Seeking explanations about drug use: methodological issues around explaining self-reported drug behaviours

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Statement

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Overview

The aim of the thesis is to examine the evolution in social scientific approaches to managing self-reported explanations for behaviour. This debate starts with the initial question of whether they should be regarded as having any scientific currency at all and, if they do, what relationship this may have to more 'objective' (and possibly contradictory) forms of data. For human sciences such as social psychology, where the answer would more often than not be affirmative about the viability of self-report, a host of further questions then arise. These range from under what circumstances should self-report be recorded, how should it be accessed (structured intervention or analysis of existing texts) to what should be done with it and who should own it.

These issues represent the critical debates that will inform the initial chapters of the thesis and which, to a large extent, represent the arguments supporting the use of primarily qualitative or primarily quantitative research techniques. These philosophical concerns have hugely pragmatic consequences for the status of both the scientist and that of the participant, whose role in the scientific procedure remains largely passive. Yet, the increasing impact of the human sciences on daily life ensures that the reverberations of this debate are felt far from the lecture theatre. The initial chapters attempt to chart both the parameters and the evolution of this debate so that its impact on the actual business of working with people can be considered in a more reflexive and principled manner.

The decision to focus on issues surrounding alcohol and drug use is that this is an area that has not only provoked considerable public debate and anguish recently (leading to much academic exposition and research output), but also that it is an area whose scientific foundations are poorly defined. Thus the medical model that has dominated statutory treatment provision sits uncomfortably alongside some psychotherapeutic interventions available, while the scientific foundations for epidemiology and intervention with young people remain unresolved territories in terms of the most appropriate scientific paradigm. Thus, 'the addictions' constitute an ideological battleground whose questions are frequently those of scientific method, yet where many young people are defined and normalised by procedures over which they have little control.

The investigation of drug and alcohol problems is a major social priority yet one for which the most fundamental of questions – 'how big is the problem?' has not yet been adequately been addressed. While there are many practical, historical and scientific reasons for this, some of the most basic are methodological and are indicative of the debate around the status of self-report. Until we can understand the complexity of the processes that inform how a person 'becomes' an addict, or why their self-reports in this area may vary (as a consequence of situational and motivational factors), then the policy questions of intervention will remain impossible to adequately address.

The thesis attempts to clarify the role of the social scientist in addressing this question by examining initially the tools at his or her disposal – first, attribution

theory (chapter 1) and then some of the more discursive approaches to understanding lay explanation (chapter 2). Much of this debate is synthesised into a model for interpreting the self-reports of drug users (whose rationale and method is outlined in chapter 3 and its initial implementation in chapter 4). While this approach identifies some of the complexities involved in understanding the narrative structures that relate to problem drug use (as a prerequisite to answering 'how many addicts are there?'), they fail to address the question of accuracy or honesty in drug reporting where there is no suggestion of addiction.

This second key epidemiological question, 'how many people use drugs?', is examined by focusing on a group of people among whom use is rarely problematic in the sense of physical dependence, but for whom any form of use is a matter of public concern. As the main method for assessing drug use in this population has been by self-completion survey questions of accuracy and honesty have been core to the methodological debate. The studies reported in chapters 5 and 6 attempt to address these questions by examining the dynamics that surround qualitative and quantitative reporting in this population.

The overall goal of the thesis is to attempt to employ research strategies deriving from methodological debate in the social sciences to improve the clarity of research philosophy in the drugs field.

Abstract

The thesis investigates the dynamics that surround participants' responses to questions about illicit drug activities. By examining the attributional and discursive literatures, the opening chapters (Chapters 1 and 2) outline the difficulties associated with assuming veridicality in question-answer dyads. Emphasis is placed on the essentially social and intentional foundations of the applied research procedure. The existing research on methodological effects in substance research is outlined at the start of Chapter 3. These form the foundation for the empirical investigations that constitute the remainder of the thesis. The studies carried out attempt to examine methodological issues in the context of applied research procedures that combine quantitative outcomes with qualitative considerations such as reflexive consideration of the role of the researcher and the status of the participant.

The first investigation demonstrates the influence of treatment status on the discourse provided by adult substance users. Drug users in contact with treatment services provide drug-related explanations distinct from those given by users who are not in treatment. This distinction is assessed in terms of a theoretical model of addiction based on discursive criteria and contextual influence (Chapter 4). These contextual influences are further examined in the empirical studies presented in Chapters 4 and 5 in which the subjects are young people whose drug experiences are assessed in the context of drug education (Chapter 5) and treatment and service needs (Chapter 6). Each of these investigations attempts to demonstrate the sophistication of discourse that respondents exhibit in their drug-related conversations and the ways in which their attitudes and understandings of these topics are shaped by the context of the experiences they have had.

Chapter 1 - Attribution Theory

1. Introduction

To examine the attributional approach to drug-related explanations it is useful to first consider the historical academic background to this method. The history of attribution theory reflects the development of a generally cognitive and deterministic approach to problems in social psychology. The emphasis here is placed on discrete decision-making processes that occur in "lay explanation". Much of the original work was conducted by Heider and is reported in his seminal work "The Psychology of Interpersonal Relations" (1958) in which explanation seeking is represented as the quest for pseudo-scientific causes of behaviour. The crucial representation here is of the lay person striving to engage in activities in a scientific manner but without the technical expertise of the "real" scientist. The task undertaken by Heider, and adopted by many subsequent social investigators, was to examine the mechanisms underpinning such causal inferences and to examine the accuracy and utility of this "naive science". The question this poses for understanding drug explanations is whether there is such a mechanism for explaining substance-related behaviours and, if so, what form does it take.

This objective was advanced by the development of Kelley's "ANOVA model of attribution"(1967). He suggested that the type of explanation that would be offered for a piece of behaviour would be inferred from the interaction of three factors - consensus, consistency and distinctiveness. These referred to the frequency with which the target behaviour was also engaged in by other people (consensus), whether

the person engaged in this behaviour frequently (consistency) and whether this action is regularly visited upon its object (distinctiveness). The example frequently cited is of Tom hitting Mary and the possible reasons for this act of violence. According to Kelley's model this would be determined by whether Tom regularly hit Mary, whether lots of people hit Mary and whether Tom regularly hits other people. The combination of answers will allow the lay person to attribute responsibility for this action to something about Tom, to something about Mary or to something about the situation. The key issue here is that this is a discrete event that allows for a discrete explanation and, as it represents lay explanation mechanistically, it allows only for one explanation for an event.

This has been the approach that has been used in the development of attribution theory - the subject is presented with a hypothetical event concerning created characteristics, a limited amount of information about the context and is then required to make an attribution of responsibility or cause. In the standardised tool used to assess attributions, Abramson *et al*'s (1981) "Attributional Style Questionnaire" the subject is presented with 12 hypothetical situations (e.g. "you have been looking for a job unsuccessfully for some time") about which the subject has to make ratings of cause and responsibility. This has been supplemented by work conducted in the field of personality research, in particular Rotter's (1966) paper, "Generalised expectancies for internal versus external control of reinforcement". Rotter outlines a scale for measuring "locus of control". This he defined as a relatively enduring personal characteristic indicating the extent to which individuals perceive that they have control over the events in their lives.

This "internal-external" dimension is one of the key features of attribution theory in terms of subjects explaining their actions and for explaining the actions of other people. An internal (or dispositional) attribution is to ascribe responsibility or cause to the actor while an external (or situational) attribution is to explain an event in terms of the context in which it occurred. This approach was adopted by Weiner (1975) in his work on achievement motivation in which he characterised explanations of success or failure in terms of three dimensions - internality, stability and controllability. The internal-external dimension was based on Rotter's concept of locus, while stability refers to the durability of the action over time and controllability to the extent to which the individual saw the behaviour as within the control of the actor.

Weiner's work was based on self-attributions of examination performance in which students gave explanations for real successes and failure. Weiner's work marks the transition for attributions from dealing with hypothetical or historical events to using natural explanations (attributions) as the basis for prediction. Weiner argued that certain explanations for failure - particularly external, controllable and unstable - offered a more optimistic prognosis for future performance than attributions that were internal, stable and global. For Weiner, the individual who explains failure in terms of lack of effort (a transitory and controllable state of affairs) has more chance of working towards a pass in the exam than the individual who explains failure in terms of things they cannot control and are enduring, such as lack of ability. This was a crucial development for attribution theory as it represented the transition to a model that was testable and potentially applicable in a range of social and clinical situations.

2. The evidence for attribution theory

One of the most comprehensive studies was carried out by McArthur in 1972 employing the standard model of presenting the subject with a sentence depicting an event and requiring the subject to choose a "why" question from a list of options based on the actor or the situation. The McArthur study was a test of Kelley's "causal calculus" and provided a certain amount of support for the consensus, consistency and distinctiveness determinants of explanation. However, it was suggested that subjects may not require all three types of information to make judgements as, in everyday life, such decisions may have to be made with considerably more limited information. To test this, Orvis, Cunningham and Kelley (1975) supplied their subjects with two or, on occasion, only one information variable. They found that subjects could infer the value of the information they had received but also could often infer the actual attribution. The authors concluded that individuals have a mental template corresponding to the causal calculus.

A substantial amount of subsequent work on attribution theory focused on the dimensions employed by Weiner as these have been regarded as having considerable practical applications. One such project was the "learned helplessness" experiments carried out by Martin Seligman (1975). Using Pavlovian learning techniques, Seligman demonstrated that dogs could come to learn the inescapability of pain and so stop trying to avoid it. Seligman believed learned helplessness was a major determinant of many cases of unipolar depression, although the original literature (e.g. Miller and Norman, 1975) presents a confused picture. For this reason,

Seligman turned to the developing area of attribution theory and Peterson and Seligman (1980) argued that it was the causal attributions for negative events that led to depression in many cases. In particular, they argued that an attributional style of internal, stable and global explanations for negative events was characteristic of depressives.

In 1979 Seligman et al correlated scores on their Attributional Style Questionnaire (ASQ) against scores on the Beck Depression Inventory (Beck, 1974) giving scores of 0.41 for internality, 0.34 for stability and 0.35 for globality. Although statistically significant these do not reach the levels required for clinical significance. Similarly the development of the Child Attributional Style Questionnaire (Kovacs and Beck, 1978) demonstrated that children as young as nine may manifest both depression and the internal, stable attributional style. Further support for the model comes from the positive events in the Attributional Style Questionnaire (it consists of six positively valenced and six negatively valenced items). When correlated with depression scores the positive events score yielded negative correlations with internality, stability and globality. For good events, depressives make attributions that are less internal, less global and less stable than do normal individuals.

This provokes a "reality" question - do depressives have a negative attributional style as their lives justify such representation, making the optimism of so-called "normals" the greater distortion of reality? Social psychology research had previously reported the biasing tendency of 'normal' subjects. Miller and Ross (1975) report on the 'self-serving bias', according to which individuals tend to take the credit for success

(internal attribution) and disclaim the responsibility for failure (external attribution). There is also an 'actor-observer divergence' (e.g. Nisbett et al, 1973; Storms, 1973) in which actors are more likely to use external attributions for their own actions, while observers are more likely to make dispositional attributions about the actions of others. The authors concluded that actors place greater emphasis on situational factors than do observers. This may be a consequence of differences in perspectives with the actor looking outwards at the world while the observer sees the actions revolving around the individuals engaging in them. This may go some way to explaining why non-drug users 'blame' drug users for their own actions while the users themselves are more likely to provide socially mediated explanations for their behaviour.

Another bias is referred to as the 'fundamental attribution error', based on the actor-observer divergence. The principle behind this is referred to as 'correspondent inference' and involves the tendency we have to infer dispositional traits from the statements made by individuals. This approach was tested using a research strategy in which subjects were asked to read or write an essay for or against a particular position, while observers were required to attempt to assess the speaker's "real" attitude (e.g. Jones and Harris, 1967). Brown concluded that "observers will draw internal inferences from an actor's behaviour unless the actor's behaviour is so fully controlled as to be robotlike" (Brown, 1986, pp. 179 - 180).

In sum, these biases have powerful implications for attribution theory. The normal individual is more likely to make favourable interpretations of their own behaviour by attributing success to dispositional factors and failure to situational factors, and by

making attributions about their own behaviour that are more likely to be situational than dispositional. These may act as powerful constraints on the generalisability and scientific testability of everyday explanations, particularly as the attributions of actors and observers are likely to be divergent. This creates one of the major dichotomies to be explored throughout the thesis - for substance activity, who contributes to the actor's explanations and how are these validated and legitimised in contexts that involve external observers? (see Chapters 3 and 4).

One possible inference is that the 'normal' participant in social psychology experiments exhibits a generally optimistic bias for both positive and negative actions. Therefore the assumption is that depressives have either a bias towards internal, stable and global attributions for negative events (and a bias towards external, unstable and specific attributions for positive events) or that they lack the positive biases that exist in 'normal' subjects. When Alloy and Abramson (1979, 1982) attempted to test these possibilities using estimates of control they found that depressives were more 'realistic' than non-depressed subjects. The conclusion they reached is that the 'normal' distorts reality to live in an illusory world of optimism, in which self-serving biases sustain a positive self-image at the expense of 'reality'.

It is this 'psychological' foundation of attribution theory that permits it to be used as a predictor of behaviour and that allows its deployment as a clinical tool. If attributions represent a negotiable psychological state that can be shifted, then attributions may have a significant role in therapeutic interventions based on cognitive-behavioural premises. However, before attempts are made to implement an "attributional

therapy", a critical examination must be undertaken of the reliability and validity of attribution theory and it's underpinning dimensions (both Kelley's and Weiner's). For this reason, the remainder of this chapter will examine the critical literature of attribution theory and the social scientist's role in interpreting "lay" explanation, while Chapter 2 will look at some of the alternative approaches to understanding the context and role of natural explanation.

Criticisms of Attribution Theory

One criticism of Kelley's model was advanced by Pruitt and Insko (1980) when they noted that the typical research procedure does not permit the subject to carry out the "naive ANOVA" indicated by the original model. They argued that the model is more accurately described as a typical cognitive heuristic than an inferior representation of a scientific model. Thus, the characterisation of lay explanation as an unconscious attempt to be scientific that is just not quite up to standard, is pejorative as it presents a misleading model of everyday explanation. This is a point that will characterise much of the discussion - everyday explanation is not scientific because its goals are not scientific. They are, in fact, purposive, interpersonal and negotiated, and it is a distortion to characterise them as pseudo-scientific.

