local districts had. Both the HEO and the DHEO commented on two occasions that the prospect of my coming to visit had spurred them on to further action, and had kept them focussed on alcohol education amidst all their other activities.



The Cumbrian example seems to indicate that the presence of a regional coordinator who regularly visits and offers assistance is one very important factor in keeping progress going. This conclusion has been reinforced many times in the analysis of the data.

#### What Have We Learned about our Pyramids?

My involvement in the pyramids was supposed to, but did not, end in December of 1983. Since then I have been involved in the National Dissemination and also still helping to run courses in the region. In addition to this first hand information, many DCM tutors and course members have been keeping me informed about their use of DCM with colleagues, clients, and 'ordinary people'.

DCM is an example of a pyramid on a fairly small scale. An example of a very large scale pyramid would be Weight Watchers International, which was started in New York by one woman, who trained a group of trainers in the early 1970s, who then started Weight Watchers classes. Instructors were trained from the ranks of the course members so that their own experience of losing weight would enable them to help other people to use the same methods. Now there are classes throughout America and the U.K., and in some other countries. This exemplifies the pyramid model on a very large scale. It has produced many amazing success stories, and no one knows how many unheralded failures.

The way our pyramid is designed, it can be replicated in other topics or other regions, starting with new pyramids. It is to be hoped that the experience we have gained from implementing pyramids in the North East will benefit other health educators.

One thing we have noticed from the data is that at the upper

levels of the pyramid there is more evidence if change. I have seen with my own eyes HEOs effectively using participatory methods on many occasions. One outstanding example of this was at a Research Seminar held at the University of Durham in November 1983. Six HEOs and the Deputy Director of the North East Council on Alcoholism were present with me and we chose not to present a lecture to the audience. I spoke for two or three minutes about what the aims of the project were and after that we involved the audience in questions, discussion and some of the exercises from DCM. The response was enthusiastic and one member of the audience commented "I have never seen professional people work together with such easy courtesy". One of the questions asked by the audience that day was: "Has the project changed your own drinking patterns?" One of the panel answered that she had cut down drastically as a result of her new alcohol knowledge; most of the panel responded that they had become more aware, but had not been drinking very much anyway, since alcohol knowledge had been part of their HEO training already. All of the panel said they felt much more confident about educating other people about alcohol.

There are many more alcohol educators in the North East region now in 1984 than there were when we started in 1981; thirty courses have been run, and about 400 people have participated in them.

There is evidence at all four levels of the pyramid that there have been various kinds of behavioural changes, the main ones being in drinking patterns and in teaching styles, but more of that in Chapter VIII.

Training the trainers seems to work best if a client-centred

model is used, and the trainers all have a chance to present the materials themselves at some time during the course. We now believe that multi-disciplinary courses are more effective because they provide links between the professions which remain useful after the courses end.

People have been known to work with professionals from other levels, to run courses at, say, level  $2\frac{1}{2}$  or  $1\frac{1}{2}$ . The pyramid is also adaptable in many other ways, and it often gets distorted as well. It would work even better with certain modifications, which we will spell out under Recommendations in Chapter IX.

There are several instances in the data where people have suggested that there might be a distortion or dilution of the methods and materials as progress through the pyramid advances. To some extent this factor is almost inevitable; people near the top of the pyramid (Beamish I and II) received more thorough training:

- a. they spent a longer time on it; each course lasted for several days, in a residential setting
- b. the facilitators for Beamish I and II were particularly highly skilled in group work methods
- c. the writers of the manual were involved in the training

So, one might easily conclude that the DCM courses run at Level Two were of a higher quality than those which took place later on in the project, and that the course content would be watered-down to some extent on each successive course.

However, being in the unique position of having looked at all of the data, and of having talked to course members and visited

courses at all levels of the pyramid, I would contend that this is not the case, for the following reasons. The quality and content of a DCM course depend on so many variables, such as:

- a. the background, skills, openness, and interests of course members
- b. future intentions of various course members regarding the use of DCM, i.e., their ability to act at the end of the course
- c. current topical items in the media, e.g. changes in legislation, headlines about drinking and driving, etc.
- d. obstacles that a particular course leader may encounter, e.g. industrial action removing course members from sessions, or varying degrees of resistance on the part of the group
- e. the positions of course members in their own organisations

There are many other differences between each particular course, but above all, the fact that the courses are client-centred means that, even moving horizontally across the levels of the pyramid, each course is different from every other one, but in any case unique among all other courses. Due to all the variables mentioned above, I have observed what I deemed to be good, moderate, and poor work, at all levels of the pyramid. The manual is the common factor, and as we shall see in the next chapter, it is designed to be extremely adaptable.

### Onward

One of the difficulties in analysing the data for this particular chapter, and then in writing it up, has been that the

pyramid and the manual are inextricably inter-related. Looking at them both together was impossible, as the reader would have been jumping back and forth like a drunken grasshopper. Separating them out has been a challenge. And then, which one should come first? In effect, they were written side by side, since it would have been most difficult to learn from the data how the manual was used without understanding the pyramid, and vice versa. So, if we now move on to examine the manual more closely in the next chapter, perhaps the reader will oblige by mentally weaving them together again?

## CHAPTER VI

### THE MANUAL

#### Introduction

The Drinking Choices Manual is the instructional system, the innovation that we are evaluating. It is also the key to the pyramid model and the thread that all the courses have in common. It has been the starting point for the writers and designers of the community-based programme and, no matter what happens to the pyramid in the future, the Manual will probably remain in health education units and other resource centres throughout the country.

Unlike the pyramid, the obstacles, and the methods, the Manual exists as a tangible object; thus there is less to say about it, as it can be examined as an entity. There is also more to say about it, as it has grown, changed, and been adapted throughout its brief history.

#### Development of the Manual

The following statement comes from an unpublished "Progress Report" on DCM, written in 1983 by one of the writers of the Manual, Dr. Ina Simnett:

"The project to train alcohol educators in the North East of England reflects the emphasis, in recent years, on the importance of enabling people to become as self-sufficient as possible in managing their health affairs. From the beginning the project foresaw that to do this we must give ordinary members of the community the knowledge and skills to become alcohol educators of their own family, friends and workmates. The expertise

at present in the hands of a few (consultant psychiatrists, Councils on Alcoholism and Health Education Officers) must be transferred to a much wider group who would in turn be active in passing on the knowledge and skills acquired.

What emerged was a tool - the Drinking Choices Training Manual for Alcohol Educators - and a model (the pyramid) for the dissemination of the training through professionals to members of the public ...

We felt that if people are to be encouraged to manage their own health problems as far as possible, we must also encourage them to manage their own education as far as possible.

Taken to extremes this would mean a completely flexible education, meeting each person's needs, and a structured training manual would seem to be in conflict with this approach. We, in fact, felt that it was important to have a tool which had been tested with groups of alcohol educators drawn from the helping professions. This tool should identify important features of the process that people need to go through to enable them to be effective educators. However, the training manual should only be seen as one part of the enabling process and could be used flexibly to meet the needs of any group or individual ...

The involvement of students in making an assessment of their own needs and planning their own programme was thus sought right from the beginning."

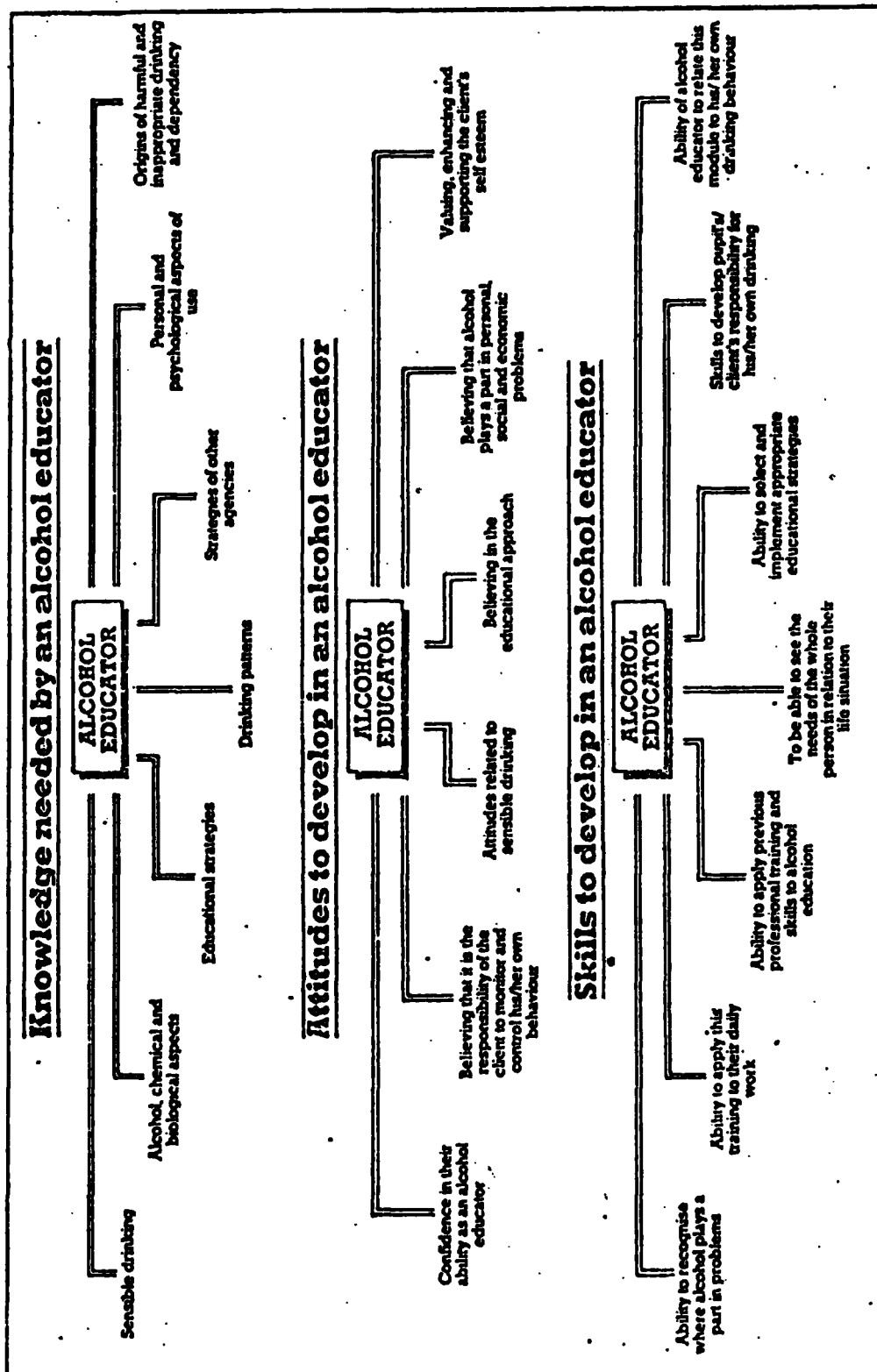
So the Manual was meant to:

- (a) provide a tool which people could actually use immediately, and
- (b) show people how to use that tool in the most flexible manner possible, so as to meet the needs of any group.

(The aims of the Manual are included at several points in this report, and so are not included here; the reader can find them on p. 6 of the Manual.)

The writers had to start with the knowledge, attitudes and skills which they themselves thought were necessary for alcohol educators to have as a basis for this kind of adaptable work.

They developed the following diagram:





One can see that each of these three areas are complex, and each contains seven topics which need to be explored. The writers had to narrow these broad areas down into course components; they used their own experiences as alcohol educators to help them choose the key elements of each topic.

For example, there is a vast body of literature on alcohol, its chemical and biological aspects, its harmful effects if misused, and medical, sociological, and psychological theories about why people abuse it. Out of this, the writers had to sift the specific information that seemed the most important for ordinary people to know, the key facts about alcohol; course members would make a further selection, or additions. The writers went through this sifting process with each topic, and laid out a teaching plan from which course leaders could start.

### Reflexive Learning

The learning in the Manual is also intended to be reflexive; course members are expected to look at their own experience and attitudes first, before looking at the issues surrounding their clients.

### Multi-disciplinary Groups

The use of the Manual with multi-disciplinary groups is also fundamental. Alcohol educators potentially come from a wide range of different disciplines (social work, health education, the probation service, etc.); by training together they can develop common understandings and learn to adapt the material for use with different groups.

### Participatory Methods

The Manual exemplifies a particular point of view about education, in that it uses participatory learning methods. The writers felt that in the past, didactic methods had not been reaching the chosen target groups and that with the sense of responsibility for one's own health comes a responsibility for one's own learning. They were concerned that people should be educated as equals and for this a democratic method was required. All of this has been built into each section and each page of the Manual. At no time is the course leader expected to take a stance as an expert and she is encouraged, by the way that activities in the Manual are set out, to take a facilitator's role.

### Adaptability

As the project progressed, the question of how closely course leaders were to follow the Manual kept arising, and with it the concomitant of how to fit it all into the time allotted to each course, and how to retain all the knowledge required. In order to embody participatory learning methods, the Manual must be adaptable. One of the key processes in participatory learning is agenda setting, another is negotiation and a third is selection.

At each stage when this question arose, the writers and the facilitator were insistent that any part of the Manual could be adapted, except for the participatory learning approach, which is intended to be retained in all cases, (which does not preclude using lectures where appropriate). In fact, selection is required because the estimates in the Manual of how much time each activity takes are not exact, they could not possibly be; it takes a group

of 30 people longer to complete an activity than a group of 10 people. Similarly, a group of young offenders may not want or need to cover exactly the same material as a group of managers from the Social Services. However, these practical considerations are almost irrelevant. A look at the Manual, pp. 13 and 14, will indicate that the writers were aware of these factors. They start with a name game and introductory exercises, and then ask group members to talk about their expectations of the course. The first knowledge-based activity, the Tour of Knowledge Card Game, sifts out what the participants already know, and identifies key facts about alcohol which are missing in that particular group.

If the Manual were rewritten now, it might well include an agenda setting exercise which even more specifically elicited the needs of the course members; by the end of the project most key tutors have been trained in such techniques.

### Teaching Plan

It seems superfluous to reprint or review each stage of the Manual in this report; it accompanies this volume and we are assuming that each reader has looked through it and understood how it is put together in a developmental sequence. The objectives for each exercise are set out, and the methods explained step by step.

The materials needed by the leader and the course members are arranged at the back, and can be used for photocopying; the writers have given permission for anyone to photocopy the materials for use on a course.

### Responses to the Manual

Throughout the remainder of this chapter, we will pay attention to the comments and reactions of the people who used the Manual; which parts were considered useful and relevant, which parts were liked and disliked, what people thought, felt, and said about the educational programme.

### Ease in Using the Manual

When it was written, the Manual was intended to be clear enough for anyone who had been on a Drinking Choices course to pick it up and use it. This has turned out to be a question which depends on personal preference. There are those who say that being on the course once is not enough, and there are several people who have attended two courses. There are those who say that one course is adequate for becoming a trainer, and others who feel that, for them, considerably more experience in group work skills is required. Some people feel that their alcohol knowledge needs expanding, even after the course. On the other hand, there are several HEOs who have run Drinking Choices courses without having attended the training days. Some of these HEOs have had difficulties in running the course and have had some negative feedback from course members. Even now we do not know whether this is because they did not attend the initial training days.

People come on the courses from different backgrounds and with different levels of training and experience. People also come prepared to take risks, or not; they come with varying degrees of openness and honesty, and all the other variables of personality. Naturally, they also come with an ability to adapt easily to DCM methods, or not.

Since DCM is now available to the general public to buy and use, TACADE have sold copies of it to people who have not been trained in its use. Some have requested training. As far as I know, no one who has purchased it in this way has complained of not being able to understand how to use it; this proves nothing except that we have not heard of any complaints, as yet.

One weakness of the evaluation is that people who bought the Manual and used it without training were not interviewed. Why? It did not occur to me to do that until it was too late.

#### Did We Need the Manual as it is Now?

Perhaps this question is unreasonable, as it is the Manual we are evaluating, but it may be interesting to consider some of the possible alternatives. We can only speculate about this, but the following seem likely.

#### What if we had written an Alcohol Education Programme using a Didactic Approach?

- (a) The HEOs are unlikely to have changed their teaching methods.
- (b) Some people would have preferred it, as it fits more easily into the time available and is appropriate to the single presentations that HEOs are asked to do.
- (c) The group work skills courses would not have followed on from the alcohol courses.
- (d) We cannot tell whether people would have gained more alcohol knowledge or not.
- (e) The Manual also aimed to develop attitudes and skills; arguably, participatory methods were essential for this, as attitudes need

clarification and discussion, and skills need practice. (See Chapter III.)

What if we had done the Participatory Learning Courses without the Alcohol Topic?

This is an even more unreasonable question, since the Manual developed out of the Alcohol Campaign and was a specific response to the need for alcohol educators.

But just to pursue the possibility for a moment:

- (a) One of the significant aspects of the Manual is that it shows how to integrate group work skills into a knowledge-based topic. This particular point is one of the aspects of the Manual that health educators seem to value the most; they can easily transfer the model to their other health topics.
- (b) Managers may have thought that the course in Participatory Learning skills was not worthwhile for their staff to attend; alcohol is seen as a problem, as are other health topics such as smoking and drug abuse. Therefore health topics are seen as timely and important for professional people to study. Three years ago participatory learning in itself would probably not have been considered relevant, but one of the spin-offs from DCM has been that now professional people in this region are demanding further training in these skills. The same spin-off has become apparent in other schemes with which I have been involved, such as YTS and TUEI, which call for participatory methods, but for which personnel have not been previously trained.

### Difficulties in Isolating the Manual

When I asked people in interviews what they thought of the Manual, their answers almost invariably indicated that they were considering the whole package, which we call DCM, i.e. the module including the course and the training. So I would go on and ask: "What about the book itself, the Manual?" Looking back at the data again, even the second response was usually about the Manual as related to the course:

- |                 |   |
|-----------------|---|
| HEO:            | It stands or falls according to the response of the group.  |
| Alcohol Worker: | It has broken the lecture tradition, the onus is on the audience.                                 |
| Course Member:  | It contains a clear framework of information which gives ideas adaptable to the audience's needs. |

It is interesting that at this stage of the interviewing, in June of 1982, some of the people in the sample were using the word "audience", indicating that the didactic habits were still influencing their language. In later conversations we tend to find the phrases "course members" or "participants".

At the end of Chapter V, I mentioned that the Manual and the pyramid are inextricably mingled, and it seems that this is as true of our sample as it is of me. It is also very difficult to say what the weaknesses of the Manual are, because they can all be answered by the fact that group leaders and course members are expected to adapt it to suit their own needs. Thus, when someone said to me during an interview:

- |      |  |
|------|--|
| HEO: | "There is too much in it, you can never fit all into the timetable", |
|------|--|

as the evaluator, I would accept that and record it. As the facilitator, at a later date, I would suggest that we could work on how to do the agenda setting and selecting process so that one would be using the appropriate parts. (This is not the place to discuss the conflicts in the facilitator/evaluator role, that comes under "Obstacles to Progress". For now it should be mentioned that during interviews I maintained my evaluator's role as much as possible, and reserved the facilitating aspects for courses and training sessions, although it did sometimes happen that people would ask me to put on my Facilitator's hat and offer advice on how to improve a course.

With this in mind, the next sections are devoted to negative and positive comments, as far as they could be said to apply to the Manual alone.

### Weaknesses

The following are comments from interviews:

HEO: The games can be threatening, and scare some people off.

DHEO: I am worried about the use of role play and counselling skills, I am not sure I know how to do them properly.

HEO: There is too much homework in it for people with full time jobs.

DHEO: It should not have been published without the evaluation being completed.

### Strengths

Course Member: It is so adaptable, I can use it for any topic.

HEO: The responsibility evolves onto the group members.

Course Member: The course is active, not passive.



This very day, in June 1984, I have been soaking again in the data, looking in true Popperish manner for comments which refute the difficulty of isolating responses about the Manual on its own; I also made the same effort to separate it from its context throughout the interviews. As one can see from the comments above, it was not easy. It was easier to separate it when I asked the question: "What did you dislike and like about the Manual?"

### What Parts of the Manual did People Like and Dislike?

#### Controversial or Difficult Sections

Although the response to various sections of the Manual and various activities were as dissimilar as each individual course member, certain themes did arise out of the data to tell us that there were specific activities which were particularly controversial.

Warm-up games seem to arouse strong feelings of like or dislike in various course members. The following kinds of contradictory comments appear again and again in course members' evaluations:

Negative	Positive
I hate games: I have always hated them.	I feel much more relaxed than I did when I came into the room.
I felt silly.	That was good for a laugh.
I could not see the point of this.	It was good to get up and move around.
I was already warmed up: I did not need a game.	I feel more comfortable with everyone now.
The game made me more tense.	

People's negative pre-dispositions towards games are especially hard to overcome and this is true of the trainers as well as of the course members. One's viewpoint on this depends on one's definition of participatory learning, as well as on a capacity to try new activities which involve possible risks of embarrassment: "I might make a fool of myself."

Also people have a wide range of preferences about how much they care to disclose about themselves; some people would rather not talk about themselves in a group, especially at the start. So certain activities which come into the category of warm-ups or re-entry exercises (referring to the group getting to know each other again after being away for a week or more) are difficult for them.

It often takes some time for newcomers to the world of groups to see the relevance of games, but the writers of the Manual felt that they served a purpose in breaking down initial barriers, and promoting a feeling of trust and friendliness in the group. Responses among course members have varied, but most of the key tutors, as we come to the end of the project, are now using a variety of experiential activities in all of the courses they teach; the games are considered by them to be relevant and useful.

#### Transactional Analysis (TA)

A second controversial area of the Manual comprises all the parts which have to do with Transactional Analysis, role play and drama. Transactional Analysis is an unfamiliar topic to many course members and at various times we have debated whether (a) to remove it from the Manual, or (b) to expand upon it.

TA is a framework for understanding how people communicate,

and how they obtain emotional rewards by playing Games in their relationships with others. (See p. 113 of the Manual). The writers felt that TA was relevant to the aims of the Manual which refer to seeing the person in relation to their whole life. The TA exercises which are included are based on ideas about why people drink, and how they use Games to justify and maintain their misuse of alcohol.

In the end, the section on TA was slightly expanded in the revisions and left to each trainer or each group to decide whether they wished to extend their background knowledge of the subject. In particular, the Karpman Triangle (p. 36 of the Manual) evokes negative and positive comment throughout all the course members' evaluations. Like the games, it was either hated or liked by various people. The role play involved in the exercise is again a source of risk for many people. Trainers needed to be shown how to call for volunteers for role play and how to deal with the situation if no volunteers are forthcoming. Social workers seem to be especially allergic to role play and the impression I received was that they had been involved in some very bad examples of it at some time in their careers. On the other hand, the exercise, when done well by people who did not mind taking the risks, was one of the favourites, and on several occasions caused considerable hilarity, as well as providing some useful knowledge about behaviour patterns. In the more recent DCM courses, the sections on TA have been deemed by most course members to be extremely relevant and useful, as they can apply the knowledge and techniques at work. The most recent course in June, 1984, which was Advanced Group Work Skills for key tutors (Beamish III) was

based on TA. Participants felt that the TA methods would be immediately useful at work.

This is an example of the way in which a concept introduced in the Manual can be expanded and applied where it is specifically appropriate.

### Listening Skills

Active Listening (p. 37 of the Manual) is a skill which requires self-discipline and insight; it also necessitates that people learn to counteract bad listening habits which have already been acquired. Course leaders had to determine how much time they wanted to spend on the listening and empathy exercises and of course this depended upon the composition and needs of the group.

Active Listening was included in the Manual because the writers saw it as a fundamental skill that leaders and participants need to function as an educational group. Educators need it in working with clients either individually or in groups, because it helps them identify how the clients are feeling and what they think their educational needs are. In a course, a classroom, or a group work setting, Listening Skills enable the leader to build an atmosphere of trust; participants learn that the leader is there to accept their comments and feelings, not to judge or analyse. Again professional workers were at times resistant to participating in these particular exercises; they "knew how to listen". With courses which extended over a ten-week period, we could observe progress in mastering the skill because active listening needs to be practised outside the group as well as inside it. In the more condensed or shorter courses, sufficient time is not available for extended practice. Often practice in active listening is given

to course members as homework. When they first try it, they get some very strange responses, like "Why are you suddenly repeating everything I say" or "What is the matter with you - you are actually listening to me?" When people get such comments from husbands or children, they sometimes refuse to go on with their homework assignment. Since it is a skill that takes many years to internalise and refine, not everyone wishes to persist and practise it. On the courses people have said things like:

"I want and need to ask questions when someone else is talking."

"My mind wanders if I don't join in the conversation."

and

"It's just too hard."

The sorts of considerations that have just been mentioned have led to various results:

- (a) Some HEOs have requested further training in group work skills such as active listening, counselling, transactional analysis, role play and the use of games.
- (b) Some people on certain courses have felt uncomfortable doing these activities. This does not mean that these exercises should be omitted. One possible conclusion is that there is something wrong with the exercises. Another possible conclusion is that trainers need skills in dealing with the discomfort of group members.
- (c) Some interviewees in the sample have said the Active Listening was the most useful thing they learned on the course. Others did not mention it at all.

As a facilitator, I myself feel that Active Listening is the key skill to all the other participatory learning methods. Whole classrooms of adults or children, even very young ones, can learn to listen without judging; this is a major factor in improving communication in a group. However, like all of the other exercises in the Manual, it was included because the writers deemed it to be relevant; now it is up to each course leader to find out if the participants agree that they want to develop this skill.

#### "Topping-up Exercise"

One exercise in the Manual has caused more difficulties than all the others combined. This is the infamous "Topping-up Exercise" (p. 16 of the Manual). I say infamous because every group that I attended had problems in working it out, and yet it is considered to be one of the key facts of alcohol knowledge that should be included in every course; we got to the point where HEOs would laugh or groan whenever the exercise was mentioned. People need to be able to calculate how much alcohol is left in the blood stream after a day of sporadic drinking so that they can determine whether they are legally able to drive or physically able to carry on other potentially dangerous activities, (e.g. operating machinery, engaging in sport). But the problem is that, although there is one constant factor, which is that the liver can eliminate one unit of alcohol per hour, there are many variables in the drinker's day, such as the amount of food consumed, the size of the person, the type of alcohol he has been drinking, his age, the intervals between drinks, and his emotional state, i.e. whether he is relaxed or under stress.

At Beamish II, three possible ways were invented of

demonstrating graphically how the topping-up effect works and they were incorporated into the newly revised Manual. Several course leaders have had many experiences facilitating this exercise, and still it is a source of confusion and amusement every time.

Confusion and amusement are not negative outcomes. As explained above, they can produce creativity and lateral thinking. Course members are learning and enjoying themselves while arguing about why the facts are so bewildering, and how the exercises could be better. On several occasions, participants have invented ways round the problems, and produced refinements or variations on the exercises which they themselves will use in running courses. An added bonus is that prospective group leaders are learning, at the same time, that an exercise that goes wrong is not a failure, it is an opportunity to learn something new, perhaps more than if the activity went off perfectly, according to the book.

All of the above is not meant to imply that group leaders should do the Topping-up Exercise and do it wrong so that everyone can learn how to deal with failure. Engineering or manipulating outcomes is not part of the process. The Topping-up Exercise is included because the facts are vital ones in alcohol education; whichever way the exercise goes, the participants are likely to remember what they learned about blood alcohol levels, because they will have been actively involved.

#### Research Project

The writers included a research project in the Manual, so that course members would learn how to gather the information that they might need for any alcohol education or counselling situation. They chose the topic of alcohol agencies so that each person would

become familiar with the provisions for alcohol services in the local community. A directory can be made available, and usually is on each course, but this does not answer the question: "Where would I really want to send my clients?". That question is often further translated on the courses as, "Which agencies can I really trust?". Open discussion about the experience that course members have had with each different agency does provide that kind of information; although their opinions may be biased, they may also be more accurate than the descriptions in the directory. This exercise can also result in course members being able to identify which of the agencies has a role to play in alcohol education and which could provide future course members, trainers, or counselling services.

This activity requires an amount of homework which is not always wanted by course members, and in courses which run over five consecutive days is impossible. However various course leaders did use it when the opportunity arose and the results were gratifying in terms of the ingenuity and new information provided by the participants. People found the information very useful, and sometimes did the project in pairs or groups, pooling their information. There are many instances of course members going on to contact the agencies and work with them in various ways.

The activities which involved gathering information, such as making lists of alcohol agencies and understanding legal restrictions on the sale of alcohol, were felt to be necessary by most course members and yet these were often the least enjoyable, being rather dry; some course members felt that people can learn how to find the information, and do not need to actually do it.



### Most-used Sections

The one exercise in the Manual which, from course members' comments, has proved to be the most frequently used, is the Drinker's Diary (p. 62 of the Manual). It is used by the professional workers with their clients and among themselves because it raises awareness of how much alcohol is actually being consumed each day of each week. Thus it encourages a drinker to look very carefully at her habits. The Diary is easy to keep, with simple instructions. It is relevant to knowledge, attitudes and skills in the learning process. In fact it is the one exercise which probably every person involved in DCM has used and about which no-one has complained.

Another popular exercise is the Road Map exercise (p. 34 of the Manual). This is often used for all the reasons which apply to the Drinker's Diary, in that people explore their own drinking careers. Course members seem to enjoy sharing their road map exercises even though they often contain some very intimate information. Again no-one made negative comments about this activity.

Most of the activities in the Teaching Plan (p. 11 of the Manual) have been presented on every course; the two names above were most often cited in answer to the question, "Which activities did you use the most at work?".

### Revisions

The first and most obvious change in the Manual has been in its general appearance. It was amended and reprinted for publication in May 1982, at a cost of £7,000. It is on sale to the general public at £9.50 per copy and is often sold to training groups by TACADE at a reduced cost. When it was reprinted for

publication, it was given a brighter cover with crisp black lettering, and attractive graphics; section dividers were made of hard plastic, with all pages on white paper so that they can be photocopied more clearly.

One of the most interesting sets of revisions have to do with the addition of games and activities invented on the spot by course members. One example of this is the new versions of the "Topping-up Exercise". (Several new warm-up activities were invented at Beamish II and elsewhere, although these were not all incorporated in the new Manual.)

The section on Active Listening, and the section on TA were re-written so that they were more extensive and provided further information and more practice in listening skills.

Any other revisions were minor ones and usually pertained to clarifying instructions or information, or sections which were confusing.

In an abstract sense, the Manual has undergone a drastic revision, in that on some of the local courses, and also on Beamish II, the Manual has been used in a very client-centred manner. The course members have been encouraged to choose the parts of the Manual on which they want and need to concentrate and sometimes there have been definite departures from the Manual, e.g. one HEO spent two sessions out of ten on his course on the Transactional Analysis background to the Karpman triangle and other family problems.

It is becoming increasingly customary for HEOs to use the Manual very loosely as a basis for a much broader approach. In my view, of course, this is greatly to be desired.

HEOs and course members are increasingly using participatory methods in their teaching. Furthermore their concept of what "participatory methods" includes is steadily expanding. The use of the module is becoming increasingly client-centred. Out of the seventeen HEOs on the Beamish I training course, ten are now approaching the course by asking course members which parts of the module they want to cover so that the work will be relevant to their own practice; three of the seventeen have not been involved in running a module; four seem to prefer the structured approach at present.

Client-centred Approach	0	_____	10	Didactic Approach
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On a scale of 0 - 10 regarding structure, one could take lectures as a 10 and group discussions as an 8, brainstorming, rounds, eliciting knowledge and information and feelings from course members as a 1, and not using the Manual at all as 0. A truly client-centred approach would require the facilitator to start from nothing, not even a structure like the Manual, but since what we are evaluating is the Manual, the 0 seems an anomaly. It is apparent that many HEOs and course members are moving towards the participatory end of the continuum. One senior worker from a Community Health Council commented to me that since she did the course, wherever she goes she sees health workers who have changed their methods and are moving towards more participation. She felt that the module had had great impact on the workers in her area.

#### Rewriting the Aims of the Manual

The techniques of this evaluation involve continuous

refocussing; this has gone on right up to the end, when it occurred to me to give myself the exercise of rewriting the aims. I have rewritten them as if I were starting now, by myself, to rewrite the Manual.

Original Aims	Evolved Aims
On completion of the course, participants will:	On completion of the DCM course, we hope that participants will be able to:
Hold the attitude that education can be an effective means of prevention.	Accept that education can be an effective approach to prevention and treatment and feel confident that they themselves can be alcohol educators.
Have confidence in their ability as alcohol educators.	Offer alcohol education to their clients and colleagues in such a way that clients enhance their own self-esteem and begin to make more sensible Drinking Choices.
Take action by educating their clients about alcohol.	
Be able to use and apply their previous experience, training and knowledge to alcohol education.	Be able to apply their alcohol education to their own lives and their own work.
Be able to see the needs of the whole person in relation to their life situation and identify the way alcohol fits into this picture.	Elicit the needs of the whole person in relation to the place of alcohol in his/her own life, and see those needs in the context of the community in which that person lives.
Be able to apply educational strategies to alcohol problems at primary, secondary and tertiary levels of prevention.	Help to elicit and meet the needs of their community as far as alcohol policies and interdisciplinary action are concerned.
Have knowledge about the development of an individual's drinking behaviour and how it is influenced by social, legal, cultural, economic, psychological and genetic factors.	Begin a process of developing client-centred counselling and group work skills for use on courses and with clients.

Have knowledge of the influence on drinking patterns in our society of cultural, economic, fiscal, legal and educational factors.

Use participatory learning methods in conjunction with any health education topic.

Have knowledge about the biochemical and pharmacological properties of alcohol and its part in the host-agent-environment system.

Understand the substance called alcohol, and how it affects the human body.

Be aware of, and understand, current theories about alcohol use and abuse.

Continue to develop their understanding of alcohol use and abuse as new theories evolve.

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Just in case the changes I have made need explanation:

I wanted any person, trained or untrained, to be able to pick up the Manual and read the aims, so I have translated it, I believe, a bit further into layman's terms.

It seemed to me that some of the aims, especially 6 - 9 were sweeping statements, too all-inclusive, and too big for the time allotted for the course. Number 9 was written in medical terms; now it has been translated.

Number 3, "Take action by educating" was written in terms which suggests that the professional does something to the client; I tried to rewrite it in terms that give the client more responsibility for herself.

#### The Future of the Manual

Without a crystal ball, we can only guess about the possible future development of the Manual. The evidence seems to suggest that it will continue to be used on courses throughout the UK. It will probably be purchased by workers in the alcohol field as

well as professional people, such as social workers, probation officers and teachers. It seems likely that the future sale of Manuals will continue to be processed by TACADE. Single copies of DCM have been sent for review to professionals who requested them in other countries: one has been sent to the World Health Organisation; another to Munich; one to Vienna and I have taken ten copies to various people whom I know in the field in America. So if one wanted to speculate about future dissemination, one could hope that the review copies could produce interest and eventually lead to requests for training in the use of the Manual. In the Conclusions, we will consider how this training can best be provided. The HEC publication which will be produced immediately following this thesis may be distributed to Health Education Units and local authorities throughout the UK and could lead to further orders for Manuals and requests for training. The HEC is presently proceeding with plans for alcohol campaigns in South West England and in the North West. A coordinator has already been appointed in the South West and one of the many programmes which is being introduced is Drinking Choices.

### Summary

The data has indicated that the sample of people interviewed found the Manual to be an effective tool for alcohol education, very adaptable, and easily used in their work. The writers structured it for those purposes, and the consensus is that they did it very well. The weaknesses and the strengths of the book itself are hard to separate from its functions as part of a package which includes training, and from the dissemination plan.

People had very different responses to the various sections of the Manual; this is probably true of any innovation.

Macdonald discusses this point in relation to an innovation in schools:

"What is emerging from these case studies is a strong conviction of the individuality of each (school) and of the need for decision making to be based on an understanding of particular cases. Advice in the shape of across the board formulae is likely to dangerously mislead. When we look at the pattern of impact in this sample of case studies we can see that they exhibit quite startlingly different patterns of response ... "

(1978, p. 32)

As we will see in the Conclusions, the fact is that people have taken the Manual back to work and have used it; they now see it as part of their repertoire of responses to the need for health education.

## CHAPTER VII

### OBSTACLES TO PROGRESS AND NEGATIVE RESPONSES TO THE PROJECT

#### Introduction

"If you hand different-shaped wooden blocks one by one to a child and ask him to build a tower, he will simply add each new block to the existing structure. The tower that results is not nearly so stable as the one he would have built had he been given all the blocks at the same time. In the first case the structure of the tower would be determined by the sequence in which the child received the blocks. In the second case he would be free to make the best use of all the available blocks. Whenever information arrives piece by piece, the way it gets put together is determined by the particular sequence of arrival. Hence the final arrangement of information is very unlikely to make the best use of what is available. This 'best use' would be the arrangement arrived at if all the information had been available at once instead of arriving piece by piece. Unfortunately, with personal experience, social history, cultural history, the growth of ideas and the growth of institutions or organizations, the information arrives piece by piece and gets arranged according to this sequence of arrival. The result is that, like the child with the blocks, one is trapped by the particular sequence of arrival."

(de Bono, 1972, p. 16)

The information arising from this study has arrived piece by piece over three years; in order to avoid being locked into the sequence, we have been using a process which Parlett calls "progressive focusing" (1974, p. 13). We have gathered data from many sources, e.g. interviews, conversations (in person and by telephone), meetings, reports, lectures, conferences, and reviews



of the literature concerned with the various aspects of the project. Periodic examination of the data evoked certain recurring themes; these themes were then discussed in the next round of interviews and conversations, and at Steering Committee meetings. We have endeavoured, at all stages of the project, to raise our awareness of underlying issues which were not immediately apparent from a first glance at the data. Now in pulling some threads together at the end of the project, we want to consider not only what made the project seemingly work so well but also what factors impeded its progress.

Parlett likens the process of sifting data to that which a map maker must go through in deciding what information to include and omit so that the map is relevant, useful and readable (op. cit., p. 1). I see it also as being parallel to writing a novel or a play: how could I write what is significant about an "HEO-or-other-professional" so that the characters with whom this report is peopled come alive for the reader, and so that the reader feels she has understood them and wanted to read further?

This particular chapter seems crucial in that respect. We want to understand people's feelings about DCM and to be aware of the things about the project which they resented, or resisted or found frightening. These are questions which may contain delicate or embarrassing points, and which people feel hesitant to discuss. In May of 1984, I have been examining the data once again, in search of the underlying factors which have caused blocks to progress, or have created feelings of negativity in the people involved.

### Risks and Changes

Certain changes are likely to happen over three years that

cannot possibly be foreseen at the beginning. Illuminative evaluation allows for these changes to be part of the formative process; nevertheless they have far-reaching impact; some of those changes are described in this chapter.

Inevitably, any innovative programme brings with it elements of uncertainty and risk. Things can go wrong; people can lose confidence; innovators can be blamed when an idea appears to backfire, or is not an immediate, unqualified success.

"Any proposal for change is seen as a threat by those who rely on established practices; and we all rely on established practices to some extent. Thus innovation always has an undercurrent of threat, below the popular and acceptable image on the surface."

(Nisbet, 1974, p. 2)

The inherent risks for the professionals, and the HEOs in particular, in this project were partly in the area of change in teaching style. The change from didactic to participatory methods, and the accompanying threat to the educator, has been discussed in Chapter III; here, in this chapter, we will explore the responses of those specific educators involved in this project.

Some people may have seen DCM as another sort of risk; e.g., if a manager in industry had a drinking problem, it might be uncovered if he attended a course or sent some employees on one. He might be expected to change his drinking behaviour, or perhaps he might feel guilty about his present habits. Some discussion of this kind of reaction is contained in this chapter.

First, however, we may understand the background to the problems we encountered if we examine the structural and circumstantial difficulties that unexpectedly arose as we went along.

## Structural Obstacles

### District Reorganisation

Everyone in the project knew that the NHS was intending to reorganise the health districts throughout the country. The last time this took place was in 1974, and the result of that reorganisation was that the areas were large and administration was costly. Now, in the reorganisation of 1984, the "area" will be eliminated, thus removing one tier from the hierarchy, and the district will be the operational unit (see Fig. IV.i, p. 138).

There were warnings as far back as spring of 1982 that district reorganisation would play havoc with the progress of Drinking Choices (not to mention its other effects). It was first mentioned in my hearing at the follow-up day to Beamish I, when the HEOs from Durham said they would not be able to do much about Drinking Choices because reorganisation was going to have drastic effects in Durham. They were saying that they would not start running courses until they were sure that they would have a job, and the same job, by the time any course that they set up would be finished.

As far as Drinking Choices was concerned, the results of district reorganisation were that there might be possible reductions in staff, leaving certain HEOs and even DHEOs without jobs. There might also be many issues about re-grading, up-grading, down-grading, which added to the air of uncertainty and resistance to starting new projects. For example, one woman had been doing a DHEO's job for many years, but on the basic HEO salary scale, and has recently been put in the position of having to re-apply for her own job.

Furthermore there have been many changes in district boundaries, especially in Cleveland and Durham, which meant that HEOs could have

started a course in a certain district and then found themselves transferred to a different district in the middle of the course.

It is difficult to estimate just how much effect these job threats had on the individual HEOs, or on the DHEOs who were making decisions about priorities and staff assignments. From analysing the comments made in interviews, I do know that they responded to the job threats in various ways, some feeling, "Oh well, I'm about to retire anyway", others feeling that their futures and those of their families were very much at risk in the current economic conditions, and there were still others who seemed to feel quite confident about their job security.

In spite of all this, some HEOs went ahead and ran courses while others were determined to wait until they knew what would happen about their jobs. Some people said, "How can we start courses when we don't know if we will be able to finish them?" This could be translated as "Why should we start courses when everything is so insecure?"

One HEO started a course, voluntarily changed jobs, and came back to his district to complete the course with his fellow HEO; others would not have considered such an option. In Cleveland, where one of the most extensive boundary changes was going to happen, HEOs ran two courses in spite of the forthcoming changes, because they felt enthusiastic about the project, and, having undergone the training, they felt committed to taking DCM on through the pyramid. It also could be pointed out that a course need only take 5 days, or at the most 5 weeks of weekly meetings, so it could be done ..... The answer to this is probably that some people were more demoralised and angry about the changes than others, and

some were in reality more at risk. Many of them, understandably, might have felt a bit rebellious and simply refused to move under the circumstances: "If they don't care about me Up There, I'll just bluff my way through until I know what's going to happen".

#### Political and Semi-political Issues

There are other politically-related issues besides reorganisation which have served as obstacles to progress in DCM. One of the most obvious forms of control available to the Government is in the allocation of funds. One offshoot of this control is represented in the cuts in Government spending, which are passed along in cuts throughout the structure of the NHS. All health districts have had to cut 1% of all cash expenditures in the financial year 1983-84; this has meant a general reshuffling of priorities, and less money available for running courses and buying Manuals. In one district these cuts have meant a long delay in initiating DCM courses, in another they have accompanied the regrading of salary scales, combining to create an atmosphere of mistrust, rumours and suspicion, in a unit which was previously characterised by a high degree of cooperation. These feelings, in turn, have distracted the staff of the unit, and changed their attitude towards work. They have been noticeably less enthusiastic and, in some cases, have lost respect and trust for their team leaders; a view of the impact of all these changes ought not to be focused on DCM alone; it inevitably affects all areas of the work of this unit.

Political decisions are at the heart of HEC plans about funding projects; the DHSS can veto a proposal or influence the council to close down a project, and may also demand certain

positive actions from HEC. The current interest, indeed the deep concern over alcohol consumption could be replaced by other topics, as the health education world (like any other area of activity bounded by political issues) is subject to trends and bandwagons. Sometimes these trends are caused by genuine concern on the part of policy makers; other times they are subject to less altruistic motives, like career advancement or sensationalism of the media. The societal unrest in the mid-1980s, reflected in the statistics on alcohol consumption, unemployment, crime, heroin addiction and the misuse of prescribed drugs, as well as the publicity about causes like the women's movement and the peace movement, among others, creates a widespread public concern, first on one topical issue and then on another:

"Societies appear to be subject, every now and then, to periods of moral panic. A condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests; its nature is presented in a stylized and stereotypical fashion by the mass media; the moral barricades are manned by editors, bishops, politicians and other right-thinking people; socially accredited experts pronounce their diagnoses and solutions; ways of coping are evolved or (more often) resorted to; the condition then disappears, submerges or deteriorates and becomes more visible. Sometimes the object of the panic is quite novel and at other times it is something which has been in existence long enough, but suddenly appears in the limelight. Sometimes the panic passes over and is forgotten, except in folklore and collective memory; at other times it has more serious and long-lasting repercussions and might produce such changes as those in legal and social policy or even in the way the society conceives itself."

(Cohen, 1972, p. 9)

The alcohol education field may be subject to such trends; as discussed in Chapter II, DCM indirectly reflects Government concern about alcohol consumption, or out of a governmental desire to

appear concerned about it. The extent to which DCM will continue and expand in the future is likely to be decided by these same factors. It is disconcerting to face the possibility that all of the work, energy and enthusiasm which went into the DCM project, could be wasted, not in terms of its present effects, but in terms of anyone in government noticing that it has happened. This is a contingency that many researchers have encountered; in a study of The Realities of Social Research, Platt reports:

"In a number of cases where research was sponsored by large organisations, private or governmental, the individual responsible had moved on by the time the research was finished and so there was no-one left to take an interest in it; in theory the organisation was the sponsor, but in practice it was an individual, and there were no administrative mechanisms for feeding in research results and so no practical likelihood that action would be taken on them ... But sometimes there were other reasons for lack of interest or action. One project had been to investigate the need for a then highly fashionable nostrum; by the time the results were in (suggesting that the nostrum was not of much relevance) the fashion was over in any case."

(1976, p. 62)

(N.B. Another comment on the trendy nature of public concerns.)

"On another project the researcher suggested that the nature of the Civil Service was a key factor: ... one makes a mistake if one views administrators in the government as being burning to improve the things they are administering. They're quite willing to improve things if it can be proved to them how it can be done, but the context in which they work is one which directs their attention to things like scandals, political things basically, and they haven't got the sort of contact, the sort of careers which would motivate them to improve (nor would it further their careers if they did improve things, because it's not clear who's responsible and they have moved on by the time it happens)."

(1976, p. 62)

In the DCM project, although the results seem to prove that "it can be done", and also show how it can be done, obstacles to

future dissemination may take the form of changes in priorities for the HEC and/or lack of further funding.

#### Circumstantial Obstacles

##### Changing Circumstances of Course Members

However carefully a programme is planned, unforeseen circumstances are very likely to arise which will obstruct or change the direction of the programme.

Four key tutors, that is people from level 1 of pyramid I, either moved away or changed districts during the three-year period. One of these tutors moved to Australia, but has kept in touch by correspondence; (unfortunately, a trip "down under" for interviews was not provided for in the budget). Another key tutor moved to a different county in the South of England; and two moved across districts in the North East. The last three mentioned, because they remained in England, were still accessible for interview, and these interviews were conducted, but at increased financial and physical cost.

Five from the sample of 35 course members moved from the North East and/or changed jobs. Of these five, three became inaccessible due to distance or due to a change in the nature of their work; it seemed to me to be appropriate to pursue the key tutors to the South of England for interviews, but not worthwhile to pursue particular course members who moved away or took up jobs where they would not be using DCM. I chose other course members to replace them. Three people from the original sample, including two key tutors, were seriously ill and away from work for long periods during the project.



### Resistance to Participatory Learning Approaches

We have already considered, in Chapter III, some reasons for resistance frequently arising in professionals when asked to change their instructional methods. This resistance was in many cases a personal and organisational block to effective presentation of Drinking Choices.

There is a long tradition of education in health education which gives the health educator a very different role from that demanded of a facilitator of participatory learning. Even when HEOs say that they already use participatory methods, it becomes evident that they are at varying places along a continuum from didactic to participatory learning.

Furthermore, there is an anomaly for people using DCM in that it is run in a democratic manner and may point up to course members that their working conditions are not, which may create dissonance. Another problem which has appeared in some DCM courses, and which may continue to become more apparent as dissemination goes on trickling down through the pyramids, is a clash between participatory methods and clients who will have been used to didactic teaching/learning methods and may prefer authoritarian group leaders. There are several options for dealing with this sort of disagreement:

- a) Skilled group leaders may be able to demonstrate to the group that they will enjoy being more involved in the learning process.
- b) The leader can ask members of the group to provide lectures and presentations, thus combining the didactic and participatory approaches.
- c) The leader can decide that lectures will be more effective for groups who prefer them.

With group leaders who have not had a great deal of experience in coping with resistance, c) above often seems to be the desirable option; with further training they might opt for a).

Another HEO who worked closely with me on DCM courses has never felt able to explain satisfactorily to his superiors that a course ought to start with an agenda-setting exercise, so that it fits the needs of the course members at that present time. He has arrived at a compromise system of sending out questionnaires to prospective course members asking them what they want to achieve from attending the course.

These and other examples of blocks to the innovations required by the Manual are not difficult to explain.

"Transformation involves the transcending of traditional boundaries and limitations ... The non-cognitive qualities that contribute to the production of a transformation include a playful attitude towards reality and a willingness to expose (even to flaunt) ideas, attitudes, and objects that violate tradition. An attitude of playfulness, a desire to toy with reality is important because it would appear that most transformations come as a discovery on the heels of many trials. Thus to some extent transformations involve an element of 'luck', but it is the kind of luck that cannot occur without the predisposing attitudes that lead to experimentation and other forms of intellectual play. No single adjective adequately summarises the personal qualities that contribute to the production of transformations. The word that comes closest to describing the cognitive qualities and one that at least does not do violence to the non-cognitive qualities is the adjective flexible."

(Jackson and Messick, 1971, p. 89)

HEOs being human, like anyone else they can be rigid or flexible, restrained or playful. It would be extremely unreasonable to expect their teaching habits to change overnight; still, fairly or unfairly, I felt that in many cases the obstacles we encountered were attributable to inflexibility on the part of an HEO or a

course member, (and to impossible expectations on the part of the facilitator! In my role as facilitator, I had a brief from the Steering Committee to encourage the HEOs in their participatory learning skills and, in view of my personal bias, it is not surprising that I often took a great interest in the use of group work methods and active listening when observing courses. Throughout the project, I had to compensate for this slant by making sure that I discussed other key issues when interviewing people.)

Another effect of my dual role as facilitator and evaluator arises in relation to obtaining evaluative comments from group members. With me running the course, it would be even more difficult than usual for group members to give negative feedback, however much I might encourage them to do so. I deliberately spent time with each group evaluating their experiences on the courses, and working to bring out the weaknesses as well as the strengths of DCM.

### The Risk of Failure

There is a considerable emotional risk involved in experimenting with new methods in front of colleagues and evaluators, with the possibility (implied or real) of being seen to fail, or to look foolish. This does not apply only to the games or the particular activities in DCM, it refers to abandoning the security of prepared lecture notes and venturing into exploring ideas with a group. Questions may arise that the leader cannot answer, and the leader wonders, "Will they think I don't know my subject? What if my mind goes blank? What if they do not like this kind of group?" It took some time for people to internalise the idea that, if one accepts the principles of participatory learning and is willing to

use them, then success/failure is not an appropriate framework in which to operate.