A similar problem is that Kelley's model of natural explanation does not allow the distinction between necessary and sufficient conditions (Hilton, 1988). This follows in the associationist tradition common to much of social science which ignores the empiricist criticism that cause is, in itself, not knowable. As Schustack and Sternberg

(1981) point out, occurrences in both the condition-present / effect-absent and the condition-absent / effect-present do not merit the conclusion that there is no causal connection, yet this is an assumption made by Kelley's ANOVA model. Rather, the conclusion that should be drawn is that if causal relationships exist they are of different types. It is the social scientist's representation of causality that is flawed and not that of the lay explainer. While this may seem pedantic, it emphasises the reflexive issue in attribution theory and its representation of its subject. The representation of lay explanation as "inferior science" cannot be sustained on grounds of natural science and can be interpreted as a mechanism by which the social scientist may assume the right to impose his explanation on that of the original subject. Here the characterisation of lay explanation as bad science is a warrant for the superiority of the attribution theorist's explanation.

A similar problem for Kelley's model concerns "counterfactuals" - the case in which the condition is absent but the effect is present. According to Jaspers, Hewstone and Fincham (1983), Kelley's reliance on co-variation is made problematic by the psychological assumption that the absence of a counterfactual may be the ordinary state of affairs (e.g. what may have happened if America had not bombed Hiroshima). This contrasts with the assumption for single events (as are presented in vignettes) that there is some salience to the information. Therefore, if one gives the counterfactual information that on one occasion Tom did not kiss Carol, the subject may assume this is salient (or unusual) and that he normally does, although there is no causal foundation for this premise.

The point is that if the contrast case has never occurred there can be no assumptions of causality. These philosophical criticisms of the lay science model are crucial as attribution theorists who stick rigidly to Kelley's model may be misinterpreting the goals of everyday explanation. These do not have to be approximations of an external, natural reality and so do not have to employ methods that approximate to it. The point is that it is only by characterising lay explanation in this way that this mechanistic and deterministic model of human activity can gain currency, at the expense of more negotiated and social interpretations of explanation.

Another problem for Kelley's model of causal explanation, albeit one he was aware of, concerns the situation in which there are a number of sufficient but not necessary conditions for the effect to occur. This is the day-to-day experience in which a complex phenomenon may equally be explained by a number of causes either singly or in combination. This situation emphasises the pre-eminence of psychological over "actual" cause - it was Mackie (1974) who first wrote of the centrality of impressions of causal relations in the field of attribution. There are two issues here - the first concerns the way in which, in attribution theory, one cause is given prominence over another. The second is the way in which one single cause is selected from a number of non-equivalent potential causes with the non-equivalence occurring at the level of explanation.

While traditional attribution theory focused on easily defined and measured events, this is frequently not the case for real "why" questions. For example, in the case of the Cromwell Street murders, the question of why the Wests committed their crimes,

elicits explanations that range from cinematic desensitisation of society to violence to inadequate policing and social care provision. The point about these factors is that they are not mutually exclusive, although all may be causal determinants of these violent acts. To assume that one of these is the definitive cause is to commit what Ryle (1949) may have called a 'radical category error', yet this is the consequence of the methods employed in the attribution literature. The point that Mackie makes is that people select causes because they have explanatory benefits rather than as a consequence of their scientific primacy.

The immediate difficulty with this, as Kelley (1967) notes, is that if an attribution of cause is traced through a series of intermediate connections to a distal event, such as adult criminality to parental separation in childhood, the chain of connections may include both internal and external factors. The parental separation (external) may have led to insecurity (internal) to tantrums (unstable) to peer mistrust (stable) to deviant behaviour (internal, stable and possibly global). As Hilton (1988) points out "internal and external causes are thus interdependent, and may even be recursively embedded in each other in an extended causal chain."

This problem is compounded by the difficulty of differentiating internal from external explanations in certain circumstances - thus, if a student is asked why she wants to be a psychologist and replies that it is because it is a well-paid job this would be regarded as an external attribution. However, if in response to the same question, the student replies that it is because she wants to earn a lot of money, this would be an internal attribution, yet one could argue that the two explanations tap the same underlying

dimension, distinguished by active or passive discourse. The possibility that the internal-external dimension is influenced by linguistic style ("it's cold today" as opposed to "I'm cold today") would not undermine the predictive function of attributions but would imply a shift of emphasis from cognitive processing towards discourse and language (see Chapter 2). However, it is important to recognise that this is a criticism of the dimensions, rather than a fundamental challenge to the attributional model.

The issue of internality is not, however, as straightforward in everyday attributions of cause as the vignette studies have implied. Characterising events as either internal or external is not straightforward, and this is compounded by the difficulties of isolating individual 'causes' from events that have multiple sufficient and necessary causes. According to Hart and Honore (1959) the salient cause is identified as an abnormal condition if there is an intention lying behind it, in which the intention is referred to as the "operative cause". Thus if a car crashes because of icy roads, but the ice on the roads results from their being hosed by a criminal intent on damage it is the hosing of the road that is deemed the cause and not the ice per se. The appropriate model here is multiple regression analysis, not analysis of variance. This challenges the "man the scientist" model in that it is the salience of conditions (i.e. although oxygen is required for a fire, it is unlikely to be cited as the cause) that increases their role as explanatory devices, rather than that they satisfy the condition of covariation. Here we return to the point that attributional cause has social and purposive foundations that may or may not be consistent with scientific causality.

People make causal explanations without any regularity in mind to support it (Mackie, 1974) as a consequence of their hopes, beliefs and social circumstances rather than as a result of rational calculation (whether conscious or not). They may use a number of strategies in isolating causes which may be connected with both linguistic and social factors that may not accord with a causal reasoning process. It may only be in an uninteresting environment such as a social psychology experiment that a concept such as man as lay scientist could seem plausible.

If the question to be answered by the subject was not "why did John trip over Mary dancing" but "Why does John inject heroin" there are a viable range of response options along the lines of:

(a) Because of something about John,

(b) Because of something about heroin or

(c) Because of something about the situation.

As a result, the style of the answer would be very different. While the original causal attribution model would claim that it is the unimportance of the first situation that makes it scientifically useful, this is why it has only limited relevance for everyday explanation. Everyday explanation is caught up in the flow of life events for the person who will only engage in a causal inference process if there is a reason to do so. This also emphasises the actor-observer difference as will become apparent in the studies of drug use and explanation presented in Chapters 4, 5 and 6.

The issue of salience has also been addressed by Taylor and Fiske (1978). In their study, subjects watched a dialogue in which either of the speakers was more visible or

they were given equal prominence. In general, the observers assigned greater causal responsibility to the actor who had been made more salient to them. Thus, the death of a drug user is more likely to be explained in terms of overdose than heart failure from natural causes as the rhetoric of drug use involves this kind of risk and overdose is part of the narrative of drug use whereas death from natural causes is not. What is salient in the mind of the attributer is central here and not necessarily related to a pseudo-scientific covariation principle. What is salient may well involve myths and narratives about drug use and what happens to drug users.

Mackie (1974) has also suggested that the attribution research to that date had not addressed the question of how hypotheses are formulated in the first place, focusing on testing existing hypotheses, which Mackie defined as "eliminative induction". This point establishes that the model will not bring to light common assumptions and will seek co-variations within a particular set of beliefs. Thus for the dead drug user, if the person ascribing cause is a coroner, then the explanation will involve some set of biological explanations, and it would be inappropriate for the coroner's report to speak of urban deprivation or Government policy. This is a consequence of the role occupied by the coroner, but it is also the type of explanation that is considered most satisfactory in that it is "scientific".

This brings to light a distinction frequently overlooked in the attribution literature, concerning the overlap in definitions of "cause" and "responsibility" - if one asks about the cause of death there is an expected level of description based on physical causality. On the other hand, if the question is about responsibility the appropriate

level of description is (inter)personal rather than physical. Here responsibility rests in the behaviour of individuals or groups, whereas cause can equally be attributed to inanimate objects. In other words, the context of the why question is a significant determinant of the range of appropriate styles of response, one of the most important aspects of which is 'who does the asking?'

This is an important issue if the theoretical foundations of social psychology experiments are to be regarded as being socially grounded, as many of the criticisms levelled at Weiner or Kelley's models of explanations relate to the rationale for the discipline rather than attribution per se. It is only if one does not accept a radical discontinuity between the "scientific explainer" (the attribution theorist) and the "lay explainer" (the subject) that it is meaningful to permit its claim to universality (or globality). This is based on the social scientist's dual (and possibly duplicitous) status as definer of a social structure he or she is party to when they leave the laboratory. The attribution theorist, as a social scientist, is here faced with a problem that the physicist is spared – namely, that he is both explainer and explained if his theory is a general rule of explanation.

It is not unreasonable to expect the experimental design to influence the motivation and willingness to participate of the subject, yet it is assumed that the only motive the participant has is compliance. If the participant is given a trivial task then their level of engagement is likely to be trivial. It is not only that such explanations lack the impetus of significant life concerns, but also that the subject must act with no context other than a paper and pencil test with a guarded and unhelpful "scientist". This

entire situation induces a rationalistic fallacy - the ensuing behaviour appears rule-bound in a context in which meta-rational considerations are removed. The participant is also likely to exhibit self-presentational biases towards logical, rule-bound and coherent activities, not necessarily because that is what she does in her daily activities but because that is what she thinks is required from someone asking assessment-style questions.

There are two contextual problems for the attribution research experiment - the context of the vignette and the context of the interaction between researcher and subject. The problem with the vignette is that it is trivial, frequently presenting unlikely situations about unknown individuals with no background information. It also forces the subject into a passive role in which the subject is given a finite and non-negotiable set of information on which to base their judgement. This is in contrast to daily life in which attributing responsibility involves information seeking and canvassing the opinions of others. Secondly, research occurs in an unfamiliar context with the participant attempting to guess the purpose of the task and anxious that they are being tested. It is foolish to assume that the subject will not develop a theory about the experiment and that this will not influence their behaviour. Thus, the interaction constitutes the context of the task and acts as a substitute for background information against which the task is performed.

These limitations with both the structure of the lay scientist model and the experimental methods used to investigate it, have led attribution theorists to develop the theory in two main ways. At a theoretical level, the model has been extended by

some writers to address some of these social and purposive criticisms, while the model has also been taken out of the laboratory to address real issues of practical importance. Particularly, in the developmental area, attribution theory has been widely utilised in examining explanations in children. For example, Sedlak (1979) has argued that young children attribute intentionality in systematically different ways from older children, while Lalljee, Watson and White (1983) have shown that children as young as five have clearly differentiated explanations for emotions and actions.

3. Attribution Interviews

As part of this preliminary investigation five interviews were carried out anonymously with social psychologists who have worked with attribution theory. These interviews were tape-recorded and lasted for between 30 minutes and one hour. The interview schedules were semi-structured and were developed around a series of key questions on the problems and issues surrounding attribution theory. The reason for conducting these interviews was to provide a further level of explanation, in which the empirical explanation and its theoretical underpinning (the attributional approach and its rationale) are themselves materials for explanation.

This is not merely an exercise in reflexive practice through which any explanation is shown to be open to its own method of analysis but is a means of examining the political agendas of attribution theory. The topic is attribution theory in general and not initially its specific application to the drugs field as it is the general application of the approach that is being examined prior to its specific use with regard to substance

misuse. By so doing the political relationship of attributing cause to drug users' explanations (given in both the first and third person) can be made more explicit. These interviews should not be regarded as characterising the interviewees, rather they illustrate some of the difficulties associated with applying attribution theory. The interviews will be dealt with by topic and are listed in a random order.

1. Attributions as categorisations

The first point made by Interviewee 1 is that much of the original experimental work was weak and naive, yet is still cited in the literature, that "people still talk about internal and external attributions and I think it would be much better had the theory moved on". The claim is that the concept of internality of attributions is confused and that too much emphasis has been placed on a concept of debatable validity at the expense of more salient cognitions. This point was picked up by Miller et al (1981) when they argued that the 'internal' and 'external' dimensions cover too much ground and that they are not easy to assign explanations to.

This claim is emphasised by the interviewee's criticisms of the internality, stability and globality dimensions on the grounds that, "Once you identify somebody along those dimensions its very unclear what you've got at the end of the day and that somebody who's doing that in a clinical setting looking at depressions might actually be dealing with quite different types of representational world than someone who's trying to do that in terms of patient's understanding of a symptom". This is based on the rigidity of the dimensions and the lack of sophistication in the characterisation of individuals that ensues. This is supported by Interviewee 3's claim that "The obvious

weakness [of attribution theory] is that, at the end of the day you can never be sure. Whether someone gives a valid account of their actions or whether I make a valid inference .... you can never be sure".

Although social scientists talk about the limitations of particular classification systems, such as those associated with attribution theory, this overlooks the possibility that it is the act of classification that is problematic. The point emphasised in the quotation from Interview 3 is that attribution theory is limited, and that this limitation is mediated both by the 'accuracy' of the subject's input and by the skills of the social scientist. However, what is unclear is what the relationship between the two is and how this is managed in a social context. Yet the need for qualitative and interpretive material is recognised in Interview 5 when the speaker claims that "There's a realisation that whilst data collection and observing behaviour is perfectly adequate it is not sufficient in itself". This is, in effect, the central dilemma with which the social scientist is faced - the complexity of attempting to marry quantitative and predictive methods with the need for discursive and qualitative interpretations.

This is recognised in the conclusion that Interviewee 1 draws that, "So, no, I wouldn't, I would encourage people to try and look for a more sophisticated description of the person or the group's causal understanding". This raises two new issues. First, the creation of any typology of linguistic performance is necessarily going to involve a crude categorisation that does violence to the original statements. Secondly, the pressures towards parsimony and sophistication are not likely to be consistent. This is not surprising as the process of explaining the explanations is a

complex task that does not lend itself to simple categories. Here it is not that attribution theory is inadequate but that it is inappropriate for the goals it has been set.

2. Attributions and the characterisation of subjects

The classification of the individual along the attribution dimensions may vary according to the reasons for using the method. That an individual may be characterised in different ways according to the motives underpinning the characterisation is a common feature of everyday life and is only surprising in a "real science" paradigm. This is recognised by Interviewee 4 in his claim that "This is when it becomes disingenuous. They [the attribution theorists] are appealing to a position which seems as if its objective but is itself a subjective position". The search for consistency is here explained as an aspect of professionalised activity rather than as a part of the observed behaviour. A drug user may characterise himself as external when explaining crimes committed, but as internal when planning future activities, depending on the context of the conversation (see Chapters 4 and 5). It is only if attributions represent an underlying reality uninfluenced by the motives of the attributer, that such shifts cannot be permitted. It is this issue that has led Lloyd-Bostock (1983) to argue that attribution theorists would examine the legal literature as the basis for a broader theoretical frame that incorporates the social context in which attributions are provided.

Social scientists are not naive in their expectations for attribution theory as a scientific method, but political assumptions about the relationship of the experimenter to subject are implicitly made. The first assumption is that the subject is "mindlessly compliant"

and enters the study without motives which can be questioned on two counts. First, even if achievable, this does not represent everyday activity, a problem for a theory with that objective. Second, the use of trivial situations does not elicit an absence of motives but the motives of apathy and disinterest. The difficulty is that the method contradicts the objective - by being neutral, this removes the everyday relevance of explanation, replacing them with impression management strategies peculiar to the context of participating in experiments. In Interview 4, the claim is made that "what social psychologists keep forgetting is that when they're trying to be objective and neutral, they are actually taking a position, a bizarre one, but a subjective position". Here the interviewee identifies the flaw of perceived neutrality as a peculiar but identifiable stance that contradicts its own objective.

The characterisation of participants as predictable also assumes that the researcher has a status separable from that of the participant. The participant is assumed to respond in a thoughtless way manipulated by the experimenter with no input or control. Antaki (1994) describes this process as a 'limited language game' in which the meaning of the vignette does not clarify whether the situation actually called for an answer at all. The assumption is that participants are thoughtless and thus fit the deterministic paradigm created for them. In this way, the research methodology for testing attribution theory builds upon assumptions about not only lay explanation but about people and their ability to provide responses on request, as if opening a drawer in their heads. This is a problem inherent in categorising or explaining everyday explanation, which is particularly acute for those who mimic the methods of natural science. The social researcher who claims that the "laws" of natural explanation apply

only to "lay" subjects is not only restricting the generalisability of his own theory but is engaging in a political categorisation. This is the assumption that the subject is not creative, hypothesis-testing and exploring in the way that the researcher is.

This provokes a demeaning picture of the research participant that inheres in assuming to impose meta-explanations on other people's explanations. The risk is in assuming the deterministic principles of natural science apply to social phenomena and, by doing so, of diminishing participants and their explanations. This problem is addressed for adult drug users and treatment provision in Chapter 4 and for young people's educational needs around illicit substances in Chapter 6. However, the risk in both situations is common - that an "expert" view is prioritised over the natural explanations of participants, whose own views are subsequently devalued. This has led more recent attribution-oriented approaches (such as Antaki, 1994) to explanations, justifications and so on to incorporate some of the discursive and rhetorical methodologies outlined in Chapter 2.

Yet this does not account for what are perceived to be the strengths of attribution theory. Interviewee 2's considers that, "it brings a certain logic to bear on choosing the correct or best route through someone's explanations to make inferences about what is the most likely reason for their action from which, of course, then one makes dispositional judgements". This is the argument that natural explanation is variable and messy, so the task for social scientists is to provide a rationale and a taxonomy of natural explanation. However, such a classification is inherently discriminatory and partial. It is political to the extent that classifications involve judgements that have

consequences and which assume the warrant to engage in this task. The right to ownership of a theoretical meta-knowledge is neither arbitrary nor disinterested.

3. The politics of attribution and the status of the theorist

Thus, in the drugs field there is a lobby that would argue that physicians are not sufficiently expert for the positions they hold as they have not experienced the difficulties of a drug-using lifestyle. The argument is that former or current users should influence policy as they know the problems in a way that is not accessible to the non-user. This argument challenges the medical model in which psychiatrists and general practitioners, through their power of prescribing, have been highly influential. The question is what constitutes an "expert". The type of knowledge employed is central in determining the 'best' explanation and this has its foundations in political influence, as well as logic or science. Therefore, the quest for 'scientific' knowledge and status is informed by assumptions about the source of information and the goals of the informer. Interviewee 5 argues that "There's always a struggle in doing research of imposing versus understanding, and in discourse analysis there is a very strong political line about letting our subjects speak and negotiation, which ends up in a complicated piece of surreptitious business in which you reveal the political story through the process of negotiation". The interviewee here recognises that even in attempting to negotiate meaning, a political agenda is set which influences how this negotiation is managed.

Interviewee 2 supports this in the claim that, "I think that at the end of the day, as psychologists, if we're doing our job properly, we can make probabilistic assessments

of situations better than a layman can or could but to some extent it is picking up the right cues and working on those cues and trying to understand what function they serve". It is the adoption of a role that has access to a body of knowledge and a series of investigative techniques that differentiates the expert from non-expert. However, expert identity may lead to the creation of a reality that validates the profession, rather than testing the external world. Under such circumstances, the generalisability of the 'reality' created by attribution research may well be questioned, as that of the medical model of substance use has already been.

The second issue from the above quotation concerns the assumption that there is a non-negotiable reality and that convergent explanation is possible. The difficulty of employing a scientific paradigm in social settings is that the method of 'truth-testing' contrasts with individual experience of negotiated agreement and multiple realities. The social scientist is in a situation in which the participant is also likely to have an opinion about the explanation the 'expert' produces, which may not agree with that expert opinion. It is here that professional warrants validate the 'expert' view. However, this authority rests on an impartiality that is hard to reconcile with the norms and rules of daily social activity.

It is only if attribution theory is assessed within its own frame of reference, by comparing the relative successes of psychologists and 'lay' people against the ANOVA model, that its superiority to lay explanation can be warranted. Interviewee 4 points out that "attribution theory works inside the laboratory due to the constraints put on the subject and it only works outside the laboratory because of the constraints

and power that operates in society to produce subjects of a particular type, of a psychological type". Here the role of warranty is seen to be two-way in which psychology has both a legitimating role for society and is vindicated because of the consequent characterisations it produces. Yet the question that must be addressed for drug research is what relevance any warrants of expertise may have for its drug using participants, as well as for the relevant social structures (see Chapter 3).

4. The ethics of attributing

While professional bodies monitor the activities of those who claim professional status (e.g. the General Medical Council, the British Psychological Society), the term refers to adherence to a set of principles and methods. The issue of adherence to rules as membership of the professional body is the warrant by which social scientists assume the status of expertise and the right to differentiation from 'lay' explanation. This not only makes lay explanation the subject of research but also casts it as inferior to the expert explanation of the attribution theorist. This is a risk incumbent in this type of meta-analysis, particularly when the subjects of the research are other people's explanations (whether the topic is of personal relevance to them or not). Again, this is one of the motivating factors that has led contemporary theorists of lay explanation (Potter and Wetherell, 1987; Antaki, 1994) to adopt discursive approaches that lead to a methodology of negotiation rather than imposition (see Chapter 2).

The social scientist, therefore, has a responsibility both to support the participants in experiments and also for the characterisations they offer for human behaviour. This is pertinent for drug research as users tend to be portrayed in the popular media in a

hostile and stereotypical way that the researcher must be aware of and manage carefully. This is complicated by the responsibility the researcher has to the research sample for whom issues of empowerment must be carefully considered. This point is made when Interviewee 2 points out that, "because attributions are made to things that, if you like, are outside the person's control .... I think we have a responsibility as scientists and as people who, by the very nature of our profession profess to care about other people and are trying to help other people, then perhaps we should be helping other people to exercise control and gain empowerment".

The issue that arises from the extract concerns the ethical dilemma the psychologist faces in deciding on a strategy that may empower the client, without confounding the goals of objectivity and neutrality. The difficulty for social scientists who work in an applied field is that the situation does not resemble that of Kelley's (op cit) "John tripped over Mary dancing" in that applied work involves real individuals whose behaviours have consequences. The difficulty goes beyond the problems of developing a model of what people are like, as the attributions have implications for those who take part, and for whom the issue of representativeness arises. The applied researcher has a responsibility for the consequences of the attributions he or she makes, which may compromise the goal of objectivity. However, this indicates two further problems - first, whether scientific objectivity and participant empowerment are compatible and second, whether the social scientist should consider their efforts sufficiently effective to impose on the lives of their clients.

5. Attribution and the ownership of knowledge

There is a tradition in social psychology in which the self-reports of subjects are treated as unreliable and inaccurate, and that they require a re-interpretation by the researcher. In Jones and Nisbett's (1971) study, subjects were stopped in the street and asked which of four ties they thought was the nicest and why. They found that subjects, regardless of the reason they gave, were most likely to choose the tie on the extreme left, irrespective of the order of the ties, which was altered in a random pattern. The authors concluded that choice was predicted by position, and that self-reports were unreliable. They argued that individuals were unaware of the "real" reason and so created a plausible alternative. This follows from a tradition in which explanation and discourse are regarded as 'inadequate' evidence for scientific postulation and is the problem that contemporary attribution theorists must address in selecting both subject area and research method. The problem this creates in examining the explanations given by substance misusers for their actions, is that it is commonly held that they are so influenced by their substance cravings that they cannot "understand" their own actions, and so their explanations are not accurate or relevant.

Two issues arise from this, one concerning the consequences of undermining self-report, while the other relates to the role of the social scientist in interpreting reality. The first point is that there is a reason for people's actions but that the actor is not always in the best position to judge this, although they may provide plausible accounts of their activities. This position goes beyond the actor-observer divergence to include motivational factors such as impression management and self-serving biases (see

Chapter 2). This assumes that the "real" world is the world of scientific method and what happens in everyday explanation is an inadequate approximation of this. However, this is tautologous to the extent that the differences between the findings of lay explanations and attribution research data is taken as evidence of the inaccuracy of the lay explanation.

The second conclusion concerns the role of the researcher as arbiter of the inaccuracies of natural explanation and the consequent status of the lay explainer. A political agenda arises in which the diminution of popular explanation promotes the social researcher as the judge of reality, a situation with moral consequences based on an expertise the literature struggles to justify. The problem is that if one chooses not to trust lay self-report, then there is a disempowerment of the individuals concerned. The empirical mistrust of self-report leaves the ordinary activity of explaining in a perilous and awkward situation. This is clearly indicated in substance use where the removal of faith in the self-report of drug users leads to an expert-driven situation in which the user is not regarded as having a meaningful contribution to make to the determination of their own situation.

Conclusion

This chapter places attribution theory in a historical context as a foundation for demonstrating some conceptual and methodological limitations and some of the underlying philosophical problems that may be associated with its incorporation in a practical, applied area work. The purpose is to demonstrate its ultimate application and theoretical relevance to one particular area of applied research and clinical work, the treatment and education of substance misusers. It is also useful as representing a paradigm of social science research in which a certain relationship is assumed between investigator and participant. This results in a model of everyday activity in which ordinary activity is characterised as inadequately mimicking the activities of empirical science, a comparison which may have disempowering consequences for those participating in research projects.

To achieve this, the literature review was followed by excerpts from interviews conducted with a number of researchers who have used or written about attribution theory in their work. The reason for doing this was to examine the reflexivity of roles associated with the act of explanation. This was done to bring to light the moral, political and professional identities associated with producing expert interpretation of lay explanation and to provide a context for attribution theory beyond the laboratory. The excerpts taken from the interviews are not meant to accurately represent the opinions of the interviewees, rather they examine some critical issues in conducting the type of investigation that attribution theory involves. The comments made here are to set the ground framing for an application of attribution theory in a more discursive version to the field of substance misuse.

The primary focus in the interviews is on two key aspects - the first being the relationship between the researcher and the subject, and the identities created for each and perpetuated by their participation in the task. The second reflects the status of the consequent material, particularly in terms of its role as a quantification of an elusive socially motivated production. The key to the chapter is to outline the problems associated with two aspects of classic attribution theory – its model of lay explanation as naïve science and a testing paradigm based on artificial vignettes.

The key issues here are around the status of explanation and its separation from meaning and context. This failing has been recognised in recent attribution work with the quest for universal laws of cognitions giving way to understandings of everyday explanations that take account of the functionality of explanation (Slugoski et al, 1993). The argument that explanations are most commonly recognised as answers to questions (Turnbull, 1986) sets the scene for a different rationale, leading to a different form of research methodology – namely, one that involves real questions that make sense to the respondent. This has led authors such as Bonaiuto and Fasulo (1997) to argue that investigations of lay explanation must account for their 'rhetorical' context, a concession that has significant implications both for the model of human understanding and for the ways in which it can be tested.

These issues are particularly prominent in some of the writings of the discourse analytic movement whose contribution to this debate is examined in the next chapter. Thus, Chapter 2 is an examination of the discursive components of explaining and

understanding "subject" explanation. In effect, much of the discourse work outlined in the following chapter is a progression from the attribution research done in the 1970's – the questions frequently remain the same but the assumptions about the role of the subject and the status of their explanations have shifted.

Chapter 2 - Alternative Approaches to Understanding Everyday Explanation

1. Introduction

This chapter examines other techniques used by social researchers to consider the everyday explanations given by people in a range of contexts, the rationale for these endeavours and their suitability for researching substance misuse and drug education. The focus extends into what have been categorised frequently together as "qualitative" approaches to extend the theoretical base beyond empirical social research methods. Following the comments made at the end of the first chapter, the aim here is to characterise both the subject and text in ways that are more open and reflexive, perhaps at the expense of precision and testability.