The responsibility for success lies with the group, and doing away with the particular risk of failure is a major aim of participatory learning.

Some course members have commented that participatory methods brought out into the open, and even accentuated, the idiosyncracies and problems of group members, which, under the more didactic methods, tend to disappear in an ethos of politeness. This factor has been seen as another risk to be encountered, or resisted. The individual personalities and idiosyncracies of the trainers were much more crucial in the effective presentation of this module than in the traditional methods.

Educators felt uncertain at times about giving up the role of the expert; one result of this, in some cases, was that the old security seemed desirable, and thus some 'backsliding' ensued. At times, what I have labelled backsliding occurred in unexpected places. An example of this was when I attended a course given by an outstandingly effective worker in the alcohol field, who had been deeply involved in developing her group work and counselling skills as a result of DCM. Much to my surprise, instead of involving her audience, she delivered an excellent lecture, complete with slides and a short question period at the end. When we discussed her presentation in an interview later, she said that she did not feel confident in using her new skills with an audience of nurses who were not expecting to participate, although she agreed with me that it might have been beneficial for them to have done so. My comments are not intended to imply that there is no use at all

for lectures, nor even that this might not have been an appropriate time to use one; this example is included in order to illustrate that familiar methods are often attractive, even when one is in a process of mastering new approaches.

### Resistance to Change

Attitude and behaviour change are complex subjects, and are not going to be explored in depth in this report, but a mention of these factors is important because perhaps resistance to change may encompass all of the other obstacles. When it comes to innovation, people can dig in their heels for a variety of reasons, and they do not always say, or even know, what the reasons are, as some of them arise at an unconscious level.

From my work as a therapist I know that people can be eager to change, and even be revolutionary or innovative in their approach to work, and still find it extremely difficult to change personal behaviours or habits which have been rewarding to them in some way. (N.B. This is as true of me as of anyone.) As it applies to DCM, this resistance can be seen at all four levels of the pyramids. To give just one example at each level, although many have appeared in the data:

Level One: Some key tutors found it difficult to change their teaching styles.

Level Two: Here we have the notorious Gap in the Pyramid. People returned from DCM courses prepared, and even in some cases eager, to run their own courses, and were not allowed to do so. We have discussed in Chapter VI the effects this had, and, in the Recommendations, what to do about it. At this point, speculating as to causes, we can surmise that in some instances the managers were

resistant to changing their procedures for dealing with employees with drink problems. They would have had to develop educational policies and methods and to replace disciplinary measures, and this would almost certainly have entailed costly and time-consuming efforts.

Perhaps too, as we have speculated elsewhere, managers would have been fearful about confronting their own drinking behaviour. A quote from my interview with a senior social worker: "Cynthia said that she and her colleagues did stop and think about their own drinking. She said that it frightened Mr. X so much that he would not come back, and he quit the course after filling in his drinker's diary." (Nov. 1982)

Level Three: Course members initially wanted to be lectured to, and directed in their work; some took a long time to accept the non-directive style; a few never did.

Level Four: At this level we have the target groups, or the baseline of the pyramid, the people for whom alcohol services and education are to be provided. Many of them find it very rewarding to drink heavily, and may strenuously resist change, or perhaps just find it difficult though desirable. A clinical psychologist discussed one of her clients with me. The client was a divorced woman with five children to care for. Heavy drinking at home and occasional nights out at the pub were her only form of recreation. The psychologist was working with her to find other options, as the woman was saying she wanted to stop drinking. But her case notes showed how difficult it was, and sometimes she missed appointments or stayed away for weeks at a time unless the psychologist went out to see her. How much responsibility should the psychologist assume?

Resistance to change, then is to be expected and can be allowed for when planning innovation:

"We should expect complex social systems, whose mode of operation must have been arrived at because it serves certain needs or produces certain pay-offs for those involved, to be resistant to change. Particularly should we expect it to be resistant to change when this threatens to involve change in status and role relationships."

(Orford, 1981, p. 195)

The range of strategies employed to resist change is wide and complex; some people work very hard at it. This particular project uses an instructional system to produce change. This is not unrealistic, as the results will show in the next chapter. The system relies on group work methods, and some of the ways in which these can be effective in dealing with resistance are outlined below:

"The study of group dynamics has begun to produce some generalizations about the factors which affect the value of groups as instruments of change.

1. A group tends to be attractive to an individual and to command his loyalty to the extent that:
  - a. It satisfies his needs and helps him achieve goals that are compelling to him.
  - b. It provides him with a feeling of acceptance and security.
  - c. Its membership is congenial to him.
  - d. It is highly valued by outsiders.
2. Each person tends to feel committed to a decision or goal to the extent that he has participated in determining it.
3. A group is an effective instrument for change and growth in individuals to the extent that:
  - a. Those who are to be changed and those who are to exert influence for change have a strong sense of belonging to the same group.
  - b. The attraction of the group is greater than the discomfort of the change.
  - c. The members of the group share the perception that change is needed.
  - d. Information relating to the need for change, plans for change, and consequences of change

is shared by all relevant people.

- e. The group provides an opportunity for the individual to practise changed behavior without threat or punishment.
- f. The individual is provided a means for measuring progress toward the change goals."

(Knowles, 1973, pp. 94 and 95)

In a DCM course, even with an experienced leader, these factors can only begin to work effectively; 5 or even 10 sessions are not long enough to develop them fully. But in groups such as those at Parkwood House, or the various self-help and Drinkwatchers' groups which have been established at Levels 3 and 4, these factors can operate to produce change. Perhaps only a few people from each DCM course will follow through to achieve that degree of implementation of the system. In Chapter IX we will recommend some ways of increasing their number.

#### Repeated Collapse of My Support System

As Nisbet so aptly puts it "Any human enterprise, if it is to flourish, needs a carefully planned basis of support services" (1975, p. 7). One key factor in the success of an innovation must also be an effective support system. This has been an issue fraught with problems and changes for me as the facilitator/evaluator. In the beginning I felt quite confident that I had established an effective support system for myself in directing the project and in completing the evaluation report, thesis and HEC publication. It seemed to me that this was my responsibility and, if properly established, such a support system would assure me of the right degree of consultation and the necessary confidence and the knowledge that I was proceeding along acceptable paths. The system would also



provide the triangulation I needed; I would always have someone with whom to check my thinking. Because this evaluation demanded extensive collaboration and cross-fertilisation of ideas, and could not be performed effectively in isolation, the regular supervision sessions and the support system were, perhaps, more crucial than they would be in some other kinds of Ph.D. projects.

Of the people mentioned earlier who moved away from the NE, two were writers of the Manual, with whom I had been working very closely. One of them was a friend and neighbour as well as being a DHEO, and was especially helpful to me. In January 1983 she moved to Bristol, as a result of her husband's change of jobs; we are still in touch, but of course communication is more difficult.

The second writer of the Manual with whom I had been in frequent contact was a DHEO and also an experienced researcher, who had kept me well-informed and was a key consultant. I mentioned her earlier: in January 1984 she went on a year's leave in Australia.

The third writer of the Manual lives in Manchester and, although we communicate frequently, he was often too busy to be available for consultation.

The key tutor with whom I ran our first DCM course after Beamish I, and with whom I conferred regularly during 1981 and 1982, has been away from work with a long illness during the autumn of 1983 and until April of 1984, when he has returned to work; I missed his assistance and advice very much.

#### Departmental Issues

In October 1983 I lost another major support, when the project

secretary had to leave for family reasons. She had been with the project from the date of my appointment to the University. She was familiar with all the material, data, literature, bibliography and the workings of the Department. She was able to advise and consult on all sorts of matters. She had attended meetings and follow-up days and knew the people involved in the project. Although the new secretary was extremely helpful, capable, and likeable, she did not have the background of being there for the first half of the project and did not know the people or the materials and had to learn them from scratch.

Meanwhile, in the School of Education, problems which could be described as political were further impairing progress in many areas of the department's work, and not just in this project. When I was appointed there had just been a massive reorganisation of staff, including a move from a variety of buildings to the present site. There was increasing pressure to reduce staff and student numbers, resulting in a fall in morale and accompanying interpersonal problems. Without exploring these issues in depth, I would comment that they were very much in evidence for people working in the department.

Lest the reader dissolve in a pool of sympathetic tears, it should be pointed out that the project and the writing have continued in spite of obstacles, without the immediate presence of all these significant people and one of my tasks has been to re-organise the system. It seemed relevant to mention this crumbling support system as a major disruption to the progress of the project.

#### Cul-de-Sacs

I found myself coming to a dead end with some people and there

are various reasons for this. Some have already been mentioned in that they were people who were not allowed to act as trainers and this made them feel there was not much use talking to me about it. On the other hand one Environmental Health Officer liked talking to me in spite of the fact that his own work in alcohol policy development was not going to be allowed to continue, for reasons which his boss would not discuss with him. In one case, which I do not understand, the dead end came because a woman who I thought was enjoying the interviews started making and then breaking appointments. After the third time this happened, I gave up.

In another similar case, one HEO always managed to be out when I came, even though I had made specific appointments. I can only speculate that there was some threat or dislike that she experienced. An unusual and extreme case: I chose not to see a woman as I found that the conversation inevitably got around to vicious gossip in spite of my efforts to stay on a Drinking Choices track; this provided an ethical problem for me. Although I wanted to hear what her opinions were about DCM, I was repeatedly unable to divert her from launching verbal attacks on her boss, and several other people involved at Level One. I told her that I felt this placed me in an awkward position, but she did not stop, so I stopped seeing her. This is the only case where I had personal reasons for not continuing with the interviewing process; I felt that conscientiousness demanded persistence, but I was not willing to listen to repetitions of abusive accusations.

#### Contact with Clients

Level 4 of the pyramid involves the passing of education and skills to clients. These clients comprise various target groups:

People with drink-related problems and their families.

Offenders.

Those who receive help from the Social Services.

Children who are clients of voluntary organisations,  
such as NSPCC

and finally, on an education level,

Students and pupils,

and many more.

Therefore one of my intended tasks was to interview a large number of clients late in the project when time had brought us to level 4. This intention was undermined by several factors.

The first one is the issue of confidentiality. Some organisations, notably NSPCC and the Social Services, were very definite in refusing to let me see their clients. The stated reason was respect of confidentiality. Again scepticism raised its head and my own personal reaction was that this sort of attitude is somewhat over-protective. Left to themselves, these clients probably would have volunteered, although this of course is only a guess; it was the fact that I was going through agencies to reach them that seemed to me to be the obstacle; the refusal was usually stated as a matter of policy.

Another major factor is that, as we have already noted, HEOs do not have much contact with clients. HEOs have been the primary source of all communication for me and they have been very good about reporting results, spin-offs and course evaluations. Unfortunately they have little to report about clients because they simply do not see them very much. As project evaluator, I have been dependent on key tutors and course members to feed information to me; I did ask repeatedly for information about clients and got

very little response.

Perhaps the most potent issue of all is the time-scale. In the last six months of the project, I interviewed more than 60 different people. If the project were going on for another year, I could go back and talk to students and pupils, prisoners, offenders and hospital patients, who are just beginning to have contact with course members; so in part the lack of contact with clients is simply due to the timescale of the project, which is scheduled to end in June, 1984. Our recommendations will include a possible follow-up to the evaluation.

As will be seen in Chapter VIII, clients did provide us with some very interesting data; let us examine the reasons why the contact I had with clients did not tell me even more about Drinking Choices. In most cases, social workers (for instance) do not mention to clients that they have been on a Drinking Choices course. Therefore clients are not aware that the social worker is doing anything different from what he or she would previously have done. In most cases the clients will have done certain exercises from the Manual, such as the Drinker's Diary or the Road Map; they are not aware that this is part of a larger picture. Likewise, it would not be part of a normal conversation between a teacher and a pupil to discuss the teacher's professional development. In the case of the young offenders whom I interviewed, they were perfectly happy to talk to me about the course they were attending with their probation officer, which was modelled on Drinking Choices, but they were not aware that this represented a departure from usual practice.

At Parkwood House, I asked key tutors whether they felt

clients could notice a difference in the way they were being educated about alcohol. They said that patients come and go every few weeks and that because of the large turnover they would be unaware of a transition or change in the teaching methods.

#### Low Level Obstacles

In attempting to understand the different levels in a structure being interpreted through participant observation, we constructed the following model:

- (a) personalities, strengths, weaknesses, personal characteristics;
- (b) significant others, including those in power locally; in the case of HEOs: people they work with, DHEOs, DMOs, nurses, colleagues and other professionals;
- (c) people in power nationally who can create work and provide funding and can have a high degree of political influence, e.g. HEC, DHSS, Government.

(Coffield, supervision session, 1983)

In this chapter we have been examining this model in reverse order, so that now, towards the end, we come to some more personal examples of obstruction or negative behaviour.

"The work people do leaves its mark on them. The culture of a profession (as the sociologist, Everett Hughes, pointed out as long ago as 1929, and novelists like Dickens even longer ago) appears in the individual as a set of personality traits. Professionals develop a personal professional style which fuses man with his work."

(Hargreaves, 1978, p. 542)

I can recount in this context an example of an HEO who said "I'm far too busy getting ready to retire to be bothered about

Drinking Choices"; or a social worker who dropped out as a DCM course member because his Drinker's Diary revealed that pressures of work have contributed to a pattern of what DCM calls heavy drinking.

I have met an HEO who did not want to be interviewed because of disliking one of the writers of the Manual, and a charge nurse in a mental hospital who came on a DCM course and then read a magazine while old women patients sat staring into space.

I came across a psychologist who did not notify me that he would not be keeping an appointment we had made, so that I drove 30 miles to talk to his receptionist. There was a teacher who kept talking to me about "no room in the timetable"; (so, why come on DCM in the first place?)

#### Delays in Writing

Two weeks before the completion of this thesis, an HEO who had read the chapter on the Culture of the HEO, told me that the Kirby Report had never been adopted! (see Chapter IV). This, understandably, caused a halt to the proceedings while I tried to sort out the implications:

1. Why did I not know this? How could it be that no-one told me and I never read it in all my searches through the HE literature?
2. Why was I given the report to read in the first place?
3. Why was it not adopted?
4. Who stopped it being adopted? Why does everyone talk about it as if it were? How can I find out?
5. What does this gap in knowledge tell me about my communications with HEOs - what about theirs

with me?

6. HELP!

Anyone who has worked to a deadline in writing a thesis will understand that this piece of information at the last minute caused a loss of precious time and therefore potential panic, thus:

7. Can I pretend I never heard this? (No, too risky, not to mention loss of academic integrity!)

A phone call to HEC and a visit to a DHEO and a return to the HEO who threw the informational bomb, sorted out the questions, but with a loss of a whole day's work on a later chapter.

The answers seem to be:

1 & 2: No-one told me because it never occurred to me to ask or check on it, since it had been given to me to read by someone at HEC as the basis of a Health Educator's job description. Though it has not been implemented as a law, it was indeed accepted and adopted in a revised version by the DHSS in 1981. Reasons for the report not being made statutory are not known to the DHEOs I spoke to, although they did speculate that the DHSS knew that with the coming reorganisation a new authority for training in the NHS would be established in a few years' time, and were waiting for that to happen. The HEO who told me it had not been adopted said he thought that some people might find it beneficial to have the HEOs' career structure be a bit foggy, and so colluded in keeping Kirby from being adopted. This would enable anomalies to occur, such as HEOs doing jobs outside the Kirby description, or certain people being promoted very quickly to top positions without proceeding upwards by the recommended grading steps.

3, 4 & 5: Most DHEOs use Kirby as a guideline anyway, and when



they themselves are appointed, their job descriptions are usually negotiated with the DMO, with Kirby as the basis. So no-one told me, and I did not think to ask.

6: I got the HELP I needed very quickly, both from HEC and from HEOs - they all made time to talk to me and sort out the problem. This is, however an example of the kind of hiccup that can cause delays in producing a report, and can, if one allows it to, cause panic and emotional disruption. In fact, as Platt puts it:  
" ... research often gives rise to a variety of stressful situations ... " (1976, p. 156), not least of which are interruptions and sudden discoveries such as the one above which cause delay and increased anxiety about completing the project on time.

Other delays in writing have been caused by:

misunderstandings, such as waiting in Durham for  
someone who was waiting for me in Newcastle.

my own resistance to new ideas.

idiosyncracies highlighted under stress.

absent-mindedness, bordering on amnesia as the  
deadline approached, and thus  
loss of necessary items such as my watch, car  
keys, books, my diary .....

Once a lengthy chapter which represented several weeks of literature-searching, was left overnight in my car so that I would be certain to take it to work the next day. Meanwhile, forgetting about that, I engaged a young friend to clean my car for me. Just before bedtime I decided to re-read the chapter, and found to my horror that it was no longer in the car. Four of us searched until I thought desperately of looking in the rubbish bin across the road; there it was in its plastic bag, looking, as my friend thought, like a load of rubbish.

### Criticism

There were examples of negative criticism about certain HEOs in their roles as group leaders. All of these were towards the beginning of the project. The following is a quote from my own notes after attending the first session of a DCM course in September of 1982:

"We arrived at 9.25, to find the room in chaos and one HEO struggling to rearrange the furniture, with no-one helping, many ladies sitting around the sides. The other HEO herself arrived late and breathless and apologetic.

The opening name game was played very badly, not many people understood the directions, and there was embarrassment all around. The HEO kept glancing at me as if I would be disapproving - I guess I was!

Things got considerably better with the TACADE game as the HEO knew it well and everyone seemed to enjoy playing it. However, he was giving people much more help than seemed necessary.

There was no wrap-up to the session and it ended in a jumble.

Afterwards I spoke to the HEO with the aim of being reassuring. I think perhaps I was, as I did receive warmer greetings the next two times I came and did have some informal chats with the HEO over coffee."

It was not always easy to find the way to be helpful and to make suggestions without seeming to be critical; no matter how gently I might intervene, the group leader might feel that he was losing face, or that he was on trial.

But these examples of stumbling blocks are minor in relation to other issues both negative and positive. One of the more pervasive negative aspects of this pyramid structure is "rising damp": apathy and cynicism.

### Cynicism, Doubts and Apathy

In an interview with an experienced man at management level

in the alcohol field, I was told:

"Alcohol is the same as anything else. It is big business. It all comes down to profit and loss and no-one cares about the individual. People want to stay in office and make money and that is how decisions are made. So if we want to influence the Government's decisions we must use political means. About 2½ years ago I and some others from the North East spoke to Labour MPs in the House of Commons. At that time Tyne & Wear Council were saying that we had no alcohol problems in Newcastle! I feel that a lot of this kind of political pressure should be undertaken by those working in the field. There was an incident a few years back in another region when I and a colleague were talking to a DMO and a Director of Social Services about patterns of service, and the DMO said - 'If I do that, people will live longer and there will be more old people and this will increase pressure on the social services, so I won't do that.' The same sorts of discussions take place nationally. Prescribed drugs are another example of this. Nobody is really concerned about it yet, though everyone knows that valium dependence, and harmanephran dependence exist and they are doing nothing about it. It affects mostly the 'underserving poor' and no-one gives a damn."

(November 1982)

This kind of cynicism surfaced in many other interviews I had with workers in the alcohol field. At times, quite a lot of it rubbed off on me .....

Because of my dual role as facilitator and evaluator and because of my own personality, interests and training, my focussing on the progress of DCM has frequently been on a pragmatic level; I have been concerned, along with my colleagues in health education, with Making It Work. While I have been busy arranging meetings and conducting interviews, encouraging and reminding people about DCM, and while I have continued my longstanding interest in implementing participatory learning, I have not always had my anthropological eyes on the wider implications and political questions surrounding the project. So it was not surprising that sometimes I suddenly tripped and fell into pits of disillusionment, and thought to myself "What is it all about?" This has certainly been an obstacle to

progress.

Like most novices, I thought at first that such doubts were due to some lack in me, and I wasted valuable time on soul-searching until I found evidence in the literature, and from my colleagues in research (especially Ph.D. candidates), that this is in fact a normal occupational hazard of solo researchers.

"These are questions about how much it all matters, to the researcher or to anyone else. Who really cares? Are the findings going to be any real use to anybody? Or are the findings isolated and separated from the real world? Could anybody ever act on them?"

(Rowan, 1981, p. 104)

Even more dismaying are the questions about the integrity and intentions of the people with the power to institute change. We know they are human, but sometimes we do not want to know how self-seeking they can be, and how they sometimes put their own careers before the needs of the people they serve. Platt makes the relevant points below about the relationship between government officials and research findings.

"It seems evident that there are many excellent reasons embedded in the structure of bureaucracies and the contexts in which they have to operate why research should not be taken very seriously as research. It has a role to play in image-building and the management of impressions, both internally and externally, but this means that its results cannot be permitted to be too inconsistent with the desired image. It does seem that, even bearing this in mind, some sponsors are unrealistically sensitive about what may be said, and pay little attention to the likely interest in it of the audience to which academic publications are addressed. When it comes to action on the results, there are many considerations other than the 'facts' or an isolated rationalistic calculation of the relation between means and ends to be borne in mind. Issues that, to the researcher, look fairly straightforward, for the member of the bureaucracy have histories and ramifying political implications. It may be shocking, but should not be sociologically surprising, that personal careers and departmental rivalries are salient among these. To the naive outsider like myself it was extremely striking to find how often researchers working for government departments mentioned the internal political significance of interdepartmental rivalries,

which could have real consequences for the research, as when one department withheld information in its possession from another. A further special characteristic of government work, in no way discreditable but often just as inconvenient for research, follows from the fact of public accountability. Any aspect of the research may be picked on by someone and made into a stick to beat the government with; there is particular sensitivity in the Civil Service to the possibility of questions being asked about it in the House of Commons. This means that pre-censorship has to be exercised to avert possible objections, even if the research procedure might seem quite innocuous to any professionally competent person; consequently certain questions are not asked, exceptional emphasis is laid on the preservation of confidentiality and anonymity, and so on. Thus some of the practical advantages that one might expect from access to governmental sources of information are not available."

(1976, p. 63)

It would be interesting, if it were possible, to follow this report on its travels and discover where it goes and who reads it .....

Doubts were particularly threatening towards the end of the project, when both healthy and unhealthy cynicism had developed, when I often felt that everyone involved - HEC, HEOs, research staff at the University, not to mention all my friends and relations, already knew everything there was to be said about DCM and that by now they could not care less, even if they had in the beginning. The Manual had been redesigned and was being sold, HEC had withdrawn financial support from the North East, HEOs were riding on new bandwagons. So to Rowan's questions above I added "Is it not too late now anyway?"

To add to the confusion, a friend who read these chapters, (which have now been read by at least six people each,) said: "Did it not ever occur to you that maybe they (the HEOs and key tutors) just did not like Drinking Choices, and thought it was a complete waste of time, but were afraid to say so?"

..... Stunned silence .....

I had to answer that no, it hadn't occurred to me. There were hints in the data, instances of discomfort and resistance, but never once in three years did anyone say "I think it is worthless". Back I went to look in the data again. All of the negative comments had been registered in this report, even the subtle ones like appointments not kept. Maybe that is what these seemingly minor disruptions added up to. I had to admit that if someone felt that strongly about DCM, it would be very risky to say so, when I, and in many cases their bosses, were so deeply involved in the project.

Also, as Zimbardo points out:

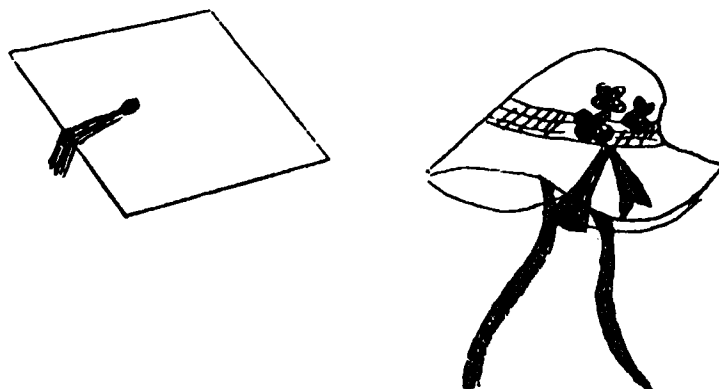
"The need to maintain group consensus can lead to 'group think', in which individual critical evaluation is suppressed and personal opinions are disregarded."

(1977, p. 105)

Many of the factors that I was in danger of taking for granted, like my own sincerity and my intentions to avoid manipulating people, were not necessarily obvious to the tutors and course members.

"Earlier I drew attention to the inevitable influence of the evaluator on the situation he is studying. This influence is much greater than the well-known experimenter-effect in classical research designs, both because evaluation is more threatening than research and because an evaluator has a greater need to build good relationships. He needs not only co-operation but access to information as well. Thus evaluation cannot be considered as a purely intellectual process in which an evaluator plans his work, collects evidence about remote events and then reports. It is also a social process during the course of which people may feel threatened, annoyed, troubled, bored, concerned, interested, or even excited. How can an evaluator handle it?"

(Adelman, 1983, p. 29)



### WEARING TWO HATS

What?!!!!!!

You are the facilitator and the evaluator  
at the same time?

Not really the done thing, is it?

How can you be objective?

But what about the impact of the researcher  
on the researched?

Oh dear ..... perhaps I should be worried .....

But what about reliability?

What about validity, replicability, plausibility,  
capability, reliability ?????

Well, in this hat I'll

Be neutral

Be objective

Ask the same questions

over and over

Listen, write, read,

analyse

Let the data speak to me

Listen

So, what's the problem?

In this hat, I'll ask people

what they think,

and feel

I'll listen, and be honest

But if it is that easy, I cannot be doing it right!

And in the Other I'll

Be warm and energetic

Make things easier,

facil-itate,

But not too easy,

challenge them.

Avoid judgements,

Never analyse

Listen

In this hat, I'll ask people

what they think,

and feel

I'll listen, and be honest

How can I handle it?

It is a job, a task .....

Get on with it.



By including this light piece of poetic reflection, I do not mean to imply that the conflicts of such a dual role ought not to be taken seriously. People outside of the project have at times expressed amazement that one should be given such a two-hatted task, and they often seem to expect the two roles to be desperately and perpetually in conflict.

I can see that it could have been a difficult challenge, for someone who has not always built evaluative procedures into their teaching or counselling or training work. Classes or groups that I have taken over the years have become accustomed to commenting both negatively and positively about whatever we are doing. By asking open-ended questions, such as, "What would you want to do differently if we did this over again?", or "What did you get out of doing that?", or "What did you notice about the film we saw just now?", I establish criticism and formative evaluation as a working habit. I usually leave space for these comments at the end of each lesson or group session. In training the HEOs to run DCM courses, we emphasised the formative nature of the exercise, asking all the way along for their evaluative criticisms of the course, the manual, our leadership, and the effects of the project; the history of this interaction between us goes all the way back to the pilot course.

It is probable that if the facilitator and evaluator had been two separate people, we might have had a more objective report; but I would contend that we might not have had such a sensitive and immediate response to problems as they arose, nor perhaps would the evaluation have had such a strong formative element to it, because I, as the facilitator, had a chance to act immediately on

suggestions which were made. Furthermore, the trusting relationship which I and the other facilitators built up with HEOs allowed us to receive gripes, gossip, information and other comments on both formal and informal occasions. This provided us with one of our points of triangulation, that is, collecting data in many different forms about the same events and experiences, in order to test for validity.

Of course, there were moments when I was so absorbed in facilitation that I had no time or attention for evaluation. Also, there were moments, as there always are, when I was disappointed or pleased with the proceedings, although perhaps those same perceptions were not shared by others. It is also true that another evaluator, one who was not convinced at the start of the value of participatory learning, would have written a very different report.

I can present no denials to refute these arguments; I acknowledge them, and do not pretend to have been an objective observer. But as Nesbit (1975, p. 11) points out: "... a basic principle is that those who devise and carry out a new idea should share in deciding how it should be evaluated."

We designed the evaluation as an integral part of the project, providing us with formative information throughout the three years. We consulted and collaborated in various ways, which have already been described.

Wearing the two hats was not a new experience for me; I find them comfortable and even necessary. In fact, I would be unlikely to be wearing a facilitator's hat without at least an evaluator's feather in it; the two roles, for me, are not as totally separate as they may appear to be at first.

I handle the potentially schizophrenic role by listening to people, using my counselling skills, and reflecting their feelings. I encourage them to talk about their boredom or annoyance. Perhaps they still felt threatened anyway .....

But could there really be such a major deception? I did not think so; I went back to see what the literature had to say about that.

Not for the first time, I found guidance in the principles of illuminative evaluation:

"In conclusion, I return to the client-centered stance of illuminative research. This stance ultimately provides the criteria by which selection takes place in progressive focusing, progressive distillation, and final writing. Our belief is that in the study of educational practices and organizations one can identify numerous personal constructs, a range of theories-in-use, hidden curricula, and numerous individual and group 'perspectives' that are rarely spelled out, fully comprehended, or critically examined. From the mass of those that are collected, one selects phenomena that persistently occur; or those that are most consistently overlooked or judged to be most revealing, interesting, pertinent, or powerful in explanatory terms."

(Parlett and Dearden, 1977, p. 111)

Client-centred ..... now there is a phrase I can relate to. In this context it says to me: If the people I am asking for information choose not to tell me, then I will not have the information; I am here to listen to what they say, I may only guess about what they might be thinking.

While stumbling over these emotional obstacles, of course I also found other answers and encouragement.

I liked Nesbit's statement on the importance of evaluation because " ... it provides a vital feedback of information to the innovating team on their strengths and weaknesses ... " and

constitutes " ... evidence from which others can form a judgement on the worthwhileness of an idea: colleagues will not be persuaded by mere affirmations of faith" (1975, p. 1). Thus I learned to cope with my doubts and put evidence about DCM on record so that other alcohol educators can use it.

I also took heart from Marshall (in Rowan and Reason, 1981) where she describes some of her methodological and personal difficulties with research, and how she copes with them:

"And at the same time there's a kind of fear that nothing is going to come out of the research and that I'm going to be left with a pile of tapes and nothing to say at the end. That's part of taking risks and using a more open method, you have to learn to live with these feelings, find them exciting rather than a problem."  
(p. 396)

"Then toward the end of analysis there's a phase when it is quite difficult. Things start to get tough, as if I'm holding all this stuff in my head and beginning to feel overloaded. I need then to close, I'm getting tired, I want to bring things together and capture it all, it feels as if I won't be able to hold onto it much longer. That's quite a tough time. But then there's a bit toward the very end when there's a kind of feeling that I know what it's all about and the structure of the data. It's a feeling of relief that I know that the data is worthwhile, that I've got something meaningful, and that I can write it, I can put it together. It's almost like having the essence of things that I can always fall back on now, so it does become more solid and more understandable. That feeling gives me confidence that I can pull it together."  
(p. 398)

### Summary

In this chapter, we have reviewed structural blocks to the progress of DCM, which were influenced by the political climate and the effects of reorganisation in the NHS. We have seen how changing circumstances inevitably impede the progress of widespread dissemination in an innovatory programme. We have considered

blocks to a major change in teaching approaches. We have considered obstacles on the HEO level and then on the even more personal level of the researcher as a human being.

As a result of encountering these obstacles, some of which have been overcome as we went along, and some of which are not within our brief, we are still left with several kinds of problems to tackle. How can we:

1. ensure that key tutors in the region will recognise and define their further training needs, and then see that these are provided for them?
2. maintain the involvement of the key tutors in planning for the further development of DCM and other alcohol services in the NE?
3. best increase the transfer of training from DCM to other topics in HE?
4. call attention to the results of DCM, so that it is noticed by the people who have the power to develop it further?
5. continue to deal with resistance to change in:
  - clients
  - management in industry and NHS
  - key tutors
  - local authorities
  - ourselves?
6. keep a support system going for DCM?
7. counteract cynicism and doubts as to the effectiveness of DCM?
8. combat apathy and keep enthusiasm going to enhance the progress that has already begun in this region?

We will make recommendations at the end of this report, which address themselves to these questions. The following chapter will discuss the positive results to which we can point, and perhaps the most relevant question of all is, how do we maintain these good results?

## CHAPTER VIII

### POSITIVE RESULTS OF DCM AND SPIN-OFFS

#### Introduction

This chapter is being written in May of 1984, four months after the official end of the fieldwork. I have been swimming through the data for almost three years, and soaking in it for six months. Having re-read all of the notes and transcripts of interviews, my letters to others and memos to myself, records of discussions with the project supervisor, Steering Committee and the other collaborators, I have also checked back with the key tutors to see where they are today in their progress with DCM. Now I can put my head above water and look at the positive results. However, in fact, this report has been writing itself, through me, since day one of the project.

"Report writing is an intrinsic and important part of illuminative investigations. It is not tacked on to the end of the study as an afterthought - as it often seems to be in many forms of research. The data of illuminative research work are often not numerical, awaiting conversion to verbal summary. Rather, they come already articulated as opinions, descriptions, stories, portrayals, and considered statements of policy. Data-processing involves dealing with a complex array of evidence. Interview notes or transcripts, observation reports, personal memoranda, historical summaries, extracts from documents, have all to be organized and collated, summarized and selected for quotation. Data analysis should naturally merge with the assembling of a first draft of the report."

(Parlett and Dearden, 1977, p. 35)

## The Soak

Parlett and Dearden's description above conjures up a mental image of enormous piles of papers, tapes, and dusty books; this vision is not inaccurate. What Parlett calls a 'complex array of evidence' does indeed look like a deluge, an overwhelming accumulation of words; one could easily drown in the soak. Now we can see another feature of progressive focusing; that is, it acts as a life preserver, and affords us a means of channelling our information so that we arrive, only slightly damp, and having made some sense of it all, at the end of the sifting process. Throughout the soak, one needs life belts (key concepts, organising principles) to cling on to, or to hang large amounts of data on.

Parlett states:

"This form of interpretive work - choosing areas of concentration and key topics and framing the study around these in a series of mid-way conceptualizations - lies at the centre of illuminative evaluation practice."  
(Unpublished, undated, p. 14)

An example of progressive focusing might be helpful at this point. I knew that the HEOs and their activities would be major aspects of this report; I also knew that I would be assuming an anthropological viewpoint, for reasons which I have discussed in Chapter I. But it was in the car on the way home from an HEO seminar in Northumberland, in 1982, that Professor Coffield and I first used the words "The Culture of the HEO". This phrase then became a major theme upon which I began to focus my attention. I began to notice, from a slightly different perspective than before, the tribal characteristics, the language, and the typical behaviour of the HEOs. I became fascinated with how they spent their time; thus, Harry's Diary in Chapter IV. In writing Chapters III, VII, and VIII, I became interested in how HEOs responded to new learning approaches. Later, in



Chapter X, I refocused on Harry as a client in the process of change. If I had not heard the words "The Culture of the HEO", the data would have been organised in a different way, and I might have been looking at people and events from a different perspective.

It was at an early supervision session that another theme emerged, as we were discussing problems that the project was throwing up for various people, and conversely, problems that were preventing the project from working. Thus the theme of Obstacles to Progress emerged. The chapter headings and sub-headings reflect the progressive focusing which characterises Illuminative Evaluation.

As I immersed myself in the collected data, comments, phrases and accounts seemed to fall into categories; sometimes they belonged to more than one, in which case they were cross-referenced; sometimes they did not seem to belong in any established grouping, so a new category was formed. If a new theme appeared, (for example, some negative feelings about games on the part of some HEOs), then I concentrated on the new theme to see if more data emerged which would indicate that this was a major factor. In these ways I let the data speak to me, with the aim of avoiding preconceived notions about what I might find. This is the heuristic nature of Illuminative Evaluation, which makes it an "evolving strategy of study, continuously updated in accord with the investigator's emerging understandings of the system as a whole, as well as accommodating changes in the system that result from the flux of unfolding events during the course of study." (Parlett, op. cit., p. 5)

The Soak took the better part of six months, during which new events and ideas were still occurring. These were either fitted into themes which were already established, or provided

new information which changed the themes or caused us to refocus.

In a way this next chapter is a celebration. We can enjoy the conviction that all the energy and money expended did indeed produce positive outcomes. Perhaps, while maintaining as objective a view as possible, we can allow ourselves to appreciate the progress we have achieved.

The poem below is an unusual example of positive feedback, a poem by an HEO.

#### The Drinking Choices Experience

Groups and Courses about health are my concern,  
So this light hearted poem is just to convey,  
How participating in a course named Drinking Choices,  
Influences my work everyday.

Donna Brandes involved me in group work,  
When I was sent to Beamish Hall,  
To attend a course to absorb all there was,  
About Ethyl Alcohol.

Lots of interesting folks came along,  
With expectations just like me,  
But what I didn't know then was,  
I was likely to become a groupie.

The chairs were arranged in a circle,  
I joined the others in the ring,  
And when we got to know each other,  
We did some active listening.

The ground rules were established early,  
The group decided what they would be,  
And when they were observed by everyone,  
It encouraged sensitive interaction and courtesy.

It does not pay to deceive or pretend,  
When trying to build up trust,  
You will be seen through in the end,  
So the golden rule 'always tell the truth' is a must.

Participatory learning methods,  
Is an effective way teaching can be done,  
And then by definition,  
Learning can be fun.

What is participatory methods people always ask,  
If you feel comfortable, close your eyes,  
Try to recall your very first recollection of alcohol,  
Then share in a round or pass.

It's not about winning or losing,  
That really is not the way,  
But not lose is the target,  
And then both you and I are O.K.

I had never thought of the worst thing that could happen,  
Nor even of the best,  
And I was in for a big disappointment,  
If I was expecting to sit back and rest.

Could I ever have an alcohol problem?  
Could my attitude and values play a part?  
Why do people drink at all then?  
We could do a brainstorm on that.

The group appears a bit lifeless,  
Something to stimulate is the aim,  
Let us play wink and murder,  
What did you get out of that game?

What would you like to do now?  
To respond to your needs I prefer,  
Let's just get it down on the flipchart,  
You've got a good list there.

The group is not all sugar and spice,  
I get the feeling something is not right,  
We can do a round and say how we feel,  
And bring the matter out into the light.

What do we do with the late comer?  
The bored, the silent and dominant too,  
The experiential technique is role play,  
I need a volunteer - will somebody be brave and do?

How can we tell if it's working?  
Have all our objectives been met?  
We can measure knowledge and skill by testing,  
But tests for personal growth and confidence are more  
difficult to set.

I appreciate the active learner's enthusiasm,  
And the difference discovering for themselves makes,  
To the interest in the subject matter,  
But resent the time that it takes.

Mary Mackers

- - - - -

### DCM No Longer Separate Entity

As this chapter goes to press, a recent development is becoming evident, which is extremely important to the evaluation. In May, four months after the end of the field work, I have been engaged in ringing each HE unit to ask the HEOs there what they now see as the sum total of the results of DCM in their district, and to ask for a few final words. The consensus is that it is no longer possible to separate DCM from all the other alcohol activities with which each unit is concerned. The HEOs see it as part of a whole picture which includes the 1974-84 campaign, the Look After Yourself programme, the in-service training which they do with nurses, midwives, health visitors, teachers and others. The Manual is seen as a useful tool for alcohol education, and the learning methods are widely applied. Most HEOs no longer see it as a separate entity, but as one of their customary materials.

One DHEO who has been ill and away from work for several months, did not agree with this consensus; he feels that he has barely started on pushing forward the DCM pyramid in his district. He says he intends to use it as a tool in all the training he does.

However, in order to sum up what has actually happened in the project, an overview of the results is presented below, (Fig. VIII.i, p. 292.)

Profile of DCM Results (as of May, 1984)

<u>District</u>	<u>DCM</u> <u>courses run</u>	<u>Community Alco-</u> <u>hol Team</u>	<u>Alcohol</u> <u>policies</u>	<u>Reorganisation</u>
Durham	3	Work with NECA		Not yet complete
Cleveland	2 (as such)	CCA →		"
Cumbria	No complete ones, many "bits"	In process	-	Established as before
Gateshead	2 (as such)	-	In process	"
Newcastle	1	NECA →		" (Awaiting 1 replacement)
North Tyneside	1	Yes - HEO is Chairman	In process	Established as before
Northumberland	4	Yes	In process	"
South Tyneside	6	Yes	Yes	"
Sunderland	3 DCM 1 Group work	Unofficial →		HEO re-established, others still waiting
<u>Beamish I, II &amp;</u> <u>III - Regional</u> <u>Training Days</u> NECA	Involved in at least 6	In the team →		

DCM courses run

<u>DCM Nationally:</u>	
Liverpool	1
Devon	1
Ireland	1
National Training	1 (1 planned for September)
Counselling Training Courses	3

Sept. 1981 - May 1984 Total DCMs run = 30 (that we know about)

### Matching DCM Aims to Outcomes

The aims for DCM courses, as stated in the Manual, are listed in the introduction to this report on p. 7, and also on p. 6 of the Manual, and are reproduced separately throughout this chapter. Trying to match these aims to the outcomes to see how well each one has been met by the project has been an exercise of forcing square pegs into round holes. Through no fault of the aims themselves or of the writers, but as a development to be desired in the process of a formative evaluation, these original aims are outdated, even in the language used and the underlying concepts. Therefore, the questions I asked in the later interviews fit only very loosely with the aims, and much more comfortably and accurately with ideas which evolved later in the project. Nevertheless, one question that people concerned with the project frequently ask me, since they are used to summative evaluations, is "How well did the results of Drinking Choices meet the original aims?"

In the succeeding sections of this chapter, we will show how the results match up to the aims, not in the numerical order of the original list, but in order of what we feel is their present significance in terms of the impact of DCM.

We also will consider a few of the events related to the dissemination of DCM which were not planned or expected but which have been reported by the people involved; we call these "spin-offs". Anyone wishing to read descriptions of more of them can find them in the appendix; we felt they were too valuable to be left out of this report, but too numerous to have all of them enclosed in the main body.

In this chapter, more than in most of the others, we can

"listen" to people's personal accounts and their reactions to DCM.

### Impact of DCM on Work

The steering committee, including the writers of the Manual,  
feel that the most significant result of the project is the very  
large percentage of people who, having been on courses, are making  
use of DCM in their work, i.e. who are now working as alcohol  
educators. Since the beginning of the alcohol campaign in 1974 there have been seminars, lectures, meetings and discussions about alcohol in this region, but very little seems to have happened at work as a result of those events, outside of the work of NECA. We believe that the difference between those events and DCM is caused by using participative methods on the courses, by getting people involved and by purposefully planning to carry the involvement out into the places of work. Another aspect of this success is that DCM courses on the whole were attended with regularity by a majority of course members, and this is not always true of adult education courses.

This outcome encompasses the first three aims of the Manual, that at the end of the course people will:

Aim No. 1    Hold the attitude that education can be an  
                                 effective means of prevention.

and

Aim No. 2    Have confidence in their ability as alcohol  
                                 educators.

and

Aim No. 3    Take action by educating their clients  
                                 about alcohol.

One could say that these three aims are self-evident in the



fact that professional people have chosen to come on the DCM courses and then gone back and used the materials, but let us examine the aims in terms of the data.

Every one of the HEOs interviewed, a total of 26 people, in more than 130 interviews, said that they felt more confident about alcohol education as a means of prevention, and more confident about doing it, and that they were using more participatory approaches in their work; WITHOUT EXCEPTION. The other key tutors and course members had a similar response, though not as unanimous as that of the HEOs, who are mostly further along in their training and experience with DCM.

#### Are there More Alcohol Educations in the Region?

In the last round of interviews, I asked this question of every person in the sample; it encompasses one of the main purposes of the project, and also relates to the first three aims. The first reaction from almost every person seemed to be "Well, of course, what a stupid question". However, when we dug a bit deeper, the answers were more illuminating:

DHEO: Yes, but you can't prove it. You can't measure what each person is doing. In my district there are 20 people who did the course for youth workers and 6 more last week on another course; but we don't know what they are going to do.

DHEO: Yes, there must be, by definition. People who were on the edges of the alcohol field have been pulled into it by Drinking Choices.

NECA: Yes, and many people from DCM and from the group work skills course have gone on to the alcohol counselling courses. A women's group has started and is getting bigger. It is definitely spreading.

Parkwood Nursing Officer: Yes, definitely. There are at least three members of staff in my own patch. I've even talked to someone from Saudi-Arabia who was interested in alcohol education materials for nurses.

HEO: Yes, over the North East region, with every health education unit involved, there must be a lot of people.

DHEO: Yes, quite a lot. Many are doing spontaneous education in their places of work; one at British Telecom, one at Federation Breweries, many on the Youth Training Schemes.

HEO: Yes, from DCM and from the counselling courses, but also from the television; people are quoting David Bellamy.

HEO: Yes, that was our original hypothesis, and it has been well proven. A lot of people have been trained.

Alcohol worker: Yes, there must be many. We have brought it home to the people on our courses that alcohol education is everybody's business.

One DHEO said to me that a lot can be done on a very informal level, e.g. spending some time talking to managers of working men's clubs, and encouraging them to cut down on the alcohol consumption of the members, while still keeping the club flourishing, by promoting family activities and the sale of light refreshments. He went on to describe to me just one of the informal ways in which he himself does alcohol education everywhere he goes, and how the people we have trained can do it. When he was on a train, going to a conference in Manchester, there was a group of lads going to a football match. He was sitting in the midst of them. When they got on at Newcastle, each one was armed with 6-8 cans of beer and they had drunk it all by the time they got to York. One lad, who did not have any beer with him, was being fed Carlsberg Special Brew, which contains three times more alcohol than ordinary beer, but he did not know that. Nor did the lads realise that because he was smaller than the rest of them he would show the effects more quickly.

The excitement of the trip to the football match was not

enough for them, they needed something more. He talked to them about what they were doing and although they laughed at him at first, eventually they were very interested in what he had to say. He asked them: How long does it take to drink a pint? How long does it take to get rid of it? What does your first drink do for you? He felt that they ended up learning quite a bit.

#### Unsolicited Testimonial for DCM

The following letter (excerpts) comes from a course member, who was writing to apologise for not attending the follow-up day. She is a housewife, who is doing some voluntary youth work, and who attended the Otterburn course with a view to improving her ability to talk to young people about alcohol. (April, 1983)

Dear Donna,

A few lines to apologise for not being able to come to Friday's "get together". I was looking forward so much to meeting everyone again and sharing our experiences but, as the time draws near it really is difficult for me to come along. I daresay you have heard it all before, but I would like to say how much personal benefit I received from our time at Otterburn.

Since Otterburn, I have chatted with a group of women about alcohol. We did an introductory round on early memories and used some of the quiz cards. Most seemed to enjoy the participation, one or two said they didn't. It was a new experience for them all. At the moment, I'm taking part in preparing a mini-workshop on alcohol education. It is being presented on 14th and 15th June to Youth Workers etc. I'm very apprehensive - it is a new role for me, but everything will be fine! I keep thinking of all the little bits of wisdom and support you gave, and find it helps enormously. I increasingly find that if I can trust, love and care (without thinking about how I'm coming across), things fall into place.

Recently, I was asked to arrange an evening activity with some 16 and 17 year old teenagers. It was part of my training with Social and Life Skills. This evening activity is meant to be fun and a "wind down"

after a day of outdoor pursuits, so the tutor had reservations when I asked if we could do a group discussion around alcohol education! He was very brave and let us do it and the young people were marvellous. It was so interesting listening to their attitudes. The tutor said the youngsters had enjoyed the discussion and he was pleased with the activity.

Well, so much for "a few lines" at the opening of this letter. Have a good day and my love to everyone.

Love,

Betty

There are many clues in this letter which could be pursued further; Betty speaks of 'personal benefit'. At Otterburn Betty was extremely shy, and spoke out in the group only with great difficulty, and with her eyes lowered. The remark 'without thinking about how I'm coming across' refers to a discussion we had about overcoming shyness by focusing attention on other people and not on oneself. At the later follow-up day which Betty did attend, she was quite outspoken, and many comments were made in the group about how much she had changed; she was accepting these comments with her head up and a big smile on her face. Although it may be hard to believe, for those who have not had similar experiences, that two weekends in a group could begin to make such a difference, Betty's response is not unusual in that respect. The letter is included here to emphasise that the methods used in DCM can go a long way towards building confidence. Betty was exploring new territory, drifting towards change, we were saying "Just try it and see if it works". As she began to get positive feedback, her courage grew. As she became braver, the methods worked better. Again, this illustrates the reflexive interaction of the work and the worker.

### Group Work Skills

The following section includes quotes from interviews held with HEOs and course members from June 1982 to January, 1983.

Many of the comments about increased confidence were centred in the use of participatory methods:

DHEO: I'm not frightened to make mistakes any more, I've learned that there are no right and wrong answers.

DHEO: I have more confidence in myself as an educator, and in client-centred methods. I have increased credibility throughout the country, and am now considered an alcohol 'expert'.

DHEO: I now use agenda setting exercises with any group, when I teach people in the field. I assess their needs first, and then we start work.

HEO: It is now much easier to plan teaching sessions, even short ones, because I feel confident in using time for warm-ups and agenda setting. I have a new question that I ask myself: "Am I getting people involved?"

HEO: I am now more tolerant, more accepting toward people in my groups, and much less dictatorial. I look at what other people think.

HEO: I am just generally more able to work with groups, more confident.

HEO: There is a whole new dimension in my work, the group work approach, which is extremely flexible. I use it wherever possible, which is now almost everywhere.

HEO: The basic philosophy of participatory learning is now applied to every aspect of my work.

HEO: As I said, I think the major change is in that I feel able to use things a lot more flexibly, and I feel more confident in adapting ideas, and for that reason I feel that I'm able to give a lot more of my attention to what is needed by the group at the time rather than worrying about whether I know the exercise and I've got it right! What I'm saying is that I feel more confident, and that confidence is largely related to more practice, because although I've run quite a lot of things using participatory methods before, I haven't run

anything as intensive as a 5-day course, using all participatory methods, mainly because that's not been practical because a lot of the things we do are tied up with other people's training schedules and you have to fit in your bit with what they're doing, and give them what they want as well, or negotiate an agreement, so I haven't been able to run a whole course using all participatory methods before. So I think it's just given me more confidence.

Excerpt from my notes on an informal interview with a course member  
who works for the Community Health Council, South Shields  
(September 1982):

"Today I met a course member who was visiting a course I was running for Health Visitors at Jarrow Teachers' Centre. I asked her if she was using what she had learned on the module or not. She said that yes, she had found it most useful. She is using the group work skills and the approaches to participatory learning in many of the things she is doing. She said that the module had had great impact on health workers in the South Shields area, and that everywhere she went, she noticed people had changed their methods and were using more participation. Her enthusiasm was very infectious!"

"Also in Sunderland, the DHEO showed renewed interest in the module with her request for me to run a group work skills course; this was designed for people who had attended a module and wanted further training; however, others could attend." (This course was run in June, 1983)

Course member, a nurse:

"Some of the staff members on the course found it difficult to accept the non chalk and talk model, but they were able to discuss it openly because the course was run so well. They were able to bring out their anxieties and then lose them and enjoy the experiential method."