This changes the parameters of the research question as the assumptions about method and outcome are influenced by the disciplinary paradigms of sociology, anthropology, media studies and literary criticism. Before attempting to define qualitative research, it is important to emphasise the inappropriateness of traditional academic discipline boundaries in addressing these questions. The deployment of terms like sociological research or anthropological method may create unhelpful stereotypes and barriers that restrict the applicability of alternative methodologies. However, the distinction contrasting qualitative approaches to everyday explanation with that of the attribution models of Weiner and Kelley are located in the methods and assumptions employed in each. Therefore, the points about alternative approaches will focus on the philosophical foundations of using certain methods and the implications for the resulting model of lay explanation.

An indication of what is meant by "qualitative", is provided by Nelson, Treichler and Grossberg's (1992) in their attempt to outline cultural studies in which they claim, "Qualitative research is an interdisciplinary, transdisciplinary, and sometimes counterdisciplinary field .... It is multiparadigmatic in focus. Its practitioners are sensitive to the value of the multimethod approach. They are committed to the naturalistic perspective, and to the understanding of human experience. At the same time the field is inherently political and shaped by multiple and ethical positions" (Nelson et al, 1992, p.4). A slightly different focus is offered by Denzin and Lincoln (1994) who point out that "the field of qualitative research is defined by a series of tensions, contradictions, and hesitations. This tension works back and forth between the broad, doubting postmodern sensibility and the more certain, the more traditional positivist, postpositivist, and natural conceptions of this project" (Denzin and Lincoln, 1994, p.15).

While such definitions may be broad-reaching and ambitious, they raise a number of important issues. The first is that, in qualitative research, there is no clear research paradigm and so contradiction and tension can be incorporated within investigations, as the work does not attempt to access reality or truth. Rather it accepts the partiality and interpretive frame of the researcher as an inevitable aspect of investigation and not necessarily as a weakness.

It is this process that permits negotiability and allows qualitative approaches to escape the restrictions of empirical research. This permits the exploration of alternative approaches that may be more useful in dealing with disenfranchised groups, such as

substance misusers. It is important to deal with the accusation that qualitative studies are conducted without method and are neither testable nor rigorous. At the very least, such approaches can be employed as restrictions on the methods of empirical investigation and as external assessments of the efficacy of quantitative approaches, when examined from a different perspective. It may not always be appropriate to test the validity of the experimental method with other empirical tools alone. To consider the role and viability of experimental techniques it is important not to assume the positivist position one wishes to examine.

Interdisciplinary tension is evident in the fields of drug research and practice, as the authority accorded biological and pharmacological theories (the 'medical model') have been challenged by experiential and sociological accounts of substance misuse (e.g. Eiser, 1982). Yet, this is not unique to the world of substance misuse, with Schon arguing that "competing views of professional practice - competing images of the professional role, the central values of the profession, the relevant knowledge and skills - have come into good currency" (Schon, 1993).

Thus, it is consistent that in a professional area in which the dominant professional values are negotiable and uncertain, that there should be a methodological rationale that denies a clear set of disciplinary principles. It may be the case that the perceived inability of academic psychologists to make regular contributions to the work of their applied counterparts reflects exactly this error - assuming that professional activities operate along clear disciplinary boundaries. Thus, there is appeal to a research approach that allows the rejection of traditional positivist assumptions in favour of a

multi-disciplinary and negotiated approach to a field with few clearly defined parameters.

The second point from Nelson et al's (*op cit*) definition is that qualitative research is "committed to the naturalistic perspective, and to the understanding of human experience" which is informative to the debate on the role of users in drug and alcohol treatments. This is expressed by Herkt's (1992) assertion that "the advent of HIV/AIDS required a new research agenda focusing on the behaviour of current injecting drug users. This required researchers to collaborate with the IDU [intravenous drug using] community to develop a conceptual framework for research and to gain access to the required data." (Herkt, 1992). This challenges the exclusivity of professionalisation by claiming a role for unstructured self-report in understanding a research area that has traditionally been dominated by medical models based on empiricist and positivist assumptions.

While this change in emphasis attempts to increase client participation, it is also a political act in which the search for a singular, consensual truth is called into question. This serves to challenge the policy prominence of medical bodies in determining the most appropriate forms of research or intervention for the group researched. Therefore, the access to the selection of research agenda and design is a significant factor in shaping the perceived status of drug users among policy makers and practitioners, as the research questions asked influence the characterisation of drug users. Thus the shift to an open research paradigm is one means by which the

substance user may be given an increased voice in the determination of social and clinical policy.

From the operational definition provided by Denzin and Lincoln (1994) it is interesting that they suggest that "the field of qualitative research is defined by a series of tensions, contradictions and hesitations" drawing from both post-modern and positivist, empirical traditions. This is significant for sensitising research procedures to the complexities of researching an area as difficult to access as substance misuse and its primary prevention. What qualitative approaches can offer is a removal of the rigidity of experimental assumptions that restricted the applicability of attributional approaches. This recognition has led a number of attributional theorists to look more closely at narrative and discourse (e.g. Harre, 1988). For researching substance activity, this permits the introduction of innovative approaches in which subjects may be accessed in ways that are less threatening than the questionnaire or interview format pursued under examination conditions.

The field of qualitative research is not a clearly defined topic in the sense of a university discipline, rather it is a collection of research styles and methods that contradict as much as they overlap. However, these permit research possibilities that would be excluded by adherence to Popperian assumptions of positivism and experimental design. This is the case when researching aspects of substance attitude and activity, where it is important to avoid intrusive techniques such as breathalysers and urinalysis in ascertaining the validity of self-reports in this field. The discussion of qualitative research methods and issues reflects the objective of this thesis - to

develop participative ways of gathering information about substance activities that yield principled and predictive methods.

2. Reflexivity and the Role of the Researcher

One of the difficulties in conducting social research with drug users concerns overcoming their suspicions about what the research is for and what the "real" identity of the researcher is (policeman, social worker, etc.). As what is being discussed is often illegal, the user may be anxious about legal repercussions, or about the consequences their comments may have for substitute prescribing, child care issues or some other aspect of the drug user's life. This is particularly pertinent as many users fund their activities through some criminal activity or prostitution, things they are not willing to disclose to a stranger.

Therefore the biases that occur in social research involving inaccuracies of recall, impression management and lack of self-awareness of the causes of behaviour (e.g. Rabbitt and Abson, 1990; Nisbett and Wilson, 1977) are exacerbated if the participant perceives the stakes as being high. For this reason, the investigator of drug and alcohol issues cannot make assumptions about the veridicality of self-report, but rather must assume that the process of undertaking this type of inquiry has an impact on what is observed and on the outcomes of the observation.

If the researcher cannot regard him or herself as detached or neutral to the research, they are then a contributory force to the research process. The qualitative literature

has frequently emphasised this participative aspect of research with Jorgenson (1989) making this point in his claim that, "Interviews, contrary to the assumptions underlying traditional methodologies - are communicative (and meta-communicative) rather than elicitative in nature....like other communicative events, they are characterised by a reciprocal perspective-taking on the part of interviewer and respondent as each guesses at the state of the other's knowledge and anticipates the other's response. How interviewees make sense of and respond to the interviewer's questions is embedded in the larger process of coming to know who the interviewer is" (Jorgenson, 1989). The research interview is therefore seen as a dance in which both parties adjust to their partner as they learn about each other's expertise and intentions. While it may the researcher's job to lead, the researcher does not have complete control, rather it is reciprocally and mutually developed. There are two phases to the researcher's role - one, their presentation prior to the commencement of the interview, the other the development of their identity in the course of the interaction - that act as indicators to the user of the appropriate style and content of their answers.

In attributional experiments, it is little wonder that the responses appear rule-bound as this may reflect the demand characteristics of the task. Thus Rose's (1982) suggestion that participants should be regarded as "reciprocators" rather than "subjects" not only challenges the disempowering of participants, it also recognises the disingenuity of assuming that individuals do not employ their normal range of social devices and management techniques in a research encounter. This has striking implications for researching substance misuse. If the client thinks the interviewer is from the police

they are unlikely to admit to criminal activity or high levels of substance use. On the other hand, if the interviewer is a physician or psychiatrist with prescribing powers they may well exaggerate the extent of their substance activities and consequent problems if they believe this is going to result in an increase in methadone dose. While these scenarios may serve to stereotype drug users, the discourse that occurs will be shaped by the participants' perceptions of the roles, motivations and objectives of each other. Therefore, these aspects of discourse must be taken into account in interpreting research procedures, whether by interview or by questionnaire.

The researcher must be aware that his or her interpretations are partial, and that interpretation restricts and diminishes the complexity of the participants' interpreted activity. One limitation of attribution theory is the assumption that explanations and the events they deal with are discrete, an assumption inconsistent with the convoluted chains of motive and interaction that characterises everyday activity. 'Reflexivity' is a recognition of this complexity and the role the researcher plays in it. As Steier (1991) points out, "our reflexivity thus reveals itself as an awareness of the recognition that we allow ourselves to hear what our subjects are telling us, not by imposing our categories on them, but by trying to see how our categories may not fit" (Steier, 1991, pp.7-8). This is about avoiding the perpetuation of the researcher's preconceptions, but also has methodological implications in that it requires the researcher to be more critical and self-aware about his or her role, and its influence on the research process. Thus, the drug worker who hands out a survey in a classroom must recognise that their presence sets in motion an interpersonal dynamic that is not irrelevant to the way the questionnaire is completed.

This problem is not restricted to researchers who use questionnaires, if they assume that this method accesses reality, rather it is a common feature of empirical research. As Gergen and Gergen (1991) argue, "Experimental procedures may furnish experimentalists with a sense of 'objective hypothesis testing', but this is primarily because the procedures (measures, settings, instruments, participants and the like) have become so fully saturated by the theoretical language that the scientist virtually 'sees' the events in these terms" (Gergen and Gergen, 1991, p. 82).

This is a problem for researchers working in substance misuse where the paraphernalia of science can often lend research procedures an undeserved face validity. This creates a scientistic mindset that can prevent researchers from critically examining their activities and outcomes. Thus, to use addict populations for drug research assumes that 'addict' is a consensual term to describe a distinct population, where an alternative approach would be that a term such as addict may well be socially constructed and purposefully deployed to achieve certain objectives (see Chapters 3 and 4). It is particularly easy for applied research to assume a positivistic mantle which allows the perpetuation of preconceptions and the reinforcement of assumptions, which may have a detrimental effect on the population studied.

The argument from reflexive research is two-fold - first, that the researcher cannot discount their own influence on the research process and, second, that the researcher must constantly be vigilant of making assumptions that distort the research product. While this requires the researcher to be critical and self-analytic, it is important to bear in mind Steedman's point that, "despite the intoxicating attraction of scientific

positivism as the best or finest sort of knowledge, most of what we know is not, and never was, of this sort. Most of what we know, most of the knowing we do, is concerned with trying to make sense of what it is to be human and to be situated as we are" (Steedman, 1991, p. 58).

Much of the appeal of positivist science is an act of faith in its mechanisms - hypothesis-testing, researcher objectivity and controlled manipulation of participants. These are perceived to be the methods of assessing a reality that is indisputable and consensual. However, this confers on the researcher the status of arbiter irrespective of the views of the participant. This difficulty is compounded when the material itself is natural explanation, as the research outcome may ignore or even contradict the explanation offered by the subject (as in the Jones and Nisbett study outlined in Chapter 1). This has increased the attention paid to alternative methods in social science, one of the most prominent of which has been discourse analysis.

3. Discourse Analysis

Discourse analytic writings can be seen as a reaction and a challenge to the rigidity of certain social cognition approaches of which the naïve science attribution model is a component. Potter and Edwards' claim that, "the psychology of attribution (everyday causal reasoning) has scant regard for the way versions of events are actively put together to bolster particular causal stories and to undermine others" (Potter and Edwards, 1992, p.1). This is critical to the discourse approach, as it is the perceived oversimplification of empirical research pursuits that discourse analysis attempts to redress. While attribution research may have provided a restricted and simplistic view

of human reasoning, the research challenge of how to characterise the diversity of human interaction while retaining some element of methodological rigour remains.

An example of this debate concerns the coherence of a dependence syndrome for cocaine use (Gawin and Kleber, 1986) given that there do not appear to be any clear withdrawal symptoms yet it is a drug that many users regard as highly addictive (Bryant, Rounsaiville and Babor, 1991). There is a contrast of narratives where the clinical narrative requires "a core set of physiological signs, behavioural indicators and cognitive symptoms" which many cocaine users do not experience yet the user's narrative speaks of high levels of craving and addiction (Gawin et al, 1989). The qualitative researcher attempts to reconcile these differences without automatically resorting to methods that informed the clinical perspective in the first place. The task for the discourse analysis is to examine the explanation in the context in which it arises. Therefore, for the discourse analyst, cocaine dependence is a phenomenon bound to the discursive acts of both cocaine users and those who work with them, irrespective of its pharmacological and physiological determinants.

For this reason, discourse analysts such as Billig (1987) talk about the "essentiality" of an event, what was important about it, rather than what was its cause in an empirical sense. Antaki's (1994) critique of the attribution approach also argues that, "We might learn from Heider's legacy that an account of explanation that was fixed on causation is impervious to context; that it has a restricted and restricting conception of language, and language exchange; and that the rather rigid methods that are built on its theoretical base are not likely to pick up much variation in the ebb and flow of

explanation in talk" (Antaki, 1994, p. 26). This is the starting point for discourse analysis - the attempt to provide a fluent and flexible approach to understanding everyday interaction not constrained by a methodology whose applicability is far from clear. The objective is to attend to the contextual and interpersonal issues that give everyday exchanges their relevance and meaning, not their cause.

Discussions of discourse and text often refer to ethnomethodology, in particular to Garfinkel's (1967) suggestion that the world of "social facts" is accomplished through discursive acts which produce and organise the circumstances of everyday life. As a result, ethnomethodological approaches are attentive to naturally produced discourse and to the role performed by the context of a discourse in producing local meanings. From these origins, Heritage (1984) argued that discourse analysis has three underlying premises. First, the structure of interactions may be observed in the regularities of conversation. Second, all interaction is contextually oriented in that it reflects the circumstances of its production. Third, because all interactions are characterised by these properties, no element of conversation can be dismissed as irrelevant. Conversation should not be regarded as an inferior version of something else but rather as a rich, complex and productive system that reflects contextual influences and whose richness is reflected as much in the details of the conversation as in its apparent themes.