Alcohol worker:

"He is using participatory methods, most of which he learned at Beamish. He said he had always been looking for such methods and was unhappy at using approaches which did not involve the course members. Beamish has given him confidence about participatory methods. He himself came from a behavioural background, but he always used methods which involved course members in activity, such as dancing, movement,

music etc., which he used with mentally handicapped patients so, although he first said Drinking Choices had had no effect, he later said that it had had considerable effect."

Medical Social Worker:

"He said the course was very valuable to him. He has talked about client-centred learning for the last 7 years and is finding more courage since the course to present things in that way. He was terrified at first but feels more confident now."

HEO's comment:

"I started out very apprehensive - the more we've done, the better I've liked it. It reminded me that I went to parties and didn't play games and always resisted. I started off with negative feelings about games, circles etc.

What turned the tide? Doing it! I still feel apprehensive when we start to do a game. I still gripe but don't resist. I've come from a business field - you expect experts. People I used to mix with would have expected a dynamic person to bounce in and present things. I'm worried about people expecting us to be experts on either alcohol or group work. When you're an expert, you can handle it when things go wrong - I might just go red and not know what to. People then tend to reassert their authority which destroys the group work."

DHEO's comment:

"I used to think I was the expert, the one who knew and was there to tell them. I had to be able to answer all questions. Now I don't think that any more. I see it as a shared responsibility and this makes it a lot easier. I now know how to give people time and encourage them to say things. I have also learned how to set up meetings so that people feel free to talk. I always thought that time was crucial and that I must stick to a structure. Now I can allow people time to say what they want to say. I discovered that the principles which apply to therapy and group work apply to teaching, and this made an enormous difference. I can use my own skills and apply them in a different setting. I learned how to get feedback and to build that into the course and I learned to give people respect and credibility to foster their own confidence. Teaching skills was what I wanted from the course and that is what I got."

The reader, having become familiar with the tasks and views of the project facilitation will not be surprised to find so many examples of positive statements about the teaching methods; however, these comments have been just a sample of many that were received; whatever questions I was asking, the subject always came up. There was one comment in the data that expressed someone's feeling of being less confident as an alcohol educator after DCM; it was an HEO who felt that he had been "doing it wrong, and was not sure he could ever do it right". The problem, as he stated it, was that he still felt he had to know everything about anything that anyone might ask him; he felt he could not face not being an expert, so he tended to step in and lecture, and then to feel that he should not be doing that. The way he solved this problem for himself was by sticking a toe into the icy water of uncertainty, opening up the discussions little by little until he felt more confident. This HEO, a year later, had successfully (in his own terms) run a DCM and several other kinds of groups.

The answer to "Do you feel any different in your level of confidence as an alcohol educator?" was predominantly positive.

Are you using DCM with your Clients? (Interview question)

HEOs do not often see clients. However, the other professionals in the sample affirm that they are using selected sections of the material. The consensus among them is that DCM is a very useful educational tool. We have been able to see some interesting results at level 4.

The clients I interviewed are familiar with parts of DCM, such as drinker's diary, road map, and why people drink, although it seems that they are not usually aware that these items come from



DCM. Clients seem to benefit from meeting with other clients in a group.

New awareness and new information are, however, important factors as well. The clients are often, at first, less aware than the professionals, or less willing to admit, the part that the misuse of alcohol plays in their offences and problems.

The instance of the Probation Officer and the young offenders has already been recorded in this report; following is a quote from my notes of my third interview with her.

"The group meets from 3 till 3.30 on a Tuesday in Blyth. The group is made up of people who come to court for offences related to alcohol. It excludes people who are already, or have been already, under treatment at places like Parkwood House. In this particular group all the people are unemployed so their consumption is limited. There should be eight on the group. Seven people came the first time. Last week only 4 people came. She is not discouraged about this because some members of the group said they even like it better that way. It is not a condition of their orders that they must come to the group. The courts in Blyth are not quite ready for that. They are working towards it but the probation officers are being encouraged to recommend in their probation reports that offenders might be sent as part of their probation onto the alcohol group. They plan to do several courses a year in Blyth. Now that she has done the Drinking Choices course she is much more aware of what a serious problem alcohol is in the Blyth area. She said that she sits in court and watches as one person after another is tried for offences related to drinking. This is true in the Juvenile court as well and she has a 16-year old client who consumes two bottles of sherry a week, which he does not drink at home. She would like to run a group for the under 18s; up to now they have been for people who can legally drink."

According to reports from people I have interviewed, the statement, "Life wouldn't be worth living if I couldn't drink", is depressingly common on level 4. Drink is one culturally acceptable way of coping with stress for some people, i.e. it is not acceptable to cry, shout, moan about the situation, so that other

ways of letting off steam are often not available. Drink is also one aspect of their lives that they like and feel that they have control over. Some men receive financial and other kinds of support from girl friends, wives, and mothers for their drinking activities as these significant others recognise the scarcity of other forms of comfort.

There are, however, several instances in the data where professionals have been using DCM successfully with clients. One probation officer attending the first DCM in Newcastle provided a dramatic incident on that course: she role-played being the leader of a group for parents of young offenders, and using DCM materials with them. Her group work skills were outstandingly effective, so we all assumed she had been using them for a long time. She said that she had never done such work before, and that she had learned from watching us as course leaders.

I interviewed her four times over the next two years; each time she gave me examples of ways in which she had used DCM materials with her various clients. She used Drinker's Diary and her new counselling skills with a couple both of whom had drink problems and related offences. They became aware of how much, when, and where they were drinking; they began to cut down. She told them she would no longer see them if they came to see her when they had been drinking. They valued their meetings with her enough to stay sober in order to see her. Over the period of my interviews with her, the clients seemed to improve slowly but steadily, with only a few instances of backsliding. The probation officer feels that DCM has added some very practical additional dimensions to her range of strategies.

This following poem came to her in a letter from one of her clients.

The Drunking Man

Tell how long it had been the whisky tasted sour, it  
was no comfort it solved nothing, and the silence that  
hung over the house deafened him.  
He thought how strange it was that tears can dissolve the  
façade of maturity.  
He thought of throwing the now empty glass at the wall,  
but he had to have a drink. He drunk till the bottle  
was empty.  
He thought he should of show his wife and child how much  
he cared before she took the child and walked out on  
him.  
He went to the bathroom to put cold water on his face  
and saw her make-up scattered around. It hadn't  
moved from the position it had fallen to in the  
argument, over money for his drink.  
He picked up the lipstick and varnis that lay in the  
basin, he thought because of my stupid drinking I  
started as a youn man.  
Then as he looked up from splashing water on his face  
he saw through the watery blur, the note scribbled  
in lipstick on the mirror.  
He wasn't sure now as he tried to focus on the words  
whether it was the water or the drink that obscured  
his view. If onley he down something about he's  
drinking before, if onley for his wife and child.  
If 'onley' if only is allways too late.  
So this is the end for the drinking man.

\* \* \* \* \*

A clinical psychologist arranged for me to see some of her clients in the out-patients clinic of a large hospital; this event never materialised. (Clients did not arrive, on two scheduled occasions.) She used diaries, counselling and educational materials from DCM with her clients, and said she was noticing gradual improvements, in the form of decreased drinking, less depression, new activities engaged in, and generally increased

cheerfulness.

### Behaviour Changes as a Result of DCM

The writers of the Manual and the rest of the Steering Committee agree that: "The second most significant result is the effectiveness of the instructional system (i.e., participative group work applied to a health education topic) in changing behaviour - including teaching styles, use of groups to educate, personal growth, health related behaviour and alcohol-related behaviour, and the application to other fields for the next section."

Aim No. 7: Have knowledge about the development of an individual's drinking behaviour and how it is influenced by social, legal, cultural, economic, psychological and genetic factors.

Aim No. 8: Have knowledge of the influence on drinking patterns in our society of cultural, economic, fiscal, legal and educational factors.

Some of the stated aims in DCM overlap as well as being representative of thinking that dates back to early in the project. Aims Nos. 7 and 8 could have been forced into many different categories in this chapter. As they stand above, they refer to such broad topics that they encompass the activities of the whole course. Perhaps they could now be rewritten: "Be able to consider an individual's drinking behaviour in relation to his/her social environment."

It may be interesting to see what I thought about this topic two years ago, being one third of the way into the project.

Quotes from a Steering Committee Report, May 1982 (D. Brandes)

"A behaviour change is required of trainers when moving away from earlier styles of learning and teaching; time and experience are showing how difficult this is for some people, and yet this is exactly what the module is demanding of its clients. This is a rather complicated point, which HEOs could discuss in their group meetings. They should notice that they have had to change their own behaviour in relation to the running of the courses, and that they have found these changes as difficult as people do when the changes involve drinking behaviour. In fact the same patterns seem to have occurred: initial resistance and hesitancy, early acceptance as something new is tried, developing into rejection as difficulties are encountered. Also apparent are the need for group support, reaching plateaux in the process of changing teaching behaviour, and backsliding when security is threatened.

This point shows that the trainers and course members have one major task in common, namely, a change in basic attitude and behaviour; both groups need to recognise the intellectual and emotional leaps required."

It can be noted from the above that progressive focusing was being used, i.e., new themes were emerging and being examined, and that we had commented even at that stage on the balances between resistance to and acceptance of unfamiliar ideas.

Impact of DCM on Clients

A change in drinking behaviour often seems to depend on a change in social/family/work situations, which is often assisted by the informed professional, as well as an individual internal decision to reform. If this is true, then DCM is appropriate as a form of training which would enable professionals to begin to see alcohol misuse in a social context rather than as a medical issue and to work with their clients on the various kinds of problems with which their clients may be coping through alcohol misuse.

Have you noticed any changes in your own drinking patterns lately? (Interview question)

HEO: I am now drinking less than I ever have in my life before. This is a direct result of being involved in alcohol education.

Social Worker: I drink less, I've stopped having a little drink when I get home from work. I have no more hangovers, and I'm more alert these days.

HEO: I've stopped drinking at all when I know I'm going to drive. I talk to my teenage daughter and her friends, sort of informal counselling; they count units now.

DHEO: I nag my husband more now; I never drank much anyway.

HEO: I'm more knowledgeable, I don't drink when I get home from work. I'm very conscious of my habits.

Charge nurse: I now consciously have one or two days off from drinking anything at all, every week, because of what I've learned about my liver. I never drink in the afternoons any more, and limit my drinking to "two or three pints, two or three times a week".

Notes from an interview with course members at the end of a DCM course (June, 1983)

"When I asked them if they felt anyone had changed their drinking behaviour because of the course, they said they felt that people were more aware. One person, who felt at the beginning that he didn't have a drink problem, by the end had agreed to cut down. One psychiatric nurse said he feels he is a lot more aware and started experimenting when he kept his drinker's diary. He talked about alcohol education more with people and when he was offering drinks was very careful to do it in such a way that people could say no and wouldn't feel pushed. Two women from the course were going to work on their husbands' drinking habits and they themselves had cut down an awful lot."

Interview Notes, March 1983

"In Cleveland I visited a probation ancillary who is presently running a drinking problems course for serious offenders. She has had very good results

with her clients changing their drinking behaviour and feels that she got everything she wanted from the Drinking Choices course without wanting to run one herself.

It is difficult to assess the effects of the group; the aim is to control and monitor their drinking. As for the success rate, one client has been dry for three months. In the past his benders have lasted three weeks. This time he came back after three days because he didn't want to miss the group. She was very pleased about this. He said, 'I just couldn't let myself go on drinking. I wouldn't let the members of the group see that example.' The members of the group talk a lot about unemployment and what they could do with their frustrations besides drink.

Her colleague, who runs the group with her, said he had the label that he had been on an alcohol course before, and people who came into contact with him asked him which is stronger, beer or lager, and then they switched to whatever happened to be the strongest. He said he found DCM very interesting and worthwhile, and he was using it in his day to day work. He said it had broadened his outlook on alcohol.

On some of the courses, participants spoke freely about their own behaviour, and/or their own experiences with alcohol."

It is very difficult to ascertain whether or not people are honest about their own drinking. I made the following comment in my notes after an interview with two teachers in 1982:

"When I asked about the effect of DC on their drinking behaviour they both felt that they had never had a drinking problem."

But, I had seen one of these teachers visibly "under the influence" every day for a week, after lunch on the DCM course.

Again, I made the comments below after interviewing a charge nurse from a mental hospital, in 1982:

"Bill was very excited about a recent project in which they took ten of their more able residents up to Berwick on a holiday. They had caravans on a site near the beach. I asked what they did and he laughingly said, 'Drink!' I asked him if they did anything else and he said they chose their own menus at a planning meeting and the meals were cooked and eaten in the caravans. They went on

walks around Berwick; they went to clubs for entertainment. There was no routine, which was the best thing, as the men could lie in if they wanted to or go for a walk. They would be planning other such trips.

The trip sounds great but how much did they drink? ..... Bill wouldn't say, he just laughed when I asked him."

As I mentioned earlier, what I do about this question of honesty is to work on building trust and establishing open communication, try to deal with my own doubts, and then listen to people and accept what they say.

#### Behaviour Change in Relation to Educational Methods

Aim No. 4: Be able to use and apply their previous experience, training and knowledge to alcohol education.

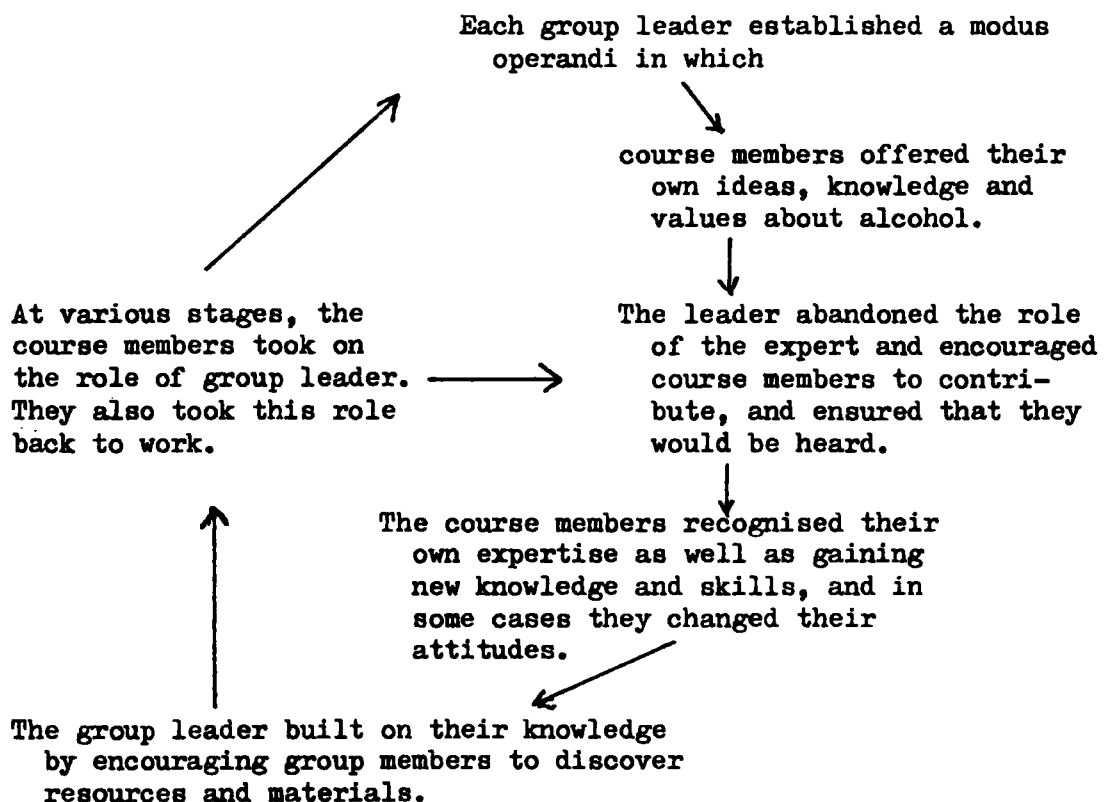
The way in which this aim was implemented in DCM was vital to the pyramid model, and to the success of the project. The intention of the instigators of the DCM dissemination is clarified on page 5 of the Manual:

"We envisage a domino effect in the spread of learning and skills from the writers of the Manual, to the Health Education Officers, from them to the alcohol educators, and from the educators to their clients. Everyone ends up going through the same process and hopefully with the same skills. There are no experts; only helpers in the educational process. The skills are skills in everyday life related to alcohol and drinking: skills needed in friendship, family living, and inter-personal relationships in work situations."

In practice, the domino effect that they wanted to create also had



a cyclical effect, as below:



This cycle is common to most kinds of client-centred group work, and to humanistic teaching methods in general, but as we have seen from some of the comments of people in this project, it was not previously familiar to many of them.

Excerpts from an interview with 2 course members, (pseudonyms) who had just run a DCM course at level 2½ in 1983:

"Gill and Bob felt that the module had much more potential than they had actually realised when they were doing the training. The people on their course worked very hard and mostly kept to the ground rules which were established by the group at the beginning. The only struggle with the ground rules was conflict between the smokers and non-smokers in the group.

If they were working with a new group who didn't know each other, they would have spent much more time on the group work skills. The group wanted someone else to make their decisions at first, but as time went on the leadership switched all the time. Gill's problem was that she felt responsible for

everything and wanted everything to work and so she took the feedback sessions very seriously whereas Bob did not. So in a way they feel that they complement each other.

By the second day the course members were taking over. Gill had to be very assertive to get the course going properly; she did not let her boss come because he could not come in full time. She was not willing to have him just sitting in on some sessions."

Looking back from the vantage point of the end of the project, we might have rewritten Aim No. 4 or else added a corollary to it:

" ..... Be able to apply their alcohol education, training and experience to their own work."

#### Transfer of Skills

This brings us to a much broader question, one which is of concern to trainers and educators, whether they work with adults or children:

" ... the problem with most training is not inherent in the training programs themselves (although many programs could be greatly improved), but rather in the process of what transfers (or does not transfer) prior to and following the training event ... "

(Knowles, 1973, p. 173)

One of my major tasks as facilitator of this project was to take steps to ensure that transfer of training did take place, but this was, in turn, facilitated by the nature of the work itself, as well as being built into all of the plans for the project.

Transfer of training happens best under certain conditions:

"The first step in analyzing an educational problem in terms of transfer possibilities is to decide on the ends to be accomplished. The second step is to select the classroom (or course) content that seems most suitable for the achievement of the objectives. This selection is made

primarily in terms of the identical-components basis for transfer, that is, the content of the training situation should correspond as closely as possible to the content of the prospective transfer situation. The third step is to decide how this content should be presented or to determine the techniques of instruction that will be the most effective ...

The teaching must stress general principles, organization of the learning, etc. The fourth step, and perhaps more important than either the second or the third, is to attempt to measure the extent to which the predicted transfer takes place."

(Humphreys, 1964, p. 225)

The success of DCM in accomplishing transfer, as documented below, was a result of the writers and key tutors having followed the steps that Humphreys outlines. We have already had much discussion of the course content, the aims, the presentation, and the techniques of instruction. The identical-components which are transferable throughout and beyond Health Education are the skills of participatory learning:

- (i) eliciting the needs of the group.
- (ii) active listening.
- (iii) negotiating.
- (iv) agenda setting.
- (v) establishing appropriate ground rules.
- (vi) abandoning the stance of the expert.
- (vii) giving the responsibility of learning to the learners.
- (viii) developing activities which involve the learners.

The key tutors and course members felt that they were gradually becoming more proficient in these skills. In the final round of interviews I asked the question:

Do you feel it is possible to transfer the participatory approaches to other areas in your work?

Again, without exception, all of the people interviewed said that they could and did apply the methods to other areas of their work, to a greater or lesser degree, and many of them added that they had developed new materials with which to do so.

Two HEOs are collaborating on a manual about nutrition, using a format similar to DCM. Two other HEOs are working with Manpower Services Commission, helping to train trainers for the YTS schemes; they use the DCM format for the training.

Notes from an interview which I wrote in November, 1983

One HEO has been doing "Personal Health" workshops. He has developed them as a response to requests for in-service training for Manpower Services, Social Services, prisons, all of whom are interested in participatory methods. On these courses he covers the following:

- examining our own attitudes towards health
- identifying health risks
- discovering links with life style
- strategies for improving personal health.

He has been running these with YOPs and young offenders and people who train them. He has developed this as a result of DCM and as a response to requests for particular topics such as glue-sniffing, VD, contraception etc. In other words he considered the format to be transferable to any subject. (A draft of an article he has written about this appears in the Appendix, Part One.) This same HEO has used participatory methods to teach music to prisoners in a Northumberland prison. He is requesting permission from the prison governor to publish an article about his work there; the article is completed and very interesting; he has used the methods he learned in DCM with the prisoners. (See Appendix, Part One.)

HEOs in South Tees have been using DCM methods in Stop Smoking courses, Health Education Certificate courses, contraception, and in other areas of their work. Other health educators in the region report similar uses:

DHEO: I have used participatory learning methods with the Health Education Certificate course, with school children, with voluntary workers, with GPs, nurses and psychiatrists.

DHEO: I think the other areas that you could do which would slot in very nicely would be things like ante-natal education, where you are working with a group of mums who are smaller in numbers, especially if you get them into communities. We have been discussing recently for example how we reach people in the Riverside Project in the lower ability areas, in the inner city areas where they would not normally come to ante-natal clinics.

HEOs have produced card games about several other topics, including drugs, statistics on alcohol, nutrition and sex education. (See Appendix Part Five.)

In the data I found examples of people transferring participatory learning skills, as a result of attending a DCM course, to the following subjects:

sex education	nurse training (under-graduate, post-graduate, and in-service)
venereal disease	
music	school health education
YTS and YOPs courses	environmental health/food hygiene
Health Education Certificate course	health education in business and industry

#### Levels of Prevention

Aim No. 6: Be able to apply educational strategies to alcohol problems at primary, secondary and tertiary levels of prevention.

The guidelines below may help us to review what is meant by these three levels in the context of alcohol education:

(Paragraph No. 6.1)

"The prevention sub-group of the Regional Working Party perceived preventive and educational efforts as being complementary, i.e. education is necessary to make the public aware of the importance of prevention; any educational efforts need to take place in the context of wider preventive strategies.

(Paragraph No. 6.2)

The Working Party identified 3 levels of prevention:

(a) Primary prevention - before the problem starts.

Target groups: children, young people, all drinkers and non-drinkers, women, youth opportunity programmes and work schemes.

(b) Secondary prevention - those at risk of developing problems. Target groups: all drinkers, especially those drinking near, at or above, safe limits. High risk occupations and groups (divorced, separated, single men, etc.)

(c) Tertiary prevention - reducing, retarding or minimising problems for those who already are problem drinkers.

Target groups: all those drinkers experiencing problems related to drinking, e.g. drunkenness offenders, drinking and driving offenders, those experiencing financial problems, marital and family problems, health problems, criminal offenders where alcohol is a linked feature."

(NECA, 1984, p. 53)

Under Aim No. 6 we include the development of educational alcohol policies in industry, business, in the NHS and other places of work, so as to reach the target groups named above.

## Alcohol Policy

(Excerpts from Steering Committee notes September, 1982):

"To what degree are HEOs responsible, and to what extent should they 'push' to help industry and government develop alcohol policies? In which communities are HEOs working with Unions on this issue? Or, is all this irrelevant to this evaluation of the Drinking Choices manual?"

In September of 1982, I asked the above questions of myself and of the Steering Committee; mention of alcohol policies kept appearing in the interview notes and other data. The job description in the Kirby Report says:

"As directed by the Area Health Education Officer, (the HEO) liaises with and guides representatives of local authorities, voluntary organisations and other agencies on health education matters."

(Kirby, 1980, p. 9)

Along with what Kirby says about it, it has become clear from the data that many HEOs are very concerned about the lack of awareness about alcohol problems on the part of managers in industry, business, the health service and other government services. Many examples of this lack of understanding were noted under "Obstacles to Progress"; in this section some examples of positive advances in raising consciousness about alcohol problems will be recorded.

In Sunderland, the DHEO and one of the HEOs have organised a Drinking Choices course for June-July 1984, which is specifically for top managers in the various services of the local authority, nursing, social services, health and probation. The hope is that at least the beginnings of sensible provisions are being made for employees with alcohol problems. There will be a focus on this course on the use of participatory methods and counselling skills as well as on early identification of drink problems through

screening, setting up provisions for counselling, developing policies about absence or leave for employees, and especially about providing alcohol education for workers at all levels in the hierarchy. (I will be co-leading this course as a free-lance consultant, at the request of the DHEO.)

#### Interview Notes, Gateshead HE Unit

"The DCM course went very well and she especially recalled a role play exercise about managers and staff with training problems. The director of NECA came to talk about alcohol policies and they brainstormed and got some ideas. The course made it even more clear that an alcohol policy was needed.

One course member, who is a personnel officer at Federation Breweries, said that Federation employees - van drivers, in fact anyone working for the company - are allowed four free pints of beer a day. They could not take it home. Some people don't take their allowance and give it to others who are then drinking even more than four pints a day. This is why the HEOs are very concerned about getting an alcohol policy started within the Health Authority which would set out how managers could take action regarding alcohol abuse."

All of the health education units in the region are active in their attempts to raise awareness and develop policies; these would be educational policies to replace either disciplinary procedures or the lack of any policy at all. The problem is to get managers, unions and employees interested and reaching agreement about it.

In Gateshead, the HEOs have been working for three years to negotiate with managers in the health service about such policies. Their DCM course was well attended and appreciated by the managers. Although half of those managers have been replaced in their posts due to reorganisation, the HEOs hope that enough of a foundation has been laid for the progress to continue.

In Durham also, negotiations have been under way for more than



three years; local breweries expressed interest in developing alcohol policies, and an acceptable document was developed by the health authority in conjunction with the health education unit (a copy of this document appears in the Appendix, so that the reader can see the kind of policy that is envisioned). These wheels grind exceedingly slowly; the HEO concerned has not been told what is standing in the way. Other similar initiatives have been blocked by reorganisation, as they refer to the health service; however, Durham HEOs see these policies as a high priority and are intending to pursue them. Drinking Choices courses are part of future plans for working with managers.

In Northumberland, the alcohol development officer, working with HEOs, probation officers and other professionals, has been concerned about developing policies. He told me that 20% of the work force in Northumberland have alcohol problems, including 260 people in the NHS. He is working with the NHS team to develop guidelines for dealing with this problem.

(Interview Question): Is there a Community Alcohol Team in your area? (If yes, have you had anything to do with developing it?) Again, this question from my final round of interviews addresses itself to Aim No. 6.

People working in the alcohol field in this region favour the idea of a Community Alcohol Team, which would constitute a multi-disciplinary service for problem drinkers. A further extension would be to incorporate this team with a service for people with drug or solvent abuse problems. This approach was first recommended in the Kessel Report (1978), and again in a report of the Advisory Council on the Misuse of Drugs (1982). Dr. Thorley of

Parkwood House, and other alcohol field workers in the region have been active in promoting this idea; it is referred to as CAT, (Community Alcohol Team) or CADET (Community Alcohol and Drug Education Team). So, a Community Alcohol Team cannot be seen as a direct result of DCM. However, with its function of increasing the number of potential alcohol educators, counsellors, and services, DCM has been instrumental in making such teams possible. Some DHEOs are engaged in seeking government funding, others find ways of doing it without such funding. Some course members have started their own informal teams. In the Appendix, Part Two, the reader can examine Dr. Thorley's proposal for the implementation of a CADET team.

The DHEO for South Tyneside has said that one of the most important results of DCM has been to create a demand in the community for a CADET team, and to publicise it so that people will "shout for training"; this process includes a very important step where people recognise the need for the services and then realise that they do not have the necessary skills to provide them.

#### Interview Notes, South Tyneside

"The DHEO feels that since the four courses that he did in South Tyneside, the spin-offs have been very important and influential in his district. The first outcome was that he developed enough enthusiasm to mount a workshop with Dr. Anthony Thorley, and that was a great success. The people who turned up were from top management in South Tyneside in all fields. He sent every one of them a copy of the transcripts of Thorley's address and the workshops in the afternoon. The Chief Constable was there, probation officers, Social Services, everyone in fact except the NHS who did not send anyone. Thorley made a remark that South Tyneside had the worst alcohol problems in the North East and that he was withdrawing his services from South Tyneside and they had better get busy and develop their own. This seemed to shake everyone up." (1983)

In South Tyneside, a social worker attended a DCM course, and then the alcohol counselling course in Newcastle. In an interview with me he said:

"Once I felt confident about alcohol skills, cases began to come to me. There is no place in the system for drink problems - they are called 'mentally ill'. People get isolated - there were no services in South Tyneside. At the moment, I've been working on weaving something into the fabric that existed - I've contacted interested people for an informal group - multi-disciplinary with clout.

We are aiming for people who are professionally trained.

Who's on it: a G.P.  
2 clinical psychologists  
DHEO  
the Principal Assistant for 'Handicap and Sick' (he sees it as a pressure group)  
the Vicar from St. Peter's Jarrow (did alcohol services in South Africa, white)  
his son - has a psychology degree and is unemployed  
representatives from the Community Health Council  
2 Community Psychiatric Nurses  
Probation Officer  
a 'client' - a journalist with an alcohol problem

We decided, rather than assuming 'expert' position, to hold day conference in St. Peter's Church to stimulate interest in the borough, to raise awareness of a major problem in South Tyneside.

We've met four times now, we meet at lunchtimes. We don't want a formal name, we call ourselves an alcohol support group. The official system is now moving to set up formal provisions, but we intend to keep going. We will use people who have been trained, in South Tyneside, to train other people at lunchtimes, with no cost, in the church hall; attendance is voluntary. We consider it a spin-off of Drinking Choices. We had an awareness of the problem, but not the necessary skills. The bureaucracy may be threatened, but we can keep going whatever they do, because it won't cost anything. We hope to establish the need for an Alcohol Development Officer, and get one working in South Tyneside. We intend to establish shop front centres in Jarrow and Hebburn; this has been 'the desert'. The journalist on our team wants to set up a self-help group. We are using the counselling skills and the Transactional

Analysis books that you gave us, and parts of the Manual, like Drinker's Diary, the alcohol units, and the road maps. We get in lecturers and hold small groups on special topics like 'Alcohol and the unemployed'. We want simple, informal ways to share knowledge with ordinary people." (January, 1984)

Now, in May, I have followed up that interview with a long telephone call, to see how his team was getting along. He was so enthusiastic that we talked for over forty minutes. He reported that the informal group was still meeting every six weeks, and that their main goal, of getting an Alcohol Development Officer in post, has been met. The Development Officer is in the NECA premises in Newcastle for now, but is hoping to move to South Shields soon. His funding comes from inner-area money, and within one-to-four years, he hopes to have the post permanently established with joint funding from NHS and social services. His job will be to provide facilities for counselling and training in the alcohol field. As he takes charge of his new post, and becomes more confident, he will be able to take responsibility for the alcohol support group. He attended a DCM course, and has plans for running more of them in the future in South Tyneside.

Five members of the alcohol support group are in the working party for alcohol developments. They meet openly and discuss priorities, coordinate their strategies, and then attend the working party meetings and speak to the managers, who 'hold the purse strings'. One of the plans in the pipeline is to keep sending people on the NECA counselling training course, so that each year there will be five or six fully trained counsellors to add to their pool. Ultimately, the goal is to have a fully trained, highly effective CADET team operating in South Tyneside.

This social worker said that he is now turning his attention to other priorities, although he still attends the working party and support meetings, engages in counselling clients as part of the team and work closely with the new development officer.

In his words: "I got a lot out of Drinking Choices, and I've given a lot back. Things are now moving in South Tyneside, where before they were static. I am very pleased with the results."

(This model of informal action is being used now in other educational programmes in which I am involved, e.g. a scheme where the aim is to raise awareness about multi-cultural problems.)

In North Tyneside there is an active CAT, and the HEO, who has been very interested in DCM, is the chairman of the team. He is involved in a screening programme and counselling scheme for patients in hospital wards who have alcohol problems. This increased activity on his part, he says, is a direct result of DCM.

In Northumberland the alcohol development officer, who was already committed to alcohol education as part of his job, has attended Beamish II, and has been assisting with development of a CAT based in Blyth, with self-help counselling groups and with training for professionals to meet the need for alcohol services.

The DHEO from Northumberland moved to a temporary DHEO post in Exeter. She had great success with a DCM for Devon Community Alcohol Team. She noticed that it was very easy to set up and get going, and that they had great enthusiasm for the participatory approach. Course members took the initiative to say that they would act as key tutors in the future, with the DHEO in a consultative role (rather than being needed to help run courses).

The Director of the Cumbria Council on Alcoholism attended

Beamish II. He then went back and established the beginnings of a CAT in Penrith. It would use part of the contractual time of a wide variety of professionals such as occupational therapists, social workers, community psychiatric nurses, probation officers, psychiatrists. They feel it is their task to raise awareness in the community regarding alcohol and drug abuse and he was going to talk to this group about their training needs, perhaps about the Drinking Choices module. (This director since changed jobs, and is now working in the alcohol field in Scotland; his successor has not yet established a working team, but it is among his future intentions to do so.)

#### Needs of the Whole Person

Aim No. 5: Be able to see the needs of the whole person in relation to their life situation and identify the way alcohol fits into this picture.

Some of the exercises in DCM are particularly pointed toward this aim, and, as we have shown in Chapter V, the data indicates that they are among the most popular and effective parts of the course. Examples of these are:

Why Do People Drink?	(Exercise No. 2.3.1)
Early Times	(Exercise No. 3.1)
Values Continuum	(Exercise No. 2.5.2 and 2.5.3)
Drinker's Diary	(Exercise No. 1.8.2 and 2.5.3)
Road Map Exercise	(Exercise No. 3.3)

(They are each explained in the manual.)

Overarching these specific exercises, however, there are much broader intentions expressed in the introduction to the manual:

"The importance of values

An important part of the educational process is the exploration of value systems, and exposing how values may contradict with actual behaviour.

Some values emphasised by the model are responsibility, self-determination, caring, problem-solving, co-operation, inter-dependence, growth in interpersonal skills, self-control, and helping. The skilled educator is both aware of his own attitudes and values and can help others to discover, define and implement theirs."

(DCM, p. 5)

One can see from the above paragraph that DCM does emphasise that certain values are preferable to others, but the word "exploration" is the key word, and if the group leader is applying the last sentence in the paragraph, then argument, contradiction, and disagreement will be encouraged, and, in turn, the differences will themselves be valued.

In facilitating and observing the DCM courses, I noticed that the exercises which explore 'the needs of the whole person in relation to the life situation' were the ones that stimulated the most lively responses, including prolonged discussion and arguments. People like talking about themselves and about what they think and feel, and also about their own experiences. On the first Newcastle DCM course, the HEO who was co-leading with me expressed astonishment at how much people were willing to disclose about themselves to a group of near-strangers; one of the conclusions that I draw from this is that some people want and need to talk about themselves, and that they will respond to an invitation to do so with a high degree of trust, in a group setting. Zimbardo puts it:

"Groups may facilitate the release of normally inhibited behaviours in members by diffusion of responsibility, imitation, anonymity, and behavioural contagion." (1977, p. 104)

I call it trust, and contend that the group leader is very influential in establishing this feeling by behaving in a trustworthy manner, i.e. by listening and reflecting rather than by making judgemental comments, by reminding the group about the confidentiality of the proceedings, and by making it clear that no one has to participate or even comment if he prefers not to do so.

There is a difference between accepting the misuse of alcohol as a coping strategy for dealing with difficult life events, and seeing people as being weak or sick because they drink. It is this sort of difference which DCM hopes to develop during the time of a course. The data indicates that course members take away exercises such as Drinker's Diary and use them with their clients, having first used them themselves. One can observe in the following examples selected from the data how course members use these exercises with their clients, in an attempt to work with the whole person.

My notes from an interview with a clinical psychologist:  
(Carole is not her real name, and I have underlined the activities she did with her client).

"Another young woman client was referred. She had been drinking heavily and then, when the money for alcohol ran out, she would take sleeping pills so as not to have to be awake and face reality. This has been going on for ten years. Carole reckons that she has had some brain damage and that her short-term memory is damaged and at first Carole felt it was pretty much a hopeless case, but they scheduled four sessions to chat and look at the entire picture and then agreed that they would make a plan of campaign after that. This client really did want to work on her drinking and she felt that taking sleeping pills so that she could escape during the day was quite a



normal thing to do. Now, much to Carole's surprise, she is making good progress. She has cut down her drinking from 8-10 pints a day to 6 pints a week and is keeping her diary. Carole talked to her about effects on her memory and her brain. She asked her to keep track of what she does when she is not actually bored so that they could perhaps plan things that she could do to keep herself interested in staying awake. She is now improving, has started reading again etc. She lives alone and is unemployed in a rough part of town. She is gay, and is in her late twenties, and her friends have a lifestyle much like hers. They move around a lot, going down to London trying to get a job, coming back etc., which Carole says has to be OK with her but which means there is basically no-one for the client to count on. Still she is improving; she has had a haircut, bought some new clothes at a rummage sale and the secretary in the office asked, 'Is that the same woman?'

Carole said she has more success with women than with men clients. The men seem to find it difficult to be seen by a young woman and they often do not come back."

(April, 1982)

Notes from an interview with a charge nurse in a mental hospital; we have met "Bill" before in this report:

"Bill says that when a new group of student nurses comes in he has a sort of 'teach in' in which he tells them about the module, and local resources and uses the card game if the students are interested. He makes this information available all the time for anyone. Bill says the drinking habits of the men on his ward are controlled entirely by the state of their own finances. Most of the men who are heavy drinkers are at work around the hospital which is how they get money to buy drink. Out of 33 men, 22 will go to the polls today (Election Day) including Joe. One of the men has a war pension and drinks every afternoon. He does not join in therapeutic activity such as work on the ward. He is attempting to slow down his drinking but in addition to his pension he sometimes wins at gambling and then wanders around town with extra money which he spends on drink. Bill works with the men individually using his mini-manual of activities selected from DCM; several men are using Drinker's Diaries, and one of them told me about units of alcohol and the topping-up effect." (June 9, 1983)

It is easier for Bill to understand and approach the 'whole person's' alcohol problems, as he is with each man in a

residential setting and is very influential in determining the daily routines; i.e., he has a captive audience.

One further example shows how the probation officer in Northumberland used Drinker's Diary and expanded it for use with her group of young offenders, aiming to have them look at their own life pictures in relation to alcohol.

"Week 4 - Targets and Keeping  
to Them

1. Drinking diaries and graph.

More detailed diaries to be filled in next week. Handed out.

Aim - To examine drinking patterns.

2. Targets

On a sheet of paper each write down your average weekly units, the average man's weekly units, your target units. Targets put onto graph.

Aim - To encourage people to set appropriate and realistic targets.

3. Ways of keeping to target

Brainstorm - Flip Chart

Alternatives to pub

Brainstorm - Flip Chart

Aim - To try and list ways of drinking less and to discover if, for the group members, there are any effective alternatives to the pub.

4. Coffee and general discussion about Video.

5. Video and Role play.

(a) Warming up exercise

Everyone, bar one, leaves the room, a small article about offending and alcohol is read to that person. He in turn passes on what he remembers to the next person .....

Aim - To help people feel at ease in from of the camera. To look at listening/communication skills.

(b) Role play - "Saying No"

Role play drinking in a pub with one person selected not to have another drink. Rest of group put pressure on individual to have another drink.

Play back Video.

Discuss with group alternative ways of handling situation.

Role play again using alternatives (if there is time).

Aim - To develop strategies of saying no.  
To become more assertive.  
To have fun and see yourself on TV!"

Aim No. 5 also interacts with the sections of DCM which are concerned with counselling people about alcohol problems. Although the module addresses itself to education as prevention, and not as treatment, for many course members the pressing concern is about how to deal with clients who have already identified themselves as having alcohol-related problems, whether they are physical, emotional or practical difficulties. One of the significant spin-offs of this project is that interested people from DCM courses have been encouraged to continue on and do the counselling course at Parkwood House.

"Voluntary Counsellor Training

The North East Council on Alcoholism, in association with personnel at the Alcohol and Drug Dependence Unit at Parkwood House, have organised two 18 months courses for the education and training of voluntary counsellors. The second of these will be complete in 1984. Trained counsellors have been accredited by the National Council on Alcoholism and, when in practice, they receive fortnightly supervision of their case load from professional staff."

(NECA Report, 1983, p. 7.44)

As far as NECA and the regional subcommittee on alcohol in the NE are concerned, the further development of counselling services is a major aim, and they see DCM as a part of this plan.

Are you using the counselling skills from DCM in your work?

(Interview question)

Counselling skills such as listening, and developing empathy, are touched on at a very basic level in DCM (see pp. 74-79).

In the process of negotiating with course members about the agenda and priorities, this section was either emphasised, or passed over, or even left out. The choice has been strongly influenced in many cases by the HEO running the course, so that in South Tyneside at least two sessions were devoted to that section, while in other districts it was omitted; the HEOs made the decision on the basis of their understanding of the needs of the group, or they left the choice to the members. Approximately 40 of the people trained have attended further counselling training courses after DCM, either those presented by NECA, or at various training centres throughout the region. When asked the direct question above, most people in the sample answered positively.

HEO: I have become much more confident in counselling people, on alcohol or on other problems that they present.

Residential Care Worker: Yes, I went on the two year part-time counselling course at Parkwood, and I have just started to work with my own clients, under supervision. This is a direct result of Drinking Choices; I never thought of myself as Counsellor material, until I went on that course. I work in a residential setting, so I do informal counselling all the time, now I'm not afraid to be alone with clients and they seem to talk to me more easily. I know how to listen.

Social Worker: Yes, I did the counselling course because of Drinking Choices. Now I'm doing full-time alcohol counselling.

Nineteen people in the sample mentioned their use of listening skills to me without being asked. (Further examples appear in the Appendix.)

#### Alcohol Knowledge

Aim No. 9: Have knowledge about the biochemical and pharmacological properties of alcohol and its part in the host-agent-environment system.

Aim No. 10: Be aware of, and understand, current theories about alcohol use and abuse.

These two aims fall into the general topic of alcohol knowledge, and on the last round of interviews the first question I asked was:

#### Have you increased your knowledge about alcohol?

Out of the 60 people interviewed and re-interviewed during the project, 40 were either HEOs with substantial knowledge about alcohol, or people already working in the alcohol field, (e.g. staff from NECA or other alcohol councils); an increase in knowledge about alcohol was not their primary aim in going on a DCM course, they wanted training in using the manual and its methods.

Twenty of the sample, however, were without previous specialised knowledge of alcohol and had this kind of learning as a primary aim.

Despite this apparent split, every person interviewed answered yes to the question about increased alcohol knowledge, regardless of which of the above groups they represented. Most of the HEOs felt that they had refined and improved their expertise, while four

felt that they still needed more, and that the manual did not extend far enough in that direction. Course members who had not been working primarily in the alcohol field expressed the view that the manual aimed at the right level for them; they said that what they needed was:

- (a) enough facts to inform clients
- (b) how to find information when it was needed

The interviewees felt (unanimously) that the manual provided these two types of knowledge very well.

Comment derived from notes of an interview with an HEO

"When I asked her about knowledge of alcohol gained from the course, she said that what struck her was that there are some hard facts, but when it comes to cultural values about drink there are no assumptions that you can make and there are many differences of opinion. I asked her how much of her time she actually spent with people who have alcohol problems and she said about one-quarter to one-third of her time."

(November, 1982)

The Future of the Manual

The results of the evaluation seem to indicate a fairly hopeful future for DCM but, without a crystal ball, we can only speculate about the possible developments. The evidence seems to suggest that it will continue to be used on courses throughout the U.K. It will probably be purchased by workers in the alcohol field as well as professional people, such as social workers, probation officers and teachers. It seems likely that the future sale of Manuals will continue to be processed by TACADE. Single copies of DCM have been sent for review to professionals who requested them in other countries: one has been sent to the World Health Organisation; another to Munich; one to Vienna, and I have taken ten

copies to various people whom I know in the field in America. So if one wanted to speculate about future dissemination, one could hope that the review copies could produce interest and eventually lead to requests for training in the use of the Manual. (In the Conclusions, we will consider how this training can best be provided.) The HEC publication which will be produced after the completion of this thesis will be distributed to Health Education Units throughout the U.K. and could lead to further orders for Manuals and requests for training. The HEC is presently proceeding with plans for alcohol campaigns in the South West of England and in the North West; a coordinator has already been appointed for the South West, who is Dr. Simnett, one of the writers of the Manual. She is already using DCM and running courses, and intends to continue doing so.

The comments referred to earlier, on the intentions of the Regional Subcommittee, seem to indicate that they want to incorporate DCM into their future work, so that it will continue to be a focal point for alcohol education, and so that the participatory learning methods will continue to be used and encouraged.

DHEOs in each district have stated intentions to run more courses as the demand arises or as they see a need to work with a specific group of professionals. These plans are in addition to the Manuals being stored as a reference resource in the library of each HE unit. NECA now has 1,000 copies for loan or sale to DCM course leaders.

#### National Dissemination

The first national dissemination training course was run in

Yorkshire in March and April of 1984, in response to requests to HEC from professionals throughout the country; it was run by Ina Simnett, Martin Evans and me. At the last session of the course, we asked participants for their comments on how they hoped and intended to use the materials and ideas from the course in the future. Their answers are recorded below, because, if what these course members hope and intend to do is carried out, these statements represent the impact that DCM can have from just one interdisciplinary course.

#### Intention

Meet up with colleagues to plan a co-ordinated/supportive approach. Identify key people/groups who would benefit from a training course.

To write a policy for the health district related to the prevention of alcohol problems.

To facilitate a discussion of the issues involved with a working group which I am chairing, to look at prevention of alcohol problems.

#### Hopes

To feel confident enough to run course (DC) for a group of trainers - i.e. Community Psychiatric Nurses, Health Visitors, Teachers. To have all young people in my district educated to choose to drink sensibly.

To run a training course(s). Adapt the approaches in manual for other relevant health programmes. Use elements of the manual for other training courses.

Training other health workers to be alcohol educators, depending largely on the outcome of the policy development.

We received thirty pages of such comments from the course members; summarised, they tend to fall into the following categories:

#### Hopes and Intentions:

To run DCM courses for Social Workers, Probation Officers, NHS, volunteers and various other groups

To work on alcohol policies for industry and NHS



To form sub-groups to meet and work on preventive and educational strategies

To train other colleagues to become alcohol educators, especially within the NHS

To use the media, e.g., weekly radio programmes on alcohol education

To start Drink Watchers and other similar groups

To transfer the DCM model to other topics

I feel that these comments indicate a positive response to DCM, and a good index of the practical uses to which the courses can lead.

The second national dissemination course is planned for September, 1984. Further developments after that will depend on how HEC decides to use the recommendations contained in this report. (See Chapter IX.)

#### Interdisciplinary Links

As we have noted earlier, in the section on Community Alcohol Teams, the links between HEOs and other professionals have been strengthened by the joint attendance on multi-disciplinary courses. The above comments from the Ilkley course show many further examples of this change as well. Other professionals have come to perceive HEOs differently than before, and now see possibilities for cooperative action with them, rather than seeing them only as experts or providers of information. HEOs see this as a very positive change, and are continuing to strengthen those links.

#### What People Say

In the section which follows we will listen, as it were, to positive comments on the project as a whole, made by the people

involved. These statements have been received as recently as two days ago (May, 1984), as well as earlier in the project, and so reflect the thinking of participants along the way.

Excerpts from a letter from a DCM course member, who works in an alcohol/drug unit in a hospital in Cheshire:

"Dear Donna,

Just a brief note to tell you that we are gradually using more and more of the 'Drinking Choices' manual in our client educational programme. So far it has proved very successful and provided much enjoyment for both clients and staff.

We are about to commence an eight session package based upon the manual which we hope to adapt to a 'Controlled Drinking' Programme later in the year. Next week I am intending to use it as a guide when I talk to Sandbach Probationary Service.

I would like to issue an open invitation to you to visit us - should you come specifically to see us or call in passing you would be very welcome.

Yours sincerely"

(28 February, 1984)

#### Interview notes, Northumberland

"The alcohol development officer is running an alcohol education support group with a social worker. It meets every week for 8 weeks from 7 o'clock to 8.30 p.m. They spend half an hour on a topic such as self-help, resources available, detoxification, medical model, abstinence vs. controlled drinking, clashes in family, etc. The course is open to problem drinkers, families, workers, etc. They use the drinker's diary and explore decision-making processes regarding alcohol, ask people what problems are arising from their drinking, home in on individual crises, and on problems coming up; for example one client with a large family is going to celebrate a wedding. He brought this up in the group and they planned what he could do using role play. They looked at how he could be assertive and avoid being lured into heavy drinking on that occasion. The course now has eight members and so far only two instances of non-attendance have happened."

(December, 1983)

Interview notes, HEO, Cumbria

"After three years of having no resource centre at all the training course made her realise that they really needed one and their team is looking in a critical way at the idea of having a resource centre. They agree that they would be better off producing their own resources so that they get the right ones. Her group with district nurses, which only used to have one hour to talk about alcohol, now has three sessions of full afternoons and she learned from me how to set an agenda with a group and has been doing this and they have said how they want to spend their time."

(December, 1983)

Excerpts from my interview notes:

Cleveland:

"One DMO remarked of a certain HEO that he was a 'changed person since Beamish II - I've never seen him so lively and eager to do his work'."

Sunderland:

"The Nurse Training Officer says there is lots of positive feedback about DCM and more people asking for training."

(November, 1983)

Cleveland:

"The Director of the Cleveland Council on Alcoholism said that they had benefited a lot from the module contact and activities and he thought that the more modules that were run, the better. It had also made people more sensitive and aware, and the influence of the module would last and extend to both professionals and other members of the population."

(December, 1983)

Northumberland:

"The DHEO reported that she was at the Blackpool Conference on Alcohol, which was organised by AEC. She sold seven copies of DCM, and could have sold many more. Again, there was great interest in how people could obtain the training in using the manual; it was fairly embarrassing not to have a ready answer."

(November, 1983)

South Tyneside: (a social worker)

"She is using it with her staff and her students because it is much easier to grasp than any of the material she has been using before. She said that

the course had had many spin-offs including the way they work with students. She felt that drinker's diary was the bit that caused the most controversy. Whole teams were talking about it and looking at their own level of drinking."

Alcohol field worker:

"The Beamish II course had great impact on me personally; it made me look again at my educational methods. I have moved more more into participatory learning. I am quite a showman as a lecturer, so it was hard to change, but I think it was also better this way."

(November, 1983)

Regional Subcommittee of the Alcohol Working Party

This body includes the District Medical Officer, and a representative from NECA, as well as one DHEO or HEO from each district in the region. It meets regularly with HEC, and its purpose is to continue to provide alcohol education and counselling services in the region. I was asked to address them in May of 1984, to present the outcomes of DCM. The reception they gave me was very cordial, so that I felt free to use my customary methods; I did not lecture, but gave them some idea of how many courses had been run, and how many people had been trained, and then asked them to put the questions which interested them. We had thirty minutes' discussion, after which I prepared to leave. However, I was asked to stay, and they then made the following positive comments:

HEO: What I wonder is, how did we manage before Drinking Choices?