The recognition of the complexity and wealth of everyday interaction represents a methodological and political shift for the social scientist. Thus, Holstein and Gubrium's (1994) recognition that, "prevailing interpretations thus emerge as

provisional adaptations of diverse local resources and conditions, serving the practical needs at hand, until further notice. Culture orients and equips the process, but interpretive inventiveness and serendipity intervene. The process repeatedly and reflexively turns back on itself, as substance, structure, and practise are enmeshed in the ongoing production, reproduction and re-designation of meaning and order" (Holstein and Gubrium, 1994, p. 268). This represents a shift in the assumptions the researcher makes about natural explanation - instead of categorisable, convergent and rule-bound, there is a recognition of the diversity and complexity of the subject matter. Similarly, it recognises that local meanings are significant and so a generalised epistemology is rejected in favour of a method sensitive to the particular, the functional and the historical in explaining everyday meaning.

This shift to a local and contextualised meaning requires a rethinking of the goals and methods for research procedures. Thus, if one accepts a localised epistemology and a determination of meaning as a consequence of the shared activities of a group, then the assumptions of universal laws that access truth must be abandoned in favour of different objectives. This is a difficult position for social researchers - while wanting to retain the clarity and methodological simplicity of empiricism, ethnomethodology and discourse analysis have shown the limitations of these methods. However, qualitative researchers are faced with the task of offering an alternative that can match the rigour and parsimony of traditional research rationales, but which recognises and protects the integrity of the discursive productions of specific groups.

Potter and Edwards (1992) produced five criteria of discourse analysis which they defined as "a functionally oriented approach to the analysis of talk and text" (Potter and Edwards, 1992, p. 27). The first emphasises that discourse analysis deals with naturally occurring discourse, in contrast to the experimental methodology of much of the social cognition research approach used in much of the early attribution theory. The advantage for working with substance misusers is that face validity is improved as many users are suspicious of formal interview situations and, if intoxicated or in withdrawal, they may not be physically attuned for such a task. Similarly, there is a demand characteristic issue in imposing an institutionalised logic on a social group who may operate according to rules inconsistent with formal procedure. Thus it not only makes the research meaningful to the participant to engage in natural discourse it also has practical benefits to the interviewer.

The second principle is that the subject matter of discourse analysis more often is the content of talk than its structure. This is not the case for early attribution theory work which is concerned with the structure of the reasoning principle, to a greater extent than with the content of the attribution. This is both a benefit and a problem - it is beneficial in that it permits the qualitative researcher to respect the integrity of what is said without imposing a meta-explanation, but it means that there is no categorisation or organisational device with which to interpret the information (Janesick, 1994). The problem for researching drug issues is that, instead of depicting the activities of the client with simple stories of addiction or abuse, there is no short-cut way to interpret or summarise the original discourse.

The third principle of this approach is that discourse analysis is concerned with action, construction and variability (Potter and Wetherell, 1987), the suggestion that people perform actions when they say things. This has its foundations in Austin's (1961) theory of speech acts, where each utterance may be considered in terms of its locution (what is said), its illocution (the intention of the speaker) and its perlocution (the effect the speech act has on its audience). This is similar to the shift from attribution to attributional research in which it is the impact of producing a particular type of explanation that is examined, rather than the determinants of the explanation itself (see Chapter 3). The advantage for drug research is the recognition that discourse is more than a mirror of states of affairs in which reality is either accurately reflected, when the interviewee is honest, or inaccurately reflected, when he or she is dishonest. The recognition that language is performative is a rejection of its veridicality and so reconfigures the purpose of research for the discourse analyst.

The fourth principle provided by Edwards and Potter recognises the rhetorical function of language (Billig, 1987), which means that understanding an account involves discounting the other available explanations. This issue will be examined in the discussion of deconstructionist writings, but at the moment it is sufficient to use the distinction given by Semin and Manstead (1983) of excuses and justifications. They argue that, for example, a drug user may explain relapse in terms of not being able to cope with the death of a friend (excuse) or as a consequence of their rejection of treatment (justification). The point here is that both of these reasons fall within the dominant narrative of drug use in a way that explaining a relapse in terms of political instability in Brazil would not. This is because rhetorical devices operate on the

assumption of shared values and meanings, agreed explicitly or implicitly by the interlocutors, and which constitute the acceptable range from which reasons may be drawn.

The final principle offered by Edwards and Potter is that discourse analysis is involved in ontological issues of reality and mind. For Halliday (1987), this is the issue of how people deal with fact and error, knowledge and truth in everyday contexts. The point here is that epistemological issues are not the exclusive preserve of academics, but are important in everyday conversations and activities, and have effects on the status of the speakers. This is what Habermas (1984) refers to as "validity claims" - the sense in which the acceptance of a claim is contingent on the acceptance of a whole set of conditions which commit both parties to certain assumptions and conclusions about each other, as well as about the claim itself. Thus, the explanation offered by the drug user for drug activities may be contingent on his or her perception of the interviewer and the response given by the interviewer to previous claims of this sort. It is important to the drug user when faced by his doctor or by a judge that the claims produced are accepted as the responses will influence their subsequent behaviours and discourses (see Chapters 4 and 5).

The salience of these issues is expressed in Antaki's outline of conversational analysis, when he claims that, "it is only in the participants' own ways of organising themselves .... that we shall find solid grounds for our analytic claims. That seems, on the face of it, to outlaw very many things with which social scientists are comfortable. The move from analysts' to participants' orientation seems to challenge

social scientists' skills as informed readers of the common mind, and professional testers of their theories about it" (Antaki, 1994, p. 187). This statement of the objectives of discourse analysis represents a challenge for the applied researcher who must guard against re-introducing positivist and expert-centred assumptions while striving to develop techniques that focus on the participant. The shift from scientist's perspective to the participant's is a huge step that challenges the methods traditionally employed in social research. The task that faces qualitative researchers is to establish innovative methodologies that draw on the work on discourse while retaining the principles of applied research, such as predictive power, coherence and consistency.

4. From discourse analysis to deconstruction

The discussion of discourse analysis is suitably closed with an example from Potter and Edwards, and a critical examination of its implications for research into substance activity and awareness. Potter and Edwards' (1992) study concerned a series of news and parliamentary reports of a briefing given by the then Chancellor of the Exchequer, Nigel Lawson, which became a debate about what Lawson had really said during a press briefing. The authors analysed how the participants' versions of events were rhetorically constructed and how these constructions were used to manage 'truth'. The press reporting of the briefing (concerning payment of benefits to old-age pensioners) was challenged by the Chancellor, who challenged the accuracy of the report. The authors examined the texts (newspaper reports, radio interviews and press releases) for strategies used by the participants to convince their audience (the reading

or listening public) that their version of events was accurate, based on vividness of memory or the corroboration of independent sources.

Potter and Edwards are not attempting to establish who is right but to assess how discourse operates in a rhetorical manner. They argue that, "what we have in total, then, is a series of discursive devices through which the journalists were able to justify their claims to having produced an accurate versions of events, such that the upshot of all their interpretive work is to formulate it as hardly necessary" (Edwards and Potter, 1992, p.68). The rhetorical device is to present the argument as so obvious that it does not require stating. The authors are claiming that in discourse, notions such as accuracy and truth occur as "pragmatically occasioned accomplishments" (Edwards and Potter, 1992, p.74), as a consequence of the interpretation process. Their claim is that even if there had been a verbatim report of the briefing this would not resolve the dispute, as the dispute is as much about what can be inferred from what is said as what is actually said. In other words, the issue is as often about the illocution as about the locution itself (Austin, 1961).

Potter and Edwards' conclude that, "What we are arguing is, that if it is everyday discourse that we are examining, then we have to deal with how such factual reportings are done, and when and for what. We need to examine discourse for what it reveals about participants' own orientations to fact and cognition" (Edwards and Potter, 1992, p.75). While this is not in itself a justification for the use of discourse analytic techniques, it suggests that discourse must be considered as a functional and social tool that is determined by the everyday rhetoric of speech. This implies that

there is not a non-discursive reality that has definitive and absolute status. To use an example from drug education, young people frequently perceive drug information sessions in the classroom to contain a moral message, warning against the use of drugs, when the session providers have argued that no such message exists. This is not a resolvable issue, but rather reflects the discursive and social conditions that constitute context in a drug education session.

The temptation is to infer that there is a flawed interpretation by the young people in this situation, but this is to make two assumptions. First, that there is an objectively accurate state of affairs and, second, that it is the adult drug educators whose interpretations are more accurate. Discourse analytic work would suggest that it is the quest for the "right" answer that is futile, and that it is more important that drug educators work out why such inferences are made, as this has important implications for the delivery of drug education in schools (see Chapter 5). It is only by perceiving the reports of young people as motivated by their discursive history and rhetorical objectives (which may present a narrative about drugs or drug education), that their active role in interpreting a drug education messages is recognised. It is only then that the young people will, scientifically, be regarded as active players in the activity of drug education, rather than as recipients of sets of instructions.

This is also a reflexive issue in that re-defining the role of the participant in research inquiry also involves a re-conceptualisation of the role of the investigator. Thus, young people are not branded as 'wrong' for assuming that the drug education message to be based on abstinence, as it is implausible to assume that the drug

educator has access to a privileged truth. Therefore the knowledge claims of the drug educator are recognised to be as negotiable and contingent as those of the young person. The argument here is that the professional narrative represents a specialist narrative but one which has no claims to superiority. However, this may be threatening for the educator who may have regarded as their ability to summon a body of evidence as the justification for their status. It is this that may be threatened by the multi-perspectival foundations of a qualitative epistemology.

This relationship between the investigator and the individuals or groups he or she works with are critical issues for the qualitative researcher, and shape both design and method. Michelle Fine (1994) talks of her research task as "Working the Hyphen" by which she "means creating occasions for researchers and informants to discuss what is, and is not, 'happening between' in the negotiations of whose story is being told, why, to whom, with what interpretation, and whose story is being shadowed, why, for whom, and with what consequences" (Fine, 1994, p.72). She is suggesting that the flat and limited way in which participants have traditionally been characterised in much quantitative social research has led to a limited political perspective and an uncritical identity for researchers. Thus to interview a "drug user" is to assume that it is drug user's status that is salient and the yardstick against which the discourse can be measured, thus excluding the researcher from a responsibility in determining the discourse and from justifying and negotiating his own position.

This demands an assessment of the context of the research encounter, a context that includes the researcher. This has consequences for the assessment of explanations,

whether they take the form of self-reports in questionnaires, or interview responses in clinical settings. The point is that, once one accepts the influence of context on the motivation and role of the explainer and, therefore, on the nature and content of the explanation, then the task can no longer be perceived in terms of cause and event. This undermines the attempt to produce universal laws from specific instances, in favour of a recognition of the groundedness of explanations and the contexts in which they occur. This is consistent with Derrida's (1979) assertion that, "no meaning can be determined out of context, but no context permits saturation". This is the claim that all explanations, whether "lay" or academic discourses, are contingent to the extent that they never account for all possible contextual influences. In other words, Derrida is arguing that no explanation is ever sufficient. These include the effects of the explainer and of the audience and of the discursive histories of both.

This claim from Derrida is supported by Culler's (1983) aphorism that "meaning is context-bound, but context is boundless". This is salient for the social scientist working in an applied context as it represents an affirmation of the particular over the general, as universal rules of explanation will inevitably be distorted by local conditions of implementation. It also demands that specific, localised influences are accorded relevance in social analysis. There are obvious political ramifications in such a shift in that it permits the individualising of systematic research. This contrasts with the utilitarianism of quantitative methods in which the individual is part of a statistical generalisation, reduced to the status of a response-emitting machine with only the researcher permitted a rhetorical role.

A variation on this approach was adopted by Schutz in his claim that, "although there is a distinctive social world in which the theorist functions - a community of scientists with its own rules and procedures for inter-subjective communication - the Theorising self is solitary" (Schutz, 1982). This is because, according to Schutz, ordinary human actions involve specific "in-order-to" motives and genuine "because" motives, whereas the social theorist is concerned only with typical ones. However, Bernstein (1971) argues that this does not discount scientific procedures or methods, rather that, "a more robust understanding of social and political reality, and of the ways in which this reality is value-constituted, does not discredit or undermine the application of scientific techniques to the study of men in society ... What is challenged, of course, is the unwarranted presupposition that only by the study of regularities can we achieve legitimate empirical knowledge of social and political reality" (Bernstein, 1976, p.157). This passage outlines much of the method adopted in the empirical investigations that are reported in this thesis (Chapters 4 - 6).

There are two main conclusions to be drawn from Bernstein's suggestions - the first is that scientific approaches should not be totally discarded in conducting social research. The second is that, when they are employed, they provide only a partial, although useful, perspective that should be examined critically and supplemented with other sources of information or evidence. Bernstein is explicit in his rejection that the social researcher must either unequivocally accept the positivistic methods of natural science or reject them altogether, in favour of a critical stance in which they must be carefully considered and their results not overstated. The remainder of this chapter will examine some of these critical approaches and the implications these have for

researching substance activity and drug education. However, it is broadly from the perspective that Bernstein advocates, and which is consistent with some of the more recent and rhetorical advances in attribution theory, that the method for the data phases of this thesis have advanced.

5. Critical writings and Deconstruction

There has been a significant history in recent years of writings critical of the mainstream of social psychology that can be dated back to Armistead's "Reconstructing Social Psychology" (1974). These deal with issues discussed above such as the treatment and empowerment of subjects and the viability of the knowledge claims presented in traditional social psychology writings. This critique is summed up in Rose's (1987) suggestion that, "the procedures of visualisation, individualisation and inscription that characterise the mental sciences reverse the direction of domination between human individuals and the scientific and technical imagination. They domesticate and discipline subjectivity, transforming the intangible, changeable, apparently free-willed conduct of people into manipulable, coded, materialised, mathematised, two-dimensional traces which may be utilised in any procedure of calculation. The human individual has become calculable and manageable" (Rose, 1987, p.129). This reflects Schutz's argument that the methods of natural science present a limited representation of human behaviour, but which indicates that there are political implications involved in this.