NECA: There has been some very good material produced in this region, as a result of DCM.

HEO: It is a distinct privilege to have had this project in our region. I do not think there is another one like it elsewhere in the country.

DHEO: At conferences and seminars, when we are asked to provide participatory exercises, people are very impressed and fascinated by what we have learned to do.

DHEO: The important thing is that we are using group work skills, not in isolation, but in a topic base, which helps people to look deeper in relation to topics such as alcohol, drugs, solvent abuse.

Group work skills courses always seem to get to a certain point, and no further, and that is because they are not using the skills in relation to a topic.

HEO: We have moved a long way in this region.

DHEO: There is a feeling that something special has been happening here, and we want to thank you.

The committee were concerned that HEC should look more closely at what to do with the information coming out of the evaluation; they want to present ideas to HEC, so that the report will be widely read and used. They are intending to take this to their next meeting with HEC.

### New Ideas

In addition to the revisions of the manual which were produced in the initial stages of this project, and incorporated in the published edition, there have been other novel ideas created by individual course members and passed on to me.

A course member devised a crossword puzzle composed of words taken from the manual.

Several card games modelled on the TACADE alcohol knowledge game have been produced.

An abacus-like structure to be used as a visual aid for the topping up exercise was devised by an Alcohol Worker in Yorkshire; it is not included here, as it is large and could not be bound into the Appendix.

A board game was designed by a course member, for use in schools or on courses. It resembles Snakes and Ladders, in that

players shake the dice and land on penalty spaces or reward spaces and then pick cards which say things like "You have drunk up all your GIRO money, go back three spaces", or "You have been to the alcohol clinic this week, you win a free pepsi".

### Job Changes

Out of the sample of 60 interviewees, 10 people that I know of changed their jobs during the three years of the project. Others have been promoted in the HE service.

One social worker left Newcastle NSPCC and I lost touch with him completely. One HEO left Cumbria to be an HEO in the South of England. Another man left an alcohol job in Cumbria for one in Scotland. An HEO from Newcastle is now DHEO in Chesterfield, and an HEO from Sunderland is now with the North Tyneside unit.

As a direct result of involvement with DCM, a social worker from South Shields who attended two DCMs and the alcohol counselling course is now the Director of the Buckinghamshire Council on Alcoholism.

The three writers of the final edition of the Manual have been very active; in fact, as we have noted earlier, one of the problems has been that they are now all busy elsewhere in different jobs.

A social worker came on a Drinking Choices course, was very impressed by it, and applied for the post of Alcohol Development Officer for South Tyneside; he is now in post. He told me his new post was a direct result of DCM.

My favourite spin-off involves a job change; a residential care worker, who was very disillusioned with his work with young female offenders, came on a DCM course in 1982. He shared his

own experiences with alcohol problems, and became an ardent supporter of participatory learning methods having previously resisted them. He turned up again on a later DCM course:

Course notes, May, 1983:

"John was there, after considerable machinations on my part to see that he came on the course. The HEOs had told him he could not come because he had already done the course at Otterburn. I knew that his personal reasons for wanting to do the course were to do with his wish to have a career change and to find a job in counselling alcoholics or some similar kind of work due to the fact that he used to be an alcoholic. At first the DHEO said that he would not back down and let him come but I worked on them until they finally agreed that he could come. On the whole he has been very supportive on the course and when the HEO asked if anyone had any particular expertise to bring to the module, John said yes he was probably the only person there who had really been an alcoholic, and he has not had a drink in seven years."

In 1983, he asked me for a reference for a new post:

Interview notes, September, 1983:

"John phoned the Growth Centre today to arrange for our social work students to visit Turning Point where he is now working.

Since I answered the phone, I talked to him about his new job. He is absolutely delighted with it and said he wished he had left his residential job years ago. He works from 9 - 5 rather than on shifts, which really improves his family life and he loves not having to worry about disciplining delinquent girls. He sounded very happy and I will arrange a visit to Turning Point in the near future."

This is probably one of the best spin-offs. He interviews men with drink problems who want to live at Turning Point, and if they are accepted he helps them settle in. When I visited, he was supervising some men who were painting the house and gardening. He counsels them and helps them look for work, and joins with "the boss" in leading group sessions. The place had a very good feeling about it; John loves his work as well.

### Knowledge, Attitudes and Skills

The outcome could also be rearranged to fit the model below, Fig. VIII.

In fact, these descriptions of attributes needed by people who would be alcohol educators, seemed to fit quite closely with the newly evolved aims.

Taking each category on the following chart (p. 344), and matching it (in writing) would be a very lengthy process; I have done it mentally and invite energetic readers to do so. I believe that the results do reflect each of these categories, and that a re-visit to the examples given in this chapter and in the Appendix will support that belief.

### How I have Changed as a Result of the Project

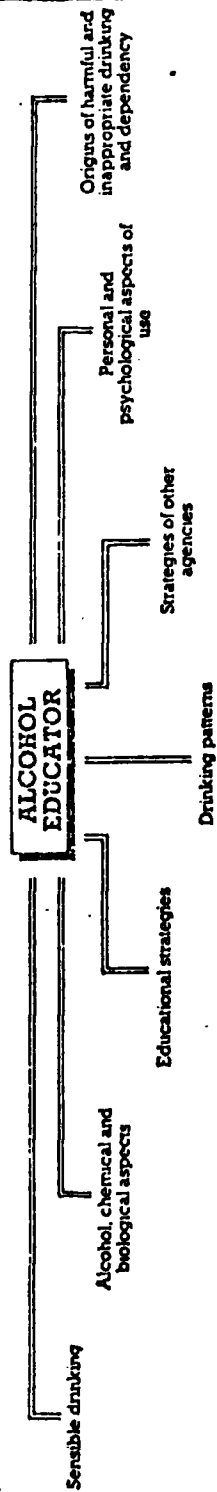
"... the myth of an entirely neutral researcher has probably seen its day. This myth should be dispelled. In descriptive and interpretative studies, investigators can make clear where they stand. They can include their private views (stating them as such) and indicate how they personally have been changed by doing the research. This kind of information provides the audience with an opportunity to weigh what has been produced in a manner that is not customary in any kind of social or educational research."

(Parlett and Dearden, 1977, p. 39)

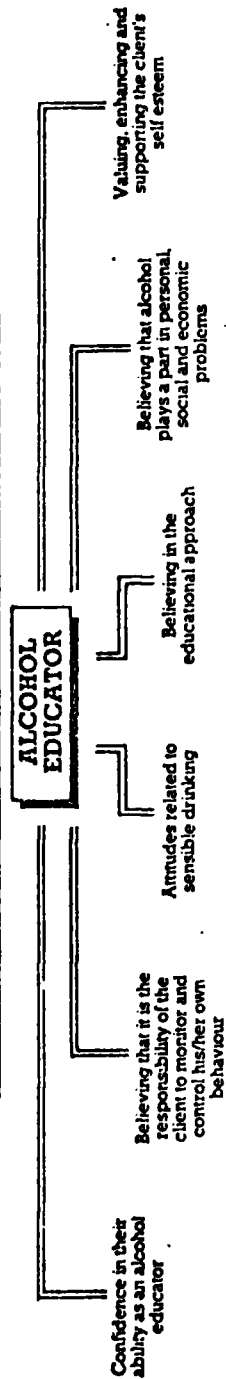
From this excerpt I take licence to talk honestly and openly about myself, my personal reactions and feelings, and the impact that this project has had on me. I am not intending to reward myself for accomplishments; rather to examine what being the facilitator/evaluator meant in terms of my personal development.



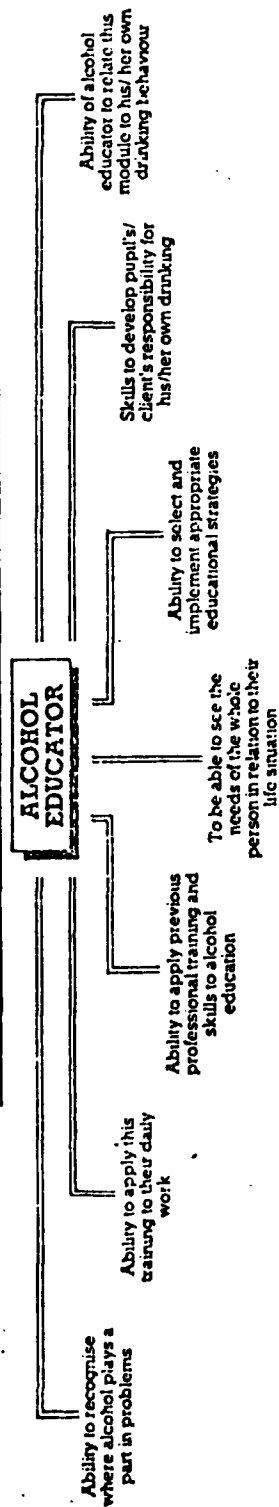
## Knowledge needed by an alcohol educator



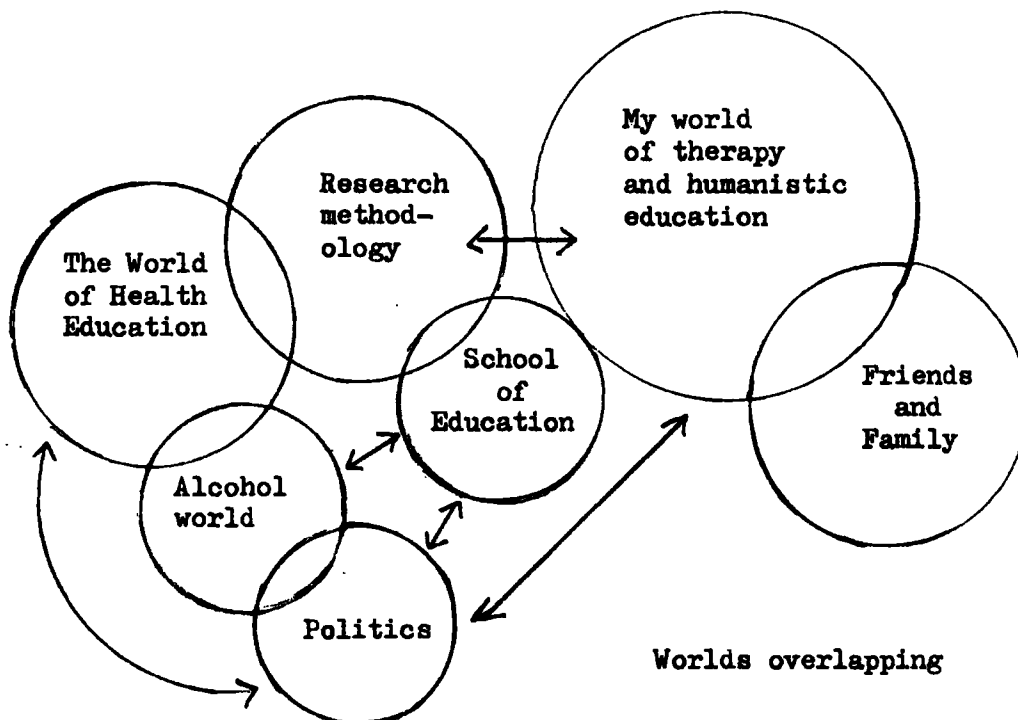
## Attitudes to develop in an alcohol educator



## Skills to develop in an alcohol educator



## New Cultures, New Languages



The above diagram shows the major cultures in which I have been immersed during the project, all overlapping and inter-relating; the culture of the HEO was slightly familiar, and the School of Education was a former workplace for me, but the alcohol world and the research world were mostly new to me.

Upon entering a new culture, one learns the language, first hearing it, then learning to speak it, perhaps to read and write it, and eventually to think in it. The degree to which I achieved this varied with the time I spent interviewing and working with people in each culture. During this process, I came to understand the attitudes and feelings reflected in the language of each culture, and became, to some degree, an insider.

"In our current society one of the ways that subcultures differentiate themselves is by developing a language that is particularly related to their behavior. This is true for craftsmen,

drug users, neurosurgeons, and minority groups, to mention just a few. A person entering one of the subgroups must learn its dialect or jargon to relate to the persons in it. Similarly, studying the subgroup's language patterns can provide some understanding of its social order, mores, and uniqueness."

(Passons, 1975, p. 75)

Research: The language of research methodology was the one most difficult for me to assimilate; it was the least familiar and the most formidable. I had petulant thoughts like "Why say ethnomethodology when you mean the study of everyday activities?" These long words, which separate the experts from the laymen, grated on my ears; I did not see the subtle differences; I felt stupid a lot. The feeling was "Just when I think I have almost grasped the kernel of meaning, it slips away again". I had to keep looking up the words in a dictionary; part of the problem was I was not speaking them often enough. I have changed my thinking about these queries since the early days, I now see that technical language, and even jargon, are fun as well as being useful.

Educational methods: Being immersed in a comparative study of didactic v. participatory methods was another difficult situation. I had to give up being right and thinking everyone else was wrong (as in the quote above), and here the challenge was much greater, because my views were so entrenched. It was with trepidation verging on despair that I approached the task of exploring the didactic end of the continuum. After reviewing the literature, and after several rewritings and discussions in supervision sessions, I finally reached some understanding about what makes people want to use didactic methods, why they enjoy lecturing, why it is considered by many people the most effective way of teaching,

most of all why HEOs resisted leaving their expert stance behind. There were vocabulary clashes and value dissonance; what the word 'discussion' means to me is NOT the same as what it means to many lecturers; I am no more right than they are. (Do I fully accept this even now?)

(Notes from a supervision session:)

" ... one major point that came like a shower of cold water, concerns my stance (hitherto unrecognised by me) of moral superiority in choosing the new paradigm. It was very productive for me, and chastening, to realise that this is what I do about the whole humanistic v. traditional debate in regard to teaching, and that I was now applying the same attitude to research methodology. Time to rewrite!"

(March, 1983)

Health Education: My introduction to Healthese, or Aitchiosian, is described in Chapter IV. This was a key language for me, I talked in it to collaborators and interviewees. Also it was an easier language to master, not such long words, not so technical or esoteric, and with less resistance on my part to overcome.

Alcohol: The world of alcohol was not in the realms of my experience; I drink, drank, drunk, very little, nor have I studied it in regard to deviance or psychology; even as a therapist I had limited contact. However, I did have some bad teenage experiences with an 'alcoholic' boyfriend, which implanted a degree of prejudice against drink problems, and I had to work to change my attitudes about this.

The categories of drink problems, the language of physiological effects of use and abuse of alcohol, the measurement of units and the topping-up effect were all new concepts. Furthermore, I entered the debate of medical v. holistic approach, again,

from a biased position; I took on the HE view for the duration of the project, and then had to attempt a view of the other side. Is it that the medics do not understand the holistic approach, or do they understand it and reject it? And vice-versa for the holists? In any case, I had to learn the language of both camps in order to write about the debate.

### Personal language block

Although my training as a Gestalt therapist has proved very useful in many ways during this project (e.g. counselling skills applied to interviews, awareness and sensitivity when dealing with people, to name just a few), this training has also intruded as a major language block in my writing. Having internalised certain habits of speech and the accompanying attitudes, I found it very hard to change. For instance, I have been taught to start sentences with "I" instead of "One", in order to personalise statements and take responsibility for them. I have learned to change "but" to "and" as a conjunction, so as not to contradict myself. There are many more of these points of speech, the main one being the exclusion of the words "why" and "because".

### "Asking 'How' and 'What' instead of 'Why'"

There is little disagreement that self-understanding converted into change is an important goal in counseling. However, too often the counselor and the counselee will pursue this goal through the labyrinth of trying to find out why the counselee acts a certain way. There are several difficulties with 'why' questions. One problem is that they smack of causality and lead to a search for the prime cause, the supreme insight that will unlock the mysteries of behavior and effect instant and effective behavior change. This path leads to quicksand. Second, 'why' is too easily answered by 'because' responses that place responsibility on external or unknown loci of control. There 'because' responses may indicate rationalization, explanation, justification, excuses, and so on. A third problem with 'why' questions is that they often

lead the questionee into 'figuring things out' in a cognitive, problem-solving fashion that rarely enhances the experiencing and understanding of emotions. Fourth, 'why' questions are usually accusatory. One way that counselors can help to break the 'why' chain is by asking 'how' and 'what' instead.

'How' and 'what' inherently include 'why' by examining the experience. Thus, the person is assisted in realizing and accepting responsibility for his behaviour."

(Passons, 1975, p. 92)

These concepts were not readily or acceptably transferable to academic writing and discussion; I have had to answer "why" with "because" on many occasions during this project!

Research skills: Whilst I was learning "from scratch" about methodologies and language, I was already conducting the research; I was reading, recording events, and talking to people. I was accustomed to obtaining feedback about my own work. I knew I wanted to collaborate and work closely with HEOs, not to remain at a discreet 'scientific' distance, but did not know how to do that and stay objective enough to be academically credible. Then I read about Illuminative Evaluation, Parlett's article in Rowan and Reason. Aha! It described exactly what I was looking for (in fact, what I had been doing) - now I had to learn to use it as a foundation and to refine my methods. My counselling skills of reflective listening and building trust were very useful in this context.

I learned to be more flexible, and to record my feelings without being ruled by them: (quote from interview notes, February, 1983):

"I felt a bit strange during the interview because I was sat at one end of a very large room with not one but two desks between me and the personnel officer. I was sitting in the only spare chair which was by the door, and her colleague was seated perpendicularly

to her desk between me and her. This seemed a very strange way to conduct an interview, especially for somebody who does it presumably every day of her life. However, she was friendly enough and I managed to make myself heard by talking in a very loud voice. I felt too shy to move my chair closer ... "

As time went on, I learned to be more assertive. If this happened now I would say, "I'd like to come and sit near you, if you don't mind".

I feel that I am a trained researcher, not a brilliant one; but I think that I now know how to conduct this sort of evaluation. Most importantly, and I never expected to say this, I would undertake an evaluation again, and I would enjoy it.

Writing style: Even now as I write this I realise that where I say "Writing style", it is considered more correct to say "Style of writing". This has been an area of challenge; how do I strike a balance between my self-expression and academic credibility?

I have almost learned to avoid sweeping statements and dramatic words like:

obviously	terrifically	must
absolutely	always	will
certainly	never	

at least in my writing if not in my speech. I have almost learned to leave out "etc", and "and so on".

Quote from supervision session:

"In the discussion about a research seminar we had attended, I said to my supervisor that I was very concerned about having to write my Ph.D. thesis in that kind of verbose, highly technical style and using the third person. I said that I felt very strongly about this and felt that people like me, and our colleagues, should be fighting to cut through this sort of pseudo-academic display and especially in this department we should be making a stand for a clear, concise, modern presentation which would update our image and at the same time pursue academic rigour. Perhaps I could write a paper on this at

some point. It is related to the manual and the Health Education Council is making an anti-gobbledegook stand which I would like to support."

Also, and this is an important point for me, I like being flamboyant, and I am an American, and patriotic as well despite my country's present depressing condition; I enjoy writing in my native tongue. How do I find a balance between that feeling and "When in Rome"?

In my writing style my biases and judgements leap out like smudges on the page; and I think of myself as being an accepting person! "Some of my best friends are teachers and social workers", but I still have to rewrite almost every paragraph I write about them to remove the judgements about their general practice.

Course notes, May 1983, DCM course for social workers:

"There was a good deal of sarcasm in the group and even in the active listening circle where a woman stated that she liked to eat and cook meals and that if her family did not eat them she ended up eating them herself, and the person next to her said 'So you are a pig'. This brought the house down and I felt that the woman really did not think it was very funny although she managed to laugh herself.

The day went quite smoothly except for two occurrences which seem worth mentioning. One was that everyone in the group was very reluctant to do the role play in Karpman triangle and the HEOs and only two other people finally joined in. In the closing round several people said that they were terrified of role play and that not only could they not join in but they were so afraid that they would be chosen and forced to do it that they actually could not even enjoy watching. I believe that social work training involves some pretty horrific role play situations. During the closing round of 'What I am taking home with me', many people mentioned active listening, others mentioned the part of the role play when we worked on how to avoid playing games such as Karpman triangle. One person who had been making cynical comments throughout the day, a man named Steve, and I note that because I have a horrible feeling I might have to choose him to interview because he was so negative, said 'I didn't learn anything at all today'. I bit my tongue to keep from saying, 'Well you must be dead then', because I feel that even if what he learned

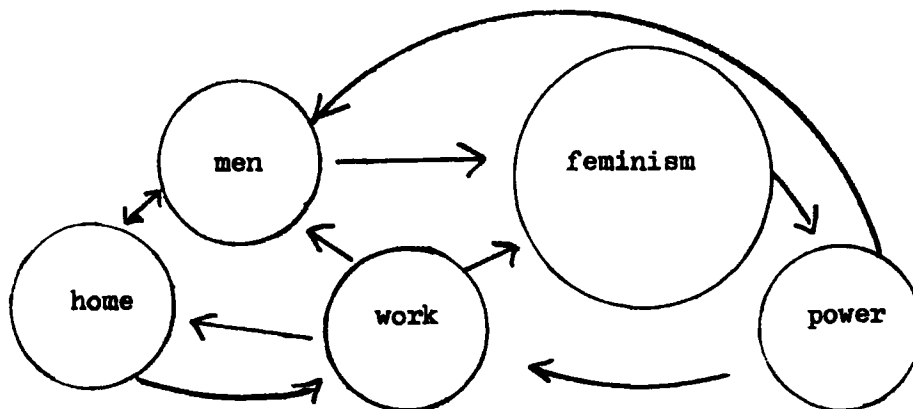


was negative or how not to do counselling training, at least he had been in the room for six hours and it must be very difficult to avoid learning anything at all."

(See what I mean about my judgements?)

How far have I come in being more objective? A long way, but I still resent being told to change my style, and at the same time I revel in any approval I receive about better writing.

Shapes and patterns: In November of 1983 I had a lunchtime interview with another researcher. She analysed the conversation we had as she saw the patterns in it. It was something like:



I felt small - it usually does not occur to me to think like that, in big concepts, all linked and inter-related. "So, how do I think?", I had to ask myself ..... I began to work it out.

I see things in terms of polarities. If you believe in astrology, it is because I am a Gemini; if you believe in the reflexive nature of work, then it is because I am a Gestalt therapist. I see every issue as having two sides or more; though it may be my side and someone else's, more often it is my side and my other side, what Fritz Perls calls "top dog" and "underdog". So my first three chapters are all about continua with disparate extremes (see Chapters I - III !). There are two sides to my two

sides as well:

advantages:

I see extenuating circumstances, give people space to be as they are, I accept and understand.

disadvantages:

I am a worrier, sometimes wishy-washy and indecisive.

I like sorting things out logically in diagrams, outlines, headings and sub-headings.

This project seems to have many triangles - the pyramids, the three writers of the manual, me - my supervisor - my secretary and more.

Personal qualities: Being single-mindedly devoted to my work on the project is still very hard, even now as Submission Day looms near. I am used to having a finger in every pie, directing the Growth Centre, used to being asked for and giving help, counselling, social time, listening. I want the money and contacts from the free-lance work. How difficult it is for me to say no, how badly I feel afterwards ..... I am learning; it is getting smoother.

It is easier now than it used to be for me to express displeasure, to disagree, to negotiate, not to please everyone all the time, to be persistent and explain that I am working under pressure, to be assertive and ask for help from my friends and colleagues.

My intuitive and affective side far overbalanced my intellectual side when I started the project, after all those years of counselling and therapising. From being an earnest, studious child with an unusually high IQ, I had gone to a super-sensitive earth-mother image. In spite of my distractedness and absent-mindedness, I feel that I now enjoy my intelligence.

I am quieter, less sociable and extroverted. At the same

time I have more confidence to be myself and wear the clothes I like. I value friends with whom nourishment goes both ways, and no longer see friends who drain me; I learned that I cannot afford them. I am usually an optimistic person, but at times on this project I began feeling very cynical about politics, government, and possibility of change: I have learned that cynicism is not a good starting point for an interview. My positive attitudes evoke positive responses.

The overall feeling is that I am a better person for having completed this project. I have lost 45 pounds since September, I like myself most of the time. Perhaps I am a bit more grown-up.

### Summary

We have shown in this chapter how people have overcome obstacles and produced positive changes and results, how they have tried new methods and ideas and slowly developed the courage and skill to apply them to their work. Since the data has spoken to us of the positive outcomes as well as of the difficulties involved, we are left with some gratifying results:

- (i) DCM is being widely used in work; there are many more people feeling confident to be alcohol educators and applying group work skills to many different topics.
- (ii) We have seen behaviour changes beginning to be evident in:
  - (a) drinking patterns
  - (b) teaching methods.
- (iii) Transfer of skills from DCM to other topics is taking place in many cases.

- (iv) Counselling services in the region have increased.
- (v) Alcohol policies and Community Alcohol Teams are being developed.
- (vi) Awareness and knowledge about alcohol have increased in this region.
- (vii) Future intentions for DCM are sounding hopeful.
- (viii) There are many interesting spin-offs from this project.
- (ix) Many people, including the author, have noticed satisfying changes in themselves, demonstrating the reflexive nature of the project.

In the next chapter we will consider how best to maintain these results, and use what we have learned about obstacles we have faced, in order to avoid them in the future.

### Part Three

This section of the thesis comprises a presentation of the results, spin-offs and outcomes of the project, followed by conclusions and recommendations. Chapter Ten explores the processes of change with individuals, groups and organisations. As an unexpected bonus there then follows a bedtime story. The DCM is included in the Appendix with other relevant documents, followed by the Bibliography.

## CHAPTER IX

### CONCLUSIONS AND RECOMMENDATIONS

"Writing upon drinking is in one respect, I think, like drinking itself: one goes on imperceptibly, without knowing where to stop ... Happy should I be could I flatter myself that this paper will be received with as hearty satisfaction as is generally felt upon the opening of an additional bottle."

(James Boswell, 'Boswell's Column, May 1780', (ed. M.Bailey), William Kimber Ltd, London 1951, p.176)

(as quoted in Glatt, 1982)

### CONCLUSIONS

#### I. Strengths

##### A) Direct Results of DCM

##### 1. Use in work

As of May, 1984, HEOs and other professionals are telling us that they use DCM regularly in their work; so much so that it is not even considered a special feature any more, but is used as a matter of standard procedure.

The manual is used to provide a basis for training courses in alcohol education for nurses, social workers, probation officers, and others who work with clients who are or could be at risk from alcohol problems.

Professionals use parts of the manual with clients,

and also with groups, such as young offenders, patients in hospitals, or self-help groups of various kinds.

In addition to this everyday use of DCM, people in this region and also around the UK are still planning and running DCM courses at all levels of the pyramid.

These courses usually show consistently high attendance rates, breaking away from the usual pattern of adult education courses, where attendance often tapers off as the weeks go by.

These results indicate that the underlying aim of creating a much greater number of alcohol educators in the region has been met.

## 2. Behavioural Changes

Several kinds of behavioural changes have been noted as a result of DCM.

- a) Clients, course members, and key tutors have reported changes in drinking patterns, increased awareness of their own habits, and that they are using what they have learned about alcohol. Many people have reported drinking less as a result of going on a DCM course, or as a result of working with a professional person who has attended DCM. Thus we believe that, given time, and in conjunction with other services, DCM can be an effective means of changing drinking behaviour at all levels of the pyramid.
- b) Most of the people interviewed have stated that participatory learning methods were for them the most useful aspect of DCM and are applying these methods, to some degree, to all areas of their work.

- c) Drinking Choices and the participatory methods used on the courses, seem to bring out creativity in the course members, who have invented games and extended the activities to fit their own purposes.
- d) An HEO's work has a reflexive quality to it; that is, what the HEO passes on to professional people in the way of training and information affects his/her own work and personal life. This factor supports the general view that is exemplified in DCM that people receive information and then make sensible choices about their own way of living. This applies as much to participatory learning methods and an approach to health education in general as it does to specific topics such as alcohol. The reflexive effect also applies as much to course members as it does to key tutors.
- e) Some course members and key tutors also feel that they have developed in their own personal growth as a result of this project; many instances of this are recorded in the data at all levels of the pyramid. People report increased confidence, feeling more assertive, and generally feeling better about themselves. Some course members have gone on to counselling courses, and are using improved counselling skills in their work.

### 3. DCM as a prototype

One of the main factors which makes DCM a useful resource is its adaptability.

- a) DCM is an example of how to use participatory learning methods and group work skills when applied to a topic base. It has already been adapted by many professionals for use with a wide variety of topics; new activities and even new manuals have been developed from DCM.



- b) It can be adapted for use in other regions and other topics.
- c) It can suit a broad range of teaching styles, from didactic to completely client-centred, depending on the needs of a group or group leader.
- d) It can be adapted to suit any course design, from short sessions weekly, to residential weekends, or any combination of meetings.
- e) The people who have used it so far represent a variety of age groups, from children in school to senior citizens; personality styles have also ranged from extrovert to very shy.  
Senior managers have used it, as well as people just beginning to be alcohol educators.

## B) Other Results

### 1. Interdisciplinary Links

- a) One of the most successful outcomes related to DCM has been the establishment of Community Alcohol Teams in some districts in this region. There is an instance in which an informal team was established by DCM course members and brought to the attention of the authorities who then provided more official services.
- b) DCM is an important contribution in the movement towards educational attempts to help people, e.g., Parkwood House, with patients in hospital and with other clients.
- c) DCM has helped develop alcohol policies in industry and the health service, although this issue is not directly addressed in the manual; it emphasises the need for educational policies throughout the work force, rather than disciplinary policies for people with alcohol problems.
- d) DCM has been a tool to focus attention and thought

on alcohol education needs, rather than just a vague concern about alcohol problems.

- e) Another successful outcome has emerged from DC: magistrates in Northumberland send young offenders with alcohol related offences on DC courses run by their probation officers. Self-help groups have also been started throughout the region, using DCM as a model for Drink-watchers, Slimming and Stop-Smoking groups.
- f) Professional workers now perceive HEOs in a different perspective, that is, they are not just local experts in health topics, to be called in on a one-off basis. They are now seen as colleagues who can be useful in developing cooperative services.

## 2. National Dissemination

The two national training courses which were offered had more applications for attendance than there were spaces available; the first one, in Spring of 1984, had 33 course members. The second, scheduled for Autumn, 1984, will be restricted to the first 25 who apply.

The response to the first course was that professionals in various parts of the country planned to run DCM courses, set up interdisciplinary alcohol teams, and train their colleagues in the use of the manual.

There has been interest in DCM throughout the UK, and also some requests from Europe and America; DCM was run in Northern Ireland recently.

## 3. The Pyramid

The pyramid model for dissemination was very

effective in spreading the training among a large number of people; another time, it could be even better if it had certain modifications (see recommendations).

#### 4. Research Methodology

The illuminative evaluation, using participant observation, was felt by HEOs and other course members to be appropriate for this project:

- a) It matched with the underlying aims and the teaching style of DCM.
- b) It was a formative evaluation, so it provided us with progressive focusing, and the opportunity to adapt and change both the manual and our methods.
- c) It was also a summative evaluation, which allowed us to make conclusions and recommendations along the way, but also to make some final conclusions at the end of the project, and recommendations for the future.

5. The Steering Committee has been an important source of advice, consultation, and development for this project. Analysing the data as we went along and producing interim reports for the purpose of briefing the committee, helped the process of progressive focusing; it allowed people to comment throughout the period of the evaluation.

## II. Problems Encountered

### A) Timing

There has been a major weakness in the time frame applied to this project.

1. Three years is not a long enough period in which to examine behavioural changes at Level 4 since the pyramid model needs to be completed through all levels and since behavioural change is known to be a very slow process.
2. The facilitator/evaluator should be appointed well before the innovation is put into practice to allow her/him to become acquainted with the cast of characters, to get a feel for the culture, to survey the scene before the innovation is introduced, and if necessary, to be receiving training in research skills appropriate for the particular project.
3. It is difficult to strike a balance between providing follow-up and support, and reaching a stage of over-kill, which may produce either apathy or discomfort, and possibly even rejection.

### B) Training

1. We do not have a comprehensive plan for the provision of training in using participatory methods. In order to use DCM most effectively, and in order to transfer the skills of alcohol education to other HE topics, people need training in groupwork skills.

2. To be most effective the manual must be adapted to the needs of a particular group of course members; leaders do not always know how to do this. They need training in agenda setting, decision making, negotiating and general participatory learning and counselling skills.
3. The manual was published before the end of the evaluation and without a provision for training people in how to use it.  
Many HEOs were very unhappy about this.

#### RECOMMENDATIONS

It seemed sensible to divide the recommendations into sections according to the main groups involved, namely, HEC, HEOs and clients.

##### I. For the HEC

###### A) HEC Publication

The Steering Committee proposes that 5,000 copies of the HEC publication about DCM be printed, and be distributed to the following authorities in districts around the UK:

HE units  
Social Services  
Probation  
NHS  
Education

This publication would be entitled:

Drinking Choices: A model for inter-  
disciplinary action

It would serve as a model to encourage staff development in each region, and show the value of interdisciplinary

cooperation and action.

This publication would be made as interesting and attractive as possible, and would contain cartoons and humour, as well as practical ideas for people who want to disseminate Health Education materials of any kind, including DCM.

An HEC monograph describing the results of DCM will also be made ready for publication.

B) National Dissemination of DCM

The Steering Committee proposes that the HEC and Alcohol Concern should consider establishing joint funding for a national dissemination of DCM by:

1. Choosing a person to be the national disseminator.
2. Having that person set up a ten-day training course in each of the ten regions which have not already had one (i.e., all of the fourteen regions except NE, NW, SW, and Northern Ireland).
3. Using the above-mentioned publication to advertise and promote attendance on the course.

C) Interdisciplinary Links

Since HEOs in the region have come such a long way in establishing links with other professionals during this project we hope they will continue to develop this kind of cooperation. Keeping Community Alcohol Teams going, and the formulating of alcohol policies in industry and the NHS are extremely important. The regional subcommittee will be very likely to encourage such development. A senior

Health Education lecturer in the region could also promote this sort of activity.

In Northumberland, the idea of asking magistrates to cooperate by directing young offenders to attend DCM courses has been quite successful. This idea could be passed on and extended to other districts, and also could be expanded to include materials for use with groups on solvent abuse, drug abuse, sex offences and others.

## II. Further Staff Development for HEOs

One of the conclusions we have reached is that HEOs in the region are needing and demanding further training. The demand has been primarily in the area of advanced group work skills and the use of participatory methods; therefore we propose some possible strategies for meeting these needs. Whatever method of provision is decided upon, the package should include:

- further training in participatory methods of learning
- negotiating skills
- agenda setting
- decision making and committee skills
- management skills
- dealing with value differences
- dealing with difficult group members
- counselling skills:   active listening
- seeking alternatives
- problem solving
- assertiveness training
- client-centred approaches to education

- A) People who are already involved in this sort of training for the HEC could be invited to do some further work with HEOs in this region.

- B) Some alternative ways of providing training have been developed as a result of what we have learned from DCM.
1. A Senior Lecturer in Health Education, if such a post were established within the region, could provide the training described above.
  2. The Society of HEOs could be requested to allow time at next year's HEO Seminar for training in participatory learning methods as applied to HE topics, using DCM as a model.
  3. The regional sub-committee on alcohol may wish to think about future training. It is possible to consider that the £2,500 remaining in the funds which HEC set aside for this project, could be used to continue to provide training through the auspices of the regional sub-committee.
  4. A pyramid could be designed which looked slightly different from DCM's pyramid:
    - Level 1: Train a greater number of trainers, including DHEOs, and HEOs.
    - Level 2: Trainers train health educators.
    - Level 3: Health educators work with clients and the general public.
  5. An addendum to the manual could be written, and distributed, with further instruction on the methods used in the programme.
  6. Trained HEOs in this region could provide, say, a day's introduction to the use of the manual and its methods, for interested people in various regions



around the country.

7. Although DCM is an educational tool and not in itself concerned with treatment, many course members at Levels 1 and 3 are very much concerned with treatment and request that it be included in the DCM course. Some HEOs feel that they are ill-equipped to meet this request. HEOs could discuss among themselves, at the Society of HEOs, or in regional meetings, what they feel would be the best way to deal with such requests.
8. The data indicates that the Beamish II training model, where course members choose and present parts of the module, is more effective in terms of increasing their confidence as alcohol educators. There could be an addendum to the manual with instructions for setting up a client-centred course.

### III. Other Issues

#### A) Continuing Evaluation

It would be advisable to come back to the North East in 1989 and 1994 to see if, where and how DCM is still being used, and to conduct a survey on drinking behaviour in the region. Use of participatory learning skills could also be evaluated at the same time. It would also be useful at that time to find out how far the National Dissemination has proceeded.

The evaluator could examine what has happened to the efforts of people in this project to design and implement alcohol education policies in the region, in the NHS and

industry. The evaluator could see whether Community Alcohol Teams were working effectively in the region. The present evaluation project is best seen as a beginning rather than an end in itself.

B) Setting up Similar Projects

1. In setting up a project such as this one, if at all possible, the facilitator/evaluator should be appointed three months before the innovation is put into practice and should spend the time familiarising himself with the field to be explored and with the establishment of the appropriate research methodology.
2. To counteract the weaknesses in the time-frame of this project, another time it would be better:
  - (a) to complete the initial pyramid and evaluation before embarking on national publication and dissemination.
  - (b) to involve more HEOs in choosing priorities for research and preparing research designs.
3. DCM is in itself a combination of techniques, and in the North East it has been applied as an adjunct to a media campaign. The question of whether these two in conjunction have been successful would have to be measured against a careful evaluation of:
  - (a) DCM on its own
  - (b) a media campaign on its own
  - (c) no campaign and no manual.We do not really know whether the manual or the pyramid of dissemination would stand alone without a facilitator/

evaluator being actively involved.

4. It is a good idea to provide a contingency fund within a project budget, such as the one we had, since it is impossible to predetermine all likely costs.
5. There should be a clear contract with the evaluator as to the aims, and conflicts of interest in the evaluation.

There should be a clear contract with the evaluator's supervisor as to just what his/her role will be.

C) Greater Involvement of HEOs

To avoid the discontent expressed by HEOs about the early publication of the manual, another time this could be handled by:

1. consulting the HEOs and asking them to provide a plan for publication and accompanying training;
2. waiting until the evaluation ends before publishing;
3. establish an agreement with HEOs so that they would know they would be deeply involved in the research until the end of the project, or they could carry on the evaluation over a period of, say, five years after the end of the project. It is very much preferable to establish this sort of contract at the beginning of the project than to tack it on at the end.

According to Kirby both DHEOs and HEOs have health education research and evaluation and dissemination built into their job description. It would be very beneficial to have someone in the region encouraging and promoting such

activities and providing a form in which specific research issues are explored.

#### IV. Recommendations for HEOs

##### A) Planning Courses

The following recommendations are aimed at HEOs when they are intending to run DCM or other similar courses. They have risen out of the data gathered from this project and, if they are followed, should result in a more effective dissemination model.

In Level 2 of the pyramid, invitations to prospective course members should include the following information:

- (a) The course is aimed at potential trainers who will then be encouraged to go back to work and run courses for their colleagues. Course organisers should determine that people at management level are committed to providing training in the place of work.
- (b) It would be a distinct advantage to have some representatives attending the course who are working in senior management posts so that they can make decisions about further training in their place of work, or at least to have them very well informed about the aims of the projects.
- (c) There could be seven training days, five run consecutively or weekly and one after three months and one after six months. This model does away with the phrase "follow-up days" and gives the impression that reporting back and evaluating the results of the initial training days is built into the course. Hopefully this might ensure fuller attendance on the last two days. It would also give HEOs feed-back on the effectiveness of the initial training.

- (d) Course managers could encourage all course members at Level 2 to run at least one DC course (or other similar course) during the training period so that they can report back and discuss problems and new ideas.

B) Anticipating Possible Obstacles

It is advisable to think about issues such as resistance to new methods, probable obstacles to progress such as reorganisation in the Health Service, industrial disputes or other factors which might stand in the way of completing a course. These issues could be briefly discussed with course members at the first meeting so that it is clear to the course members that they are making a commitment to attend all the training days and will be expected to find ways of dealing with obstacles.

C) Condensing the Pyramid Model

If a pyramid model is to be used, it takes a long time for the innovation to percolate through to Level 4. Therefore Level 1 could be condensed so that it runs in less than three months e.g., if there are nine training days they could be held consecutively or weekly, or the model of 2 x 3 days could be used.

If all the above issues are considered both in planning the course and in initial contact with course members, it is hoped that some of the snags we encountered with DC can be avoided.

D) Mini-manuals

Some professionals at Level 3 have produced "mini-

manuals" specifically designed for use with certain clients. For example, a psychiatric charge nurse in Northumberland uses simplified alcohol information drawn from DCM, Drinker's Diary, Road Map and so on in counselling individual patients. HEOs could provide similar mini-manuals for other professionals who come to their units.

E) Producing Other Materials

HEOs in a region could support each other in transferring participatory learning methods from one topic to another so that if someone produces material on drug abuse or sex education or family life, there could be a forum for sharing these materials so they are not being reproduced simultaneously in several units.

V. Clients

Successful change is not likely to occur following the single application of any technique.

It would be asking too much of many human beings to change the drinking patterns of a life time because of one exposure to DCM. Drinking behaviour cannot be seen solely in individual terms; the economic condition of the North East is bleak and the future even bleaker, with unemployment on some local housing estates as high as 60%. Long-standing local traditions of coping with unemployment and other problems involve heavy drinking. Alcohol education has its place in an overall plan to improve the situation and some of the results of DCM, such as the development of Community Alcohol Teams, increased

awareness on the part of social workers, industry, and other workers in the area, may all go a long way towards reducing the problem. The pyramid model means a slow percolation of the effects of DCM through the community over a period of several years; it is only now becoming possible to assess its effects.

### BEAMISH III

In June, 1984, a special event happened as a result of DCM. Beamish III was a residential three-day course for seventeen key tutors in the region, not a start of a new pyramid, probably, but a course in advanced group work skills for those who were interested.

Course leaders were imported from Manchester, and had expertise in the application of Transactional Analysis techniques to working with groups and clients in general, and those with alcohol problems in particular. The course was organised by four HEOs, two each from Beamish I and Beamish II, and funded with money remaining from the DCM project, with the encouragement of HEC, and supported by the facilitator/evaluator.

Some comments:

HEO: I went there thinking, What else can we do that we have not done already? I came away amazed at how much I had learned about myself and improved my skills.

Alcohol field worker:

The course was excellently organised, the leaders were warm, sympathetic, and amenable to altering the course programme so that we got exactly what we wanted. The parts I found most usable and useful were the exercises on problem solving, assertiveness, and the theory and practice of Transactional Analysis, with practical experience of how to use it with groups and clients.

I received three other reports about the course, with the same feedback. The people I heard from all agreed that they wanted more of that kind of practical training .....



### Library Lament

(written while researching on innovation, November, 1984)

Change and innovation  
Increased participation  
It works if we but knew it,  
Ah yes, but how to do it?

It's all very well for you, they say,  
But will it happen every day?  
We know it's been evaluated,  
But can it all be replicated?

So to the library, search the shelves,  
The authors answer for themselves,  
So many views, the Great Debate  
And '84 is out of date  
Already Freud has been superseded  
He wasn't what the 60s needed  
But Goodman, Perls, and Hefferline  
Have come up with a new design ...  
But wait, their strength has faded quick  
And now we turn to Watzlawick ...

Oh Watzlawick, Oh Watzlawick,  
Your Manipulations make me sick,  
And yet you are so wise forsooth,  
Perhaps it's you who knows the truth,  
But if you're right and Rogers wrong,  
Then I've been diddled all along.

My fingers ache, my eyes are bleary,  
On each page, another theory,  
The judges are so hard to please  
In the game of Bibliographies.

The list is finished ... no, too soon!  
Did no one mention Thomas Kuhn?  
And Maslach and Maslow, and good old Zimbardo,  
And Parlett, and Marshall, and Judy Chicago?

And Coffield and Cohen, and my friend McGuiness,  
Sikorski, Ginorski, and what about Bennis?

And Dewey and Laing and then Bennett and Skinner,  
And what are the chances of stopping for dinner?

And would I, oh could I, oh dare it be known,  
That sometimes on Tuesdays, I've thoughts of my own???????

## CHAPTER X

### STEPS TO SUCCESSFUL CHANGE

#### Introduction

This chapter is being written nearly a year after the end of the project. The purpose in writing it is to draw together some of the threads which were left dangling in previous sections which, woven together can give us more insight into the process of change. At this distance, perhaps we can take a more objective look at the Drinking Choices Project, the planning behind it, and my impact upon it.

In fulfilling the task of facilitator/evaluator of the Drinking Choices Project, I acted as a change-agent; this is a role in which I have had extensive experience during 25 years as a mother, teacher, therapist, counsellor, consultant and business woman. In this chapter I hope to demonstrate that the role of change agent is much the same in any of the above situations, and that the processes of change are similar, though set in different contexts. I intend to encapsulate the processes and I will use the words 'teacher', 'counsellor', 'change agent', 'therapist' interchangeably, because that is how I experience them. I want to add that I use the word 'therapy' to mean anything which a person does in order to feel better about herself, including counselling, but also less emotionally intensive activities as swimming, jogging, reading, dieting, or talking about a problem with a friend.

I interact with people in a particular way because I am a

client-centred therapist and a student-centred teacher, and because I am me, and therefore different from any other change agents, just as each client is different from any other client; I will attempt to portray this interaction and to show that the factor which is constant and generalizable is the processes of change.

So, the challenges in the first section of this chapter are:

- a) to simplify and explain briefly how I go about engaging in a programme of change with another person, be he a client, friend, student or HEO;
- b) to use layman's terms and avoid technical language (so that the reader does not think he is drowning in jargon, and so that each word does not have to be defined);
- c) to distill an extremely complex intuitive process into a few basic steps; not for the layman to use as a Do-it-yourself guide, but so most people can understand the processes;
- d) to bring the intuitive gut-level activities of an experienced practitioner up to the surface to be examined intellectually, or as Argyris and Schön describe it, to formulate a "theory-in-use" (1978, pp. 11-13). They use an analogy which compares the process of forming a theory-in-use to riding a bicycle, which requires a fluid, uninterrupted series of motions and does not allow time for analysis of the process while it is happening:

" ... these sequences depend for their performance on Gestalt qualities that we lose if we attend to the particulars of the explicit program. Thus, learning to ride requires both learning the program and learning to internalize the program."

But in a later work (1983, p. 281) Schön states that " ... there is nothing in reflection, then, which leads necessarily to paralysis of action". I do not find the need for reflection paralysing, indeed I find it fascinating, exacting and fruitful.

Well-trained and skilled professionals do what they do from long practice and so are not required to think through every step every time they work, and indeed may be unaccustomed to articulating what are in fact implicit theories. A dentist knows a molar from a bicuspid and a rotten tooth from a healthy one, and does not need to ask herself why she knows it; however, sometimes the "why" must be made explicit to a patient or a dental student. As Parlett says (unpublished, 1984, p. 66), some professional knowledge is easily expressed, some of it is much more difficult to articulate as it is usually used without thinking, but most of it can be spelled out although it may take time and effort.

"The expert who is a successful teacher is someone who can both operate inside a body of knowledge, but also talk about it in ways that make sense to non-experts." (op. cit., p. 74)

For the past ten years, I have been running training courses for people who want to use counselling in their work. I do this by first counselling the course members themselves about whatever issues they choose to present. The rationale for this being the first part of the training is that they ought to be aware of themselves before they work with other people in a counselling setting, and that they ought not to ask clients to have experiences which they themselves are afraid to have, a position powerfully argued by Egan:

"Skilled helpers have their own human problems, but they do not retreat from them. They explore their own behaviour and know who they are. They know what it means to be helped and have a deep respect for the helping process and its power."  
(1982, p. 28)

In the second phase of the training, I ask the other members, who were observing or participating in the counselling session, what they noticed and learned about what we were doing. They tell me what they saw, heard and felt, and what they themselves experienced; we

discuss it, we all ask questions. I know that if I just say "I knew what to do because I have been doing it a long time and I followed my intuition", that is a cop-out; it does not inform them, and it makes it look as though my skills are inaccessible to them. Part of the training for all of us is that I must be able to speak intelligibly about what I have been doing; this exercise is now customary and easy for me. Schön (1983, p. 62) calls it reflection-in-action.

"When a practitioner reflects in and on his practice, the possible objects of his reflection are as varied as the kinds of phenomena before him and the systems of knowing-in-practice which he brings to them ... Reflection-in-practice is central to the art through which practitioners sometimes cope with the troublesome 'divergent' situations of practice ... Sometimes he arrives at a new theory of the phenomenon by articulating a feeling he has about it."

In fact, in running training courses, one of the aspects I always enjoy is the process of articulating the feelings and ideas on which good practice is based; I find it exciting to demystify proceedings which sometimes seem magical to clients. Schön stated that

... "we are most likely to initiate reflection-in-action when we are stuck or seriously dissatisfied with our performance."

(op. cit., p. 280)

While agreeing that this can often be the case, I would argue that, for me, the reflection is usually initiated by the necessity to explain my actions to people in order to give them access to skills and knowledge, in the context of training.

Later in the course, the participants go through the same process that I did, by practising their counselling skills while being observed and then questioned by all of us.

## The Chapter to Come

The processes of change have been broken down and described in different models in the literature; I will describe in the first part of this chapter how I would break them down into seven purposeful stages, in the light of certain assumptions from which I usually operate. Like other assumptions, these are debatable and falsifiable; they are not sacred tablets, but are a modus operandi which works for me.

I will illustrate the explanation with examples from case studies of three of my own clients, one from the project, and two in lesser detail from my private practice, so that the reader can see applications both within and outside of the Drinking Choices milieu.

In later sections of the chapter I will relate the seven steps to the project as we carried it out, and also to innovation in larger organizations. I will relate DCM to some general trends in society in the '80s which seem to indicate that the project was appropriate to the contemporary scene.

Another thread which will continue throughout the chapter is the issue of resistance; blocks both small and vast will be touched upon. No panaceas will be offered, but the chapter will concentrate on what can be done, by organizations and by ordinary people.

### Assumptions of a Client-Centred Change Agent

In working with people I operate with a set of assumptions which are not only inherent in what I do and say; they are also openly expressed to the client, and they form part of a verbalized agreement between us. The assumptions stem from the works of Rogers and Perls, and others, who have tested them and recorded the results on a regular basis over the years; I have also tested them, and am able to sustain them on the strength of my own experience.

I assume:

- that " ... the client has all the tools needed to make any personal changes needed or wanted." (Van De Riet et al., 1980, p. 71).

- that I can purposefully and yet with integrity, adopt a stance of unconditional positive regard for the client, to which the client may, sooner or later, respond with trust.

- that the client has a willingness to change and grow, indeed a desire and a need to do so, and at the same time she has resistance and fear about changing; these two factors are equally acceptable.

- that the client is in charge, is fully responsible for her own behaviour, comes to me of her own free will (even if referred at the outset), can stop when she wants, can disagree with me or refuse my suggestions.

- that " ... if I can provide a certain type of relationship, the other person can discover within himself the capacity to use that relationship for growth, and change and personal development will occur". (Rogers, 1961, p. 33)

These assumptions operate as my ground rules, and they are revealed to the client as we proceed. The client can refute them,

or negate my assumptions. I then have a choice as to whether or not we will continue to work together; so does the client. A client's refusal to accept ground rules does not necessarily prove that the assumptions are wrong; it proves that the particular client does not choose to work with them at the time, for any number of reasons, but often because they pose some sort of threat; as Rogers says (1951, p. 390):

"Experience which, if assimilated, would involve a change in the organization of self tends to be resisted through denial ... "

The ground rules in themselves may prove threatening, and it is one of the counsellor's tasks to minimize the threats and therefore the resistance, through positive methods, which we will be exploring in this chapter.

### Seven Steps to Change

People may choose to change something about themselves for many reasons, and they may go about it in an infinite number of ways, taking seventeen paces forward and twenty-two back, or going astray by leaps and bounds; a client-centred counsellor will set herself to follow the path that the client takes. However, in this section I am going to set out a linear progression through a series of stages which in reality would usually happen with overlaps, and repetitions, and in a very complex pattern. I would argue that each of these steps would be encountered at some stage in the process of change, although not only in the following order.

#### A. Initial Motivation: the Impetus to Change

Q.: How many client-centred counsellors does it take to change a light bulb?

A.: One, but the light bulb has to really want to change.



Remembering that one of our assumptions about people is that they both want to and fear to change and grow, there still may be a vast variety of immediate reasons why a particular change is sought; perhaps to conform to the standards of a group of peers, perhaps because a present situation is intolerable, perhaps as a result of a learning experience which shows a person that his usual behaviour is outdated or harmful, or a host of other reasons.

Usually there arises some conflict between an external situation as perceived by the client, and an internal feeling, or else some conflict between two contradictory feelings and/or thoughts in himself. For example, a single woman may want to meet an attractive man, and she knows that unmarried men of her age congregate in large numbers at The Hare and Hounds; she has agreed to go there with her other female friends from work. At the same time she is afraid that if she did meet a man she would not know what to say to him, and he probably would not like her anyway. In Gestalt therapy this conflict is called Topdog v. Underdog, or manipulation of the self. Both Topdog and Underdog always assume that we ought to be changing something about ourselves:

" ... the topdog or perfection-oriented part of the person continually demanding; the person continually trying to change or improve; the underdog continually sabotaging the effort ... the underdog engages in scare tactics that often immobilize the person".

(Van de Riet et al., 1980, p. 72).

Another way to talk about this inner conflict is Festinger's theory of cognitive dissonance (1957, p. 3):

" ... the existence of dissonance, being psychologically uncomfortable, will motivate the person to try to reduce the dissonance and achieve consonance. ... I am proposing that dissonance ... is a motivating factor in its own right."

. Applied to a distressing impasse, the same principle might be manifested in the following way:

Mrs. Smith's Topdog

"I have been married and miserable for twelve years; I hate my husband, he treats me like dirt. It's time I left him."

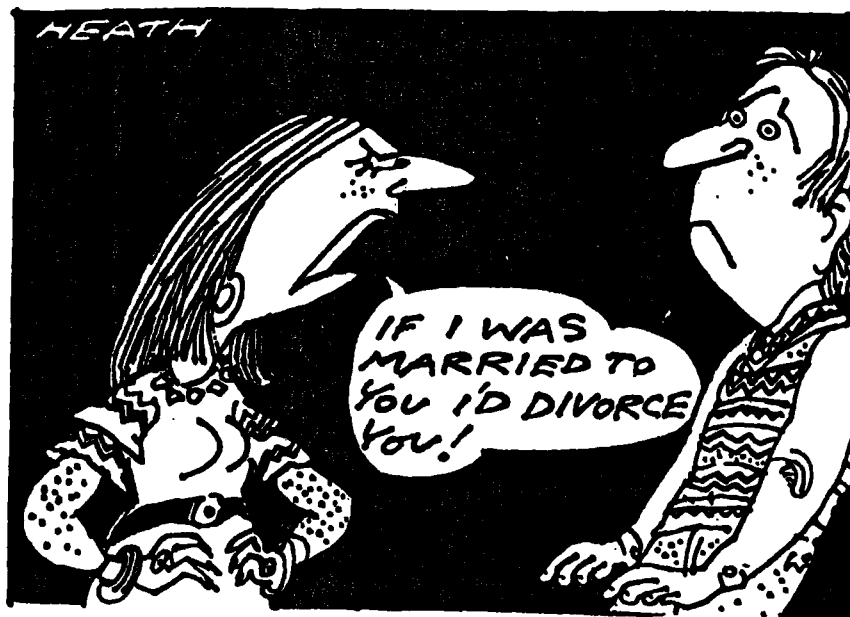
Mrs. Smith's Underdog

"I am scared to be on my own, I have no way to earn a living. I don't know how to cope."

Topdog v Underdog = cognitive dissonance. If the state of discomfort becomes disturbing enough, Mrs. Smith might:

- a) continue to worry, subject herself to stress, perhaps turn to valium, or excess eating, smoking, or heavy drinking, for comfort
- b) murder her husband and collect his insurance
- c) consult a marriage guidance counsellor
- d) look at ways of changing her own behaviour so that she either tackles her husband directly about the way he treats her, or finds ways to cope effectively.

She has many other choices, of course, but she may stay stuck because she is unaware of them.



Consider our Harry Edward Orr from Chapter Four, who of course is a character based on a composite of real HEOs, all of whom were among the key tutors, and were interviewed frequently. I have attempted to interweave my contact with "Harry" through all of the above steps, to present a relevant case history in which I was the change agent with an actual client.

I have known him as such for almost four years. In November, 1984, I had a "post-final" interview with him, showed him the outline for this chapter, and distilled some of his reactions, which will be included at the end of this section.

Harry had been teaching people about good health practices, using slides, posters, pamphlets and overhead projectors to supplement his lectures. He felt competent at working that way, but he didn't really enjoy it because he and his students were bored. Now, along came the change agents, (myself, Martin Evans, Ina Simmet, Linda Wright and others) and we said "Oh, Harry, what do you think about this other way of teaching, called student-centred learning methods?"

#### Harry One

"Looks good, people are involved, might be more effective, more fun! I've been feeling bored and frustrated because my old methods don't work."

#### Harry Two

"Help! I don't know how to do that! I might look foolish!"

Harry One plus Harry Two = Cognitive and affective dissonance. Harry wanted to move, feared to change, and was stuck as to how to proceed. (The change agent can help, as I hope to demonstrate.)

Cognitive dissonance, then, can produce a degree of discomfort,

ranging from mild to extreme. It can produce rage, frustration, or a sense of being stuck. Most people do not like feeling uncomfortable for very long, so the discomfort can create motivation for change.

To go back to Harry, in fact his discomfort did grow as he was increasingly exposed to new learning methods.

Looking back through the data I collected, I found an interview from October 1982, when Harry talked to me about Harry One and Harry Two, i.e. his respect for the new methods and his lack of confidence to try them. In Harry's case, he was strongly motivated not to disregard what he was learning; the motivation in his case came from a healthy desire to grow and change in his job. Harry is basically a health-orientated person anyway, but also we see again the reflexive nature of health education; Harry knew that stagnation was unhealthy for him and chose to move on, just as he chose good food and exercise, and chose not to smoke. He was consulting me as to what to do about the conflict he was experiencing.

### B. Establishing Trust

The counsellor, teacher or other change agent is the partner in the building of trust; the client is involved through agreeing that they will work together in the first place, through self-disclosure, and through a growing awareness of the assumptions and ground rules that are operating.

The client realizes that nothing is being done to him, that he always has options available to him. He can come, go, start, stop, talk, or be silent, he is at all times encouraged to be responsible for his own actions. The change agent exemplifies the ground rules by all of her behaviour. She is open in her manner, and makes appropriate

disclosures about herself; i.e. not sharing intimate secrets, but perhaps describing a time when she had similar feelings, or perhaps sharing general information about her own family, friends, or life style. She displays integrity by maintaining confidentiality, keeping agreements, and by telling the truth as she sees it in the present moment, to the best of her human ability.

This last factor is so important in teaching that I want to sidetrack long enough to emphasize it. I would assert that some of the discipline problems that teachers suffer in schools (and that parents encounter at home) come from attempts on the part of the adult to cover up or distort the truth. Children are acutely sensitive to lies and evasion, and they are perceptive about identifying the "ring of truth" when they hear it. If they think they are being lied to they may lose respect for the adult. This can lead to an attitude of "Why should I do what she tells me? She's a liar."

Time and again I have experienced the phenomenon of telling the truth about what I am feeling and thinking at the moment, and being met with increased openness and evident respect on the part of the student or client; if I try to cover up I usually find myself in some kind of trouble, perhaps with a block in communication.

So, with Harry Edward Orr, I encouraged him to discuss his lack of confidence, I listened to his problems as he began to try out the new ideas. I accepted his conflict about whether or not he wanted to make radical changes. I told him the truth as I saw it, and through counselling helped him to discover that his lack of confidence was an old myth about himself, carried over from his childhood, and that in his present roles of HEO, father, husband and adult, it only served as an excuse for not changing.

Let me emphasize that I did this at an appropriate time, i.e.

at a time when a relationship of mutual trust and respect had developed and where the ground rules were firmly established. It seems there is an upward spiral here, and that the more the two, (client and change agent) trust each other the more they can tell the truth, and vice versa.

### C. Assessment of the Situation

"... wherever you want to go you have no choice but to start from where you are."

(Popper, in Magee, 1973, p. 103)

This statement captures the existential views embodied in client-centred work. Perhaps a list of what this sort of change agent does not do will help to clarify the way in which she helps a client take stock of where he is.

She does not

- ask for a case history
- probe, ask searching questions
- analyse verbal communication
- impose ideas or advice
- ask "why?"
- praise, blame, or criticize

The client is encouraged to unfold his own story, to take stock of the situation by describing it. He will, of course, be selecting all the time what he chooses to tell. The process of disclosure operates so that the client is learning more about himself.

"What is essential is not that the therapist learn something about the patient and teach it to him, but that the therapist teach the patient how to learn about himself. This involves him becoming directly aware of how, as a living organism, he does indeed function." (Perls et al., 1951, p. 41)

What the counsellor is doing meanwhile is listening, reflecting, noticing, observing, and experiencing the unfolding story along with the

client, in an atmosphere of acceptance.

Q.: How many humanistic therapists does it take to change a light bulb?

A.: None. We accept him as he is.

Much of the counsellor's experiencing is done on an intuitive level, and is fed back to the client.

" ... there is a respite from ordinary social pressures, and the customary penalties for misbehaviour are humanly withheld. As the experiment of therapy proceeds, the patient dares more and more to be himself. He voices the statement that elsewhere he could only think, and he thinks the thought that elsewhere he could not acknowledge even to himself." (op. cit., p. 39)

This powerful passage describes the environment of safety that I work to create with each client, however long that may take; sometimes I wonder how we managed to create a social climate in which people have to 'dare' to be themselves. (A point to explore another time .... )

So, how did this safety factor work with our Harry?

Harry knew from his past meetings with me that I would not laugh at him or criticize him; I asked him if I could be there at his first DCM course, and he said yes, knowing I would not be judging him. Having watched and listened as he led the session, I later asked him to tell me what he noticed about it (Interview, February 1983). He said he was feeling low and discouraged.

Harry felt that he had talked too much and yet missed out some information that was important. I did not ask him why he did that; as mentioned earlier, asking why produces rationalizations, defences, and explanations. Instead, I asked him what he would do differently next time. He told me that he would divide them into small groups and help them to find the information themselves and then pool it, as he had seen us do on the training course. He had several other ideas about how he could run the session better the

next day. Realising that he himself could come up with these creative solutions helped to raise his confidence.

I commented that he had only reported negative observations about himself, as he frequently did, and asked him if he had noticed anything positive about his leadership.

"Yes", said Harry, "I got them to laugh, they seemed to enjoy the day."

In helping Harry take stock of the situation, I was working to extend the framework of his own awareness, and build up his confidence.

Part of the approach involves supporting the client in facing important or sensitive issues, not avoiding or running away from them. Four major strategies assist us in confronting present issues:

a) staying in the Here and Now

No case histories are necessary, as we are looking for the client's experience at the present moment.

In an interview with Harry, (November, 1984) he told me in some detail that his grandmother always used to find fault with him, and he could trace his tendency to see himself negatively back to that relationship. I did not ask Harry why she behaved that way. I asked him, "How do you experience that kind of criticism now?"

Which brings us to:

b) asking the right questions

If I had asked why his grandmother was so critical, I would have been directing Harry back into the past to look for rational explanations, at a stage in his life when he was relatively powerless to deal with his grandmother.



Instead, my question enabled him to stay in the present, where he is potentially capable of handling the relationship.

c) observing and exploring non-verbal behaviour

I try very hard not to analyse or interpret non-verbal signals; if I interpret them, then they are no longer available for the client to investigate. If, while talking about his grandmother, Harry was clenching his fist, I would not say "Aha! You clench your fist, you would like to hit your grandmother!", nor would I say: "Why are you clenching your fist?". I do not want an explanation which would sidetrack us. I would ask Harry to exaggerate the movement, and then to tell me what he would like to do with his fist. (If he were pounding his knee with his fist, I would ask him to pound a cushion instead; self-injury is not in the contract.) We would probably find Harry experiencing some of his old anger for the criticizing grandparent.

d) Accepting, exaggerating

Any feeling which Harry experiences at the time is acceptable, (remember Perls' words about thinking the unthinkable thought). A frequently used method is to exaggerate the feeling, allow it to be as intense as possible. This allows the client to work through to a feeling of completion, in a supportive environment. Harry can complete his unfinished business with his grandmother by experiencing his anger fully.

#### D. Resistance

There comes a point in each therapeutic or learning process in which the client will acknowledge his own resistance to change. So, in becoming aware of her behaviour, the single woman may have learned: "Oh, I see. I don't go anywhere where I could meet single men because I decide in advance that they won't like me, then I don't have to risk being hurt." Or Mrs. Smith might find out she has been delaying doing anything about her marriage, not only because she was afraid to be alone, but also because she liked having a large house and two cars. Usually there will be a reward, a payoff for staying stuck in the conflict, and that payoff is present and immediate, and so more powerful than the desire to change.

In the February, 1983 interview, Harry's discovery of his own resistance was quite dramatic; an excerpt:

DB: So how is it that I see you as this confident, jokey, easy-going sort of person, and you see yourself as timid and hesitant?

Harry: (Sitting up in his chair and grinning)

Because if I let anyone see how confident I really am, I'll have to take risks and do things. I'd have to stop being lazy and get off my bottom ...

Harry went on to describe the payoff he got from being passive and not initiating new ideas at work; his boss didn't allow him to start new projects because he acted as if he couldn't handle them. This enabled Harry to spend his days doing what he felt like doing, and not having to be committed to anything.

DB: So, what's wrong with that? Sounds pretty pleasant and easy.

Harry: Well, I don't really like myself much when I do that -

I feel lazy and I know I'm not doing my best.

DB: What would you be giving up if you chose to change that behaviour?

Harry: My easy life. But I won't be able to get away with it now that I've seen what I'm doing. I won't let myself!

Here we see another example of the interweaving of the seven steps: Harry's new awareness or insight about himself has resulted in increased motivation to grow and to adopt new behaviour. Harry's choice to give up his resistance was based on self awareness, and his new awareness included an insight about his own forms of resistance.

#### E. Awareness

Awareness is one of the primary rewards for which client and change agent are working together, and is both a stage in itself, and a continuous thread running through the relationship.

" ... Our strategy for developing self-awareness is to extend in every direction the areas of present awareness. To do this, we must bring to your attention parts of your experience which you would prefer to stay away from and not accept as your own. Gradually there will emerge whole systems of blockages which constitute your accustomed strategy of resistance to awareness. When you are able to recognize them in your behaviour, we shall turn to direct concentration on them in their specific forms and attempt to re-channel the energy with which these blockages are charged into the constructive functioning of your organism." (Perls et al., 1951, pp. 114-15).

The reader is asked to notice in the above extract the words: " ... when you are able to recognize ... ". The client is involved in a joint learning experience with the counsellor. All the time the awareness is being extended and developed, all the time the client is receiving non-directive support from the counsellor, and together they are working for that recognition, that awareness.

Again responsibility is part of the process; the client is expected and assumed to take responsibility for his own awareness or lack of it, and his own resistance and motivation.

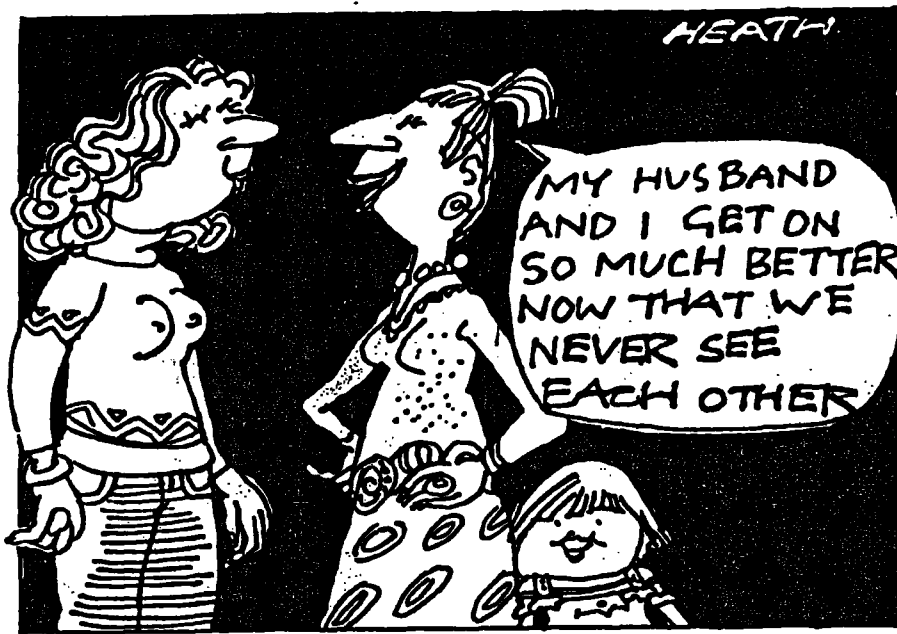
An important relevant concept is the Perlsian notion of figure/ground.

" ... 'Figure' is the focus of interest - an object, pattern, etc. - with 'ground' the setting or context. The interplay between figure and ground is dynamic, for the same ground may, with differing interests and shifts of attention, give rise to different figures ... "  
(op. cit., p. 51)

An example: each day I walk up through my little garden to my front door. The garden exists as a blur of green along the path, my focus is on the door, or I am looking through my ring of keys for the right one. But today a flash of white catches my attention, and I focus on a white rose which I hadn't noticed before. It is the figure standing out from the green background. Another time the flash of white might be a piece of paper blown in through the fence, and I may focus on it to pick it up.

The single woman in the pub might have been aware only of a communal blur near the bar, the men fading into a background of smoke and noise, and she might have avoided or resisted looking that way. If she heard someone calling her name she might turn round and see one figure emerge from the blur, as she recognized a new male colleague from her office.

Mrs. Smith might have gone for many months or years "making the best" of her married life.



Then one evening, perhaps, her husband took her to an office party where he ignored her completely and spoke only to an elderly vice-president of the company. She had thought that she was quite accustomed to that sort of treatment, but that evening suddenly it became the focus of her awareness, she felt devalued, and angry. She began to think about how she could get out of her present situation.

(Here again, motivation, awareness, and responsibility are all interwoven.)

Ever since I met Harry, he had told me that the reason he seldom did anything new at work was because his boss was old-fashioned and reactionary. So Harry was not taking responsibility, but attributing his own static position to his boss. After the interview when Harry became aware of his own desire to grow, he no longer blamed his boss. He began to suggest ways in which they could try out some new ideas in their unit. He sounded more confident and more determined; to his surprise, his boss encouraged him to run a Drinking Choices course with another HEO.

The position of being stuck had been reinforced both by Harry and by his boss; perhaps the boss was not quite so reactionary as Harry thought, but lacked confidence in Harry because of his past behaviour. But also, if Harry perceived his boss as the cause of the problem, he probably treated the boss differently than he did after he took responsibility for himself.

That incident highlights another factor which I find attractive about client-centred work: the unpredictability of what can transpire when I have no investment other than to support the client in changing as he wants to. Perhaps I could have told Harry at the beginning that his boss was not responsible for Harry's own impasse. I could have saved a lot of time that way ... perhaps. But coming from me it would have had much less impact than it had when Harry discovered it himself. So the work stayed unpredictable, neither of us knew what would happen, and I followed Harry as he worked his way through to his own insight. This unpredictability is an active moving force in therapy or in any change process; Perls, Hefferline and Goodman call it "creative precommitment" (1951, p. 44), that is being committed to movement, but without determining the direction in advance, being interested in and aware of the possibilities that are available in any direction. To the extent that the therapist is committed to following the client without trying to influence him, to that extent the potential for change is not being limited or delineated from outside the client. In terms of the reward for me as change agent, this means that the relationship with a client is fresh each time, full of surprises, never boring:

"In our experience, most good therapy is  
centred on assisting the patient to break  
through a series of impasses ... "  
(The Gouldings, 1979, p. 6)

I never know where the next breakthrough will lead us. Since one of the aims of working as a change agent in this way is to increase the client's ability to support and look after himself, then any attempt on my part to give advice, pave the way or remove the possibility of frustration, would be to defeat the aims. Giving advice, in my experience, usually results in my own frustration, as the client might accept it and then blame me if it proves to be wrong, or praise me and keep coming back for more if it turns out to be right. Or he might ignore it, or refuse it entirely, which is not beneficial to our relationship; he could get into feeling rebellious, or disrespectful, or dependent.

In Gestalt counselling or therapy one of the traditional methods is 'two-chair work', or 'the empty chair', which describes a dialogue between the client and whoever, or whatever, he needs to contact more clearly. So our Mrs. Smith might in her imagination put her husband on the empty chair and talk to him. The physical mechanics of the exercise involve using a real empty chair, with the client seated facing it. Mrs. Smith, talking to her husband, might tell him how she was feeling about him and their marriage. She would then sit in the empty chair, "be" her husband and voice his feelings about the marriage. It is fascinating to watch this "switch", and to notice how Mrs. Smith might take on the characteristics of her husband, assume his mannerisms of speech and posture. The aim of the dialogue is to achieve clarity and insight, and to add another perspective.

In the case of the single woman, the dialogue might be between her 'topdog' and 'underdog', and the aim would be for her to become aware of how she sabotages herself.

With Harry, we never sat down with the two chairs and explored

his problem with his boss using Gestalt therapy. We did talk at length, many times, and at one point I asked him a "two-chair-type" question: "What would you like to say to your boss that you haven't said already?" Harry gave one answer at our first interview: "I'd tell him to retire". And another answer at a later date: "I'd ask him to let me take more responsibility". And still another when I saw him recently: "I've changed jobs, I can't blame my boss any more, I've got to improve the job myself."

#### F. Problem Solving

Like illuminative evaluation, problem solving with a client is a formative process. Throughout the relationship we are gathering awareness and information, using what we have learned to increase our ability to move forward more effectively.

Like Popper, I regard living as

"... first and foremost a process of problem solving ... which calls for the bold propounding of trial solutions which are then subjected to criticism and error-elimination ... " (1973, p. 74)

To put this more succinctly, the essential question which I like to ask any client or student about his behaviour is:

"Does it work for you?"

and what I mean by that is,

"Does it achieve what you really want?"

If the answer is no, then we can try a different solution, a different way of behaving, which we can discover together. If the answer is yes, then my ground rules say I will accept that answer, although I can always comment on it, and we can explore it further, if either of us is not entirely comfortable with it.

So, having joined with the client in identifying his motivation to change;



having established some degree of trust between us; having together assessed the situation as it is now; making sure that the client is ready to "own" the problem, i.e., take responsibility for it; having become aware of resistances and how to deal with them, and both of us having reached a degree of awareness about the client's feelings and behaviour; we are ready to look at alternatives together. Again please notice that all of the above does not take place in any particular order, and that all the way along it is the client who feels, or does not feel, complete for the present time, and ready to move on.

"The client's 'problem' may be resolved through the choices made. The goal for the therapist, however, is the educated awareness of the client as to what the client is doing, how it is being done, and any life patterns that may emerge from these awarenesses. Conscious awareness facilitates choice by enabling the individual to be what he or she is, without trying to be what he or she is not." (Van Der Riet et al., 1980, p. 79)

### Analogy

The framework of change within which we work as counsellor and client could be compared to the skeleton of a building constructed with steel girders. The structure is strong and well put-together; the doors and windows, floors, walls and ceilings, are in pre-determined places. There are many different ways, within the structure, to reach the top floor - the client's satisfaction or feeling of completion. If that is where he wants to go, it is fairly predictable that he will get there, but the route is unknown. He could spend the rest of his life exploring the building and end up with the realization that there is more to know about than he could ever know. Or he could spend weeks and months on the ground floor and learn so much that he could take a lift

directly to the top. Or, he could learn how to explore, how to deal with problem-solving, and how to map out a route, and then he could go wherever he pleases in the building, up and down, back and forth. His choices are limited by his own imagination and creativity, and by the structure itself: of course, he could find the way out of the building as well. One could perceive the change agent as the scaffolding which upholds the framework until the client is ready to dispense with that support. Change, like houses, needs to be built from the bottom up and cannot be imposed from the top like a roof on a house that has no foundation or walls.

#### G. Contracts

My own particular blend of Gestalt and other learning methods leads me to the use of the word "contract", (which may smack of Behaviourism to some people, but which for me is a way of establishing ground rules and agreements).

At the close of a session, (interview, class, or lecture) I like to have an agreement with the client(s) about the way forward which has just been chosen. We both then have a feeling of continuity, trust and clarity, and agreed purpose. If it is the last meeting then I would want us both to have a feeling of closure, of completion, but also a contract about the direction in which the client is intending to move for the moment. The two factors, completion and contract, can provide a unique synthesis of satisfaction for now and optimism for the future, an optimism which does not say "Everything is going to be perfect now", but which says "I am going to take a risk and see if it works, if not, I know how to re-solve the problem."

Interview, November 1, 1984

At my suggestion, Harry and I met for lunch, to celebrate his new job as HEO in a different district. I asked him if, and how, he thought he had changed over the past three years.

Harry: I feel much more confident. I am free to express opinions and make suggestions, and those don't have to be perfect or high-powered. My teaching is less academic, and people listen and also join in. In Health Education we often over-sell our expertise, then the clients keep calling us back to do it again, when what we want is for them to develop their own expertise. Now I have the confidence to sit back and say little, but take an interest in what they say and do. I now have more insight into myself, so I am able to listen, and want to hear what they say. The reward is that they like themselves and also me. I don't worry any more about people and what they might throw at me, I am prepared for anything. Now I can accept and value both positive and negative feedback.

Harry said a lot more, and I had many pages of notes. One comment he made seemed to me especially quoteworthy:

"I'm not nervous any more, and I don't use any formula for my teaching. When I used to be nervous, I looked anxious, and people used to worry about what they could say without upsetting me; you don't disagree with someone who's anxious."

Harry felt that a manifestation of his confidence was that now people felt free to disagree with him.

Harry emphasized throughout the interview that he felt he had changed both professionally and personally as a direct result of his involvement with the Drinking Choices Project, and that he felt very positive about the changes.

#### Progress Report

Of the three clients mentioned so far, Ms. Single Woman has stopped coming for counselling, joined Dateline, and is going out with a solicitor. Mrs. Smith is still coming for counselling, has

chosen to stay with her husband, and is bringing him (almost willingly on his part) to every third counselling session.

Harry is still going strong; seeing me from time to time, and being very active at work. He described his current work activities to me as follows:

Five DCM courses planned for the near future

Training tutors for Look After Yourself courses

Work with nurses - find out their needs and wants, plan courses for them on Health Education

Teach on the Health Education Certificate Course

and many other routine activities of his unit, such as planning meetings, staff meetings, lectures, work in schools and hospitals.

#### Everyday Stumbling Blocks

Of course progress is not always achieved in easy stages; with individuals and with groups obstacles do appear. In this section I will identify some of the more common everyday sorts of negativity and obstacles which oppose the seven steps to change; later we will look at some blocks on a much larger scale.

In my experience in working with individuals using client-centred methods, we can usually proceed fairly smoothly through the seven interrelated stages; the truth is we usually do, because resistance, being the major obstacle, is an expected and healthy part of the process. Together the counsellor and client are a force which can deal with some of the objects in the path. Since resistance is viewed as a necessary step in the process of change, and enables us to look at the payoffs involved in staying stuck, it is not regarded as a deterrent.

Of course, circumstances can change, clients leave, move house,

go into hospital, fall in love, change their minds about changing their lives, decide that they do not like looking at themselves, or that they do not like the counsellor. They can stop at any time, and sometimes do so long before they reach a feeling of completion or resolution.

In addition to these circumstantial sidetracks, each of the seven stages has an opposite, or polarity, and it is these negative factors which get in the way of progress. These polarities can belong either to the counsellor or client, student or teacher, organisation or change agent - or to the relationship itself.

### Polarities

#### Positive Steps

1. motivation  
(cognitive dissonance)

#### Possible Dangers

energy loss  
indifference  
apathy  
being stuck  
payoffs  
helplessness  
complacency  
adaptation  
dynamic conservatism etc.

2. establishing trust

cynicism  
duplicity  
competition  
sarcasm  
manipulation  
defensiveness  
secretiveness etc.

3. assessment

predetermined ideas, legends,  
myths  
ignoring new factors  
reaction rather than  
pro-action  
indoctrination  
fear  
denial etc.

4. resistance

depression  
apathy  
pretense  
lack of responsibility or  
blame  
"it doesn't really matter"  
payoffs etc.

5. awareness

lack of awareness  
blindness  
repression  
nose-to-the-grindstone  
looking for short-term  
solutions  
habit etc.

6. problem solving

powerlessness  
tunnel vision  
lack of imagination  
linear (not lateral) thinking  
build on errors, enshrine  
ineffective practice  
previous investment in  
outcomes etc.

7. contract

unreliability  
failure to keep agreements  
hidden agendas  
unrevealed clauses  
duplicity etc.

Any of these blocks may appear in a relationship in which the aims involve change of behaviour or attitude. When they appear, they become the short-term focus of the work, and so long as the client stays willing to proceed with the relationship, they can be recognised and dealt with; in other words, a mini-process involving the same steps will develop, with the new block as its central issue.

Once again I would like to emphasize that the seven steps do not occur in any particular order, but are overlapping, and are often experienced simultaneously.

How Trends of the '80s relate to DCM

In Chapter VIII I discussed in great detail the ways in which

the DCM project proved its own success; there is another way to look at the project, which I think may further illuminate the basic reasons for success. John Naisbitt, an American researcher/consultant based in Washington, who acts as an adviser to large corporations such as American Telephone and Telegraph, General Electric, Richfield Oil, and also to the White House, though some may doubt that this constitutes a recommendation; he has recently analysed the predominating content of the US media, and identified some major trends and concerns of the 1980s. They are the topics which take up the most space in newspaper columns and on television and radio. His book, "Megatrends" outlines ten of these trends, and explores their implications. I have selected a few which seem relevant to this project, in this country, at this time. (I have underlined key words):

- Although we continue to think we live in an industrial society, we have in fact changed to an economy based on the creation and distribution of information.
- We are moving in the dual directions of high tech/high touch, matching each new technology with a compensatory human response.
- In cities and states, in small organizations and subdivisions, we have rediscovered the ability to act innovatively and to achieve results - from the bottom up.
- We are shifting from institutional help to more self-reliance in all aspects of our lives.
- We are giving up our dependence on hierarchical structures in favour of informal networks. (1984, pp. 1-2)

Let us see how some of these trends relate to our project.

### Networks

The group of HEOs that was first trained in September, 1981, went through the steps though not in order. At the point where they themselves, or perhaps 13 out of the 17 of them, had assimilated the steps and had begun to be able to use them, they stopped being a

group and became a network, as they went back to their own HE units to begin setting up DCM courses. They were performing at various levels of competence and confidence, and several of them chose to work with me beside them or with another HEO beside them, for their first experience as group leaders. A definition of network (which I have long used but forgotten the source) is: "A network is an organisation such that any point in it can be the centre". Thus, any HEO could initiate a DCM course, and they did, and they came back to the former group to share what they had learned and to pool ideas for moving ahead.

Q.: How many HEO's does it take to change  
a light bulb?

A.: Fifteen. One to screw in the light bulb  
and fourteen to share the experience.

The networking principle was also welcomed by the HEOs, as they had previously felt isolated in their individual units. They frequently stated that one of the best things about DCM was that they were working across district boundaries with people on their own level within the structure of the health service and that they were now in contact with people with whom they could work in partnership, by solving problems and making plans. As Naisbitt points out:

"The vertical to horizontal power shift that networks bring about will be enormously liberating for individuals. Hierarchies promote moving up and getting ahead, producing stress, tension, and anxiety. Networking empowers the individual, and people in networks tend to nurture one another.

In the network environment, rewards come by empowering others, not by climbing over them.

If you work in a hierarchy, you may not want to climb to its top. At a time when decentralist and networking values are becoming more accepted and when business must do the hard work of reconceptualizing what business they are really in while facing unprecedented foreign competition, it is not the ideal time to be a traditional-type leader, either political or corporate." (1984, p. 204)



Now that I look back on it, I see the Pyramid model as containing networks at Levels I, II and III, and perhaps even four. The following are a few examples.

Level I: The HEOs initially formed a network as described earlier, which included the various members of the Beamish I course. Later the network expanded to include HEOs and other professionals from Beamish II, and also various combinations of people from I and II.

Level II: Another network exists which now includes NECA, social workers, nurses, probation officers, and other professionals who were trained by HEOs. They keep each other informed of developments in the region which are relevant to alcohol education.

Level III: The social worker who started the informal alcohol team in S. Tyneside initiated a network which had him at the centre, but he soon moved to the outskirts of the network as he turned the responsibility over to other people.

Level IV: In the case of the young offenders in Northumberland, lads from the two DCM courses began to see each other outside of the probation office setting; they seemed to share some common interests!

Other networks exist which inter-connect the four levels; or perhaps it would be more useful to look at the pyramid now as one big network.

### High-Touch

The group work methods in DCM were accepted relatively easily by the course members and especially by the HEOs, and I would suggest that this is because of the trend towards what Naisbitt calls

"high-touch", that is, the need to be in close contact with other human beings, in an age of technological leaps. HEOs were aware that the MSC has asked for YTS and TVEI courses to be taught using participatory methods, one of the aims of which is to improve the sense of responsibility and self-worth of the young people. They also knew that group work is currently gaining popularity in schools and colleges. In other words, they knew they were part of a trend, though they might not have known about the "high-tech"--"high-touch" principle.

#### Self-Reliance and Information

Another trend working in favour of DCM relates to the message behind the project: that each person is responsible for her own health, and that we hope to provide information and education, not to take over, for instance, a person's choices about drinking. This is congruent with client-centred methods, as we have mentioned many times before, and according to Naisbitt, is also part of a major trend towards self reliance. Naisbitt was referring to the US, in which 100 million Americans now exercise regularly, smoking has decreased drastically in the past two decades, and people have reduced their fat intake and switched from hard liquor to wine. The same trend is observable here in Britain, where we can see health food shops in evidence, even in small villages, slimming clubs and magazines are abundant, people of all ages wear track suits and running shoes, and professional people often come out of their offices to go jogging.

DCM's authors/planners were aware of these trends though they did not label them in Naisbitt's terms; they added impetus to the progress and success of the project.

## Avoiding the Right-Wrong Trap

At the start of any new training course I usually say to the group:

"I am going to start off with you the way I would with any other group, that is by getting to know you, finding out what you need and want, and working with you in relation to your own agenda. I also would say the same thing to any individual with whom I intended to establish a working relationship."

I often meet with some degree of disbelief. Teachers tend to think that the methods will work with them, but not with students. Students tend to think vice versa. Midwives often accept that it has worked for them on their course, but can think of 22 reasons why it won't work with their clients. I have found that they remain sceptical until they try the methods themselves, by slow degrees, with their own clients, after which they often congratulate themselves for making the methods work.

Two questions (at least) arise out of this observation:

- a) Why are people so doubtful about the widespread effectiveness of the methods?
- b) Why do the methods, in fact, seem to work with most groups?

The answer to the first question, to my way of thinking, is that people want to be right. If I come along with a new method and demonstrate that it works, then in order to accept that, your mind has to reject some old ideas, and thus to admit that you have been doing something wrong all these years. Or so many people usually react.

"What the mind does to survive is to try to keep itself intact, replay the same tapes, prove itself right. That becomes now the purpose of the mind: to survive by again and again proving itself right ... the mind begins to do all it can to avoid dealing with the new material. It runs away from the training data the way you and I run from a burning building, and for the same reason: SURVIVAL!"

(Rhinehart, 1976, p. 172)

This wanting to be right is another form of resistance. One way to deal with this resistance is to use it, to turn it to good advantage by exploring its payoffs and comparing it to other possible ways of behaving. Another way is to avoid the whole concept of right/wrong, success/failure. My approach when working with teachers, or HEOs, for instance, is: "There are many different ways of encouraging learning. Perhaps you haven't heard of this one that I'm offering, and you might like to explore it, it belongs on a continuum of

traditional	_____	student-centred
didactic		participatory

methods of teaching, and you can place yourself anywhere on that continuum once you see what is comfortable for you, and once you are familiar with the whole range of methods. While it is true that I myself belong on the far right edge of that particular continuum, I know that not everyone is comfortable there. But until you are familiar with the whole range, you cannot make an informed choice."

The answer to the second question above has also been mentioned previously. The reason client-centred methods can work for most people is because they ARE client-centred. They are tailored and progressively re-tailored to the needs of any individual or group, and can be expanded to suit exam syllabi, state-dictated curricula, or exotic and unusual problems, say, in a marriage or family. This is where the combined imaginations of counsellor and client, leader and group, or, as we shall soon be arguing, manager and organisation are harnessed together, so that the possibilities for lateral thinking and unusual solutions are exponentially increased.

#### Leadership v. Charisma

In addition to the above indication that DCM was riding along on

the currents, rather than fighting its way upstream, I would still contend that an important factor in its success was effective leadership at many different levels.

One aspect of the leadership was that we provided what Nisbet (1974, p. 1) calls

"three significant requirements for successful change ... support services, the involvement of (HEOs) in the process of change, and the provision for evaluation."

In fact, in DCM the support and involvement were combined with the evaluation, by the use of follow-up days, repeated visits, informal interviews; in short, formative evaluation.

A criticism which is sometimes aimed at a project like this one is that it was implemented by a charismatic leader, and so cannot be replicated. Sitting here at my typewriter I have been thinking again about charisma; I have discussed this issue earlier in the thesis. One of the most powerful teachers I have ever met is Dorothy Heathcote, who is internationally known for her work in Drama and Education. She is tough, dynamic, and exceptionally charismatic, and one of the problems students on her course usually encounter is the impossibility of trying to be like her. Some of her students have been known to imitate her Yorkshire accent, sit as she sits, talk to children as she does; they usually fail. As they become more confident in themselves, and as they internalize the student-centred methods, they stop trying to imitate Dorothy, and start using their own creativity and leadership skills. I am saying that charisma is born out of confidence and enjoyment, and it can be nurtured, and can even be learned through extensive involvement with the methods I have been describing in this chapter.

People have told me at many different times, and at all four

levels of the pyramid, that they have benefitted from the excellent client-centred leadership provided on the DCM courses. The positive results and spin-offs also add to this evidence. So I would contend that the success we experienced was due in part to effective leadership on the part of course leaders; the steering committee, and I include myself here, along with the academic supervisor; and the HEOs themselves, and not to any single charismatic leader.

### Filling a Gap in the Literature

As a consultant with experience in education and industry, I have long been acquainted with Organizational Development (OD) theory; I like it because, by definition, it is ...

" at once a conceptual framework and a strategy aimed at helping organizations to become self-correcting, self-renewing systems of people who are receptive to evidence that change is required and able to respond with innovative, integrated programs and arrangements ... " (Schmuck et al., 1977, p. 3)

and therefore it is client-centred. I have found the work of Schmuck and his colleagues useful in my work in schools. I also have a nodding acquaintance with the work of Lewin, and his force-fields concept, and am on limited speaking terms with systems theory.

"Illuminative evaluation falls within the general definition of a 'systems' approach. Thus it is holistic in outlook ... concerned with the entire network of inter-relationships ... "

(Parlett, undated, p.1)

I have met the debates in the literature on organizational change, and have tried to absorb the inter-active reflections of the theorists as they respond to one another's ideas with approval or disagreement. This is a body of literature rich in technical language and studded

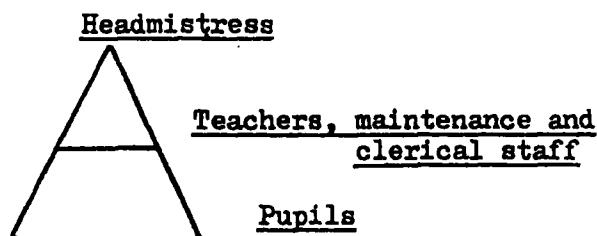
with diagrams, and it is a large body with many branches, as well.

But I have not found a basic layperson's guide aimed at an audience of non-specialists, which tells, in familiar terms, how to proceed with innovation. Again, such a guide would not make a layperson qualified to be an OD consultant, but it could make the processes clearer. So in the following section I will attempt to construct the bare bones of such a guide for client-centred innovators.

"The OD consultant does not impose solutions but instead brings to bear his or her knowledge about human interaction and the processes of change for the purposes of helping a group to identify its own circumstances, determine its own goals, and select the innovations its own members wish to implement.  
(Schmuck et al., 1977, p. 3)

#### An Example of Change in a Single School

Schools are complex organisations, with complicated pyramids built of departments, houses, and various levels of teaching staff and other workers. Even a small school is not a simple organization, but it is an example of a single pyramid. The small school where I used to teach in California, had three hundred pupils in twelve classrooms, aged 5-11, and had a pyramid like this contained within its walls:



Of course the school did not stand isolated in its own playground, it also fitted into a much larger structure of: LEA, Santa Clara County, the State of California, and on up to John F. Kennedy

in Camelot.

I was a classroom teacher when a new headmistress came to our school and began, quite methodically, to change the way it was working. She held a staff meeting and told us that she had some new ideas, and was counting on enlisting our cooperation. She asked us to describe the school, and how it worked, and tell her about the things we liked and didn't like (assessment). This was not a school in a state of crisis, and as Nisbet says, (1974, p. 3)

"... the school which is well placed to try out a new idea is one in which there are already existing good channels of communication ... and the capacity to bring problems out into the open."

Our school would have fitted that description, so the headmistress was not faced with as many problems of innovation as she might have been in a less positive climate.

She instituted a new kind of staff meeting; it was structured along client-centred lines; we took turns chairing it, and the chairperson for the week collected items for the agenda. We kept strictly to time limits. We had a chance to air resentments and share appreciations. (establishing trust) The headmistress kept a fairly low profile except when it was her turn to run the meeting; however, she did insist on some changes in policy. For instance, corporal punishment was abolished completely, and all punishment avoided as much as possible; she persistently explained her reasons for this policy. (explaining ground rules)

A student council was formed, and students participated, with the help of a staff consultant, in developing responsibilities and rights of students. (problem solving at all levels)

The atmosphere in the school began to change for the better. Discipline problems decreased; academic improvement was not formally



measured, but was reported by teachers; teachers expressed loyalty to the headmistress and to colleagues; meetings were interesting and for the most part free of conflict. We learned to listen to each other. Problem solving structures were used in staff meetings and in classrooms, and even the appearance of the school improved; less vandalism, less litter, kids were planting vegetable gardens and growing flowers. These changes happened over a 3 year period before I moved to a high school.

This is an example of change in a single pyramid organization, initiated by a single person, but where participation was encouraged on all levels. Again, because this is a section of a chapter, and not a book in itself, I have simplified a complex process.

The Drinking Choices pyramid was a more complex organization and the set, or group, of all HEOs in the Northeast of England was not really a visible organization at all. There is an issue here about implementing change, using the same methods, but having to initiate movements on a much larger scale.

Indivi- duals	Loose network (HEOs)	Tight single organization (a school, a course, a therapy group)	Unstructured organi- zation (all HEOs in NE)	Quango (HEC)	Govern- ment or Political Party
X	X	X			

In the figure above, the X's signify organizations where one person can have considerable impact in initiating change. In the more complex systems, one person can still act, but they would either have to have enormous power, or would have to be enlisting support and creating a team effort.

Top-down innovation does not always work very well, because there may be resistance to ideas imposed from above, and because the people at the top are often not well enough informed about the conditions at the ground level. The initial campaign on alcohol education in the Northeast is an example of this, where the media campaign was started by the HEC, using a non-local advertising company, and without consulting the ground forces, i.e. NECA and the HEOs, to see whether they could handle the response. They were not able to deal with the great demand for services, and the campaign was assessed by the HEOs as a failure.

In the case of the California school which I described, the innovation began with one person, but her first step was to involve everyone concerned, at every level, and she broke down the traditional hierarchy to create a combined effort.

A Bottom-up scheme for introducing change is exciting, because ordinary people are demonstrating that they care about an issue, that they are not apathetic. But there is always the danger of the big hammer of power crashing down from above, stopping the action and leaving people feeling defeated, crushed, and powerless. I remember an incident in a different school in California, where 200 students, in a supposedly democratically-run school, staged a sit-in, protesting over a small issue: they wanted some vending machines installed for cokes and snacks, using Student Council funds. They sat down on the grass after lunch, and refused to come in to class. The Principal raged around through the crowd for a bit, ordering them to move, and when they didn't, he set up a public address system and threatened them all with suspension if they weren't in class in three minutes. Looking ashamed, and probably imagining what their parents would do if they were suspended, they stood up and straggled

back to class, joining their less courageous friends who had not attempted the sit-in. The big hammer strikes again!

In a paper on in-service training, David Settle, Director of INSET for Birmingham wrote:

"Past evidence indicates that where change is introduced without the support of the classroom teacher it may flourish momentarily based on the personal credibility of the initiators but there will be no sustained integration into normal practice ... The message for me is clear. As long as learners, whether they be teachers within INSET or pupils in classrooms, remain as mere receivers of someone else's view of what they need to know, to become, to be, then the outcomes will be limited to that which is visible today: teachers with a dwindling commitment to their work and pupils who cannot wait to rid themselves of school, taking with them the bare remnants of 11 years learning which for them had no explained purpose and in which they had no say, either in what was to be learned or how the learning would take place."

I would take David Settle's theme one step further; I agree that the support of the teachers is needed if innovation is to succeed, but it will have an even better chance to flourish if support comes from all levels of the system, including, and sometimes especially the students, or clients of the system. If lines of communication for assessment, problem solving, planning, implementation and evaluation included everyone, and if the system were client-centred, it would be a network, and it would start from where the students are now in terms of their needs and wishes being taken into account. As with any network, the centre would sometimes be occupied by some other group in the system, e.g. if the parents had a certain initiative in mind, or if the community had a particular problem to resolve.

A bottom-up model of change is sensitive to the needs of the majority of the people involved, the clients, or workers on the ground level of the usual sort of pyramid. It has the advantage of

gleaning ideas from a wide variety of different angles, and therefore decision can be based on much more informed thinking. Naisbitt says that there is a trend in this direction in America:

"The failure of centralized, top-down solutions has been accompanied by a huge upsurge in grassroots political activity everywhere in the United States. Some 20 million Americans are now organized around issues of local concern." (1984, p. 113)

However, the two major weaknesses of a bottom-up model are the lack of resources and the lack of power; power to prevent intervention from above, and power to carry out executive decisions, to make things happen, and to overcome resistance. Zimbardo et al. put it this way:

"Resistance to change in a social, political or economic system is the analogue of resistance to persuasion in the individual - multiplied by a hard-head factor of  $10^{10}$  ... " (1977, p. 195)

A strictly top-down model has the advantage of executive power and greater resources behind it, and this ought not to be underestimated no matter how enthusiastic or optimistic we innovators might be. Later in the chapter we will explore some of the major obstacles which can arise in the process of mobilizing initiative in the face of that power at the top. But the top-down model does have major weaknesses too, in that it is insensitive to the needs, demands, and ideas of the people who will be most affected by the change. In fact Naisbitt claims that initiatives which are taken

"by the state or neighbourhood in the absence of an effective top-down solution ... have staying power ..... are resistant to top-down intervention and become models for others still grappling with the problems." (1984, p. 112)

There are many other arguments in both directions in the literature, and this theme is of crucial importance to people working in the field of alcohol abuse. The present strategies in that field

are tending towards a combined model,  $\downarrow \uparrow$  . An example would be the forum to be held by Alcohol Concern, the national voluntary agency on alcohol misuse. The forum is scheduled for January, 1985, and invitations have been issued to people known to be, or expected to be, interested in the alcohol issue. The newsletter advertising the event states:

#### F I R S T   F O R U M

Kenneth Clarke, Minister for Health, will address Alcohol Concern's First Forum. This will be an important occasion which will present an opportunity for members to learn at first hand about the Government's thinking on alcohol-related matters. Even more importantly, perhaps, members will be able to say to the Minister what they think the Government should be doing.

The rest of the Forum will also enable members to express their views about the kinds of policies which Alcohol Concern should develop. Each of the formal sessions will be followed by group discussions when members can address particular problems and issues of concern to them. A record of the proceedings will be kept so that account can be taken of the views expressed in the continuing process of policy development.

(Nov. 1984)

I have underlined phrases which indicate to me that this is a model aimed at many levels of change agents.

Consider the following model, where the seven steps used in counselling individuals are applied to larger organizations:

#### INDIVIDUALS

Motivation: An individual decides that he wants to change or improve some aspects of his life, or realizes that something is not working: he experiences cognitive dissonance, wanting to change, but being stuck.

#### ORGANIZATIONS

Someone in an organization decides that change is necessary, that the systems being employed do not work, i.e., do not work to the organization's net advantage, in terms of cost effectiveness, morale, good health, productivity, working conditions, positive energy or spirit.

Establishing trust: a partnership is established in which both parties are open, value each other, and act with integrity, keeping their agreements and working together.

The person wanting to institute change can work to establish trust, open communication, partnership, at all levels of the organization. Networks in which responsibility is shared can be established to replace rigid hierarchies; people can be valued and consulted at every level, as a start. Not everyone will want to be consulted, especially at first, this has to be acceptable as well; people can opt out or in.

Assessment: the change agent does not come in to criticise and enforce change, he encourages the client to take stock, to see WHAT is happening, not why, and to look at the stuckness, to see what solutions have been tried unsuccessfully. Change agent listens, is not critical.

Change agents can get feedback from all parts of an organization, can ask members to take stock of what is happening now, what is not working, what solutions have been tried in the past. Change agent is not critical, is looking for the most divergent feedback.

Resistance: Counsellor helps client look at the rewards for staying stuck, discover what the resistance is doing for him. Resistance is accepted and valued.