Many of the critical writings take the form of commentaries or, as with the Edwards and Potter (*op cit*) material, the arguments advanced are largely descriptive. Thus, not only do they fail the test of falsifiability that denies them predictive status or testability, they also have limited applications for practical research, at least those forms of applied work that rely on data-based information. However, this makes the mistake of assuming that all research must be based on empirical assumptions and that research products represent increments in a body of exact scientific knowledge. If, however, one accepts the critical literature, then the epistemological assumptions of positivism represent a limited perspective and its methods only one way to represent events that, through technical accomplishments, have been granted a position of exaggerated prominence. Therefore the task set qualitative research is twofold - to attempt to develop innovative methods for researching key social issues and to define the boundaries for traditional science research methods.

The recognition of a political significance in research goes beyond the assumptions of naive objectivity that are traditionally adopted by researchers, in which the research relationship is characterised by an impartial researcher and a subject who disinterestedly provides honest responses. Thus, Parker's (1992) argument that "selves should not be seen as 'parts' selected at will, but as set in a variety of power-induced discourses" (Parker, 1992), implies a complex research context. Here the participant makes sense of a situation in which he or she has choices with consequences beyond the immediate question-answer dyad. The more contentious issue is whether this perceived diminution of participants in research is disempowering, and creates a power disparity between the researcher and the

researched. The point made by Parker is not just that research presents a simplistic account of how interpersonal dynamics operate, but that this relies upon a power disparity in which the participant is denied access to the explanation of his or her behaviour.

The claim being made by both Rose and Parker is that the structuring of traditional research procedures (from applying for research funding through to access to publications in "accredited" journals) favours a particular kind of voice. They would argue that this voice is phallocentric, rationalised, dehumanised, Westernised, middle class and white, as most academics, policy makers and fund-holders are middle-aged, middle class, white males. Therefore the science that results is most favourable to the interests of this group, and so the task for the qualitative researcher is to provide a voice for groups whose needs and experiences are not recognised by this definition of "knowledge". Thus, to an adolescent in a post-urban, peripheral housing scheme in Britain, the drug education message "Just Say No To Drugs" is not meaningful or realistic. The political argument is that traditional social science provides a limited perspective accessible only to a small, elite group and whose scientific truths are only beneficial to this group.

This knowledge is not revolutionary and its dissemination in the world of substance activity is most obviously manifested in the reluctance of many substance users to participate in research projects. This reluctance is not simply a consequence of fear of the information being passed to the police or social services, but often represents a dissatisfaction with previous research encounters. The problem is that the research

agenda is devised by a researcher who, particularly when clients are paid, expects a certain type of response to questions that, to the subject, may appear misleading, offensive or ridiculous. As a result, the way in which the interviewee characterises the researcher and the encounter are critical determinants of their responses. As Jorgenson (1992) has claimed, "beyond their basic understanding of her role as a "questioner", exactly how respondents go about fashioning an identity for the interviewer depends on diverse elements" (Jorgensen, 1992, p. 216).

The interviewee is aware that the drug educator or researcher has beliefs about substance activity which mesh conceptual, moral and political arguments, and these will have informed the reason for and the content of the questionnaire. Yet the "addict" is not defined by his substance misuse, nor is it the sole determinant of his self-concept. This is Parker's point about "parts selected at will" in which the researcher defines the interviewee by his or her substance misuse while all other beliefs, attitudes and expectations are suppressed. Rose (*op cit*) argues this is not naive behaviour by the investigator, rather it is a prerequisite for social control. The categorisation of individuals into convenient "coded, materialised, mathematised, two-dimensional traces" (Rose, 1987) is a political device which lays the foundations for a manipulative scientific model. While this may be extreme, the methods of qualitative research are geared towards rectifying this power disparity, and to increasing the participant's access to decision-making activities in the research procedure.

6. Deconstructing Scientific Endeavours

Post-modern approaches represent a challenge to assumptions about the way in which research should be conducted, and the role of the investigator as owner of the research. Shotter (1993) represented the traditional approach as, "a single framework to function as a 'structured container' for all such events, thus to create a stable, coherent and intelligible order amongst them, one that can be intellectually grasped in a detached, uninvolved way, by individual readers of the theoretical (textual) formulations they write" (Shotter, 1993, p.57). Shotter argues for a more involved role for researchers, to participate in "the political struggles over which representations of a 'worldview' should be 'literalised' into a 'world-order' .... those who are concerned with finding a 'history' or a 'tradition' of their own, have begun to object to the monological, ahistorical systems of 'central-planning and administration' which exclude them" (Shotter, 1993, p.63). This is a radical shift from the goal of objectivity to a recognition of the political potential of research. The search for truth is discarded in favour of a participation in local, goal-oriented realities. Thus, the goal of objectivity is challenged by an overtly political attempt to create a voice for groups previously excluded from research procedure.

This has influenced the areas qualitative researchers have investigated as well as the methods employed, such as the "alternative" literatures developing in feminist and ethnic group research. Olesen (1994) has argued that female qualitative researchers, "are highly conscious of the absence of women's voices, distortions, and the charge that preparing the account in the usual social science modes only replicates

hierarchical conditions found in the parent discipline [be this sociology or psychology], where women are outside the account" (Olesen, 1994, p.167). Here ownership of science is represented as excluding the interests of women, and science is characterised as phallocentric. Therefore, to adequately serve the interests of women, a completely different approach must be adopted. The most extreme feminist critique not only suggests that women have been excluded from the ownership of research, but that the principles on which empirical science is based contain a bias to preserve the status quo. However, the rationale for qualitative research is not to regard this as a hypothesis to be tested but as a rhetorical position that challenges the dominant narrative of positivism.

The deconstructionist approach does not provide a programmatic alternative to traditional research, rather it offers a reflexively critical stance. Shotter, representing this tradition of emphasising and empowering the individual, discusses the case of explanation. He asserted that, "As what people say and do is always open to criticism and judgement by others, an essential part of them being free individuals in a modern society, is them being able to justify their actions to others when required to do so - they require a capacity to be able to articulate 'good reasons' for their conduct" (Shotter, 1993, p.162). Shotter is claiming that the qualitative approach requires consideration of roles, norms, values and choices that bind that individual to the group, rather than considering human behaviour as the product of lots of discrete individuals in categorisable and finite situations.

This transition not only emphasises the role of voices, but also rejects the concept of the individual as autonomous subject, whether investigator or participant in the research procedure. This is a challenge to the conceptualisation of the individual as a coherent set of traits and values that can be classified outside the context of their activities. The issue is methodological and philosophical - the characterisation of individuals as units simplifies the task of the researcher by representing interpersonal activity as manageable and manipulable (Rose, *op cit*). However, this portrayal of individuals as consistent, discrete and rationalised assumes a status for human behaviour that contrasts with the everyday experiences of interpersonal action as uncertain, ephemeral and open to dispute. This is also the political point raised by Olesen (*op cit*) in that it is the ownership of knowledge that alternative approaches such as feminist epistemology wish to contest. Thus, the shift from attribution theory to discursive methods can be characterised as a philosophical shift in the perceived status of the research participant.

The challenge to the status of the researcher as value-free is supported by Steier's (1991) claim that, "the knower is always a constitutive part of his or her own process of knowing and moreover, that much of it is negotiated with others" (Steier, 1991). The claim to detachment refers to the process of conducting the research and to the way in which it is reported and written. It is around this writing process that much of the post-modern concern has arisen. (Post-modernism is defined by Cahoone (1996) as, "a recognition of pluralism and indeterminacy that modern or modernist thought had evidently sought to disavow ... a new focus on representation or images or information or cultural signs as occupying a dominant position in social life"

(Cahoone, 1996)). The concern is with the groundedness of interpretations, as discourse must account for the uncertain, the inconsistent and the incongruous that characterise everyday life and human interaction.

The status and autonomy of the writer are challenged by Barthes (1974) in his argument that, "the text is not a line of words releasing a single 'theological' meaning (the message of an Author-God) but a multi-dimensional space in which a variety of writings, none of them original, blend and clash". Barthes denies the writer privileged access to the meaning of the written lines, in part because such a meaning may not exist, but also because any given writing can only make sense in a con-text of other texts and discourses. While these are radical suggestions, this is a democratisation of the ownership of knowledge from the privileged few who have access to a voice in publication, to anyone who may happen to read the text. The claim is that the meaning of text resides in the reader and not the writer. If there are many readers, each of whom interprets a text in different ways there will be many meanings to the text - this is exactly the 'intention' that Barthes and other post-modern writers have in challenging the relationship between author and text.

The methods of deconstruction are linked with the writings of Jacques Derrida, who argues against the expert status of social science and against its interpretive function. Derrida claimed that "linguistically mediated processes within the world are embedded in a world-constituting context that prejudices everything; they are fatalistically delivered up to the unmanageable happening of text production, overwhelmed by the poetic-creative transformation of a background designated by

archewriting, and condemned to be provincial" (Derrida, 1979). This continues the theme established by Barthes that is critical of the tradition of assuming the omniscient status of the author, by emphasising the impossibility of authorial independence from the contingencies of writing and interpreting. What Derrida is claiming is that engaging in language production, either text or discourse, binds the writer to the context of writing. This he referred to as "intertextuality" - the inability of any writing to escape its origins in other written texts and the impossibility of separating the intended message from the means of its transmission.

The issue of intertextuality, although primarily applied to text, is also relevant for discourse and so influences the interpretation of conversation. The main issue is the contextual embeddedness of any speech act, according to which meaning cannot be considered as separate from the method of its production or its conversational derivatives. This reflects a Saussurian approach to linguistics according to which the meaning of a word cannot be considered as fixed, rather as residing in its mode of application. The main caveat is that to impose a set of values on discourse is to deny the origins of its meaning in the shared assumptions, values and intentions of the context in which it occurred. Any reading of a text, whether by an observer or by the author, is grounded and contingent, and its relation to the original text is no more necessary than its relationship to all other texts that it is associated with.

The second relevant aspect of Derrida's work is the notion of the unwritten text. This is the idea that the political is inherent in writing and that there is a suppressed text that emerges at the margins of the text, and which reveals the dominant discourse

through a play of what Derrida referred to as 'doublings' within the text. This relates to the notion of intertextuality in that it is the boundaries of meaning that define the relationships between texts and which define text in social and political ways. Sallis (1992) argues that, "The voice is the pivot on which Derrida's text turns. It is what would empower speech, what would grant to expression the capacity to become transparent, self-effacing, in such a way as to allow the expressed meaning to present itself in pure ideality" (Sallis, 1992). Discourse is laden with contextualised meaning and it is this that acts in a generative exchange of creativity through which language defies, defines and creates tensions and movements.

This applies to discourses of substance misuse and education through the critical role, and is manifested in a challenge to the dominant, medical discourse. As Gasche observes, the deconstructionist approach is "concerned with determining the limits (the conditions of impossibility), of the possibility of systematicity and system formation" (Gasche, 1987). Thus it represents a means of examining the limitations of explanations given by substance misusers and the double binds that fray around the edges of the narratives they produce. However, it also represents a critical approach to the dominant medical discourse against which the activities of substance misusers are cast. It is in this role that deconstructionist approaches can examine the assumptions and stereotypes that surround the activity of studying and writing about drug issues. The critical examination of text and narrative works against the ready acceptance of mythologies of natural science and lay explanation alike.

7. Foucault and Power / Knowledge

Foucault's work asserted that there is an intimate relationship between power and knowledge, in which power is perceived as residing in relationships between individuals rather than as located in institutions or individuals. For Foucault, the political is inherent in discourse as 'truth' is determined by power relations. He argued that "truth is a thing of the world: it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power. Each society has its regime of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true" (Foucault, 1972).

This quotation illustrates what, for Foucault, were the main themes of political activity in discourse, although here 'political' refers to everyday relationships between individuals, as well as the legislative and executive functions. The point is that to have one's views given a privileged status by the formal structures of knowledge implies an approximation to truth, irrespective of any underlying reality. Knowledge (and therefore power and truth) reside in the relationships between social institutions in such a way that only certain voices are accorded status. This is because they are more appropriate to the dominant "political economy" of truth. Thus the ownership of drug 'truths' resides in political and economic apparatuses, such as hospitals, universities and the media, so that to have a view legitimised it is necessary to engage one of these institutions.

Foucault's interpretation of explanations involves 'discursive formations' (the regularities that occur between statements, objects, concepts or thematic choices) and the argument that contradictions within and between discourses are inherent in their meaning. Foucault claims that "A discursive formation is not ... an ideal, continuous, smooth text that runs beneath the multiplicity of contradictions, and resolves them in the calm unity of coherent thought ... It is rather a space of multiple dissensions; a set of different oppositions whose levels and roles must be described" (Foucault, 1972). This allows the meanings of everyday activity to be recognised without a standardised political epistemology. Thus, there is no assessing the accuracy of the subjective reports of participants whose explanations are functional and contextually meaningful.

Foucault's emphasis on the integral relationship between knowledge and power implies that the researcher should recognise the ubiquity of the power-knowledge relationship beyond the university. He argued that, "It is not possible for power to be exercised without knowledge, it is impossible for knowledge to engender power. "Liberate scientific research from the demands of monopoly capitalism": maybe its a good slogan, but it will never be more than a slogan" (Foucault, 1972). There are two issues here for investigating substance issues - one, that the researcher be aware of the political aspects of the research they undertake and, secondly, that knowledge accredited to doctors and psychiatrists is partial in that it represents the interests and objectives of one particular group. As a result the methods of positivism are more likely to reinforce the mechanisms of state rather than advance the voices of the disenfranchised.

This is the point that has arisen from Foucault's original research - the classification of an individual to a social category with negative connotations, such as mentally ill or criminal has repercussions for the individual but also for the structuring of the group who makes this decision. This is the situation for substance misuse research as the use of categories such as "addict" have consequences beyond the discourse (see Chapters 3 and 4). The use of traditional research methods and techniques may perpetuate the disempowerment of a group whose voice is continually denied them by the structure of manipulations of knowledge and power.