Change agent helps the organization see what it is getting from the status quo, from not changing. Blame, criticism and praise are avoided, resistance is used as part of the process. People are less likely to stay stuck when they see others participating in movement.

Awareness: Throughout the steps of the process, awareness is being increased, client and counsellor see and learn more each time they refocus their attention. Figures emerge and stand out from the background.

Focussing on areas of the organization where problems are noticed, figures emerge from the background, people learn, notice and discover, become more conscious of their environment, and of their own behaviour within it.

Problem-solving: Counsellor and client use their imaginations and lateral thinking, change the solutions, find alternative behaviour to try out.

People in networks throughout the organization can use their pooled ideas and extended imaginations to come up with new solutions, new ways of

behaving. Worker participation promotes change at all levels. Lateral thinking is exponentially increased.

Contract: Client and counsellor agree on small, manageable steps forward, to be reassessed and revised if necessary.

Agreement is reached as to which new solutions will be tried. Everyone participates in re-focussing and revision. Change occurs in small, manageable steps which are open to continual evaluation by all concerned.

Like Watzlawick and his colleagues, in the statement below, my experience leads me to take a risk and suggest that my system could work on a larger scale, in large organizations, and even in governments.

"Looking at larger social systems, we find as common problems impasses, escalations, and grand programs that are structurally identical to those encountered in the more personal areas of human life ...

On the other hand, it should not be assumed beforehand that our approach will be impossibly difficult to apply to large systems just because they have posed great difficulties to other approaches - especially if these approaches were of the same problem-engendering nature as the ones we have studied in the preceding chapters. The only reliable basis for judging the value of a method remains the result achieved by its application.

(1974, pp. 158-9)

#### Finding Allies, Creating New Networks

The models I have outlined above are meant to demonstrate that the seven step process designed for individual change can be adapted for use in complex organizations, and that when the organization is very large it will take time and many innovators to make it work. My experience has shown me that within almost any system I can find people who think as I do, and who only need some agreement, encouragement and support, as they are already motivated to make changes.

"Even in a hierarchy, there is an informal network within the formal structure. Find it. For some people, it is worth the effort to locate and work only in a network-style environment. Outside of work, this is the time to start your own network or join one and get connected with like-minded people.

Today we live in a world of overlapping networks, not just a constellation of networks but a galaxy of networking constellations." (Naisbitt, 1984, pp. 204-5)

As I have travelled about I have worked in many different settings; so far, I have always been able to find allies, other people who shared my humanistic ideas. Allies are the first components of a network. The more widely spread throughout the organizational structure, the more effective your alliance may be. If there are some allies available at the top, they can help to prevent the hammer effect by seeing that new ideas receive resources and approval, and time to prove themselves won't premature evaluations so that they can be put into practice. The allies on the ground level and middle level are equally crucial, so that the people who do the work are involved in the planning and design for innovation. The people at ground level need to be consulted and involved and are in a good position to assess how the organization really functions in terms of job satisfaction, effective or dysfunctional systems, flexibility or rigidity. Furthermore, if they are consulted they tend to feel valued, rather than ignored and imposed upon. The assessment stage, leading to the awareness stage, ought to operate at all levels of the organization for maximum feedback.

The new organization, according to Naisbitt, will be

"rooted in informality and equality; its communication style will be lateral, diagonal, and bottom-up; and its structure will be cross-disciplinary."

(1984, p. 198)



### Fitting the Culture

The new system or innovation should be designed to fit the culture of the existing institution.

"Anyone who has spent time with any variety of organizations, or worked in more than two or three, will have been struck by the differing atmospheres, the differing ways of doing things, the differing levels of energy, of individual freedom, of kinds of personality. For organizations are as different and varied as the nations and societies of the world. They have differing cultures - sets of values and norms and beliefs - reflected in different structures and systems. And the cultures are affected by the events of the past and by the climate of the present, by the technology of the type of work, by their aims and the kind of people that work in them ...

... modern theories of organization are increasingly persuaded of the wisdom of the appropriate, of the match of people to systems, to task and environment, of inter-relations between all four, of what has come to be called the systems approach to management theory. This is a word sufficiently vague to cover all manner of specific approaches but it tends to connote inter-relationships, feedback mechanisms, and appropriateness of fit. (Handy, 1976, p. 177)

"The wisdom of the appropriate" is a very appealing phrase to me; it embodies, once again, the principle of the client-centred approach; the way to find out what is appropriate in the way of innovation is to ask the people who will use it. I had to learn to operate within the culture of the HEO, not against it, and therefore I had to become familiar with it and understand it at the start of the project.

### Quality Circles

A new concept in industry is the quality circle,

"... a small group of about ten workers doing similar work, who meet to discuss work-related problems." (Naisbitt, 1984, p. 201)

Communication of new ideas and decisions filters up from the bottom rather than the other way around. This same method could be applied

in the health service, social work, education, and politics.

A social worker who is a friend of mine told me today that in her organization the following sequence of events occurred:

1. a team leader, interested in setting himself up for promotion (note, initial motivation) by drawing the attention of top management to a project of his. He is genuinely interested in improving the practice in Child Care, wanting to look at ways of preventing so many children from coming into Care.
2. He talked to like-minded colleagues, from several other area teams.
3. People heard about this beginning of a network, and wanted to be part of it, so that it now includes people from the five surrounding areas.
4. He wrote to the local Deputy Director of Social Services; and briefly sketched out for him the area of work the group wanted to look at, and asked for his approval (avoiding the local hammer). He gave his blessing, and encouraged them to go ahead, and to produce a report for him.

So, they have gone through

1. Motivation and assessment
2. Finding allies
3. Networking at the "bottom"
4. Seeking approval from the top (locally)
5. Setting up communications ↓↑ in both directions

Next they will have to find a way to gain acceptance from a wide number of people at the bottom, so that their ideas will not go from them, to the top, and come back down as instructions from above.

### The Big Black Swan

Obviously, I have been using the preceding sections to build a case for a top-down-bottom-up combined model for change, and I will be describing how an expanded community based plan for action to prevent alcohol abuse, could be mapped out, using such a model. It will be set in a context of optimism and my own previous experience with the

success of such operations. But first, in Popperian manner, I will attempt to refute the possibility of such a plan.

In Chapter VII we explored some of the obstacles that we met in DCM; but these obstacles did not really include the more compelling issues of power which follow.

### Major Obstacles

#### Overshadowing Issues

For myself, and for some others with whom I have discussed this chapter while writing it, the alcohol abuse problem in this country is severe, but not as threatening as other grave issues such as:

- A) nuclear war, nuclear energy
- B) terrorism and war
- C) social inequalities
- D) unemployment
- E) industrial action
- F) presently incurable diseases, such as Cancer and Aids

While alcohol abuse costs the country vast sums, it is not, for most people, in the same worrying category as the problems mentioned above, and pressure groups do not have the same degree of fear pushing behind their efforts.

### Apathy and Cynicism

Because of the enormity of problems such as those listed above, some people develop attitudes which say:

Why should I care, everything's in a mess anyway?

or

I'm helpless against all those overwhelming pressures

or

No one up there cares about me, so why should I bother about anyone else?

or

Eat, drink and be merry, because there won't be any tomorrow anyway.

## Power v. Change

As Zimbardo et al. have said:

"Every change in one part of a system creates a reaction in another section. Even when you know how to produce a desired effect ... there is one more obstacle to overcome before principles of change become policy-power. When new ideas are transplanted into policy, they invariably are opposed because change is threatening." (1977, p. 193)

Thus political controversy and resistance can cause paralysis of movement. Even when an innovation is initially encouraged from above, a change of power/control can cause the hammer to fall. As Naisbitt says:

"power that is bestowed from the top down can be withdrawn if the donor's priorities change." (1984, p. 112)

## The Force of Tradition and Dynamic Conservatism

Tradition can be heartwarming and can bring people closer together; I think of the American holiday of Thanksgiving, a time to visit the family and celebrate or experience a spiritual uplift, without the tinsel and commercialism of Christmas.

But tradition can also equal inertia. The deep-rooted traditions of heavy drinking, for instance which we mentioned in Chapter Two, can be of such specific use to people that they would be extremely difficult to change. In fact, we change agents would be wise to ask ourselves what we have to offer which is preferable to the release, the companionship or the temporary oblivion found at the pub.

People sometimes fight to keep things the same because it costs less financially, involves less risk, and often entails less work. Often it seems that the young people are keener on change than the old, who have more to lose and are more entrenched. Each generation sees the young people wanting to change things anyway, partly just to be different from their parents, but also to sort out the injustices that they see in the old system. The optimal condition in which we would see a synthesis of the best of the old ways and the best of the new ideas is extremely difficult to achieve, partly because of the force of dynamic conservatism.

### Determined Optimism

These and many more forces, including the ones which bore down specifically on this project, as described in Chapter VII, are ever-present in our society. So, what stops us from turning into lemmings or sloths and just giving up the fight?

I am not intending to dismiss these horrific problems when I assert that each person has his own way of dealing with the nightmare issues; among many other ways, people can choose:

- religion
- optimism
- despair
- escape (including drinking)
- joining causes and pressure groups
- fatalism and hedonism
- working very hard at innovation

For myself, I choose what I call determined optimism; I do not want to live in an emotional state of cynicism or despair, so I work very hard to achieve what I consider to be worthwhile innovations, which address, on some small level, the major issues listed above. In fact, the more I am told, "it can't be done", the more I want to work at doing whatever "it" is at the moment. For me, and for many of my professional friends, the feeling is: there is nothing else to do but keep working.

An example of this attitude was the question of how my business, the Growth Centre Tyneside, got off the ground despite a script that went like this:

DB: I'm going to start a Growth Centre in Newcastle.  
Friends  
& Advisers: What's that?

DB: Well, a place where people come to do group work and counselling, and to be trained in how to do it, to promote personal growth and human potential.

F & A: You'll never get it off the ground.

DB: I think I can, there are successful ones in Chicago, California and other places.

F & A: Yes, but this is England. People here are much too busy getting on with living and working. They don't have time to contemplate their navels.

DB: I am already running groups all over the country, people actually do have time to work on their problems and explore their own possibilities.

F & A: Who will pay? Do you have any capital?

DB: I can buy a house, and then the clients will pay.

F & A: You'll never get it off the ground .....

DB: Watch me .....

The Growth Centre Tyneside operated successfully for seven years. Not a single neighbour ever objected to the noise we made, and we were granted planning permission to run the business in a residential neighbourhood. Over the years the business was financially and professionally successful: more than 30 social work students were sent there on placement for training in group work, and we enjoyed a nationally good reputation in the 'groupie' world as well.

I am not discounting the training and experience and skills behind our success, when I say that what made the difference was the pervading ethos of determined optimism; on a small scale, exactly the same sort of thing that keeps the Greenham women in their camps, singing in the rain and cold. Determined optimism is the inner certainty that we ordinary people can change the world, if we do not sit back and use cynicism and despair as our excuse for doing nothing.

### So, What Can We Do?

According to Parlett (unpublished, p. 13):

"New themes are added right up to the end of the study. Themes are not cast in permanent fashion, but remain 'interim' for as long as compatible with the requirement also to achieve closure and to complete the study."

In this month of November, 1984, I have re-interviewed six of the key people involved in the project: Jane Randell from HEC; Ina Simnett and Martin Evans, (two of the writers of the Manual); a DHEO and two HEOs. In looking at some of the new themes, I have asked them, and myself, the questions on which this chapter is based. The following plan is one answer to "What Can We Do?; or rather a composite of answers from the above people.

### A Multi-level Plan

In some Regional Health Authorities (such as Cambridgeshire, where Martin Evans is the newly appointed DHEO), there are bodies known as Joint Development Teams, comprised of NHS staff, social workers, educators, and representatives from other disciplines. This is standard procedure in community development work, as Hubley (1979, p. 2) points out:

"Problems are seen to be inter-related and not compartmentalised into the traditional boundaries of health, housing, education and social welfare agencies and workers from the different bodies are encouraged to work together. Any attempts to bring about change are fully based on the culture and beliefs of the community."

In Martin's district there is one team devoted to Health Promotion, which has eight action groups on separate topics such as:

smoking  
food and health  
accidents  
exercise  
alcohol

and  
young people  
the elderly  
the disadvantaged

All of these priority groups have equal status, and all have overlapping interests and widespread professional representation.

Martin Evans chairs the alcohol action group which includes

a psychiatric consultant from a clinic for  
problem drinkers

a social worker from the same clinic

clinical psychiatrists

Director of Cambridge Council on Alcoholism

a probation officer

a policeman

and more - a group which will act as a "think-tank".

They want to develop alcohol policies for industry, starting with the RHA, and carry on a major industrial alcohol education campaign, using DCM along with other tools.

They hope to have a researcher looking into community facilities for young people, and also into places in the area where there are an unusual number of drink-related accidents. For example, there is one pub where an inordinately large number of accidents happen at pub-closing time; a bus service has now been scheduled to pick up people at the pub at 11:00 p.m., an example of creative problem solving, but only one example among several dozen which Martin told me about. He said "You have to give away power to get it back"; (meaning that the more that responsibility is delegated, and spread within a network, the more powerful the whole group will be); with that slogan in mind, he has managed to recruit 150 people from the community into action groups in the past three months, people with varied skills who want to make a difference in the world.



Some of the other ideas which came out of the last six interviews, all aimed at a multi-level approach to a community problem, are listed below:

make links with the local news media, to call attention to the plans in an attempt to enlist support from the top

put alcohol on the agenda of higher level meetings

keep talking about it!

build structures which will help to create a centre of excellent practice, and which will facilitate community development

create more health education posts for lecturers in universities and colleges

(and many more ideas)

#### DCM<sup>100</sup>

An intensified and expanded DCM project could add impetus to a plan like the one above, and could apply the seven steps. DCM<sup>100</sup> would need to be designed as a multi-level model, and we would start to:

1. Find a network of allies in the region, who are interested and who are capable of determined optimism and lateral thinking. I would try to work quickly and make as concentrated an effort as possible, to do away with discouraging time-lags.
2. Establish motivation; understand what is driving me/us to do this: perhaps a mixture of altruism and ambition, a personal sense of responsibility coupled with a desire for fame, or, at least, recognition. Some people want to contribute to society, and to make a difference in the world.
3. Refine the group population by making sure that it contained:

- a. some people with drink problems
- b. some of the most active HEOs, social workers, etc.
- c. someone from HEC, and later hopefully someone from DHSS at a top level
- d. experienced group-trainers/counsellors.

Then, together

- 4. Devise a workable pilot scheme, with built-in formative evaluation, not attached to an academic degree, which would include some of the following components, and others which have not yet been thought of:

(The x's below indicate initiatives which are already being tried somewhere in the UK as results or as spin-offs from DCM; these are just the ones that we know about.)

ways of drawing money to the scheme

a strategy for convincing the government that alcohol problems are NOT cost-effective; in other words, that the costs of a heavy-drinking population are greater than the revenue from alcohol;

an advertising campaign on a much greater scale, which would include good, humorous, well-made films on alcohol education, for Television audiences

x - a large-scale training programme for counsellors of people with drinking problems, but starting with assertiveness training and intensive counselling for the original group so that they can effectively train others

x - a scheme to avoid the hammer effect, by finding someone at the Top, who would like to make her mark in the world by supporting this scheme

find ways to discourage drinking and driving, through education, and through pressure on all levels to initiate better legislation

find ways of making sure we had lots of publicity

x - create a post for one of the most dynamic members of the Think Tank group, so that there was a very effective person making sure that the plan went forward, e.g. an alcohol coordinator for the region, but with some money and pressure behind her/him

spend a minimum of time assessing the situation before we start, use the previously suppressed Braun

report and our own knowledge of the problems; keep on with assessment throughout the project.

- x - work on plans for alternative cheap forms of social activity for pubs and clubs, involve brewers and publicans
- x - use DCM much more intensively in schools, hospitals, colleges of education, FE, TVEI, YTS, social work training courses, police training courses, and keep going; reduce the time lag between planning a course and executing it; draw a PLANNED pyramid, so that we would know where the next courses were going to happen.
- x - convince off-licenses to promote non-alcoholic drinks in the same way that they now have 'specials' on wine and hard liquor and beer

give ourselves a concrete, achievable but optimistic goals, and assess our success by canvassing people for their reactions and by watching alcohol sales, numbers of people with known drinking problems, hospital statistics over five years

think of other effective ways of monitoring our success

- x - use the formative evaluation to learn from our mistakes, but immediately, not ten years later; and also use it to keep our optimism high

use the effective pilot scheme as a model for other regions

- x - continue using the model of regional and national courses for multi-disciplinary groups of professional and voluntary workers

"It is not enough for anyone with power, (whether in government or some lesser organization) to have policies, in the sense of aims and goals, however clearly formulated. These must also be the means for achieving them. If the means do not exist, they must be created: otherwise the goals, however good, will not be reached." (Popper, in Magee, 1973, p. 76)

DCM<sup>100</sup> would be about creating means to work towards improved awareness and knowledge, on the part of the public, about alcohol. The Joint Development Team is another model; they could work side by side, or be integrated together.

## The Power of Working Together: Political Skills

It does not seem likely that there could be an easy way to counteract the hammer effect, that is, the use of Power to squash an innovation which might threaten a precious status quo, either by legislation against it or by withholding resources. Certainly, by myself I do not have a ready strategy now. What I do have is a growing conviction based on experience of innovation and on increased familiarity with research regarding the initiation of change, that a multi-level team could find ways of warding off the hammer blows, or even enlisting the powerful forces onto our side. Rothschild argues:

"One needs to try the chance of collateral knowledge and ideas from a wide range of different sources being brought to bear on a problem with which this information and these ideas are not usually associated. This is the principal benefit one gets from discussing possibilities in a large group of persons." (1977, p. 108)

## What Ordinary People Can Do

One of the ideas behind DCM was that almost everyone can learn to be an alcohol educator. There are actions that an ordinary person can take on his own initiative:

- learn about himself
- learn about alcohol
- join pressure groups
- join in peaceful opposition to alcohol advertising  
e.g. in the cinema, on TV, or on billboards
- press for desired (by him) changes in legislation
- avoid drinking and driving
- look after himself and talk to family, friends  
and colleagues
- write to M.P.s, join in lobbying groups

## What We Take Away From DCM

I was feeling doubtful when I started on the last six interviews,

thinking that perhaps I had overestimated the impact of the project; in fact, I felt the need to focus in on what some of the key people were thinking about it all at six months' distance. Without any prompting from me, each one said the same sorts of things. They felt that they themselves had made changes which they would be sharing with other people, which would last, and which they would take with them to their new jobs and projects. Each one of them had already started new initiatives and were using what they had learned in DCM, and with positive effects, and in the world of alcohol education.

... "Having found a core of strength and sanity within, those who have learned to trust themselves are more comfortable about trusting each other."  
(Ferguson, 1982, p. 34)

That is what I think student-centred learning is about, and what I have seen happening within our pyramid, not to everyone, but to a goodly number who will spread what they have learned.

Certainly I have already taken what I have learned and applied it to my new job as an educational consultant in Birmingham, and with encouraging success even at the beginning. I will attempt to crystallize below some of the many things I learned:

What I brought with me to DCM

A crusader's zeal

Intuitive gifts plus intelligence

Membership in networks of teachers, therapists, friends

Rebelliousness and arrogance

Intensive experience in several fields

What I am Taking Away

Determined optimism

Increased objectivity

Reflection in practice

Additional networks of health educators, and other professionals, new friends

A degree of academic humility

Wider experience in more fields

Skills as therapist, teacher,  
facilitator

Additional skills as a  
researcher, pseudo-anthro-  
pologist, health educator

Biasses and judgements

Awareness of polarities,  
greater ability to under-  
stand the biasses and  
judgements of others

A language of extremes and  
exclamation points!

A language slightly more  
temperate and with a new  
technical vocabulary

Experience as an innovator

Reflection and deeper under-  
standing about how to  
make innovations happen

Two respectable degrees, a  
diploma, more than 1400  
hours of adult education  
courses, and three books  
published

Working for a PhD. from a  
respected University and  
a new book

A sense of humour

A more political awareness

- - - - -

The time for closure is finally here. As a farewell message,  
consider these lines from Zimbardo, et al., who have been friends to  
me throughout this report: (1977, p. 195)

"In drawing our journey together to a close we  
must be cautious about urging you to go out and change  
the world. Idealists, freedom-fighters, self-  
actualizers, liberationists, and revolutionaries are,  
under other attributional perspectives, mad dissidents,  
troublemakers, opportunists, and usurpers. To all  
would-be agents of social control, we say, Do not  
demand that we give you our children to live in a  
world of your design even if you can guarantee they  
will emerge as saints not sinners, specialists and  
not nobodies. The world should be of their design,  
too, their world even if created by their follies,  
fantasies, and foibles. They must choose rationally  
to follow life's paths, not be chosen randomly to play  
out someone else's script. Most crucial is our reali-  
zation that what you now ask to be given, you would  
take if and when you had enough power to do so. Our  
actions as agents of change must then be informed with  
knowledge, tempered with wisdom, and always infused  
with compassion.

- - - - -

There is a need to continue to validate and illuminate the message above. So that although this piece of research is finally complete, I will be wanting to use my new perspectives to look again, and to enable other people to understand and design their own worlds.

## THE PRINCESS AND THE SWAN

### A Cautionary Tale

Once upon a time, in a kingdom far away, (for these kingdoms always are, aren't they?) there lived a beautiful princess. Having little or less to do, since she was numbered among the long-term unemployed of the kingdom, she became very bored, and so she took to coping with her boredom by drinking vodka, secretly, in the garden. She then had to find strategies for coping with her drinking problem. The court physician told her that her values were getting cloudy, and that she should try exercising in the garden, but he forgot to tell her to leave the vodka bottle behind.

One day, when she was walking a bit unsteadily by the stream which trickled down through the garden to a lovely small moat by the castle, she thought she saw a black swan, swimming gracefully upon the mirrored surface of the moat. "Oh dear", she cried, "It is not my values that need clarifying it's my eyesight!" And she tottered back into the pyramid-shaped castle where her eccentric Egyptian Father was sitting with his courtiers, dabbling, as he was wont to do, in positive empiricism, which in those days was called alchemy.

"Popper, Popper!", she burbled, for that is how she burbled him, "I thought I saw a black swan in the garden, but can that be possible? I have always thought all swans were white."

"Aha!", chortled her father, for he dearly loved an



experiment after luncheon, "An opportunity to falsify a previously unassailable hypothesis! We will test it out immediately! Mind you, we may decide that because it is black, it cannot be a swan .... "

So he called for his servants and instructed them to go to the pool immediately, and bring back this alleged refutation. They all ran obediently out of the pyramid at Level 1, except for one not so humble servant who stood his ground declaring: "I'm not moving until the district reorganisation is complete. By this time next year, I might be out of a job!"

"You needn't wait till next year", retorted the King, and banished him forthwith.

Soon the loyal servants returned with the stately black bird, which they had indeed found swimming about the moat at the lower end of the stream, in serene majesty, but in considerable conflict with the other waterfowl over his political leanings.

The King looked him over. "I shall ignore the fact that you are dripping on my Turkish carpet", said the Monarch, "If you will tell me what those letters, DCM, emblazoned in gold upon your chest are supposed to indicate."

The Swan stood proudly and looked the King in the eye. He had an OHP under one very long arm, a training manual under the other, and in his hand, so to speak, the keys to an economical little red car with a hatchback, which stood outside in the courtyard.

Finally he spoke: "The letters stand for Democratic Cygnets' Movement, and I am on my way to a committee meeting just now. I was just having a little fitness-swim in your

moat. However, I can see that you need my help here first."

Looking disdainfully at the serried ranks of courtiers, he immediately organised them into a circle, and began doing a round of "The best thing that's happened to me this week."

The King was not too pleased, because in the past most of the wandering minstrels who arrived in his chambers had always given pleasant little one-off lectures, and demanded little in response. However, the Minstrel Swan assured him that he did not have to participate unless he wanted to, and invited the King to play Bumpety Bump Bump, a game which he had always particularly detested. Demurring, the King turned around, and was astonished to see his daughter run forward to embrace the swan. The Princess, who had read a few fairy tales herself in her time, gave him a resounding kiss on the beak, in the hopes that he would change into a handsome Prince, who would carry her away and change her social situation, thereby eliminating her alcohol problem along with her maidenhood.

Much to her dismay, the swan remained the same and opened his manual to begin the educative process which would almost certainly, (for nothing is ever certain in the Social Sciences) prevent the further abuse of alcohol in the kingdom.

"Wait just a minute", cried the Princess. "I just kissed you, and you are still a swan, and a black one at that. I thought you would turn into a handsome prince, and that hypothesis is based on a rigorous review of the literature!"

"Do not believe everything you read, my dear", the swan answered.

"But Popper said ... ", she protested.

"Anything that Popper said is open to refutation, lovely Princess", he replied logically. And he turned back to the group, who were patiently sitting, waiting to be told everything they needed to know, but little did they realise that they hadn't even established the ground rules yet!

The Princess, quite overwhelmed by this new concept, turned to her Popper and said, "Oh, Popper, isn't he wonderful?"

Her father, somewhat taken aback, was not sure whether to say something urbane and witty like "Well, my dear some of my best friends are swans but I wouldn't want my daughter to marry one ... ", or to launch into one of his favourite indignant diatribes on logical positivism, and so he stood musing for a moment. And then, in a flash of Illuminative Insight, he realised that here was a most interesting psychological phenomenon, Love at First Flight, and in a testable form, even.

And so he nodded wisely at his daughter, and said, "Well, I admit that the evidence indicates that he is wonderful, and if anything were able to refute that hypothesis, it would be marriage to you, my dear, and so I advise you to set your cap at him, because he would almost definitely be a feather in it, one way or another.

Of course we can only speculate, being social scientists, about whether or not they lived happily ever after. But then, as Popper pointed out, (Magoo, 1982), "A meaningful relationship must contain meaningless statements", (or words to that effect).

And so dear reader, since this is a cautionary tale, we  
offer the following moral:

Always remember,

A black swan in the courtyard is worth  
several thousand white ones swimming  
around on a moat.



## APPENDICES

## Glossary

AHA	Area Health Authority
CADET	Community Alcohol and Drug Education Team
CAT	Community Alcohol Team
CHC	Community Health Council
CMGR	Centre for Mass Communications Research
DC	Drinking Choices
DCM	Drinking Choices Manual
DCP	Drinking Choices Project
DHEO	District Health Education Officer
DESS	Department of Health and Social Security
DMO	District Medical Officer
HE	Health Education
HEC	Health Education Council
HEO	Health Education Officer
HEU	Health Education Unit
HP	Health Promotion
HPU	Health Promotion Unit
LAY	Look After Yourself
NHS	National Health Service
NTI	National Training Initiative
OD	Organisational Development
OHP	Overhead Projector
OHT	Overhead Transparency
PHT	Primary Health Team
QUANGO	Quasi-Independent Government Organisation
RHA	Regional Health Authority
RMO	Regional Medical Officer
TA	Transactional Analysis
TACADE	Teachers' Advisory Council for Alcohol and Drug Education
YTS	Youth Training Scheme

## Appendix Part One

The following section illustrates  
Transfer of Participatory Skills  
to other Topics

"Hello, Health Education?"

(Written by Martin Craig, HEO, Northumberland)

"We've got a group of fifteen kids and we'd like something about health - they've done money, the Police have been in and they've had the woman from the housing action group."

"We'd like something about drugs, V.D., smoking, sex, contraceptives, alcohol, glue sniffing and accidents at work - they have their coffee break at ten, so you could have them from half-ten to half-twelve."

"Maybe you could bring a film? Something to scare the pants off them."

"You're the bloke with the contraceptives? Better get in quick, there's a pair of them rolling about under a table in there!"

"If they shout you down, just do half-an-hour and let them go early."

"Quiet - shut up - now last week you were talking about sex, so we've brought Mr. Craig in - he's an expert ... "

Follow that one! Just a few of the more memorable requests and comments I heard during an eighteen month period of providing 'personal health' sessions for young people from YOP schemes, Community Industry, young offenders' establishments and youth groups. In this article I hope to describe how these sessions have evolved into participative 'health workshops'; how they can be expanded into useful projects, and to suggest how youth workers and training officers can tackle the problem of bringing in 'experts' to 'cover' complex and/or controversial areas of adult life.

There are 207 District Health Authorities in England, Wales and Northern Ireland. Out of these, roughly 180 Districts maintain working Health Education Units, employing in total approximately 420 full-time Health Education Officers. Local needs, population and geographical size all determine how departments operate; but most units will establish broad priorities within the Health Service, Education, Social Services, industry, Manpower Services and the voluntary sector. It is difficult to provide anything other than a superficial service if HEOs become involved in working with small numbers of the general public; for this reason much of our work involves in-service training for key workers, both professional and voluntary. For such training to be practical and useful, we need to know about the job these key workers do and the people they work with, particularly when young people are involved. So, when YOP leaders and youth workers began to ask for 'health' sessions for their trainees, I felt justified in agreeing, despite our normal policy of suggesting that in-service courses for the trainers would be more appropriate and cost-effective.

So began many visits to dusty rooms and disused schools, where I



would be introduced (against a background of hissing lighters and scraping matches) to small, suspicious groups of teenagers as:  
"the expert on health ..... "

1. FROM 'ONE-OFF HEALTH TALK' TO 'PERSONAL HEALTH WORKSHOP'

The following suggestions outline a framework within which young people can:

- a) Examine their own attitudes to issues of physical, mental and social health.
- b) Identify for themselves the main risks to personal health.
- c) Discover some links between health and how they live.
- d) Identify pressures on them to adopt certain ways of life - some harmful.
- e) Discuss and evolve strategies to cope with such pressures and to make personally appropriate 'health choices'.

As these aims imply, the approach must be PARTICIPATIVE. Young people have every right to 'switch off' if someone tries to tell them what is good and bad for them, however strong the evidence. A group of young people recently told me why I should carry on using the participative approach:

"So you can find out about this group"

"Find out what we know already"

"Give us a chance to tell you our opinions"

"Find out more about ourselves"

"Find out more about you"

"Break the ice ~ break down barriers"

"Give us a chance to show off a bit"

"Less boring somehow"

"If we already know what you're telling us, you might make a fool of yourself"

"Stops me dozing off - I don't like it!"

In my experience, the key issues of any aspect of health will be raised within a group during one session. Although an 'expert' could reel off these key issues in five minutes, the group would probably let them slip by without interest. When the group generate the issues, they will emerge as personally relevant and be valued by group members. I deliberately use the word 'issues' rather than 'facts'; because, like all other aspects of life, health affects and involves our feelings and relationships with others, and we need much more than 'knowledge of facts' in our personal survival kits.

## ACTIVITY TWO:

### GROUP IDENTIFY MAIN RISKS TO PERSONAL HEALTH

This activity cannot realistically examine all the potential risks to the health and well being of young people; it is presented in simplified form so that the exercise can be carried out without the presence of a health professional. It is also designed to link into activity three, where the group discover connections between health and lifestyle.

Resources: OHP/FLIPCHART/BOARD.

Method: Leader writes 'KILLERS'

Leader asks group to 'brainstorm' a list of 'things that kill most people in this country today'.

No discussion yet.

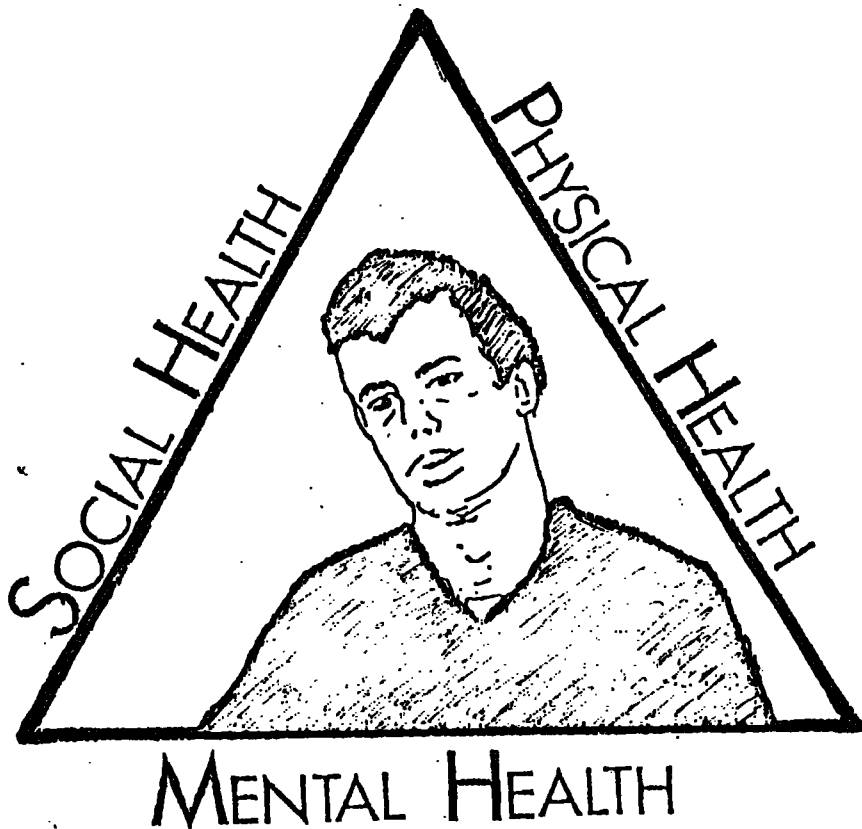
#### Two typical lists from groups:

1. 'Cancer' 'Bad Flu' 'Whooping Cough' 'Suicide'  
'Heart Disease' 'Accidents' 'Murder' 'Food Poisoning'  
'Chest Infections' 'Drugs' 'Alcoholism/drink' 'Polio'  
'Injuries at Work' 'Pneumonia'.
2. 'Kidney Disease' 'Cancer' 'Heart Attack' 'Drugs'  
'Car Crashes' 'Violence' 'Boredom' 'V.D.' 'Liver Disease'

Leader then asks group to 'rate' their list in terms of what they feel the 'top 3' killers are. At this point there is usually a lot of discussion and often an appeal to the group leader to adjudicate. The discussion will be more valuable if the leader directs such questions back into the group, " ..... can anyone answer that?" ..... "What do you think?" etc. At this stage the discussion is more important than accurate statistics.

When the group have voted for their 'top 3 killers' the leader can ask them how they would change their list to apply to their own age group, 15-19. In every case I have experienced, the group have correctly identified 'accidents' as the biggest threat to their lives at present. The group could discuss this: suggesting how, for example, becoming pregnant might affect a girl physically, mentally and socially.

The leader could ask "What happens if one side of the triangle is weak? If a person is depressed? If they find it hard to make friends?"



Leader concludes this activity by suggesting that all aspects of health can be considered in terms of

- (1) How they affect me physically
- (2) How I feel about them and how they affect my feelings
- (3) How they affect my relationships with other people.

Appendix, Part Two

The following section contains a model  
of an Industrial Alcohol Policy, and a  
proposal for a CADET team

An Example of an Industrial  
Alcohol Policy

Proposed Alcohol Policy for a large  
Company in the NE Region

ALCOHOL POLICY

Introduction

Why is it necessary:

There are two reasons why such a policy should be considered by this Company. Firstly, because of the alarming increase in the number of drinking offences in the Company. Secondly, that by the nature of the Company's business employees are exposed to greater risks of problem drinking than other industries and we therefore have a responsibility to help such employees. It must be clearly understood that the Company regard alcoholism as an illness in need of treatment and that this policy is designed to help employees who are ill.

Fundamentals:

This policy is two-fold with two very clear objectives in mind. Firstly to establish a clear policy on what happens to employees who are caught drinking or being under the influence of drink at work. Secondly, to establish a procedure to help employees who have committed no breach of discipline but who are suspected of having a drinking problem.

A. Drinking Offences:

The aim here is to gain acceptance of a disciplinary procedure on drinking offences. To achieve this it is essential to provide an alternative to disciplinary action for employees caught drinking. This alternative will be inclusion on the Company's alcohol recovery scheme details of which appear later in this paper.

The procedure would then be as follows:

An employee who is caught drinking or under the influence of drink will be interviewed by his Department Manager and a member of the Personnel Department (either a Personnel Officer or the Health and Safety Manager). The employee will be encouraged to seek professional help and the means of seeking this confidential help will be explained to the employee at this time. If the employee accepts that such help is required and to do this the employee must accept that he has a drink

problem, then disciplinary action will be suspended and they will take part in the alcohol recovery scheme. If the offer of such help is refused then disciplinary action will be taken. The action should take the form of a suspension and final warning for a first offence and dismissal for a subsequent offence. It is important to include here that if after accepting professional help we are informed by counsellors that in their opinion the employee does not have a drink problem or that the employee is failing to attend counselling sessions then disciplinary action may be taken. This is because the policy is designed to help employees who are ill through alcoholism and is not for the protection of employees who flaunt Company rules by drinking to excess on random occasions.

**B. Employees suspected of having a drinking problem:**

This is the more difficult area to deal with as the important question is who is involved. We must therefore define carefully which people we are concerned with under this part of the policy. This can best be defined as follows. 'These are employees who have committed no breach of discipline in the form of a drinking offence but whose Manager feels may have a drinking problem which is affecting job performance to such an extent that disciplinary action may be necessary'. Job performance includes such things as attendance and timekeeping.

**Identifying the Employees:**

We are not suggesting that Managers spend their time on an alcoholic hunt in the Department but it is important to pin-point employees early if a recovery is to be successful. The weakness in many Company policies is that the employee is often pin-pointed too late for treatment to have any effect which leaves dismissal as the only option. There are many ways of recognising the problem and possible signs are as follows:

- frequent lateness
- repeated short periods of absence
- proneness to accidents
- frequent changes in mood
- frequently borrowing money from colleagues
- poor job performance
- shaky hands
- bleary eyes and flushed complexion
- medical certificates for nervous disorders, dyspepsia, gastroenteritis, etc.

There are many ways of recognising the potential problem drinker

and our Managers would need training in this area. Many films are available which could be shown. It is important to say at this stage that our Managers are not qualified medically to brand an employee an alcoholic. Any approach to an employee with a suggestion of help must be made on the basis that the employee's unsatisfactory job performance is going to lead to future disciplinary action.

#### Interviewing the Employee:

Once a Manager has identified a 'problem employee' he should obtain details of the professional help available in this area. This information is available from the Personnel Department or Nurses and takes the form of a counselling service provided by 'The Dumbarton Council on Alcoholism', 92 Collage Way, Dumbarton. Counselling sessions take place on Tuesday, Wednesday and Thursday evenings from 7.00 p.m. to 9.00 p.m. This organisation are also in touch with Alcoholics Anonymous where they can be referred if the problem is very serious.

The Manager then speaks to the employee on the basis of unsatisfactory job performance and tries to ascertain whether a drinking problem exists. Here again a training need exists for our Managers in the art of counselling. If it is clear that drink is not the problem or the employee refuses to accept that a drinking problem exists then the normal disciplinary rules take over if necessary. If the employee accepts that he had a drinking then he can become part of the recovery scheme.

#### The Recovery Scheme:

Once an employee has accepted that he had a problem with drink he should be referred to the local Council for professional help. This referral is based on the understanding that:

- the treatment is on a confidential basis
- the employee whilst undergoing treatment is considered to be absent through sickness and receive Company sick benefits.
- the Company agrees that the employee's job will be available to him on completion of his treatment, unless it is mutually agreed that this will endanger the recovery
- no disciplinary action will be taken against the employee unless it is clear that the individual is incapable of responding to treatment or refuses advice and guidance offered by professional advisers.

#### Following Treatment:

Once in the opinion of professional advisers the employee has

fully recovered he should be allowed to return to work to his previous job. If there is any danger that this may affect continued recovery an alternative arrangement must be made. If it is clear to all concerned that it is undesirable for the employee to return to work in a whisky plant then an attempt should be made by the Company to find the employee work with another firm in the area. I am sure that many local firms if contacted would be sympathetic to this idea providing that the employee was in other ways satisfactory.

If after some time back at work an employee is found to have relapsed then it is obvious that they cannot continue to work in a whisky plant and should be dismissed. It may be felt in this type of case that an effort should be made to find alternative employment for the person concerned but the majority of Company schemes indicate that dismissal is normally the result of a relapse. The attitude being that the Company's responsibility had already been discharged.

#### Conclusion:

This is a discussion document on the problem of alcoholism in the Company which has been compiled with a knowledge of such schemes in existence in other firms. I feel the success of this policy rests on the retention of the two-fold approach, the acceptance of the policy as an alternative to disciplinary action and our acceptance that alcoholism is an illness and that we are trying to help sick people as opposed to protecting from disciplinary action those employees who drink at random.

It is also worth mentioning that without exception, other Company policies state clearly that this procedure applies to all employees from Directors to Toilet Cleaners and I feel the same rule must apply to our policy.

JNY/FM  
25th February, 1980.

Durham Area Health Authority  
Health Education Department.



Plan of Dr. Thorley's Proposed Alcohol  
and Drug Education Team (CADET)

Action Co-ordinating Group

Service Development at the District Health Authority/Local Authority level: the Community Alcohol (and Drug) Education Team (CADET).\*

In order to initiate some form of linked multi-disciplinary service for problem drinkers and the increasing problem of problem drug takers and solvent problems, District Health Authorities, in co-operation with Local Authorities, probation services and existing specialised non-statutory drug or alcohol agencies, should consider developing an inter-agency team; the Community Alcohol and Drug Education Team (CADET). Where developing community alcohol teams already exist, it may be very reasonable and logic to attempt to integrate a drug component within the Community Alcohol Team and so use the limited resources to cover alcohol, drugs, and solvent problems under one aegis. The principle of the CADET model is that it enables a very basic District level service to commence with a minimum of new resource being utilised.

The principle of a focus for a multidisciplinary team to deal with problem drinking was first advocated in the advisory report: the Pattern and Range of services for Problem Drinkers (the Kessel report) of 1978, page 20, paragraph 4.24. The more recent Advisory Council on the Misuse of Drugs Treatment and Rehabilitation Advisory document published in December 1982 and providing wide ranging service orientated advice with regard to problem drug takers, explicitly spells out a modified form of the CADET labelled as a District Drug Problem Team in appendix G, page 135.

Although there is technical knowledge which differs between the areas of alcohol, drugs and solvents, most of the advisory, educational, supportive and counselling skills that a team would require are exactly the same. It is unlikely therefore that authorities with modest but nevertheless significant prevalences of drug and solvent problems, would want to set up a separate team for drugs only, and therefore it is advisable that all these problem areas are subsumed into one team.

\* The CADET first proposed by Dr. A. Thorley in 1980.

The CADET operates only at the District Health Authority/Local Authority level. Its work and development is informed by the specialist members of the team, and the management of its member agencies, and if drugs are being considered the contribution of a district drug liaison or drug advisory committee, or sub committee of a joint care planning team.

The CADET acts as an advisory, supportive and educational body to non-specialist (often primary) health and social services personnel, as well as other non-specialist personnel in hospitals and hostel settings. It has a multi-agency constituency, and provides at least a 9.00 a.m. to 5.00 p.m., 5 day week service for professional and lay volunteer workers. The team is not seen of itself to be a specialist agency which receives all referrals for clinical care or client case work, but individual members may receive referrals on behalf of their base agencies, and work with their clients in a specialist capacity at their agencies.

The constituency of a CADET will vary from district to district but a notional viable team would be made up of specialist workers from various agencies as follows.

1. District Health Authority input:  
Medical sessions (consultant psychiatrist/other specialist/G.P.)  
Psychiatric nurse (community services) or hospital based with community interest  
Health visitor (possibly linked to a primary care health centre)  
District Health Education Officer sessions.
2. Social Services input:  
Social worker (with a special interest in alcohol and/or drug and solvent problems).  
This post should perhaps be at Level 3 or above so as to advise Social Services Departments regarding management, education and co-ordination of generic workers. This is the kind of post which it is suggested Local Authorities might consider setting up as their contribution to a social work response to problem drinking and drug taking.
3. Probation Service input:  
Probation Officer (identified by the probation service as an adviser and worker with a special interest in Alcohol/drugs within that service). Several probation authorities already are considering such a post.
4. Non-statutory input:  
Social Worker/community worker/residential care worker (from a non-statutory agency, e.g. Council on Alcoholism, Residential alcohol or drug project, day centre or counselling unit).

5. Lay Volunteer input:

A role for lay volunteers trained to counsel or man phones possibly linked to or part of a Local Council on Alcoholism, etc.

Such a team may have a geographical base (e.g. Social Services Area Team Office, local probation office, hospital clinic or unit, or non-statutory alcohol or drug project), but may merely exist through close telephone contact between agencies, but have an identifying address for administrative purposes. The team does not therefore require of itself a building or any other office resource other than already exists within the member agencies. This is because the team as outlined in its work, does not exist primarily as a clinical and case work resource but as an advisory, supportive and educational resource for other non-specialist agencies.

The development however, of specialist secondary services other than the team members acting from their own agencies, could, of course, place through a variety of planning structures, especially throughout funding, and local probation initiatives. It is hoped these statutory agencies would support initiatives made in non-statutory projects and agencies. The CADET therefore could be a useful source of work experience and advice which could best inform local planning initiatives for further specialist services.

Each member of the teams will themselves provide specialist treatment/rehabilitation for problem drinkers (and possibly problem drug takers and those with solvent problems) back within their own agencies. Thus, for instance, a CADET probation officer would give the team one or two sessions ( $\frac{1}{2}$  days) each week when he or she is on team duty. The rest of the time that probation officer would work in the probation office, utilising generic probation skills, but always have a special interest in alcohol, drugs and solvent problems within the probation service. That probation officer would therefore act as a specialist resource within the probation service to develop a more effective probation service response to his client group. Similar arrangements could be made for team members from other disciplines within their own agencies.

Once a CADET was constituted it would necessarily require to meet regularly to develop a policy which was acceptable to all agencies. Some teams might agree upon a team coordinator or even a team leader to which other team members would be answerable, but it is more likely that each team member would be directly answerable to his or her senior officer within the constituent agency management system. Such a model linking work between agencies necessarily requires all constituent agencies to work close together. Individual CADETs will differ as to how much inter-agency client management can be agreed upon.

CADET members themselves could meet weekly or monthly, to review policy and to evaluate the progress about the advisory and educational function of the team. These meetings may not be unlike Local Authority case conferences called upon specific clients or problems between agencies. Those conferences can exist to outline exactly where boundaries between various sorts of responsibility for the client or the service actually occurs. Meetings could monitor at a level of enquiry which clearly reflects the level of awareness amongst non-specialist professional workers about services, and the prevalence and service requirements of alcohol and drug problems in general. CADET team meetings can therefore pass this information back to the member agencies of the team, and other planning and support structures at the local authority and health authority level so as to inform a future planned response of further services.

CADET Members would probably find it useful to work together initially to provide a locally relevant resource pack. Such a pack could contain outlines of local services, telephone numbers and general educational material about alcohol, drugs and solvents. CADETs may also wish to organise short educational events to further support the skills and capacity of non-specialist workers. They could work with Local Authority training departments, and in conjunction with nurse courses, and post graduate medical educational centres. Such a resource pack should be seen as a developing and evolving resource and should be reviewed from time to time by members of the team. It should always be made freely available and widely distributed to specialist workers at times of contact from the team.

Dr. A. Thorley,  
Parkwood House Alcohol &  
Drug Problem Service.

April 7th, 1983.

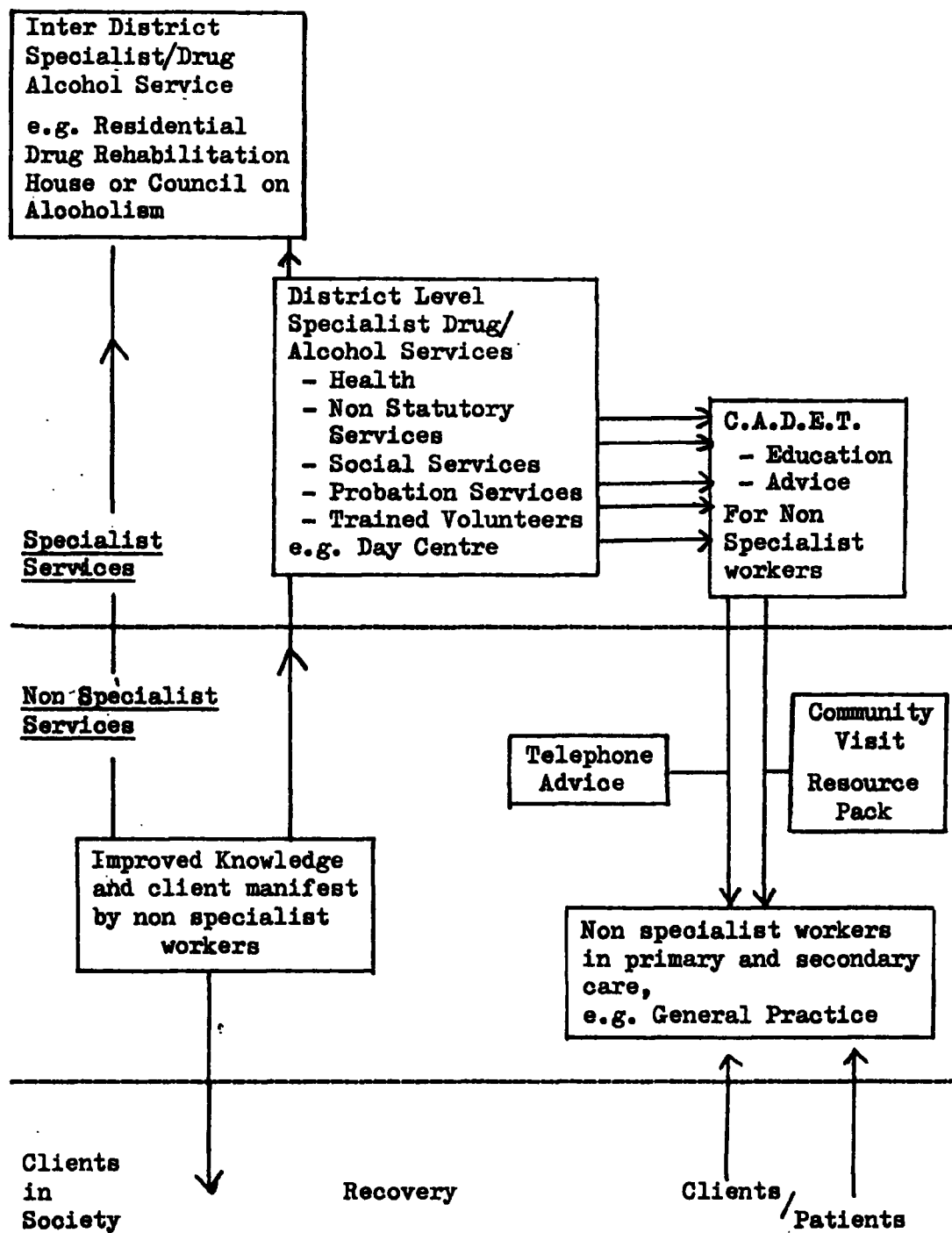


Fig. 2. Functional role of a Community Alcohol and Drug Education Team in relation to District Specialist and Non specialist services for Problem Drug-Takers and Drinkers.