8. Discourse analysis, power and social researcher

There is a paradox for researchers attempting to derive laws of human behaviour - on the one hand behaviour is consistent, but on the other people do change. The issue here is that statements like this only become problematic if the assumptions of positivistic empiricism are adhered to and an apportionment of causes to effects is considered a prerequisite to scientific investigation. The qualitative researcher, on the other hand, would be inclined to argue that the reason the person-situation debate (Mischel, 1968) cannot be resolved is that it asks the wrong kind of question. It makes limiting assumptions about human science and it attempts to impose universal principles on something that is grounded in the specifics of the interaction in which it occurs. Therefore, the conclusion many qualitative respondents would produce is that it is not that we need to remember that individuals may change dramatically, but that the search for consistency is in itself based on a misconception about the relationship between the natural world and human intersubjectivity. This is both because there are

a huge range of potential determining factors for human behaviour and because few possible explanations have clear empirical status.

This also represents the issue that deconstructionist writings would challenge - the idea that writers or speakers are causes of text or discourse, rather regarding the process of speaking or writing as grounded in the relationships between texts or speech acts. As Steier (1991) has argued, "the knower is always a constitutive part of his or her own process of knowing and, moreover, that much of it is negotiated with others" (Steier, 1991). Thus the attempt to differentiate the real person from their speech or writing is rendered irrelevant if one rejects absolute, causal assumptions about personhood. This would be replaced by the assumption that the text serves a particular function in the context in which it is produced and that this does not have a bearing on truth, nor does it commit the speaker to any given status. Thus, the impetus for investigating substance activity is that there is often little point in attempting to assess the accuracy of report by categorising into truth and lie, as this is a crude and unrealistic representation of the way in which real-life explanations arise and operate.

The recognition that the task of the scientist is not to implement an impartial taxonomy in the interests of increasing a benevolent knowledge base increases the responsibilities of the researcher. This has two main aspects - the impact of the research on the participant and the impact on the public domain when the results are published. Yet the recognition that the assumption of professional disinterest is limited, also has implications for professional practise and for the status of the

researcher as well as for participants. The question of responsibility has been subsumed in some empirical investigations as the moral code of professional bodies has been created with a set of ethical guidelines (e.g. The British Psychological Society's guidelines (1992)). The emphasis has been on the way in which research has been conducted rather than examining the consequences of subjecting a participant to a set of investigations and assumptions. Therefore the right to determine what is appropriate is determined by external bodies (in drug research this often takes the form of permission granted or denied by hospital ethics committees).

The questions raised in this way are intended to protect the participants from harrowing or threatening procedures. In research into drug education and substance misuse among young people the focus has tended to be on the priming effect of asking questions about drugs, rather than about the appropriateness of such an intrusion in a context in which there is power disparity between researcher and participant. While raising issues about substance misuse with young children may raise ethical questions, it is no more serious than creating a dilemma where a young person is obliged to lie or not complete a form for fear of negative consequences. Thus, in a classroom situation, the young person is aware of the fact that there is frequently a disapproval of substance activity which may compound existing fears that information may be passed on to social services or the police.

Therefore, for the young person who does use illicit substances or alcohol, however safely, there are countervailing pressures. On the one hand, there may be a need for information about the risks associated with street drugs, although many young people

may be primed to believe that the classroom is unlikely to be the arena for honest information-giving (see Chapters 5 and 6). On the other hand are the fears associated with accurate disclosure. Furthermore, all of this occurs in an intrusive format where the very fact of asking this type of question is invasive. The key point is that, while asking the question may be imperative for the advancement of knowledge or science, this occurs irrespective of the particular local demands and tyrannies it inflicts on the specific young people that are involved.

As discourse analysts have argued, this form of traditional, empiricist research has tended to exclude the interests of the participant. However, it is not only that this may be politically unacceptable, it may also have detrimental effects on the research findings, in that, most of the time people are trying to understanding things they have a stake or interest in. When people talk, they are telling stories where they've got a stake or interest, and they understand other people's versions of events in terms of that stake or interest. The argument here is that traditional methods exclude or ignore the local context in favour of the quest for the general. However, in that actions are influenced by specific daily motives, to create a science that excludes these is to create a generality that does not relate to any specific instances, and misrepresents the individual. To return to the situation of researching drug education in the classroom, this leads to a situation where the artificiality of the questioning context leads to question-response dyads which are meaningless in terms of the real-life drug encounters young people may have in their daily lives (see Chapter 5).

However, this should not be regarded as an uncritical acceptance of the methods of discourse analysis, whose rejection of prediction in favour of rhetoric and description can be problematic for research in general and for the research of substance activity, an area in which prioritising rhetorical devices is a key task. The discourse analyst set out his position in the claim that, "The emphasis on prediction is a very much traditional social psychological narrative, that what one's doing is predicting and I think it became so for psychologists when their predictions were so duff. In a sense if you've got no idea why people do what they do, at least you can get lots of statistical regularities and then you might be able to predict something. That didn't work either it turned out, but I just don't see prediction as an appropriate way of looking in general at what people do because of the rhetorical, action-oriented nature of action isn't predictable in a simple way" (Potter, *pers. comm.*)

The problem with this claim is that, if there is no systematic descriptive frame that is capable of application, then it is difficult to differentiate this approach from another form of armchair philosophising. This leads to the situation in which all texts are accorded equal prominence, a situation not particularly useful in attempting to address some of the issues involved in drug use or harm reduction. This is the area in which discourse analysis is most open to criticism as it permits the perpetuation of the prejudices and beliefs of the writer. If there is no hypothesis and no clear decision making device to determine which texts are to be critically analysed, then the process is open to political manipulation.

However, this can be justified on the grounds that prediction testing has often been used as a spurious justification for investigating areas with no clear theoretical direction and, as a result of which, statistical tests have replaced clear argument as the yardstick of scientific rationality. This does not sufficiently encompass the difficulties of social science research as discourse analysts are open to the accusation of "throwing the baby out with the bath water" by discarding all forms of prediction and hypothesis testing in favour of rhetoric and persuasive arguments.

The risk is that discourse analysis develops a set of assumptions, moral and political, that are shared by all its adherents whose publications come to reflect not the critical approach required in social psychology but the preferences and prejudices of this group of academics. Thus the discourse analyst claims in discussing the discourse of members of the National Front, "I've got no interest in going back to those people and re-negotiating with them about it, and Mick Billig has done a whole series of interviews with National Front and written that up, and the idea of him going back and negotiating with them about their position is laughable" (Potter, pers. comm.).

The argument the discourse analyst is putting forward is that the claim made by traditional researchers of objectivity is fraudulent and that as long as the qualitative researcher is open about his or her political assumptions and values, there is no benefit in attempting to pretend to adhere to a neutrality that is dishonest. However, this leaves the discourse analytic movement open to the criticism that it is little more than a vehicle for the expression of a particular set of political values. As a consequence its writings may be ignored by 'mainstream' social scientists as it can be

argued to represent little more than a rationalisation of the opinions and prejudices of the individuals who produce it, however interesting or clever the arguments may be. The claim would be that it is rhetoric rather than evidence that is prioritised in some of the qualitative approaches.

Therefore, a fundamental problem with importing such an approach to the investigation of substance misuse is a perceived lack of credibility, in an area in which the voicing of prejudices and unsubstantiated opinions is commonplace. Therefore, the attempt to incorporate a critical and participative approach to substance-related issues must be based on access to the warrants of knowledge as it is imperative that one set of biases and prejudices are not merely supplanted by another. Therefore, the overall strategy of the method to be employed in the empirical parts of the investigation can be summarised as the utilisation of an innovative and principled qualitative method that is both predictive and critical, and which aims to augment the empowerment and involvement of participants.

Therefore the final consideration before the application of this method can be considered is the critical aspect, deriving from the deconstructionist approach. This position is set out most clearly in the claim that when you're carrying out research of this kind there are certain kinds of power and responsibility. The interviewee has certain rights to speak and certain worries about how the information will be used which are aspects of the research setting. For the deconstruction theorist it is this relationship that can be questioned, problematised, and possibly overturned. This derives from the groundedness of the interview in the context of its occurrence.

The fact that traditional interviewing has been naive in the assumption that the interviewer is detached and gives nothing, while realities about the interviewee emerge, is rejected in favour of a reflexive and grounded approach in which both participants create a shared reality and meaning. For substance research, this is not a pessimistic conclusion in that it is precisely this form of interpersonal contact and shared meaning that is at the core of the research and the therapeutic relationship. It is this type of conceptual misunderstanding that has led to misguided second-guessing about the "validity" of both research and clinical interviews. It is by equating the status of researcher and participant that their shared role in developing meaning can be understood as an aspect of everyday sense-making.

This approach forces the researcher to be critical of assumptions about role determination in the context of clinical or research interviews. The point from Foucault's writings (1975) is that power should be considered as a dynamic factor in interpersonal contact and not as residing in individuals or their claims to knowledge or power. As a consequence, the development of an interaction involves a negotiation of power, partly determined by role identities. Therefore, it is not sufficient to say that certain questions are disempowering as this is, in itself, a pejorative assumption about the status of the participant.

The difficulty with assuming that power and knowledge may differ from one interview to the next is that it makes comparisons between interviews problematic in a way not foreseen in traditional research. If the context in which the interviews occur

is not a common theme, new relationships are formed throughout as well as between interviews. The deconstructionist claim would be that bodies of 'preferred' knowledge be treated with scepticism regardless of their source and that knowledge be seen as an act of creation that occurs in each discourse.

The final claim about researching substance use that has its foundations in the deconstructionist approach is the reluctance to accept the tenets of a particular theory or method. This is the attempt to safeguard against the replacement of one type of mythologising with another. This is to avoid substance use being 'understood' in the form of one academic discipline (social psychology or anthropology) or another (medicine or psychiatry). This is the issue of 'owning' the knowledge about a particular subject issue, in this case substance misuse, and the extent to which this is predicated one professional status. This is about the cost this inflicts on the participants. Thus, for the deconstructionist, people learn how to fill out questionnaires and "turn their feelings and desires into categories that are demanded and they learn to regulate themselves so that when they are interviewed by their health visitor or doctor or whatever, psychology starts to work, starts to become rooted in the way people talk" (Parker, pers. comm.).

There are a number of important issues concerned with imposing a certain type of knowledge on participants. The first is that any method, in particular those that use closed categories, are likely to impose meanings on respondents (Schuman and Presser, 1981) who are trying to make sense of the situation they are faced with. Therefore there are demand characteristic risks associated with a methodology that

imposes a structure, as questionnaires do, on the respondents. This is relevant in sensitive social research such as substance misuse where the pressures to provide responses may be salient for respondents.

However, there is a second issue in using empirical social science, which involves creating artificial limits on the range of responses available to participants. This is most obvious in a questionnaire, but reflects researchers' assumptions that only certain responses make sense, which although rational, may not apply to the chaotic world of the substance misuser. For this reason, the critical approach should be utilised for other sources of information that can be examined in terms of the interests they serve and those they suppress (see Chapters 5 and 6). Other methods can also be used reflexively to challenge the assumptions that are made in the course of analysis of the discourses of substance misusers and young people expressing their opinions about substance issues.

9. Conclusion

What this chapter has done is to introduce issues that have arisen in writings that are insufficiently covered by the term "qualitative". The general approach involved in this area has been to explore alternatives to the assumptions and methods of traditional empirical positivism, drawing upon the fields of feminist writings, anthropology and literary criticism. Although there have been accusations that the qualitative approach is little more than a rationalisation for a lack of systematicity and rigour, this does not reflect the precision and care that characterise many of the works in this area.

Whether the methods employed by the qualitative research approaches are satisfactory does not disguise the important issues that have prompted social scientists to challenge the universal applicability of empirical methods.

The chapter has focused on three approaches in particular - the literature on reflexive writings that are common to the qualitative approach, the area of discourse analysis that has grown up in response to traditional methods in social psychology, and the writings of Derrida and Foucault, which have, perhaps unfairly, been grouped together as 'deconstructionist'. The examination of this literature has attempted to take a critical perspective, of both the critical writings themselves and of their implications for empirical methods in social research. However, they are also key methodological advances that have contributed to the participative and predictive approaches outlined in the next three chapters for researching substance misuse and drug education. These writings have been critical of the interview and questionnaire methods often used in empirical social research. The reflexive approach emphasises the role of the researcher as an active participant in the situation, a situation laden with political and social relevance. In some way the key conclusions to draw from this work in undertaking research into substance misuse is the need to examine the context of reporting and the rhetorical foundations that underpin it. The shift from the attribution research rationales that underpinned the ANOVA model and Weiner's dimensions to rhetorical intentionality is a transition in both conceptual models and, resulting from this, the most appropriate ways of gathering research information from substance users.

What this has implied for a qualitative investigation into drug research is the need to employ a range of qualitative techniques, while retaining the primary objectives of quantitative approaches. This involves the use of a clear theoretical approach and the need to test predictive hypotheses, while encouraging the participation and empowerment of those involved in the research process. This has led to the development of a method and theory concerning the social and political deployment of the term "addiction" outlined in Chapters 3 and 4. This is followed by two investigations of researching drug awareness and activities in two areas, the Lothian region around Edinburgh (Chapter 5) and the Easterhouse housing estate in south-east Glasgow (Chapter 6).

Chapter 3 - Development of a Method for the Principled Analysis of Discourse

1. Introduction

The difficulties associated with assessing the validity and accuracy of substance misusers' self-reports are well-documented (Iguchi et al, 1988). For researchers, self-reports are often the only source of information available, while clinicians may also rely on self-report given the cost and delays involved in urine and hair analysis. Furthermore, urinalysis is open to manipulation by clients (Magura et al, 1987) who may substitute clean "urines" for drug-positive ones or avoid the clinic on days they will be tested (Nolimal and Crowley, 1990). Clinicians and researchers make decisions on the basis of the self-reports but are left to speculate about its accuracy.

This issue was addressed in the validation of the Opiate Treatment Index (OTI) (Darke et al, 1992). The authors based this scale on "objective data rather than the impression of interviewers" (Darke et al, op cit). HIV risk behaviour was validated by conducting collateral interviews with partners, criminal self-reports were checked against conviction rates, drug use was assessed by urinalysis and health scores by medical examination. The authors argue that the OTI is a comprehensive assessment of substance misuse, from which a total score can be obtained. However, there are problems with this approach. In collateral interviewing, partners are as susceptible to self-presentation biases as the original respondents. The problem is that if one does not have faith in self-report, this is unlikely to be restored by gathering further self-reports from another source, particularly one who is no less likely to have a stake in the outcome.