Appendix, Part Three

In the following section there are selections  
from four of the Steering Committee reports;  
confidential passages have been removed.

## Health Education Council Research Project

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## HEALTH EDUCATION COUNCIL, ALCOHOL MODULE

### REPORT TO THE STEERING COMMITTEE

15th September, 1982

### INTRODUCTION

It has been one year since this project started. During that time, I attended the training course for the HEOs, interviewed all of the HEOs at least once, most of them twice; and also helped them organise and implement their module courses.

In April I began working full time at the University of Durham, under the supervision of Professor Frank Coffield. We have met at least once a week since April (excluding August). We have completed an outline of the eventual report and thesis, begun the review of the literature on research methodology, and discussed each section of the work.

The most important task, however, was to choose a methodology appropriate to the problem being tackled. There were two main reasons for rejecting the standard, "scientific" form of evaluation (involving pre- and post-tests). The first reason was practical in that training had started in September 1981 but the research involving Durham University had only begun in April 1982. The second was theoretical in that both Frank Coffield and I wanted to resist the pseudo-certainties of the statistical approach. Instead, a democratic or illuminative form of evaluation (see Walker, 1980;<sup>1</sup> Partlett, 1981<sup>2</sup>) was decided upon whereby all participants in the research are involved in a dialogue rather than being treated as research subjects. This methodology, which seeks to close the usual gap between researcher and researched in an atmosphere of mutual respect, was thought capable of tapping the sensitivities involved in both participatory learning and attitude and behaviour change in trainers and clients.

We have devised a system for choosing interviewees and for conducting and reporting on interviews. I have conducted about 30 interviews, both structured and informal, and these have been summarised. We have been working out ways of tackling problems that arise in the project and of processing and organising the basic data. A secretary, Mrs. Kathleen Meacham, has been assisting with the recording and filing of materials, working eight hours per week.

1 Walker, R. (1980) "The Conduct of Educational Case Studies: Ethics, Theory and Procedures". In Dockrell, W.B. & Hamilton, D. (Ed's), Rethinking Educational Research, London: Hodder & Stoughton.

2 Partlett, M. (1981) "Illuminative Evaluation". In Reason, P. & Rowan, J. (Ed's) Human Enquiry: A Sourcebook of New Paradigm Research, Chichester: John Wiley.

I have participated in the training of HEOs in using participatory learning methods and have facilitated the running of seven of the module courses. We have prepared reports on each of these courses, and interviewed the HEOs involved. Now I am starting on the next level of interviews, with people who have completed one course and are using the material professionally in some way.

These activities are described in slightly more detail in this report and this report also includes:

A review of the central issues emerging and constraints which are operating  
 Comments of HEOs and other course members on the weaknesses, and revisions and strengths of the module  
 Timetable  
 Financial Statement.

\* \* \* \* \*

STATE OF DEVELOPMENT OF THE PROJECT  
15th September, 1982

Alcohol Module Courses Completed

<u>Locality</u>	<u>Trainers</u>	<u>Course Members</u>	<u>Course Length</u>
Newcastle	Ian Fairfax Donna Brandes	Multi-Disciplinary (Organised by NECA)	10 evenings
Northumberland	Pauline Amos Martin Craig	Multi-Disciplinary	I. 5 days
		Multi-Disciplinary	II. 5 days
		YOPs trainees	4 days
S. Tyneside	Richard Day Donna Brandes	Multi-Disciplinary	I. 10 afternoons
		Multi-Disciplinary	II. 9 afternoons
Gateshead	Joan Armstrong John McCluskey Donna Brandes	Social Services	10 mornings
Cleveland	Val Abbas Anne Carter Maureen Storm	Multi-Disciplinary	5 days

Sunderland is now beginning a multi-disciplinary course to be run by Ray Duffel and Jim Robson, (although Jim is now working in N. Tyneside). This will be a course of 8 full days.

Durham has not been able to undertake a course due to reorganisation in the Health Service.

N. Tyneside is planning to start one now that there are two HEOs there.

S. Tyneside and Newcastle both have more courses planned for this autumn, as does Northumberland.



There have been enquiries from various parts of the country, including a recent one from Fyfe, about how to get started on the module.

Another course is planned for S.E. Northumberland in November.

Several others are in the pipeline.

Without exception, all of the trainer-HEOs listed above have been extremely co-operative about planning together, keeping notes, being interviewed after the completion of a course. No-one has ever refused me an interview, or in any way hindered the evaluation process.

#### Some of the Activities of the Facilitator/Evaluator

Starting in April, my supervisor, Professor Frank Coffield and I, began the complicated and rewarding process of collaborating on this project, getting to know each other, and establishing working methods between ourselves and our secretary, Mrs. Meacham.

We first established a schedule of weekly meetings, which are recorded either in our own notes or in Mrs. Meacham's minutes. At these meetings we engage in any of the following activities:

- review progress
- plan ahead
- read about and discuss methodological issues
- discuss my role at the University
- tighten the research design
- process material gathered from interviews and course reports
- choose criteria for choice of interviewees
- plan for publication of interim articles
- tackle problems arising in the research or the project.

In addition to these meetings, since April I have:

- (1) Facilitated two training days for HEOs in the Northern Region
- (2) Established contacts and created rapport with:
  - HEOs and AHEOs
  - Trainers and trainees on courses
  - Alcoholics Anonymous
  - North East Council on Alcoholism
  - etc.
- (3) Visited alcohol clinics in US.
- (4) Developed a reading list which, of course, is continuously growing
- (5) Begun the initial chapter on evaluation for the dissertation, which will include a review of the literature
- (6) Helped with the revision of parts of the module
- (7) Almost completed an article on Group Work Skills in Participatory Learning, for publication soon
- (8) Facilitated along with HEOs seven module courses, and written reports on these (approx. 65 sessions)

- (9) Consulted with and advised HEDs who ask for help
- (10) Kept track of the manuals
- (11) Completed 27 interviews, transcribed and processed these
- (12) Travelled approximately 1500 miles.

\* \* \* \* \*

### SOME CENTRAL ISSUES PRESENTLY UNDER CONSIDERATION

#### I. Training the Trainers to use the module

Only now, after a year's involvement, are the trainers beginning to become aware of, and bring out into the open, their problems (as well as their enthusiasms) in using the module. The real problems, the ones that critically affect the actual implementation of the module, are frequently emotionally loaded or risky, and disclosure requires a degree of honesty and trust which takes time to develop. These problems are discussed under "Constraints" in the next section of this report,

What is becoming most evident to me as the project evaluator is that those trainers who participated in the course at Beamish on group work skills are more effective and comfortable in using the module than those who did not. An awareness is developing among the HEDs and anyone involved in using the module of how crucial a role the training in participatory methods plays in trainer effectiveness. Using these methods has created a range of responses, including a resistance to the idea that participatory learning techniques can only be learned through active participation (à la Beamish). No book, film or manual alone can provide the experiential learning required for this training. Furthermore, three days of training is not long enough to evoke the attitude and behaviour changes necessary on the part of the trainers who intend to use participatory methods for the first time. Before the last training days, HEDs thought that the term "participatory methods" meant open discussion. Now most of them are aware that it means much more than this. Continuous training and monitoring is a necessary part of the project, in my opinion, and should be a top priority for those involved.

A behaviour change is required of trainers when moving away from earlier styles of learning and teaching; time and experience are showing how difficult this is for some people, and yet this is exactly what the module is demanding of its clients. This is a rather complicated point, which HEDs could discuss in their group meetings. They should notice that they have had to change their own behaviour in relation to the running of the courses, and that they have found these changes every bit as difficult as people do when the changes involve drinking behaviour. In fact the same patterns seem to have occurred: initial resistance and hesitancy, early acceptance as something new is tried, developing into rejection as difficulties are encountered. Also apparent are the need for group support, reaching plateaux in the process of changing teaching behaviour and backsliding when security is threatened.

# University of Durham

School of Education

## Health Education Council Research Project

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### HEALTH EDUCATION COUNCIL, ALCOHOL MODULE

#### REPORT TO THE STEERING COMMITTEE

for the Meeting on Monday, 27th June, 1983  
at The Growth Centre, Tyneside at 12 noon

#### CONTENTS

- I. Introduction
- II. Use of Time
- III. Themes Appearing in the Research
- IV. Questions

\* \* \* \* \*

#### I. Introduction

It has now been two years since I was appointed facilitator/evaluator for DCM. The past three months have brought some advances in the dissemination over the pyramid: these will be presented in chart form at the meeting.

#### II. Use of Time

This term my intention was to complete the writing of the first two chapters and begin on the third and the introduction to the thesis, as well as to continue with my roles as facilitator, evaluator and member of staff of the School of Education.

Following is a breakdown of how most of the time has been spent in the various roles:

#### A. Evaluation Hat

Otterburn (Northumberland) alcohol module

Interviews:	Level 1	3	(number of interviews)
	" 2	5	
	" 3	2	
	" 4	4	

Attended final evaluation session for Cleveland module

Attended HETI meeting in London.

B. Facilitation Hat

Organised and ran Follow-up day for Beamish II

" " " second weekend of Otterburn module

Assisted N. Tyneside module planning,  
ran one day of it,  
attended another half-day

Organised and ran Follow-up day for Beamish I

" " " Otterburn Follow-up day

" " " 6 x  $\frac{1}{2}$ -day sessions on group work skills, Sunderland  
(spin-off through Laura Brown)

Interview with Maureen Storm re. her Cert.H.Ed. dissertation.

C. Research Fellow Hat

Visit from Elspeth Gray (University of Bristol)

Completed first drafts of Chapters 1 and 2

Visit from Steve Marshall (University of Hull)

Meetings with Frank (10)

Prepared for and attended Proposed-Research-Unit meetings (3)

School of Education, Research staff meetings (5)

Attended half of HEC Seminar, Warwick

Organised and ran my own research meetings (1)

Attended John Catford/David Player meeting on Positive Health

Visited Barbara Whitton, Nick Heather (Dundee)

Visited Sam Docherty (Edinburgh).

D. Member of University Staff Hat

Attended MA student/staff party

Workshop on Participatory Learning, Amble

Meeting re. Participatory Learning with John Storey (DES)

Consulted with four MA students re. exams (2 each)

Helped plan and run Social Skills Conference

Two interviews with Cleveland researcher re. social skills

Attended three Board of Studies meetings

Ran two sessions of Counselling course for John McGuinness

Ran one Further Professional Studies session for John McGuinness

Planning Research Seminar (School of Education)

Lecture for Education Society

Conference on Participatory Learning

Attended internal examiners' meeting.

### III. Themes Appearing in the Research

#### A. Some New Developments and Spin-offs

In Cleveland, Ann Carter, HEO (Beamish I), ran a module with Pauline McGill, a Clinical psychologist (Beamish II) for a multi-disciplinary group; this group included Arthur Ward, Durham AHEO (or is it DHEO?) who was in this way expressing interest in the module. Tom Bailey says that Whitbread Breweries have expressed interest in having a module run for their staff and in formulating an alcohol policy. The Nursing Officer, the occupational health staff and the Personnel Officer are all very interested in and enthusiastic about this idea.

In Cleveland also a brewery is keen to do a module within the company. HEOs in South Tees have been using DC methods in Stop Smoking courses, Health Education Certificate courses, contraception, and in other areas of their work.

Fred Anderson and Jim Robson ran a module for social workers, this being the first module in N. Tyneside. As a result, a training officer who attended the module is planning a module for other staff, a nice level 3 development.

Martin Craig (as well as many others) continues to apply DCM methodology to all of his work. He has been invited to visit the Doncaster Council on Alcoholism to talk to them about the module; the Director had told the local HEOs about it and there was much interest in the manual.

Kris Holliday, HEO (Beamish II) applied module methods to the Health Education Certificate course, as well as to much of her other work.

One DMO remarked of a certain HEO that he was a "changed person since Beamish II - I've never seen him so lively and eager to do his work".

Ina reported that she was at the Blackpool Conference on Alcohol, which was organised by AEC. She sold seven copies of DCM, and could have sold many more. Again, there was great interest in how people could obtain the training in using the manual; it was fairly embarrassing not to have a ready answer. (All queries were referred to Martin Evans.)

In Sunderland Mary Mackers (Beamish II) and a medical social worker, Geoff Judson, ran a module for social workers, thus providing a combined input from levels 1 and 2, to create a level 3 (or 2½?).

Also in Sunderland, Laura Brown showed renewed interest in the module with her request for me to run a group work skills course; this was designed for people who had attended a module and wanted further training; however, others could attend.

Richard Day reported from S. Tyneside that a proposal for a CADET (Community Alcohol and Drug Education Team, alternatively referred to as District Drug and Prevention Team) has been presented to and approved by the Area Health Authority. They think it is a good idea and Richard feels that it is on its way. He considers this to be a spin-off from DCM and it was given a huge boost by Anthony Thorley's presentation in February to local professionals. In Richard's words - we have "rocked the boat" and "shaken the tree".

There now seems to be a very keen interest in group work skills training; it has been mentioned at both Beamish follow-up days and by course members from various modules.

#### Research Seminar

Research seminars at the University of Durham occur approximately once every month and are well attended by members of staff and other interested people. These are normally very formalised - one hour lecturing followed by 30-40 minutes on questions. However I am planning to run one on rather different lines. I intend to take along 3-5 HEOs who have definitely changed their teaching methods as a result of DCM to explain what has happened to them and their methods; this will be unrehearsed. I have begun asking for volunteers.

#### Level 4

In the past three months I have met some few clients from level 4 of the pyramid. The most interesting was a group of 6 young offenders who had, as part of their probation order, to attend group meetings. A follow-up meeting had been organised at the end of their six sessions so that I could interview them. They were distinctly uninterested in the effects of alcohol on their health, but seemed to gain a lot from the meetings, which were client-centred and unusually well-attended.

So far, based on a small sample of evidence (and without reference to the literature!) I could make the following tentative conclusions:

- (a) Clients seem to be familiar with parts of DCM, such as drinker's diary, road map, why people drink, etc; however it seems that they are not usually aware that these items come from DCM.
- (b) Clients seem to benefit from meeting with other clients in a group.
- (c) A change in drinking behaviour seems to depend more on a change in social/family/work situations, which is often assisted by the informed professional, rather than an individual internal decision to reform. If this is true, the implications for DCM would be that we need to concentrate on a form of training which would enable professionals to see alcohol misuse in a social context rather than as a medical problem and to work with their clients on the various kinds of problems which their clients may be coping with through alcohol misuse.
- (d) New awareness and new information are, however, important factors as well.
- (e) A visit from me, or a follow-up day, is important in sustaining professional interest in this alcohol aspect of their work with clients. Several people have mentioned to me that they have been putting things off regarding activities in alcohol education until they realised that I was coming to see them soon, which served as a trigger to actually get things done. This evidence is supported by comments made at the follow-up days to the effect that the support from the group tends to keep them going.
- (f) Six weeks (as in the above-mentioned group) is not long enough to cause behaviour changes.
- (g) The clients are often, at first, less aware than the professionals, or less willing to admit, the part that the misuse of alcohol plays in their offences and problems.

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### HEALTH EDUCATION COUNCIL, ALCOHOL MODULE

#### REPORT TO THE STEERING COMMITTEE

1st December, 1982

#### INTRODUCTION

Due to the fact that the agenda of the Steering Committee has many other items on it, I have been requested to keep this report as brief as possible. It is my intention to give the Steering Committee a picture of what has been happening between September 15th and December 1st and what the plans are for the immediate future. Due to the short time gap between the end of the second regional training course (November 24th) and the most recent HEO training day (November 30th) and the Steering Committee meeting (December 1st), many of the most recent conclusions will have to be reported orally.

#### CONTENTS

- I. What has the facilitator/evaluator been doing?
- II. Copy of the article produced on group work skills (presented separately).
- III. A picture of the present state of the pyramid (presented separately).
- IV. Timetable and plan for next term.
- V. Criteria for success of the project.  
(This is the item I would like to discuss with the Steering Committee)
- VI. Revisions of the manual.
- VII. Some current conclusions.
- VIII. Questions about operationalising the aims of the Manual (presented separately).

I. What has the facilitator/evaluator been doing?

I have conducted 17 interviews following through on levels 1, 2 and 3, and exploring ways of getting to level 4. (It must be realised that these levels are not as clearly delineated as it may sound.) One hour-long interview requires first of all that the interview be arranged, which is sometimes very difficult and time-consuming. Then it requires approximately an hour of travelling time and 90 minutes of transcribing time, mine and my secretary's combined.

I have been participating in the MA course at the University of Durham, running six sessions on humanistic education, and carrying out a few other duties at the University.

I have assisted in planning and implementing the second regional training course at Beamish and have done the sessions on group work skills for that course.

I have written many revisions of my article on the transition to group work skills and have finally sent it off to the Times Educational Supplement hoping for publication.

I have run four of the sessions on Richard Day's Courses III and IV, i.e. the ones to do with family problems and transactional analysis.

I accompanied Linda on a trip to Leeds, helped run a session with the students on the diploma course, and attended a meeting about Linda's project.

With one of my colleagues at the University I have been learning how to approach the research methodology necessary to carry out my project and beginning to write the chapter on review of the literature on evaluation. This is the part of the timetable which is behind schedule.

I have planned and implemented a further training day for HEOs and consulted with HEOs about their own courses.

I have been forced to concern myself with the intricacies of university politics in order to allow this project to be completed at this University. I have been meeting, on an irregular basis, with Frank Coffield to consult about the research, and the politics. The contract between the Health Education Council and the University of Durham is being renegotiated.

I have been reading the literature on evaluation and also the literature necessary as background to my article.

Although this has not as yet demanded any of my time, just as a point of information, I would like to notify you that I have been appointed to the Board of Studies of the School of Education.

I have discussed the project with Ina, Linda, Frank, John McGuinness, Ian Rodger, other research assistants and fellows in the University and various other people in the field.



#### IV. Timetable and plan for January-April, 1983

I will continue to keep abreast of every course that is being run, obtaining registers and evaluations, and keep track of the professions of course members so that we can see who is showing an interest in the module. I will record and will continue to analyse all reports of courses being run. I will continue to provide training days on group work skills for HEOs and other interested parties. I will continue to assist HEOs in whatever way they may request. There is a possibility that I may assist Fred Anderson and Jim Robson in running the first North Tyneside module.

I will continue to meet with Frank Coffield and with other colleagues who are concerned with this project, Linda's project, and other related projects.

I will continue with the pyramid of interviews, following through with two members of every course that is running and re-visiting HEOs and former course members from the early courses.

I will be making a concerted effort to carry the interviews through to level 4 (see conclusions).

It is my intention to complete rough drafts of the first two chapters by the end of the term. I can see now that this will require that I set aside sufficient time each week to do nothing but read and write. It is difficult for me to strike a balance between the priorities of

- (a) the action research, i.e. courses, interviews etc. and
- (b) the actual writing of the thesis.

On the one hand it seems that while the action is happening, that should receive first priority. On the other hand I don't want to find myself at the beginning of 1984 with none of the writing done.

#### V. Exploring the criteria for success of the project

Here we have another dilemma. On the one hand my brief is to implement a participant observation in which I and other people involved in the project watch, record and analyse what is happening. Because of my personal orientation and training, I have not viewed the project as having a success/failure factor; indeed I have made every effort to establish it as an exploratory exercise. On reflection, and as a result of discussion with Frank Coffield, on the other hand, I see that there are ways in which the whole system could fail. Some of these ways are:

- (a) HEOs in general could feel antipathetic to the module or to my facilitation of it, or to me personally, in which case the whole project would come to a halt.
- (b) Course members could say the course was useless.

- (c) A major change of the personnel involved in the project, such as Ina's leaving the region, could cause disruptions.
- (d) Reorganisation in the Health Service or the Health Education Council could cause either cessation of funds or disinterest on the part of HEOs.
- (e) The Government or the Health Education Council could suddenly decide to stop supporting the various alcohol campaigns.

So it becomes evident that there is a success/failure element to the project.

There is another factor which influences how we think about the project, which is - Are people being honest? This is a critical question in all research. How can we distinguish between half-truths, defensive answers, outright lies and straightforward, honest replies? It is especially difficult to obtain negative comments from course members and clients since, without long-established, trusting relationships, people are unlikely to feel safe in giving such feedback. Do the reports we get have validity?

With these factors in mind, I am engaged in a process of trying to objectify and operationalise the apparent success of the project. Certain elements can be seen in terms of aims, or as posing questions about what people are doing at any given time.

- (a) What is being taken from the module and used?
- (b) How is it adapted and changed for specific purposes?
- (c) Why are those parts of the module chosen and not others?
- (d) How and why do HEOs and course members resist/use the group work skills?
- (e) Are there conflicts between the way the module is written and the notions of traditional teaching methods?
- (f) Is there a conflict between the way the module is written and the notion of participatory learning?
- (g) Does the module extend to all four levels of the pyramid?

Ways of making the assessment of what is happening as objective as possible are continually being explored and refined. For example, if I devised a questionnaire to be sent to all course members and HEOs towards the end of 1983 in an effort to assess exactly what they have done with the module, this would involve several hundred people and, from my past experience, I would expect about a 30% response which would provide me with a sample.

Some HEOs are keeping diaries of exactly what they are doing on the project.

I am continuing to emphasise to all the people whom I interview that negative results are just as important as positive ones and to encourage them to be very honest in their responses to my questions.

I am asking the Steering Committee for any ideas they may have about objectifying the data that I am collecting.

# University of Durham

School of Education

## Health Education Council Research Project

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Professor F J Coffield MA, M Ed

## HEALTH EDUCATION COUNCIL, RESEARCH PROJECT

### STEERING COMMITTEE REPORT

November 14, 1983

### Introduction

The action phase of the Drinking Choices Project is entering its last stages. The last round of interviews will be completed before the end of December. Follow-up days and such activities will be carried out independently of the Facilitator/Evaluator, for the most part, as will any other courses using DCM or other related material. The initiative for any further activities within the Northern region will come from HEO's or other professionals. This Steering Committee meeting will focus at least partly on the future of the manual.

#### I. Activities of the Facilitator/Evaluator since June 27.

Completed four chapters of thesis:

##### Introduction

- I. Review of the Literature on Research Methodology
- II. Review of the Literature on Alcohol
- III. Review of the Literature on Participatory Learning

Gathering data for chapter on "Culture of the HEO"

Began compilation and analysis ("soak") of all the data which has been gathered

Meetings with Professor Coffield and with project secretary

Organised research seminar for School of Education, for November 28, involving HEO's who are using DCM

Held Beamish II Follow-up Day

Attended departmental research meetings

(Flew to U.S. and back for holidays)

Attended HETI meeting in London

Conducted 22 interviews in Northern region and elsewhere

Arranged last round of interviews (approximately 46 people)

Conducted lectures and seminars within the School of Education and at New College

Interviewed candidates, and appointed new project secretary

Attended Health Education Workshop in Stannington with Professor Coffield

Attended (and helped to plan) meeting and dinner with the Vice-Chancellor, with Dr. Player and his colleagues at Durham University

Organised Follow-up Days in late November for Beamish I, II, and Otterburn courses (last ones)

Mainly, and most consistently, gathered data and worked on thesis

## II. New Project Secretary

Professor Coffield and I took great pleasure in appointing Mrs. Aileen Jones as the new secretary to this project. She has had a great deal of experience within this University. She was our choice out of four excellent candidates, any one of whom would have been suitable, because of her relevant experience, her intelligence, and her lively and interested manner. Mrs. Meacham has, regrettably, left the department.

## III. Professor Coffield's Trip to Munich

Professor Coffield will report to the committee about his visit to Munich where he lectured to WHO about young people and health.

## IV. Report of the Meeting with Dr. Player in Durham

Professor Coffield, Linda and I will discuss our impressions of the visit, and discuss the implications with the committee.

## V. Recent Spinoffs (a few out of dozens)

Richard Day is planning an alcohol module in a South Tyneside hospital. Psychiatric nurses, doctors and other medical staff will be attending.

Richard and Jim Robson are collaborating on a nutrition manual using a similar format to DCM. There are several more examples of collaboration in developing health education materials.

Martin Craig has used participatory methods to teach music to prisoners in a Northumberland prison. He is requesting permission from the prison governor to publish an article about his work there; the article is completed and very interesting. He has used the methods he learned in DCM with the prisoners.

Anne Carter in Cleveland has written a report on her Inner City project, which involved 13,000 people. Again, she has been using groupwork methods throughout.

Joan Armstrong and John McCluskey in Gateshead have been working with Manpower Services helping to train trainers for the YTS schemes. They are using their group work skills, as MSC requires all YTS courses to be participatory.

In N. Tyneside, Jim Robson is organising a 'training-the-trainers' DCM course for tutors of post-graduate nurses, and will be staying on to do health education with the nurses. He is working with Dave Bailey (from the Otterburn course) who now works at Turning Point (a day centre for people with drink problems.) They have organised a counselling scheme and a screening process for patients in hospital wards. He is now chairman of the local Community Alcohol Team.

Janet Smith, Northumberland Probation Officer, having done DCM last year, is now running her second DCM group for young offenders.

Five enthusiastic HEO's, who feel that they have changed their educational methods since DCM, are coming to the Research Seminar in the School of Education, Durham. This seminar will be run on completely participatory lines, perhaps for the first time. I will speak for two minutes about the project, and then the HEO's will answer questions and hold a dialogue with my colleagues at the University. This, in my opinion, is a courageous enterprise on their parts!

Ina had great success with a DCM for Devon Community Alcohol Team. She noticed that it was very easy to set up and get going, and that they had great enthusiasm for the participatory approach. Course members took the initiative to say that they would act as key tutors in the future, with Ina in a consultative role (rather than being needed to help run courses).

Ina has also been asked to address the Faculty of Community Medicine of the Royal College of Physicians next Spring. The topic of the conference will be strategies for community health, and for alcohol in particular.

Laura Brown (Sunderland AHEO) says she is "pushing" for another Regional Training for DCM, with a large input on group work skills; she has proposed this to NECA. Laura also wants to pilot a series of DCM/group work skills for next year for her Well-Women's groups; this proposal has also gone to NECA.

#### VI. The Cumbria Example - An Example of one Area's Progress

The account that follows is a factual summary of some of the results of DCM in Cumbria.

##### November, 1982

Six people from Cumbria attended Beamish II.

##### January, 1983

I attended a meeting in Carlisle of five of those people who were planning to work together on implementing DCM courses in their region. They outlined plans for a course for youth workers, interdisciplinary courses, work with staff of a day centre, etc. (and more).

.....  
Winter, 1983

DCM course for youth workers  
Multi-disciplinary group in Penrith  
MSC Trainees' course

.....  
Last interview, October, 1983

I visited Carlisle again, and interviewed the acting Area  
HEO and another HEO.

We discussed spinoffs:

Group work skills course for health visitors, and for multi-  
disciplinary group.

DCM used on Health Education Certificate course.

Cumbria Health Education Unit now has a resource centre.

The HEO's interviewed felt that DCM, together with Working with  
Groups, had had a very great impact on their work. Everyone in  
the unit is now using participatory learning methods in all areas  
of their work.

Out of the original six who attended Beamish II, one has had a baby,  
so has been away from work. One has a new job in Aberdeen, and another  
has a new job in Dorset. This leaves three still in Cumbria. Future  
DCM courses are in the planning stage.

## VII. Proposed Chapter Headings for the Thesis

### Introduction

- I. Review of the Literature on Research Methodology
- II. " " " " " Alcohol
- III. " " " " " Education (in this field)
- IV. Tracing the Project through its Phases
- V. Strengths and weaknesses of the Module
- VI. Effects on the project of the restructuring of the National  
Health Service and regrading of HEO's
- VII. Spinoffs
- VIII. (etc.) Other themes (disclosed by sifting data)

Conclusions

Bibliography

## VIII. Questions and issues for Steering Committee to discuss

Consider Jane Randell's proposals for DCM dissemination.

Consider Regional Sub-committee's proposal for purchase and use of  
manuals.

The Regional Sub-committee for the working party for the North-east alcohol campaign is going to propose to the HEC that the sub-committee will purchase 1,000 copies of DCM from Tacade at half-price, and that each Health Education unit will stock enough manuals from this supply so that they could run two courses at once. The course leader would be given a manual, and enough on loan for the course members, who could buy them at the end if they wanted.

Consider Regional Sub-committee's proposal for a post of Writer-Coordinator for DCM.

What shall we do about requests now for DCM courses, similar to the ones from Hull, Merseyside, etc?

What is to be done with the old (unrevised) manuals? Can Gateshead have them?

What would be the best way to address the member of HEC council who has doubts about this method of evaluation? Shall we send him a copy of Chapter I?

(For Tom Bailey) What is happening about alcohol policies and DCM courses in local breweries?

*Looking forward to  
Monday's meeting -*

*I wish you happy  
travelling. -  
Dana*

P.S. Unfortunately Frank is ill and unable to discuss this report with me today. We usually go over it together, this time it is purely my responsibility!

D.B.

#### Appendix, Part Four

The next section contains the two newsletters which were sent out to everyone in the interview sample, i.e. key tutors, related people from NECA and HEC, and the course members selected to be interviewed



# DRINKING CHOICES

## newsletter



### EDITOR'S NOTE

There has been a lot of positive feedback about the last newsletter, (which was supposed to be the 'first and last'), and there is a lot of news to tell, so here is your LAST LAST newsletter from the Drinking Choices project.

We have again selected at random from the mountain of data which has been collected from interviews, courses, meetings and follow-up days; these are just highlights of all the activities that have been going on since last July.

I am now in the midst of "the soak", that is, a long period of immersion in all the data, from which we will draw conclusions and make recommendations. I have listed some of our tentative conclusions and recommendations, and would be very pleased to discuss them with any of you, so please indicate on the enclosed postcard if you would like to talk to me about it.

Donna Brandes

## REUNION AND FINAL PROJECT MEETING

Who: You and all your families are invited.

Where: Meet at the Growth Centre Tyneside, 54 St. George's Terrace, Jesmond, Newcastle upon Tyne. (Telephone: Newcastle 814860)  
We will all go to Jesmond Dene if the weather is nice.

When: Sunday, July 8th at 12.30 p.m.

What: Picnic at 1.00 p.m.  
Short meeting at 3.30 p.m. to share our activities and plans re Drinking Choices.

Bring: Food and beverages to share at the picnic.

What for: To celebrate!  
R.S.V.P. on enclosed postcard.

\* \* \* \* \*

## ORDINARY PEOPLE

Ina Simnett suggested that it would be interesting to know how alcohol education has been passed on by you who have been involved in Drinking Choices to 'ordinary people' (i.e., not offenders, clients, pupils, etc.). So if you know anyone, sons, daughters, partners, friends, who have changed their drinking behaviour or attitudes since you did DCM, please fill in that part of the postcard as well, and I will come and talk to them about it.

## NATIONAL DCM TRAINING

The first national training for DCM (Beamish<sup>2</sup>) will soon be held. The first three days are in Harrogate in February, and the second half is in Ilkley in March. Trainers are: Donna Brandes, Martin Evans and Ina Simnett (in alphabetical order, of course!) Course members, selected on a first-come-first-served basis, come from all over the country, and the format will be client-centred, à la Beamish II.

## RESEARCH SEMINAR

On November 28, 1983, some DCM people participated in a research seminar at the University of Durham. Pauline Amos, Martin Craig, Anne Carter, Richard Day, Barbara Howe, Mary Mackers, Jim Robson, and Donna Brandes organised the seminar, which was attended by staff and students of the School of Education, and some members of the public. We departed from the usual didactic (report followed by questions) method, and involved the 'audience' in questioning us and exploring the effects of DCM on our work. Two comments from the participants at the end:

"We learned more about teaching methods than about evaluation."

"I have never seen professional people work together with such easy courtesy."

(We all loved that last phrase, which came from a librarian.)

The seminar, though it was impossible to plan or rehearse it in advance, since it was audience-centred - a new phrase - came off as though it had been a carefully rehearsed television panel show. One of the HEOs said "That was great, can we take it on the road?"

I have tried to convey the joyful and satisfying feeling we got from the occasion, but without bragging. If you want us to take it on the road, do let me know.

## AND NOW FOR THE NEWS

A Social Worker in South Tyneside, having done Drinking Choices, has set up an interest group to plan a local alcohol team. The committee is comprised of G.Ps, psychologists, nurses, social workers, clergy, and other professionals. They are meeting in their own time, in lunch hours, to discuss and plan provision of services for people in South Tyneside with alcohol problems. They are making good progress, and intend to keep their project going no matter what other formal provisions may be made by the health or social services.

An Environmental Health Officer in Cleveland adapts parts of DCM for use on food hygiene courses for staff at Debenhams and for YTS schemes.

HEOs in Gateshead have been involved in training YTS trainers for Manpower Services. They have also been helping medical social workers set up advisory services for hospital patients and their relatives.

A clinical psychologist in Cleveland who attended Beamish II, has been running a Drinkwatcher's Group.

A care worker in a men's hostel in Newcastle has attended DCM, almost completed the counselling course at Parkwood House, and has been counselling clients with alcohol problems.

A probation officer's client wrote the following poem:

### The Drunking Man

Tell how long it had been the whisky tasted sour, it was no  
comfort it solved noting, and the silence that hung over  
the house deafened him.

He thought how strage it was that tears can dissolve the facade  
of maturity.

He thought of throwing the now empty glass at the wall, but he had  
to have a drink. He drunk till the bottle was empty.

He thought he should of show his wife and child how much he cared before she took the child and walked out on him. He went to the bathroom to put cold water on his face and saw her make-up scattered around. It hadn't moved from the positions it had fallen to in the argument, over money for his drink. He picked up the lipstick and varnis that lay in the basin, he thought because of my stupid drinking I started as a youn man. Then as he looked up from splashing water on his face he saw through the watery blur, the note scribbled in lipstick on the mirror. He wasn't sure now as he tried to focus on the words whether it was the water or the drink that obscured his view. If onley he down something about he's drinking before, if onley for his wife and child. If 'onley', 'if onley', if only is allways too late. So this is the end for the drinking man.

---

Forgive me for omitting so many more spin-offs - we must have room for conclusions and recommendations.

---

If we were doing this project again, what would we do differently? (or, what has actually changed because we now know what to do differently?)

- (a) Appoint the facilitator and evaluator before the pilot project. The evaluator would use the time to train as researcher if not already trained, and to soak in the culture.
- (b) There should be a clear contract with the evaluator as to the aims, and conflicts of interest, in the evaluation.
- (c) There should be a clear contract with the evaluator's supervisor as to just what his/her role will be.
- (d) Since the HEOs have been consulted on many issues relating to the project they should also have been consulted regarding the publication of the manual by TACADE. This was one thing about which many HEOs were unhappy.
- (e) At Beamish I the project facilitator could have been one of the trainers, to provide continuity.
- (f) It should have been made very clear to HEOs at Beamish I that they were collaborating as researchers on this project, and they should have been given the opportunity to devise a form that their collaboration could take. This could have been done with contracts between the evaluator and each individual HEO.
- (g) We have learned that the Beamish II model, i.e. client-centred use of the manual, has more effect than Beamish I model. If we had known that, Beamish I could have been done à la Beamish II.
- (h) With the departure of Ina Simnett, Linda Wright, Ian Fairfax and Kathleen Meacham, the collaborative support system for the evaluator temporarily collapsed at various points. Could nothing have been done to prevent all this? (I don't think so, these are unforeseen circumstances).

- (i) In the national dissemination we made a point of having people come on the courses who were definitely going to have a trainer's role, and who would come in pairs with another professional from their authority to provide support when they got back to work. This could have been done on all Level II courses, thus ensuring the move to Level III.

This project was initiated by alcohol educators in the region, so they are the first set of interested people. The HEC is the second set, HEOs are the third set, other professionals are fourth, and everyone else, we know not who, are the fifth. Where and how do their interests conflict?

Should we make drink more expensive? It is now cheaper in proportion to wages than it used to be and perhaps this is not in society's best interests, although the Government may think it is.

Have any of our innovations become problems in their own right?

How do people (HEC, professionals, the Government, researchers) resist recommendations for change?

#### Conclusions: Negative aspects of DC

- (i) It is difficult to get so much time off for people to come on courses, and yet, as an agent for organisational change, the course is not long enough.
- (ii) There is too much material for the time allocated unless people are willing to select on the basis of specific group needs.
- (iii) Some people are much better at using the manual than others. Is it to do with personality differences and range of skills available to each individual?
- (iv) It requires careful and high quality training to use the manual properly, that is, to optimum effect.
- (v) It needs a support group in terms of follow-up.
- (vi) Level II is very limited in its impact on Level III, for reasons which will be analysed and used to change future models.
- (vii) Many HEOs had strong reservations about the sale of manuals without training. We should have built into our plans that trained HEOs would definitely be encouraged to train other professionals in the use of DC, and that area and district HEOs would allow this to happen.
- (viii) The material in the manual concerns alcohol education but the course itself inevitably brings up issues of structural and cultural problems in society which DC in itself has no power to change. There is a basic inconsistency in the democratic participative style and the system in which it is going to be used. Most of the professional people on the course are working in rigid hierarchies abounding in inequalities and will run into opposition when trying to carry DC further. We are trying to create equalities, and the inequalities are everywhere around us. We assume that human resources are the most important factor. Other systems in our society may not make this assumption.

Attending a DC course can make people more aware of problems which they cannot solve, e.g. in many cases, alcohol problems are a symptom and not the main problem, which is often social inequalities.

#### Conflicting interests

This project attacked certain standard ways of didactic teaching. Some people find it uncomfortable, for various reasons, which will be discussed in the thesis. The same

comment is true of the research methods; new paradigm does not appeal to everybody. The same is also true of the "sensible drinking" approach and the change over from the medical model to an holistic one.

Another area that is resistant to change is drinking habits in a culture where drink is desperately important and historically celebrated.

The manual is called Drinking Choices. We must give more than lip service to the fact that some people will choose to go on drinking, e.g. young offenders who have nothing to do. Some people, having started a drinker's diary, actually stop doing the drinker's diary rather than stop drinking; health education can tell you things you don't want to know.

We will never know what would have happened if reorganisation of local health districts had not occurred in the midst of the DC project. Certainly it has been stated by many people in the project as a reason for not running Level II and Level III courses.

Increased unemployment in the North-East is likely to lead to heavier drinking; work gives a person something to do. There are no easy answers to the alcohol problem in the North-East. Group work cannot change ancient and popular traditions. Horror-exposé does not work either and many people do not admit that alcohol can be damaging to them.

Skills and habits and attitudes do not change overnight. There are leaps and hesitations and fullstops. There are very few conversions.

#### Conclusions: Positive aspects

DCM is a model that helps people to work better and enhances self-esteem and confidence.

Although the manual that is being evaluated has already been published and disseminated nationally, the results will still be of interest to the parties involved and can have an impact on policy decisions, e.g. extending the alcohol campaign to other parts of the country. It may have added credibility because it has the stamp of Durham University on it.

Illuminative evaluation is appropriate if one is involved in programme change, because it allows for continued modification of the methodology to respond to events as they occur.

There is an internal evaluation system operating within the project; that is, HEOs and other professionals have been evaluating it through interviews and follow-up days all the way along. This internal evaluation is the essence of the project report (thesis), and one of the elements of a formative evaluation.

DC may not have influenced the Government in any way but it may be able to influence health authorities and industry regarding alcohol policies. It is being used in some work situations.

This model can be transferred effectively to other health education topics.

We have demonstrated that it is workable for professional people from various disciplines to train together as equals and as a result of the interdisciplinary parts of the project, HEOs are doing this with other professionals and also providing resources for them.

The evaluation and project have improved the manual. Strengths and weaknesses have been noted and clarified; some revisions have been incorporated in the new edition.

If the pyramid structure works, and we must examine how far that is true, then it is a model for future development. We must look at the question of whether or not it is appropriate to write and issue a series of manuals on the DCM model, each on a different topic, or whether people must be trained to do that themselves.

## Conclusions/Recommendations

There has always been the knowledge that the HEC would withdraw from the North-East campaign and that alcohol education would continue to be a priority in the North-East anyway. It would be good to see Dr. Wilson regarding the intentions of the regional sub-committee for carrying on the campaign.

HEC could:

- (a) follow-up in five and ten years' time to see what happened to DC (the manual), and to participatory learning in the North-East.
- (b) having withdrawn from the North-East campaign in 1986, HEC could and may well look at what is happening to drinking behaviour in the North-East in 1996.
- (c) examine in a few years' time what has happened to the efforts of people in this project to design and implement alcohol policies in the NHS.

HEC could do a survey in five years' time and again in ten years' time to see if anybody is using DC or following it through spin-offs. Three years' time is certainly not a fair test, it takes that long to get courses running, travel through the pyramid model, and make the necessary contacts with people. The evaluation must consider what could be done at all levels of the pyramid and what has to be done to move forward.

Innovation and continued evaluation should go hand in hand.

It would be a useful exercise to compare the results of DC to the aims in the manual, even though this is not required by the methodology.

It may be possible for one HEO from the Society to take on the role of DCM's continuing coordinator, to keep DCM alive in the region.

Groups and Courses about health are my concern,  
So this light hearted poem is just to convey,  
Now participating in a course named Drinking Choices,  
Influences my work everyday.

Donna Brandes involved me in group work,  
When I was sent to Beamish Hall,  
To attend a course to absorb all there was,  
About Ethyl Alcohol.

Lots of interesting folks came along,  
With expectations just like me,  
But what I did n't know then was,  
I was likely to become a groupie.

The chairs were arranged in a circle,  
I joined the others in the ring,  
And when we got to know each other,  
We did some active listening.

The ground rules were established early,  
The group decided what they would be,  
And when they were observed by everyone,  
It encouraged sensitive interaction and courtesy.

It does not pay to deceive or pretend,  
When trying to build up trust,  
You will be seen through in the end,  
So the golden rule 'always tell the truth' is a must.

Participatory learning methods,  
In an effective way teaching can be done,  
And then by definition,  
Learning can be fun.

What is participatory methods people always ask,  
If you feel comfortable, close your eyes,  
Try to recall your very first recollection of alcohol,  
Then share in a round or pass.

It's not about winning or losing,  
That really is not the way,  
But no lose is the target,  
And then both you and I are O.K.

I had never thought of the worst thing that could happen,  
Nor even of the best,  
And I was in for a big disappointment,  
If I was expecting to sit back and rest.

Could I ever have an alcohol problem?  
Could my attitude and values play a part?  
Why do people drink at all then?  
We could do a brainstorm on that.

The group appears a bit lifeless,  
Something to stimulate is the aim,  
Let us play wink and murder,  
What did you get out of that game?

What would you like to do now?  
To respond to your needs I prefer,  
Let's just get it down on the flipchart,  
You've got a good list there.

The group is not all sugar and spice,  
I get the feeling something is not right,  
We can do a round and say how we feel,  
And bring the matter out into the light.

What do we do with the late comer?  
The bored, the silent and dominant too,  
The experiential technique is role play,  
I need a volunteer - will somebody be brave and do?

How can we tell if it's working?  
Have all our objectives been met?  
We can measure knowledge and skill by testing,  
But tests for personal growth and confidence are more difficult to set.

I appreciate the active learners' enthusiasm,  
And the difference discovering for themselves takes,  
To the interest in the subject matter,  
But resent the time that it takes.

Mary Mackers





# d R I N K I N G c H O I C E S

## newsletter



### EDITOR'S NOTE

This is the first, and perhaps the last, Newsletter to bring you up to date with the progress of the Drinking Choices project. There have been so many spin-offs and so many exciting things happening that it would take a thesis or a book to tell you all about it (and luckily it is not time for that yet - that will happen in July 1984!) So please forgive us if we have left out some spin-off that is dear to your heart. We have just selected some at random so that you can see the wide variety of interesting developments.

I am still collecting any bits of information, large or small, about your alcohol education activities, and I will be doing so right up until next July, so please remember to send me a postcard or phone me if you are doing something related to Drinking Choices, also if you have any clients I can talk to who have received the benefits of your Drinking Choices training. Remember that this is a collaborative project and what is making it work is the communication between you and me, for which I sincerely thank you.

Donna Brandes.

## A NOTE FROM THE AUTHORS OF DRINKING CHOICES

The following statement is a response to the increasing controversy about how the manual was meant to be used, i.e. there are those who think it should be used verbatim and every exercise from Day 1 to Day 5 should be covered; and, on the other hand, there are those who like to use a very client-centred approach in which the content of each course is negotiated with course members. At a recent Steering Committee meeting the editor asked three of the four authors of Drinking Choices what they thought about it. The following is a summary of what they said:

The writers and the project facilitator do not believe that Drinking Choices should be used as a total package. It is intended as a framework for client-centred work, which means that it should be suited on each occasion to the needs of the group. Agenda setting is an integral part of participatory learning and must be done in the presence of course members. Drinking Choices should be run different ways with different groups; and, although groups may resist this at the beginning and want to give the responsibility back to the course leader, the sharing of responsibility and the processes of negotiation are necessary elements of participatory learning. Further, each activity should be completed to the satisfaction of the course members and therefore should not be rushed. This means that inevitably some sections will have to be missed out; whatever the opinion of the leader, the selection should be made by group consensus.

If you want to run a Drinking Choices course and are not sure about your ability to do it in the manner described above, please contact Donna Brandes for further assistance.

### WHERE DO I GET IT?

Drinking Choices is now available from TACADE, 2 Mount St., Manchester, M2 5NG at a cost of £9.50 per copy. People running training courses may have to charge extra to cover the cost of manuals. However the copyright regarding the manual has been waived by the publishers to the extent that trainers are free to copy sufficient of the material to run a course.

### ALCOHOL POLICIES

Various HEOs are working with their district authorities to develop alcohol policies. This is happening in Gateshead, Durham and several other places. Liaising with industry and local breweries about this matter is an important adjunct of health education.

### NEWS FROM LOCAL AREAS AND DISTRICTS

#### Cleveland

Cleveland has been in the throes of re-organisation (but we won't go into that here!). When the dust settles, it will be obvious that they have been proceeding with Drinking Choices anyway. Cleveland has done three Drinking Choices modules and there have been an enormous number of spin-offs. HEOs have been or-ordinating with other professionals, such as probation officers, clinical psychologists,

members of local councils on alcoholism and others to organise courses. They have also been using participatory methods in all of their work, applying them to ante-natal work, Health Education Certificate courses, inner city development, and also to Stop Smoking groups. One probation worker has been using what she learned on Drinking Choices to work with a group of offenders who have drink-related problems and has found these methods very successful.

### Cumbria

A variety of professionals who have completed Drinking Choices have been meeting regularly to support each other in keeping alcohol education going in Cumbria. They have identified groups for further training and education. A two-day course was held for youth workers and the response was extremely enthusiastic. Work is proceeding to establish a community alcohol team in the area and local community groups seem very interested in developing alcohol education. Several other projects are in the works.

### Durham

After long, unavoidable, delays due to re-organisation, lots of new things are in the pipeline in Durham. Three members of the Health Education Department have completed the Drinking Choices training course and are available to organise training courses for other health professionals. They are proposing to run seven training courses between next November and April, to be held in Darlington, Bishop Auckland and Durham. It is interesting to note how they are planning their course staffing, with one HEO as a course co-ordinator, one psychologist and one support professional to help. Negotiations about an alcohol policy are also under way with a local brewery.

### Gateshead

Gateshead have completed two modules already and are planning one for YOPs trainers in July. They have been particularly active in working for the establishment of an alcohol policy with local NHS managers. They are designing other educational materials, using participatory methods, along the lines of Drinking Choices.

### Newcastle

As a result of the second regional training course last autumn, the staff at Parkwood House were able to suspend for a week their usual activities in the clinic and concentrate on a full week of Drinking Choices. The staff were particularly enthusiastic and eager to implement the knowledge and methods that they had gained. At least two more courses are planned for the near future in Newcastle and work on a CADET scheme for the area is well advanced. NECA joined forces with the HEO and other alcohol field workers to present a day on alcohol use and misuse for paramedical workers at Freeman Hospital. This was well attended and

extremely well presented. Because of their involvement in Drinking Choices, we have had a closer than usual contact with NECA and have been counting on them for many kinds of support to this project. In addition to their regular alcohol activities, they have been instrumental in establishing a two-year counselling course for people who have attended the module; they have also supported the Sunderland training in group work skills, to name but two of their notable efforts.

### North Tyneside

Recently the number of HEOs at North Tyneside has been doubled (from 1 to 2), thus making it possible for them to increase their alcohol activities (we don't actually mean that they can now go out drinking together!). A Drinking Choices module was run for social workers, including the training officer, and one member of that course then presented aspects of the course to the staff at a local community home. As a result of doing the alcohol module twice, one course member has changed his line of work and is now going to be working full-time with people with alcohol problems. These spin-offs are in addition to laying the groundwork for a lot of future alcohol education developments.

### Northumberland

Northumberland has run four modules, the last of which comprised two residential weekends at Otterburn Hall for a multi-disciplinary group. Course members have been very active in Northumberland in various kinds of spin-offs. The Otterburn course held a follow-up day and those who attended found it extremely useful to know what the others were doing and to be able to support each other and keep renewing the contacts. One important spin-off is that the four community policemen who attended the course have been using participatory methods in many aspects of their work. Charge nurses at a local mental hospital have been using materials from the manual with their clients (as have many professionals in all of the districts). Two HEOs have been using participatory methods in unusual and innovative ways. One has been working in prisons developing educational units on contraception, alcohol and other topics of interest to the prisoners. Both have been applying what they have learned about group participation to all of their health education work.

### Northumberland (continued)

An alcohol development officer, who shall remain anonymous of course, has been working on establishing a network of people interested in alcohol education; he has conducted a survey among the local professionals about their training needs regarding alcohol and has established a support group for people with drinking problems. With his encouragement, a local probation officer has been running a weekly group for young offenders with alcohol-related problems and has received support from the local magistrates for this so it seems likely to be a continuing feature.

### South Tyneside

The anonymous, sole HEO in South Tyneside has been very active. Four courses were run in quick succession for local professionals, including educational welfare officers, workers from NSPCC, teachers and others. The courses were supported with an unusual number of resource materials

and information for the course members.

A CADET team for the area seems a likelihood in the near future, due to the tireless efforts of the AHEO. Further courses are planned for next autumn as well as efforts to produce a course in level 3 of the pyramid (i.e. run by a course member).

### Sunderland

Two courses have been run in Sunderland so far, one of which was run by two HEOs and the other (at what we call level 2½ of the pyramid) by an HEO working jointly with a medical social worker. An interesting spin-off occurred when the AHEO initiated a course on group work skills for interested professionals including some who had already done Drinking Choices.

Although it is much too early to make any final conclusions, several things have become obvious in the project evaluation:

1. Follow-up days for course members, and visits from HEOs or the project facilitator, seem to enhance the efforts of professionals to get alcohol education activities started.
2. Many people on all levels of the pyramid are eager to have further training in group work skills and participatory learning methods.
3. National dissemination of Drinking Choices and the necessary training for effective presentation in other regions of Great Britain is much to be desired and various people around the country are putting their energies into making sure that this happens.

Donna Brandes, HECRP, University of Durham, School of Education. Tel: Durham 64466 x7277

14.7.83

Appendix, Part Five

The concluding section contains games  
invented by course members.

WAYS OF CHANGING MY SURROUNDINGS TO HELP  
SELF CONTROL

(Written by Two Probation Officers in Cleveland  
for their weekly group with offenders)

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If the  
problem  
is made  
worse by

Strategy to use

---

Money

- carry a small amount of money with you
- let wife, relative, or Post Office keep the rest
- ask somebody to accompany you cashing a giro
- arrange to dispose of most of your pay as soon as you receive it, before pay day drinking session

Company

- ask friends to help slow down, keep to a low target
- stay with moderate drinkers, avoid heavy drinkers
- stay in company of wife or safe relative
- don't accept round drinking

Home

- avoid keeping alcohol in house
- don't leave signs of drink: empty cans, beer mats
- re-arrange furniture if you have a favourite drinking seat
- other drinks - tea, coffee, water, etc.

Pub

- limit drinking by: start with orange, and use oranges and shandies at intervals
- take small sips instead of gulps and put the glass down instead of holding it
- drink halves
- limit yourself to a safe target, e.g. 2 pints
- talk to people - rather than drinking alone

- use games, darts, etc., to space out drinking
- stay with slow drinking friends and drink no faster than they do

Time

- avoid pub at lunch time
  - go to pub later in evening
  - avoid a last drink before closing time
  - plan some interesting visit or meeting for yourself alternative to a drinking time
  - make sure empty times at home are filled with plan of activities, especially involving other people: hobbies, visits to people, job hunting, household tasks
-

**WARNING SIGNS :**

1. Do you require a drink next morning?
2. Do you prefer to drink alone?
3. Do you lose time from work due to drinking?
4. Is your drinking harming your family in any way?
5. Do you need a drink at a definite time daily?
6. Do you get the inner shakes unless you continue drinking?
7. Has your drinking made you irritable?
8. Does it make you careless of your family's welfare?
9. Have you become jealous of your husband or wife since drinking?
10. Has drinking changed your personality?
11. Does it cause you body complaints?
12. Does it make you restless?
13. Does it cause you to have difficulty in sleeping?
14. Has it made you more impulsive?
15. Have you less self-control since drinking?
16. Has your initiative decreased?
17. Has your ambition decreased?
18. Do you lack perseverance in pursuing a goal since drinking?
19. Do you drink to obtain social ease?
20. Do you drink for self-encouragement?
21. To relieve marked feelings of inadequacy?
22. Has your sexual potency suffered since drinking?
23. Do you have marked dislikes and hatreds?
24. Has your jealousy, in general, increased?
25. Do you show marked moodiness as a result of drinking?
26. Has your efficiency decreased?
27. Has your drinking made you more sensitive?
28. Are you harder to get along with?
29. Do you return to an inferior environment while drinking?
30. Is drinking endangering your health?
31. Is it affecting your peace of mind?
32. Is it making your home life unhappy?
33. Is it jeopardizing your business?
34. Is it clouding your reputation?
35. Is drinking disturbing the harmony of your life?



PROBATION AND AFTER-CARE SERVICE CASE RECORD

**PART C -**

FORN. W. 1111  
2  
Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Sheet No. \_\_\_\_\_

**RECORD OF CONTACT**

*Date & Name  
of Officer  
Responsible  
for Entry*

9.12.81  
A.A.CAMPBELL

Meeting : A. A. Campbell, John Evans, Elaine Clark.

Group to meet in eight week cycles. Referrals to be made for whole cycle. May allow flexibility. Referrals must be seen first by AAC, EC, or JE individually.

Week 1 : Introduction of names and why we come to group. Concept of Monitoring own drink. Reporting back on progress.  
Meetings to last 2 hours (10 - 12). Coffee break - 15 minute  
Presentation of forms to be brought back (and discussed each week).

Week 2 : a) Physical and psychological effect of alcohol.  
b) Monitoring and discussion.

Week 3 : a) Questionnaire from A & A - P.24.  
b) Monitoring and discussion.

Week 4 : a) Why do people drink?  
b) Monitoring and discussion.

Week 5 : a) Alcohol and the Law and the Community.  
b) Monitoring and discussion.

Week 6 : a) Alternative Strategies - Community Resources.  
b) Monitoring and discussion.

Week 7 : a) Basic Facts about drinking.  
b) Monitoring and discussion.

Week 8 : a) Evaluation of Group.  
b) Plan second programme.  
c) Monitoring and discussion.

Break for 2 weeks. Staff evaluation.

Venue : Conference Room.  
Coffee - Sugar - Milk.

Memo for Referral.

To begin after Christmas : to start on 12.1.82.

Support Group for Problem Drinkers.

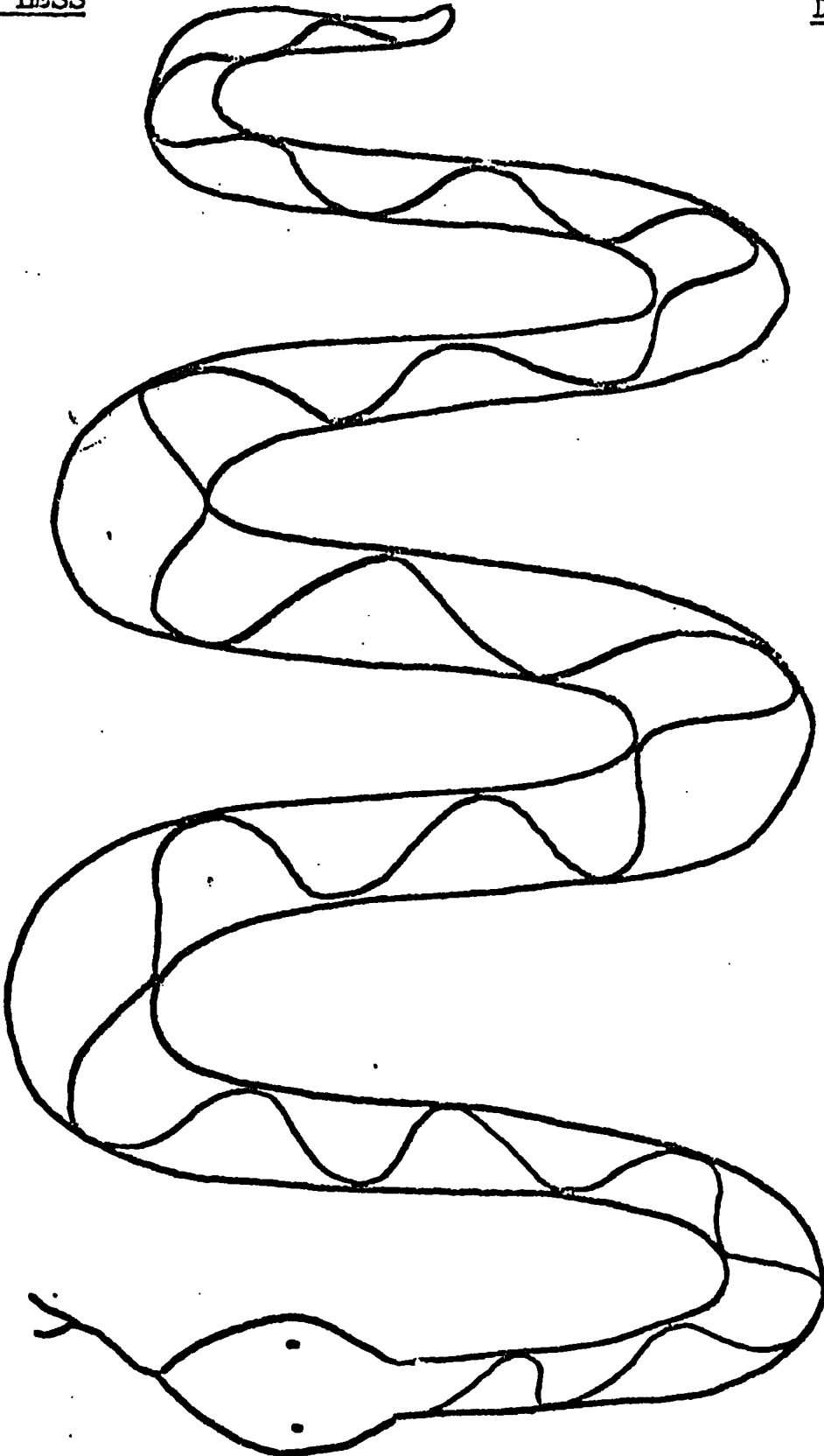
Referrals - AAC, EC, JE : to be seen individually first - Maximum 8.

## SNAKES

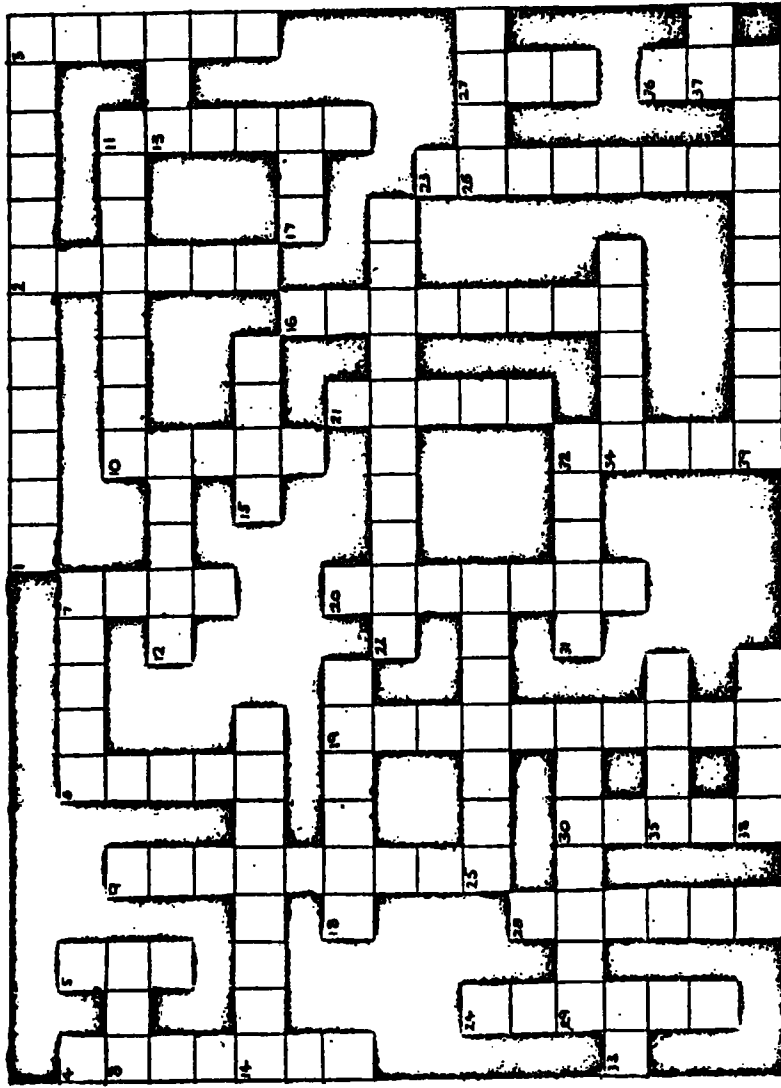
The aim of this exercise is to try to link how much you have been drinking at different times of your life with things which have happened to you - eg jobs, marriage, family, finance, and so on.

DRINKING LESS

DRINKING MORE



Crossword Puzzle based on the Manual designed by a Course Member.



CLUES: ACROSS

1. Does the FOS make it difficult to read? (12) (Page 89)
6. Organ which breaks down the harmful poisons. (5) (Page 58)
8. Old-fashioned word for beer. (3)
10. A label for one who drinks one to two units occasionally (7) (Page 14)
12. They can form in the stomach after excessive consumption (5) (Page 100)
13. Sounds like entrance to pub (3)
14. This amount of alcohol does no harm (8) (Pg. 63)
15. See 37 Across
17. If more than your energy needs then alcohol is turned into this (3) (pg. 101)
18. Ten of these is the maximum fine for a drunken offence (6) (Pg. 83)
22. N.E.C.A.'s large word (10) (Pg. 121)
25. These have 35-40% alcohol (7) (Pg. 97)
- 26 & 36 Down. Does this exercise help you find your way in life? (Pg. 118) (4,3)
29. See 23 down
34. Social Influences (5) (pg. 109)
33. Initially sounds suitable for alcoholics and drivers! (1,1) (pg. 68)
34. They absorb alcohol faster than men (5) (Pg. 103)
35. Sounds like a Scottish measure (4)
- 37 & 15. Their address is 61 Great Dove Street, London (2,4) (Pg. 68)
38. The .... of absorption is affected by many factors (4) (5)
39. It's this counting the cost of additional drinks (7,2) (Pg. 56)

DOWN

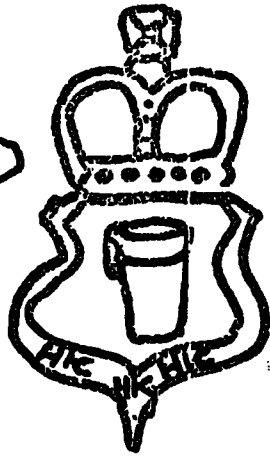
2. See 28 down.
3. First route for some of the unchanged alcohol (6) (Pg. 68)
4. Shape for role-playing, not Algebra (7,8) (Pg. 119-120)
5. Initially they will help at New Oxford St. London (1,1,1) (Pg. 68)
6. 4-8 drinking points is the upper .... (5) (Pg. 63)
7. "Drunk and Proud" is one of these (4) (Pg. 75)
9. North ranks 3rd for this alcohol-related complaint (9) (Pg. 60)
10. Means of alcohol disposal, along with sweat (5) (Pg. 58) breath and
11. Legal limit of alcohol per 100mls of blood when driving (6) (Pg. 83)
16. See 4 down

19. Alcohol is this type of drug (10) (Pg. 99)
20. In this city, 89% of 10-14 year olds have tasted alcohol (7) (Pg. 92)
21. The total numbers of these must not exceed 9 or 9 1/2 (5) (Pg. 84)
23. & 29 acc. Name of this course, sounds optional (8,7) (cont)
24. This organisation works primarily in schools and colleges (6) (Pg. 67)
27. Initially located at Maudsley Hospital (1,1,1) (Pg. 68)
28. & 2 down The country with the highest cirrhosis rate (6,6) (Pg. 60)
30. One of the special brews (5) (Pg. 98)
32. 3rd Why the body removes excess alcohol (5) (Pg. 54)
36. See 26. Across

# UNIVERSITY OF



# TOPITUP



Having completed, complied with, and consumed  
all the required conditions on or off the premises,

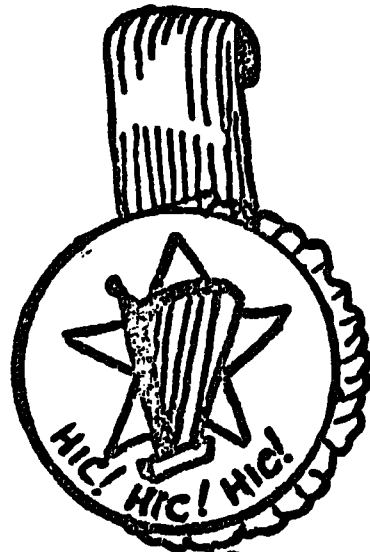
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is licenced as:

## MASTER OF ALCOHOL

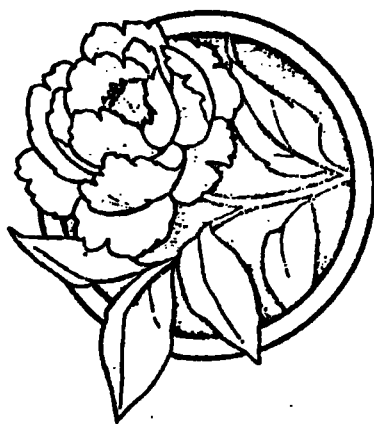
(and is entitled to the letters MALC.)

Witness my seal -----



**Chancellor.**

TO DONNA  
THANKS FOR COMING  
INTO MY LIFE EVEN IF IT  
WAS ONLY BRIEFLY



ALL THE BEST ON YOUR  
BIRTHDAY AND MANY MORE TO COME

LOTS OF LOVE

FROM [George]

Whatever you do  
when your birthday is here,  
Hope your day  
is as special  
as you are all year.

Happy Birthday

MAY DAY

## BIBLIOGRAPHY

- Abercrombie, M.L.J. (1979) Aims and Techniques of Group Teaching. Society for Research into Higher Education, University of Surrey.
- Adams, Lee (1983) Health Education/Health Promotion - Definitions/Aims/Issues. Health Education Council.
- Adelman, Clem (Ed.) (1984) The Politics and Ethics of Evaluation. Croom Helm, London.
- Agar, Michael H. (1980) The Professional Stranger. An Informal Introduction to Ethnography. Academic Press Inc., New York.
- Alschuler, Alfred S. (1980) School Discipline: A Socially Literate Solution. McGraw-Hill, New York.
- Anderson, L.F. (1931) Pestalozzi. McGraw-Hill, New York.
- Argyris, C. (1960) Understanding Organizational Behavior. Tavistock.
- Argyris, C. and Schön, D.A. (1978) Theory in Practice: Increasing Professional Effectiveness. Jossey-Bass Publishers, San Francisco.
- Armistead, N. (Ed.) (1974) Reconstructing Social Psychology. Penguin, Middlesex.
- Ashton, F. (1982) "Teacher Education: A Critical View of Skills Training". Journal of In-Service Education, Vol. 8, No. 3, Summer.
- Ausubel, D., Novak, J.D. and Hanesian, H. (1968) Educational Psychology. A Cognitive View. Holt, Rinehart & Winston, New York.
- Bailey, H. and Purser, B. (1982) Coventry Alcohol Education Group. A Constructive Programme for Working with the Offender with an Alcohol Problem. Coventry and Warwickshire Council on Alcoholism.
- Banks, Olive (1976) The Sociology of Education. B.T. Batsford Ltd., London.
- Bannister, D. and Fransella, Fay (1971) Inquiring Man. The Theory of Personal Constructs. Penguin Books Ltd., Harmondsworth, Middlesex.

- Batten, Thomas R. (1967) The Non-directive Approach in Group and Community Work. Oxford University Press.
- Bennett, Neville (1976) Teaching Styles and Pupil Progress. Open Books, London.
- Best, R., Ribbins, P. and Jarvis, C. (1983) Education and Care. The Study of a School and its Pastoral Organization. Heinemann, London.
- Bier, W.C. (Ed.) (1962) Problems in Addiction: Alcoholism and Narcotics. Fordham University Press, New York.
- Bligh, Donald A. (1972) What's the Use of Lectures? Penguin Books Ltd., Harmondsworth, Middlesex.
- Bragg, Melvyn (1977) The Hired Man. Coronel Books, Hodder.
- Brammer, Lawrence M. and Shostrom, Everett L. (1977) Therapeutic Psychology: Fundamentals of Counselling and Psychotherapy. Prentice-Hall Inc., New Jersey.
- The Brewers' Society (1982) UK Statistical Handbook. Brewing Publications Ltd., London.
- The Brewers' Society (1982) Brewing Review.
- Brown, George I. (1971) Human Teaching for Human Learning: An Introduction to Confluent Education. Esalen/Penguin Books Ltd.
- Brown, George I. et al. (1976) Getting It All Together: Confluent Education. Phi Delta Kappa, Bloomington, Indiana.
- Bruner, Jerome S. (1971) The Relevance of Education. Norton & Co., New York.
- Brunn, K. (1982) Alcohol Policies in the United Kingdom. Report by the Central Policy Review Staff. Sociologiska Institutionen, Stockholm University.
- Bruyn, Severyn T. (1966) The Human Perspective in Sociology. The Methodology of Participant Observation. Prentice-Hall Inc., New Jersey.
- Bryant, Clifton D. (1974) Deviant Behaviour: Occupational and Organisational Bases. Rand McNally, Chicago.
- Bumstead, D. and Eckblad, J. (1984) Introduction to Life Business Work. Unpublished paper.
- Bynner, John (1981) Issues in Methodology. Open University Press.
- Cahn, Steven M. (1970) The Philosophical Foundations of Education. Harper & Row, New York.

- Campbell, Donald T. and Stanley, Julian C. (1963) Experimental and Quasi-Experimental Design for Research. Houghton-Mifflin, London.
- Caruana, Salvino (Ed.) (1975) Medical Council on Alcoholism: Notes on Alcohol and Alcoholism. B. Edsall & Co. Ltd., London.
- Central Policy Review Staff (1979) Alcohol Policies. Government Publication.
- Centre for Mass Communications Research (1982) Evaluation of Alcohol Education Campaign in the Northeast of England. Leicester.
- Chafetz, Morris E. and Demone, H.W. (1962) Alcoholism and Society. Oxford University Press Inc., New York.
- Chambers and Morehouse (1983) "Cooperative Model for Preventing Alcohol and Drug Abuse". NASSP Bulletin, Vol. 67, pp. 81-87.
- Charleton, Anne (1983) "An Experiment in Health Education". Adult Education, Vol. 56, pp. 39-43.
- Chicago, Judy (1975) Through the Flower: My Life as a Woman Artist. Doubleday, N.Y.,
- Chick, J. (1983) "Medicine and the Media". British Medical Journal, Vol. 286, 7 May, p. 1509.
- Coffield, Frank; Robinson, Philip and Sarsby, Jaquie (1980) A Cycle of Deprivation? A Case Study of Four Families. Heinemann, London.
- Cohen, Stanley (Ed.) (1971) Images of Deviance. Penguin Books, Middlesex.
- Cohen, S. (1972) Folk Devils and Moral Panics.
- Colman, Andrew (1982) Game Theory and Experimental Games: The Study of Strategic Interaction. Pergamon.
- Cornish, Derek B. and Clarke, Ronald V. (1975) Residential Treatment and its Effects on Delinquency. Home Office Research Studies, HMSO.
- Cox, C.B. and Dyson, A.E. (1971) The Black Papers on Education. Davis-Poynter Ltd., London.
- Curwin, Richard L. and Fuhrmann, Barbara S. (1975) Discovering Your Teaching Self: Humanistic Approaches to Effective Teaching. Prentice-Hall, New Jersey.
- Dalzell-Ward, A.J. (1975) A Textbook of Health Education. Tavistock, London.



- David, Kenneth and Cowley, J. (1980) Pastoral Care in Schools and Colleges: with specific references to health education and drugs, alcohol and smoking. Edward Arnold, London.
- Davies, D.L. (1983) "Alcoholism". Midwife, Health Visitor and Community Nurse, Vol. 20, pp. 124-126.
- Davies, Ian and Raistrick, Duncan (1981) Dealing with Drink. BBC, London.
- Day, Richard (1982) Report of the Conference on Drug and Alcohol Abuse in South Tyneside.
- de Bono, Edward (1972) About Think. Jonathan Cape, London.
- Dellinger, Dixie G. (1982) Out of the Heart: how to design writing assignments for High School courses. Berkeley University, California
- Department of Health and Social Security (1976) Prevention and Health: Everybody's Business, p. 87.
- Department of Health and Social Security and Welsh Office (1979) The Pattern and Range of Services for Problem Drinkers. Report by the Advisory Committee on Alcoholism.
- Department of Health and Social Security (1981) Prevention and Health: Drinking Sensibly.
- Department of Health and Social Security (1983) NHS Re-Organisation: Grading of Health Education Officers.
- Developed by Joint Committee on Standards for Educational Evaluation (1982) Standards for Evaluation of Educational Programs, Projects and Materials. McGraw Hill, London.
- Dewey, John (1938) Education and Experience. Collier Macmillan, New York.
- Dockrell, W.B. and Hamilton, David (1980) Rethinking Educational Research. Hodder & Stoughton, Sevenoaks, Kent.
- Dodwell, P.E. (Ed.) (1972) New Horizons in Psychology. Penguin, Middlesex.
- Dorn, Nicholas and South, Nigel (1982-83) "Alcohol and the Media", International Quarterly of Community Health Education, Vol. 3(2).
- Dorn, Nicholas (1983) "Drink, Discipline and Demonology". TES, 22 April, p. 52.
- Dorn, Nicholas (1983) Alcohol, Youth and the State. Croom Helm, London.

- Douglas, Mary (1982) In the Active Voice. Routledge & Kegan Paul, London.
- Down, N. and Nortoft, B. (1982) "Health Careers". Institute for Study of Drug Dependence, pp. 2, 65.
- Doyle, Kenneth O. (1975) Student Evaluation of Instruction. D.C. Heath & Co., London.
- Draper, Peter; Best, Gordon and Dennis, John (1976) Health, Money and the National Health Service. Department of Community Medicine, Guy's Hospital Medical School.
- Draper, Peter; Best, Gordon and Dennis, John (1977) "Health and Wealth". Royal Society of Health Journal, June.
- Edwards, Griffith and Grant, Marcus (Eds.) (1977) Alcoholism: New Knowledge and New Responses. Croom Helm, London.
- Edwards, Griffith and Grant, Marcus (Eds.) (1980) Alcoholism Treatment in Transition. Croom Helm, London.
- Egan, G. (1982) The Skilled Helper, Model, Skills and Methods for Effective Helping. 2nd Edition. Brooks, Cole, Monterey, Cal.
- Entwistle, Noel J. (1973) The Nature of Educational Research. Open University Press, Milton Keynes.
- Entwistle and Nisbet (1976) Educational Research in Action. Hodder & Stoughton, London.
- Esland, Geoff; Dale, Roger and Sadler, J. (1972) The Social Organization of Teaching and Learning. Open University Press, Milton Keynes.
- Evans, M. and Satow, A. (1983) Working with Groups. HEC/TACADE.
- Fagan, J. and Shepherd, I.L. (1970) What is Gestalt Therapy? Harper and Row, New York.
- Fagan, J. and Shepherd, I.L. (1970) Gestalt Therapy Now. Harper Colophon Books, 1970.
- Fajardo, Roque (1976) Helping Your Alcoholic Before He or She Hits Bottom. Crown Publishers Inc., New York.
- Fantini, Mario D. (1976) Alternative Education: A Source Book for Parents, Teachers, Students and Administrators. Doubleday, New York.
- Faure, Edgar et al. (1972) Learning To Be. The World of Education Today and Tomorrow. UNESCO, Paris.
- Ferguson, M. (1982) The Aquarian Conspiracy. Personal and Social Transformation in the 1980's. Granada, London.

- Festinger, Leon (1957) A Theory of Cognitive Dissonance. Stanford University Press, California.
- Franklin, Billy J. and Osborne, Harold (1971) Research Methods: Issues and Insights. Wadsworth Publishing Co. Inc, California.
- Freeling, Paul and Barry, Susie (1982) In-Service Training: A Study of the Nuffield Courses of the Royal College of General Practitioners. NFER, Nelson, Berks.
- Froebel, Friederich (1899) Education by Development. Appleton, New York.
- Gatherer, A. et al. (1979) Is Health Education Effective? Health Education Council, London.
- Glaser, Barney and Strauss, Anselm L. (1967) The Discovery of Grounded Theory: Strategies for Qualitative Research. Aldine Publishing Co., Chicago.
- Glasser, William (1969) Schools Without Failure. Harper Colophon, New York.
- Glatt, Max (1974) The Alcoholic and the Help He Needs. Taplinger, New York.
- Glatt, Max (1982) Alcoholism. Hodder & Stoughton, Kent.
- Glazer, Myron (1972) The Research Adventure. Promise and Problems of Field Work. Random House Inc., New York.
- Goldstein, Gerald and Neuringer, Charles (1976) Empirical Studies of Alcoholism. Ballinger Publishing Co., Cambridge, Mass.
- Gordon, Peter et al. (1983) Is Teaching a Profession? Institute of Education, University of London.
- Gordon, Thomas (1974) Teacher Effectiveness Training. Peter H. Wyden, New York.
- Goulding, M.M. and Goulding, R.L. (1979) Changing Lives Through Redecision Therapy. Grove Press, New York.
- Grant, Marcus and Swinner, Paul (Eds.) (1979) Alcoholism in Perspective. Croom Helm, London.
- Grant, Marcus and Ritson, Bruce (1983) Alcohol: The Prevention Debate. Croom Helm, London.
- Griffiths, David (1981) Psychology and Medicine. British Psychological Society, London.
- Hamilton, David (1976) Curriculum Evaluation. Open Books, London.

- Hamilton, David et al. (1977) Beyond the Numbers Game. Macmillan, London.
- Handy, C. (1976) Understanding Organisations. Penguin, Middlesex.
- Handy, C. (1979) Gods of Management, Who They Are, How They Work and Why They Fail. Pan Books, London.
- Hargreaves, David H. (1972) Interpersonal Relations and Education. Routledge & Kegan Paul, London.
- Hargreaves, David H. (1982) The Challenge for the Comprehensive School: Culture, Curriculum and Community. Routledge & Kegan Paul.
- Harre, Romano (1970) The Principles of Scientific Thinking. Macmillan, London.
- Harre, Romano and Secord, Paul F. (1972) The Explanation of Social Behaviour. Blackwell, Oxford.
- Harre, Romano (Ed.) (1976) Personality. Blackwell, Oxford.
- Hart, Harold H. (Ed.) (1970) Summerhill: For and Against. Hart Publishing Co., New York.
- Hawker, Ann (1978) Adolescents and Alcohol. Report of an Enquiry into Adolescent Drinking Patterns carried out from October 1975 to June 1976. B. Edsall & Co. Ltd., London.
- Heather, Nick and Robertson, Ian (1981) Controlled Drinking. Methuen, London.
- Heather, N. et al. (1983) "A Comparison of Objective and Subjective Measures of Alcohol Dependence as Predictors of Relapse Following Treatment." British Journal of Clinical Psychology, Vol. 22, Part 1.
- Herndon, James (1971) How to Survive in Your Native Land. Simon & Schuster, New York.
- Heron, John (1982) Empirical Validity in Experiential Research. Rowan and Reason.
- Hills, Philip, J. (1976) The Self-Teaching Process in Higher Education. Croom Helm, London.
- Holt, John (1972) Freedom and Beyond. Dell, New York.
- Holt, John (1977) How Children Fail. Penguin Books Ltd., Middlesex.
- Holt, Maurice (1981) Evaluating the Evaluators. Hodder & Stoughton, London.

- Hostler, John (1981) The Aims of Adult Education. Manchester Monographs, No. 17.
- Houston, G. (1982) The Relative-Sized Red Book of Gestalt Therapy. Rochester Foundation, London.
- Howgate, Lynn (1982) Building Self-Esteem Through the Writing Process. Berkeley University, California.
- Hubley, John (1979) "Empowerment". Extracts from Kindervatten. Leeds Health Education Diploma Course.
- Hubley, John (1980) "Community Development and Health Education", Journal of the Institute of Health Education, Vol. 18, pp. 113-120.
- Hubley, John (1982) The Notion of Felt Needs. Leeds Health Education Diploma Course.
- Hudson, K. (1978) The Jargon of the Professions. Macmillan, London.
- Humphrey, George (Ed.) (1963) Psychology Through Experiment. Methuen, London.
- Hunt, Linda (1982) Alcohol Related Problems. Heinemann, London.
- Husen, Torsten and Kogan, Maurice (Eds.) Educational Research and Policy. How do they relate? Pergamon Press.
- Illich, Ivan (1971) Deschooling Society. Harper & Row.
- Ingalls, A. (1983) "Alcohol on College Campuses". Chronicle of Higher Education, Vol. 25, Part 9.
- Jackson, P.W. and Messick, S. (1971) "The person, the product, and the response: conceptual problems in the assessment of creativity". Personality Growth and Learning. A Source Book, p. 89. Longman.
- Jahoda, G. (1972) Children and Alcohol. A Development Study in Glasgow. HMSO, London.
- Jahoda, Marie (1982) Employment and Unemployment - A social-psychological analysis. Cambridge University Press.
- James, A. and Young, M. (1979) Kids and Cops. University of Durham, Department of Anthropology.
- Janis, Irving and Mann, Leon (1977) Decision Making. Free Press, New York.
- Jellinek, E.M. (1980) The Disease Concept of Alcoholism. College and University Press, New Haven, Conn.

- Joint Committee of the Central and Scottish Health Services Councils.  
(1964) Report on Health Education. HMSO.
- Kaplan, Harold and Sadock, Benjamin (Eds.) (1975) Comprehensive Group Psychotherapy. The Williams & Wilkins Co., Baltimore.
- Kendall, R.E. (1979) "Alcoholism: A Medical or Political Problem?" British Medical Journal, Vol. 9, No. 13, p. 783.
- Kessel, Neil and Walton, Henry (1965) Alcoholism. Penguin Books Ltd., Middlesex.
- Kilich, S. and Plant, M.A. (1981) "Regional Variations in the Levels of Alcohol Related Problems in Britain". British Journal of Addiction, Vol. 76.
- Kinney, Jean and Leaton, Gwen (1978) Loosening the Grip. A handbook of alcohol information. The C.V. Mosby Co., Saint Louis.
- The Kirby Report (1980) "The Kirby Report": Health Education. The Recruitment, Training and Development of Health Education Officers - a report of a working party of the National Staff Committee for Administrative and Clerical Staff, issued for comment. Chairman, R.W. Kirby. HEC.
- Knapp, R. (1971) Handbook in Research and Evaluation. Isaac & Michael, San Diego.
- Knowles, Malcolm (1970) The Modern Practice of Adult Education: Andragogy versus Pedagogy. Follett Publishing Co., Chicago.
- Knowles, Malcolm (1978) The Adult Learner: A Neglected Species. Gulf Publishing Co., Houston.
- Lacey, Colin and Lawton, Denis (Eds.) (1981) Issues in Evaluation and Accountability. Methuen, London.
- Lathrop, Richard G. (1969) Introduction to Psychological Research: Logic, design, analysis. Harper & Row, New York.
- Leeds Health Education Course (Undated handouts).  
 "Approaches to Health Education"  
 "The Who Regional Programme in the Health Education and Life Styles"  
 "Ethics and the HEO"  
 "Directive and Process Approaches to Health Education"  
 "Some Definitions of Health Education"  
 "Characteristics of the Self-Actualising Person"  
 "An Introductory reading list on community development and health education"

- Leevy, C. et al. (1975) "Liver Disease of the Alcoholic". Medical Clinics of North America, Vol. 59, No. 14, p. 915.
- Lerner, Max (1957) America as a Civilization. Simon & Schuster, New York.
- Leventhal, H. (1971) "Changing Attitudes and Habits to Reduce Risk Factors in Chronic Disease". American Journal of Public Health, 61: 1208-24.
- Lindeman, E.C. (1926) The Meaning of Adult Education. New Republic, New York.
- Louer, R.H. and Handel, W.H. (1977) Social Psychology. The Theory and Application of Symbolic Interactionism. Houghton Mifflin, London.
- MacDonald, Barry and Walker, Rob (1976) Changing the Curriculum. Open Books, London.
- MacDonald, Barry (1978) The Experience of Innovation. Centre for Applied Research in Education, University of East Anglia.
- McCall, George J. and Simmons, J.L. (Eds.) (1969) Issues in Participant Observation: A Text and Reader. Addison-Wesley, Reading, Mass.
- McGregor, Douglas (1960) The Human Side of Experience. McGraw-Hill, New York.
- McGuiness, John (1982) Planned Pastoral Care: A Guide for Teachers. McGraw-Hill, New York.
- McLeish, John Matheson and Park, James (1973) The Psychology of the Learning Group. Hutchinson University Library, London.
- Magee, Bryan (1982) Popper. Fontana Paperbacks, Glasgow.
- Mansfield, Peter (1982) Common Sense About Health. Templegarth Trust.
- Margulies, Newton and Wallace, J. (1973) Organisational Change Techniques and Application. Scott Foresman, Glenview, Illinois.
- Marsden, Dennis (1982) Workless: An Exploration of the Social Contract between Society and the Worker. Croom Helm, London.
- Marsh, Peter; Rosser, R. and Hane, R. (1980) The Rules of Disorder. Routledge & Kegan Paul Ltd., London.

- Marshall, Judi and McLean, Adrian (1983) Intervening in Cultures. University of Bath, Centre for the Study of Organizational Change and Development.
- Maslow, A. (1954) Motivation and Personality. Harper and Row, Evanston, Ill.
- Maslow, Abraham (1966) The Psychology of Science. Harper and Row, New York.
- Maslow, Abraham (1969) Toward a Psychology of Being. Van Nost. Reinhold.
- Maslow, A. (1970, rev. ed.) Motivation and Personality. Hayser & Bros., New York.
- Maslow, A. (1976) The Farther Reaches of Human Nature. Penguin Books.
- Mehrens, William and Lehmann, Irvin (1978) Measurement and Evaluation in Education and Psychology. Second Edition. Holt, Rinehard and Winston, New York.
- Merton, R.K. (1938) "Social Structure and Anomie". American Sociological Review, Vol. III, pp. 672-682.
- Milgram, G.G. (1982) "Youthful Drinking Past and Present". Journal of Drug Education, Vol. 12, Part 4, pp.289-308.
- Miller, Peter (1976) Behavioural Treatment of Alcoholism. Pergamon Press, London.
- Miller, Steve (1978) Experimental Design and Statistics. Methuen, London.
- Mills, C. Wright (1970) The Sociological Imagination. Penguin, London.
- Morris, Lynn and Fitz-Gibbon, Carol (1978) How to Measure Program Implementation. Sage Publications, Beverly Hills.
- Morris, Lynn and Fitz-Gibbon, Carol (1978) Evaluator's Handbook. Sage Publications, Beverly Hills.
- Mouly, George (1978) Educational Research: The Art and Science of Investigation. Allyn & Bacon Inc., Boston.
- Moustakas, Clark (1956) The Teacher and the Child. McGraw-Hill, New York.
- Naisbitt, John (1982) Megatrends. MacDonald & Co., London.
- Neeson, Brian (1983) "Time for a Radical Challenge?" TES 22nd April.
- Neill, A.S. (1962) Summerhill. Victor Gollancz Ltd., London.



- Nisbet, John (1975) "Innovation - Bandwagon or Hearse?". Curriculum Innovation. Croom Helm, London.
- Oppenheim, Abraham (1968) Questionnaire Design and Attitude Measurement. Heinemann, London.
- Orford, J. (1981) "Institutional Climate" in Psychology and Medicine, D. Griffiths (Ed.) British Psychological Society and Macmillan Press.
- Page, E.B. and Cronback, L.J. (1964) Readings for Educational Psychology. Harcourt, Brace & World Inc., New York.
- Parkas, T.P. (1954) Newcastle As It Is: Reviewed in its Moral Aspects, Social State, and Sanitary Condition. Committee of the Newcastle upon Tyne Temperance Society.
- Parlett, Malcolm and King, J. (1971) Concentrated Study: A Pedagogic Innovation Observed. Society for Research into Higher Education, London.
- Parlett, M. and Hamilton, D. (1972) Evaluation as Illumination: A New Approach to the Study of Innovatory Programmes. Occasional Paper 9, Centre for the Research in Educational Sciences, University of Edinburgh.
- Parlett, Malcolm and Dearden, Garry (1977) Introduction to Illuminative Evaluation: Studies in Higher Education. Pacific Soundings Press, California.
- Parlett, Malcolm (1981) Illuminative Evaluation. Wiley and Sons Ltd., Chichester.
- Parlett, Malcolm (1983) Experiential Knowledge. (Unpublished Chapter.)
- Parlett, Malcolm (undated) "Illuminative Evaluation" in International Encyclopedia of Education: Research and Studies. (Article No. 035/90698) to be published by Pergamon. As yet unpublished and undated.)
- Parrott, A. and Flude, R. (1983) "A Curriculum Fit for Adults?" Adult Education, Vol. 56, No. 2, pp. 117-121.
- Parsons, D. (1952) The Social System. Tavistock, London.
- Passons, W. (1975) Gestalt Approaches to Counselling. Holt, Rinehart and Winston, New York
- Pearson, Geoffrey (1975) The Deviant Imagination. Macmillan, London.
- Perkins, E. (1982) "Health Education - a new field for adult education?" Adult Education, Vol. 55, No. 1, pp.21-26.
- Perls, F., Hefferline, R. and Goodman, P. (1951) Gestalt Therapy. Crown Publishers, New York.

- Perls, F.S., Hefferline, R.F. and Goodman, P. (1973) Gestalt Therapy, Excitement and Growth in the Human Personality. Penguin, London.
- Peters, Richard (1959) Authority, Responsibility and Education. Allen & Unwin Ltd., London.
- Phillips, Derek (1971) Knowledge from What? Theories and Methods in Sociological Research. Rand McNally, Chicago.
- Plant, Martin (1981) Drinking Careers. Occupations, Drinking Habits and Drinking Problems. Tavistock, London.
- Plant, Martin (Ed.) (1982) Drinking and Problem Drinking. Junction Books, London.
- Platt, Jennifer (1976) Realities of Social Research. Sussex University Press.
- Plutchik, Robert (1974) Foundations of Experimental Research. Harper & Row, New York.
- Postman, Neil and Weingartner, Charles (1969) Teaching as a Subversive Activity. Delacorte, New York.
- Radical Statistics Education Group (1982) Reading Between The Numbers. A Critical Guide to Educational Research. BSSRS Publications Ltd., London.
- Ramprakash, Deo (Ed.) and Morris, Jackie (Assoc. Ed.) (1984) Social Trends, No. 14, HMSO, London.
- Reason, Peter and Rowan, John (Eds.) (1981) Human Inquiry. A Sourcebook of the New Paradigm Research. John Wiley & Sons, Chichester.
- Reid, Donald (1983) "Value for Money? Does health education really work?" TES, 22 April.
- Reid, Evan (1981) Social Class Differences in Britain. Grant McIntyre Ltd., London.
- Report of the NE Regional Working Party on Problem Drinking (1983) Drinking Problems? Current Practice and Policy Guidelines for Industry, Commerce and the Helping Agencies.
- Revans, Reg. (1982) "Action Learning: Its Origins and Nature". Higher Education Review, p. 20.
- Rico, Gabriele and Claggett, Mary (1980) Balancing the Hemispheres: Brain Research and the Teaching of Writing. Berkeley University, California.
- Rinehart, L. (1976) The Book of Est. Holt, Rinehart, N.Y.

- Robinson, David (1979) Talking out of Alcoholism: Self Help Process of Alcoholics Anonymous. Croom Helm, London.
- Robinson, David (1979) Alcohol Problems: Reviews, Research and Recommendations. Macmillan, London.
- Robson, Colin (1975) Experiment, Design and Statistics in Psychology. Penguin Books Ltd., Middlesex.
- Robson, J.E. (1981) Health Education in the Treatment of Alcoholism. Unpublished.
- Rockwell, S.K., Stohler, R.F. and Rottmann, L.H. (1981) 4-H Junior Leader Alcohol Education Project. (Nebraska Prevention Center for Alcohol and Drug Abuse, Report No. 2.) University of Nebraska-Lincoln.
- Rogers, Carl (1961) On Becoming a Person. Houghton Mifflin Co., Boston.
- Rogers, Carl (1965) Client-Centred Therapy. Houghton Mifflin Co., Boston.
- Rogers, Carl (1969) Freedom to Learn. Merrill, Ohio.
- Rorstad, Peter (1982) Facts and Statistics on Drinking in the North East. Unpublished.
- Rothschild, Lord (1977) Meditations of a Broomstick. Collins, London.
- Rowntree, S. and Lavers, G.R. (1952) English Life and Leisure. Longmans, Green & Co., London.
- Rubington, Earl and Weinberg, Martin (1973) Deviance. The Interactionist Perspective. Macmillan, New York.
- Rutter, Michael et al. (1979) Fifteen Thousand Hours: Secondary Schools and their effects on children. Open Books, London.
- Samples, Bob; Charles, Cheryl and Barnhart, Dick (1977) The Wholeschool Book. Teaching and Learning late in the 20th Century. Addison-Wesley Publishing Co., Reading, Mass.
- Sandmaier, Marian (1980) The Invisible Alcoholics. Women and Alcohol Abuse in America. McGraw-Hill Book Co., New York.
- Schmuck, R.A., Runkel, P.J., Arends, J.H. and Arends, R.I. (1977) The Second Handbook of Organisational Development in Schools. Mayfield Publishing Co., Palo Alto, CA.
- Schön, D.A. The Reflective Practitioner. Undated.

- School of Education, University of Exeter (1984) The Hargreaves Challenge: A Response. Perspectives No. 13.
- Schwartz, D. (1977) "The Mass Line as Consumer Participation and Community Involvement". International Journal of Health Education, Vol. XX, Issue No. 3.
- Schwartzman, Helen (1983) "The Ethnographic Evaluation of Human Service Programs." Anthropological Quarterly, Vol. 56, No. 4, pp. 179-190.
- Scottish Education Department (1975) Adult Education. The Challenge of Change. HMSO, Edinburgh.
- Seixas, Frank (1981) "What! Still using that old term Alcoholism and still calling it a Disease?" British Journal on Alcohol and Alcoholism, Vol. 16.2, pp. 78-86.
- Seltiz, C., Jahoda, M. et al. (1964) Research Methods in Social Relations. Holt, Rinehart and Winston, New York.
- Settle, D. (1984) Ownership. Unpublished paper, Birmingham L.E.A.
- Shotter, John (1975) Images of Man in Psychological Research. Methuen, London.
- Silberman, Melvin; Allender, Jerome and Yanoff, Jay (1972) The Psychology of Open Teaching and Learning. Little, Brown and Co., Boston.
- Simmons, Jeanette (Ed.) (1976) Making Health Education Work. American Public Health Association.
- Simnett, Ina (undated) The Buck Stops Here. Unpublished.
- Simons, Helen (Ed.) (1980) Towards a Science of the Singular. Centre for Applied Research in Education, University of East Anglia.
- Smart, Reginald (1976) The New Drinkers: Teenage use and abuse of alcohol. Addiction Research Foundation, of Ontario, Canada.
- Smith, A. (1975) Paper Voices: The Popular Press and Social Change, 1935-1965. Chatto & Windus, London.
- Smith, Peter B. (1973) Groups within Organisations. Applications of Social Psychology to Organisational Behaviour. Harper and Row, London.
- Smith, Peter B. (1980) Group Process and Personal Change. Harper and Row, London.
- Smith, Richard (1982) "The Politics of Alcohol". British Medical Journal, Vol. 284, 8 May.

- Sobell, M.B. and Sobell, L.C. (1978) Behavioral Treatment of Alcohol Problems. Plenum Press, New York.
- Sparrow, Freddie et al. (1973) Evaluation in Curriculum Development: Twelve Case Studies. Macmillan, London.
- Special Committee of the Royal College of Psychiatrists (1979) Alcohol and Alcoholism. Tavistock Publications, London.
- Spooner, R. (1983) "What it takes to be a real teacher." Education, Vol. 162, No. 4, p. 270.
- Spradley, James (1980) Participant Observation. Holt Rinehart and Winston, New York.
- Stacey, M. (1977) "Health and class: people who are affected by the inverse law of care." Health and Social Services Journal, June.
- Stake, Robert (Ed.) (1975) Evaluating the Arts in Education: A Responsive Approach. Merrill Publishing Co.
- Steiner, Claude (1971) Games Alcoholics Play. Ballantine Books, New York.
- Steiner, Claude (1979) Healing Alcoholism. Grove Press Inc., New York.
- Stenhouse, Lawrence (1967) Culture and Education. Nelson, London.
- Stenhouse, Lawrence (1975) An Introduction to Curriculum Research and Development. Heinemann Ed. Books Ltd., London.
- Sutherland, Ian (Ed.) (1979) Health Education, Perspectives and Choices. Allen & Unwin, London.
- Szasz, Thomas (1962) The Myth of Mental Illness: Foundations of a Theory of Personal Conduct. Secker & Warburg, London.
- Taylor, William (Ed.) (1973) Research Perspectives in Education. Routledge & Kegan Paul, London.
- Thomas, J.M. and Bennis, W.G. (1972) Management of Change and Conflict. Penguin.
- Thorley, Anthony (1980) "Medical Responses to Problem Drinking." Medical Education International, pp. 1816-1822.
- Thorndike, Robert and Hagen, Elizabeth (1969) Measurement and Evaluation in Psychology and Education. John Wiley & Sons Inc., New York.
- Tones, B.K. (undated) "Health Education: Prevention or Subversion?" Unpublished.

- Tones, B.K. (1979) "The quest for professionalism - professionalising health education in the health services and the schools." Institute of Health Education, Vol. 17, No. 2.
- Trethowan, W.H. (1977) "Alcoholism: The Possibilities for Prevention." Health Education Journal, Vol. 36, No. 4.
- Tuckman, Bruce (1978) Conducting Educational Research. Harcourt, Brace, Jovanovich, New York.
- Van Dalen, Deobold (1973) Understanding Educational Research. McGraw Hill, London.
- Van De Riet, V., Korb, M.P. and Gorrell, J.J. (1980) Gestalt Therapy: An Introduction. Pergamon Press, New York.
- Watts, A.G. Education, Unemployment and the Future of Work. Open University Press.
- Watzlawick, P., Beavin, J.H. and Jackson, D.D. (1967) Pragmatics of Human Communication: A Study of Interactional Patterns, Pathologies and Paradoxes. W.W. Norton, New York.
- Watzlawick, P., Weakland, T. and Fisch, R. (1974) Change: Principles of Problem Formation and Problem Resolution. W.W. Norton, New York.
- Weinstein, Gerald and Fantini, Mario (Eds.) (1970) Toward Humanistic Education: A Curriculum of Affect. Praeger, New York.
- West, Donald (1967) The Young Offender. Pelican Books, London.
- Wick, John and Beggs, Donald (1971) Evaluation for Decision-Making in the Schools. Houghton Mifflin Co., Boston.
- Wilkinson, R. (1983) "Are You Fit to Train Others?" Education and Training, July, p. 30.
- Wilkinson, Tony (1981) Down and Out. Quartet Books, London.
- Williamson, Bill (1982) Class, Culture and Community. A Biographical Study of Social Change in Mining. Routledge & Kegan Paul, London.
- Wilson, P. (1980) Drinking in England and Wales. An enquiry carried out on behalf of the Department of Health and Social Security. HMSO, London.
- Wiseman, Jacqueline (1979) Stations of the Lost: The Treatment of Skid Row Alcoholics. University of Chicago Press, Chicago and London.

- World Health Organisation (1954) Health Education and the Public. Report No. 89.
- World Health Organisation (1982) Basic Documents. Thirty Second Edition. Geneva.
- Youngman, M.E. (Ed.) (Undated) Rediguide 2. Evaluating the Literature. TRC Rediguides Ltd., Nottingham.
- Youngman, M.E. (Ed.) (Undated) Rediguide 7. Attitude Assessment. TRC Rediguides Ltd., Nottingham.
- Youngman, M.E. (Ed.) (1978) Rediguide 28. Essential Empirical Concepts. TRC Rediguides Ltd., Nottingham.
- Zimbardo, Philip G., Ebbesen, Ebbe and Maslach, Christina (1977) Influencing Attitudes and Changing Behavior. Addison-Wesley Publishing Co.
- Zinker, J. (1977) Creative Process in Gestalt Therapy. Brunner, Mazel.