The assessment of criminal records is also questionable as the higher the validity correlation, the less faith one may have in the self-report. If the correlation is high it is likely that the interviewer is reporting only crimes for which he or she has been convicted and omitting those that have not been recorded by the police. Finally, unless urine testing is frequent and supervised, it may underestimate substance activity (Kidorf, Stitzer and Brooner, 1994). Howard, Bell and Christie (1995) found that 14% of users reported not taking heroin when urines suggested that they had, and 9 % of reports of heroin use were not indicated by urine testing. The difficulty with all three validating mechanisms is that disparities they demonstrate between self-report and 'objective' measures only further cloud the issue of how to deal with the self-reports.

The logic of attempting to validate drug-users' self-reports is flawed as substance misuse is a "biopsychosocial process, which refers to the patient's inherited and biological vulnerabilities, psychological predispositions or morbidity, and pervasive social (i.e. economic, legal and cultural) influences that converge to both forms and perpetuate addictive behaviours" (Moolchan and Hoffman, 1994, p.139). These variables, in turn, shape and are shaped by discourse about substance-related issues. It is the social discursive underpinnings of substance behaviours that are missing from many of the attempts to quantify drug activity by objective measures (see Chapter 2).

Examining discourse in a social context is inherent to understanding certain substance issues. In an attribution study, Eiser (1978) argued that smokers' preparedness to label themselves as "addicted" may make it more difficult to persuade them to stop

through their own efforts. Eiser argues that this may result from the user's investment in Parsons' (1937) "sick role". This has informed the disease concept of addiction in which self-determination is superseded by explanations based on addiction as a medical illness. The impact of the medical model is such that methadone treatment is now the most common form of intervention for opiate problems in the US and UK (Platt, 1995; ISDD, 1994). However, this style of treatment has been called into question in terms of its efficacy and cost. Annis (1986) has argued that 90% of addicts can not only be detoxified outside of the hospital, but that they need no medication to do so.

In the inpatient-outpatient debate, it is argued (Miller and Hester, 1986; Annis, 1986) that there is little difference in long-term treatment outcomes, although residential treatments remain popular. Cummings (1991) argues that one of the few justifications for inpatient detoxification is that "while the patient is away for 28 days, all concerned can cherish the illusion that something is being done to forever fix the problem" (Cummings, 1991, p.515). This is a recognition that drug treatment deals with beliefs and expectations as well as pharmacology. As Gossop (1982) has argued, "an important part of what is generally called the drugs problem is the set of attitudes that society maintains towards drugs and drug taking" (Gossop, 1982, p.2). Societies differ in their perceptions of what constitutes unacceptable substance taking. As a result, there is no clear relationship between the chemical properties of a drug and society's response, as drug risks are mediated by social perceptions of consequences, perceptions that have their origins in discursive patterns and forms.

It is an institutional categorisation in many Western countries that allows alcohol, tobacco and caffeine to be classified as safe while cocaine and heroin are prohibited. When American troops were in Vietnam more than 25% were believed to have used heroin. However, Robins et al (1974) report that after their discharge, only 7% of veterans used any opiates. Among those who said they had been addicted while in Vietnam, less than 10% felt that their addiction had persisted beyond their return. As Gossop (1982) argues, the period in Vietnam represented an escape from all the normal social and moral restraints. The evidence from Vietnam is that drug addiction is bound up in social issues, and can never be sufficiently explained by a medical model.

This is particularly the case for those labelled "addicted". This was examined by Eiser and Gossop (1979) who looked at perceived control, perceived dependence and treatment expectations in 40 drug out-patients. They concluded that there are two independent factors in the way users perceive their own addiction. The first, "hooked", is a fear of withdrawal, a perceived inability to give up and an unwillingness to try. The second, "sick", is a perception that drug use is an illness. While the Eiser and Gossop study assumes the concept of addiction without challenging it, Eiser, Sutton and Wober (1977) address this for third-person attributions. They concluded that the most important determinant of whether smoking was seen as an addiction was whether the respondent (not the target) smoked. This implies that addiction is not a simple application of medical criteria, but a complicated process involving social, interpersonal and political agendas. These are underlaid by

attributional factors, identified in experiments conducted by the Addiction Research Group at Strathclyde University.

The most commonly cited of these is the Davies and Baker (1988) investigation of interviewer effects on self-reports. 20 drug users were interviewed twice, once by an academic and once by a fellow user. Contrary to expectations, the academic was presented with higher levels of drug use, and more addicted self-ascriptions than was the fellow user. The authors concluded that the self-presentation of substance use varies between interactions and that these variations are not random. That the self-presentation of substance misuse may be manipulated to achieve certain effects reflect the self-presentation issues that shape all social encounters (Goffman, 1971).

McAllister and Davies (1992) interviewed 20 smokers from a Stop Smoking Clinic twice. After the first interview, the smokers were divided into a 'heavy smoking' and a 'light smoking' group. At the second interview the words 'light smoker' or 'heavy smoker' were printed on each page of the questionnaire and were visible to the respondent. Those who had been classified as 'heavy smokers' provided explanations emphasising lack of control, high stability and internality in their follow-up interviews. Those categorised as 'light smokers' provided attributions that were more external, controllable and unstable - explanations that contrast with the "addicted" explanations given by 'heavy smokers'. The authors concluded that a clinical context is likely to produce 'addicted' accounts that are influenced by subjects' knowledge of the dynamics of the interview. Both of the above studies suggest that the types of

explanations that are given are a consequence of the context of the interaction and the objectives of the participants.

O'Doherty and Davies (1987) found that the majority of negative life events are reported at a time close to the interview and that this helps to make sense of the drug user's life situation at the time of interview. The comparison here is with Stott's (1958) paper on the recall of negative life events in mothers of Down's Syndrome babies who reported more negative life events during pregnancy than did mothers whose babies did not suffer from this disorder. This led to the suggestion that Down's Syndrome resulted from stressful events in pregnancy, a result that has since been superseded by pharmacological explanations. Mothers whose babies have this disorder make sense of this experience by reconstructing past life events. The past events are not only antecedents of current states of affairs but are causal determinants of explanation in discursive and social terms.

In applied research, the events to be explained are central to the lives of the explainers. The participant will almost certainly have considered the task they are being set as a part of everyday sense-making. However, the drug user's reporting of this is also likely to reflect what they consider the purpose of the question being asked. Thus the mothers of the Downs' Syndrome babies do not want to be held responsible for the illness, and so they provide an "external" explanation. It is the strategies that people use and the variability in the accounts they produce that are at the heart of making sense of everyday explanation. With regard to the reports of substance misusers the questions to be considered are 1) under what conditions are

certain types of explanation most likely to be provided? and 2) what are the consequences of giving particular types of explanations for subsequent behaviour?

2. Design

The research attempted to develop a method sensitive to the contextual determinants of explanation. The study built on the McAllister and Davies (op cit) study, in which explanation shifts were found only in closed category questionnaire items, but not in open discourse. To examine this effect, the current investigation examined natural explanations (Silverman, 1973). The method developed as part of the process of data collection. The funding was provided by the Chief Scientist's Office of the Scottish Office to examine explanation changes in drug and alcohol users, both in and out of contact with clinical services. In methodological terms, the goal was to outline a framework for interpreting natural attributions provided by drug and alcohol users. Its clinical goal was to establish the predictive significance of explanations given by users for subsequent explanations and for drug and alcohol-related behaviour.

The study was a repeated measures design in which attempts were made to contact participants on three occasions, divided by a minimum of six months. They were interviewed on each occasion about their substance activities and their understandings and attributions for them. The subjects were to include primary users of a range of illicit substances (and alcohol) and were to be divided between those who, at the start of the project, were in contact with clinical services and those who had no form of clinical contact. The investigation involved four geographical sites - three urban, Glasgow, Edinburgh and Newcastle, and one mixed, suburban and rural, Ayrshire.

As each of these sites were different health authorities, there were marked differences in the services available to problem users of both alcohol and illicit drugs, and different distributions of what services there were, between statutory and non-statutory provision. Thus the study was a four by two design in which four locations were used to compare substance misusers in and out of treatment (the issue of treatment will be examined in more detail in the procedure section of the methodology). While this design permitted a cross-sectional analysis, there was also a repeated measures component, in which the researchers attempted to contact each participant on three occasions, although this did not always prove to be possible as a result of drop-out and geographic mobility.

3. Rationale

The study used a minimally cued, semi-structured interview as an attempt to overcome the limitations of questionnaires in assessing substance misusers. The argument is that, as discourse is functional and purposive, what is required is a method that recognises the contextualised functionality of discourse. One objective was to develop a taxonomy of the ways in which shifts in context lead to shifts in discourse. This provides a means of understanding the function of types of discourse and the contexts in which they are most likely to occur. The aim was to develop a qualitative procedure that is empirically testable and replicable. The method employed is based on an interview of around 15 minutes. This interview style is similar to Rogerian approaches to non-directional counselling (Rogers, 1961), although the focus is more on the explanatory than the descriptive. The purpose is to elicit natural

attributions and to assess the ways in which explanations have context-specific applications and purposes for speaker and listener.

The initial phase involved the development of the content of the interview. This involved determining the introductory speech (when recruiting the user to the study) as well as selecting initial questions. The second aim was to develop an interpretive frame for the conversations. Method and analysis were not pre-determined aspects of the research but evolved as interviews were carried out. This is not because the method was atheoretical, but because the functionality of substance users' discourse was developed into a method that was responsive to the style and content of interviews.

4. Model of addiction as a social construct

What became apparent from the pilot interviews was that addiction was a core term in the language of substance users, both those in contact with addiction services and those with no contact (for young people's perceptions of 'addiction' see Chapter 6). This concurs with the conception of addiction developed by Davies (1992), in particular the argument that this term can be strategically employed. Davies goes on to argue that "This form of explanation can legitimise drug-related behaviours insofar as it places them, in a sense, where the person cannot 'get at them' and thereby removes the element of volition; and hence absolves any 'guilty verdict' that might otherwise attach to the behaviour" (Davies, 1992, p. 114). However, the current argument goes beyond the use of the addiction term as a first-person attribution, and extends the definition to third-person explanations. It is not only the drug user who

may choose to attribute their own behaviour to addiction, but other people may do the same thing, especially in terms of categorising the individual as an "addict".

The suggestion is that it may not only be in the interests of the user, but also some of those with whom they have contact, for an addiction label to be attached. It is this social deployment of the addicted ascription that is at the crux of the current theory. Indeed, the self-ascription would carry no weight if there were no external validating forces whose acceptance of the 'addicted' label may serve to strengthen, if not reify, addicted status – this is similar to Becker's concept of secondary deviance within labelling theory (Becker, 1961). The model developed concerns the types of interactions that occur between drug or alcohol users and significant others, and attempts to assess the interpersonal and discursive forces that operate around the attribution of addiction.

The basis of this theory is that to be categorised as addicted is not exclusively negative, either for the user or for those with whom the user has contact. While it may be beneficial to the user in court to explain their activities as an unavoidable consequence of their addiction, others may participate in this explanation. The mother who has her purse stolen may feel better believing that her child has an "illness" that caused him to steal, rather than that they are intrinsically bad or selfish. A second group of individuals who may conspire in the labelling of 'addicts' are those professionally involved in the 'addiction industry'. If there are no addicts then there can be no addiction services, and so it is in the interests of addiction services to find and treat as many addicted individuals as possible. This is not to imply that drug

workers try to create addicts but that, at the very least, there is a symbiotic relationship between addict and service provider.

The concept of expertise plays a critical role in the current conceptualisation of addiction in that it is through the mediation of a third-person attribution and ratification of the addicted status, that the applicability and credibility of the addiction self-attribution is enhanced for the substance misuser. Thus, while the drug user in court on a theft charge claims that that they had to steal to support their habit, the functionality of this argument may be apparent to the judge familiar with such claims. However, when this claim is supported by a letter from the accused's G.P. or drug worker, the user's claim to addicted status has received an expert legitimisation that the judge may be less inclined to challenge. Thus, for the substance user for whom the label 'addict' has functional appeal, it is important that they can enlist the assistance of a third party whose expert status confirms the addicted label, ideally with the weight of science behind it.

However, the external legitimisation of this label is at a cost. Although they may have escaped prison, the user may now be required to attend a detoxification programme and attend their drug agency on a weekly (or even daily) basis. Further, they may discover that what was a temporarily convenient label is not easy to discard, now that the threat of incarceration has gone. The legitimisation of an addicted status has two consequences - first, that it requires the existence of experts and, second, that it is binding and results in certain assumptions about the status of the user.

The model presented below is a discursive theory of addiction, in which the attribution of addiction is contingent on the functional labelling of behaviour. This is negotiated between the perpetrator of that behaviour and some external agencies who have a legitimised expertise. The discourse examined is that of the substance misuser, although it is assumed that this reflects socially mediated discourses. This is a social model that attempts to explain discursive behaviour as it occurs in drug related settings. The model consists of five stages, which reflect phases of a drug-using career, although it is not the case that all users will experience all five stages.

PRE-ADDICTION PHASE		**ADDICTION PHASE**		**BEYOND ADDICTION**
STAGE 1	***STAGE 2***	***STAGE 3***	***STAGE 4***	***STAGE 5***
Non-problem use	Problematic use	Addiction	Shadow of addiction	Addiction rejected

Table 1: The five stages of the discursive model of addiction

The three phases of the model refer to social experiences of addiction and reflect the ways individuals describe their substance activity. These social dynamics emphasise certain types of explanations but discourage others. The first and last phase are both conceived of in relation to the "addicted" phase, in which explanations revolve around the self-attribution of addiction. This explanation will have received social recognition from a general practitioner, a court or a drug agency.

The classification of stages can be conceived of as the phase of recreational use (stages 1 and 2), the phase of addiction (stages 3 and 4), and a phase when the concept of addiction no longer applies, either by the user's own choice or because of a institutional denial of its applicability (stage 5). These three phases correspond to different explanatory styles around the core concept of addiction. The three phases can also be conceived of in terms of the structuring of addiction institutions. Those in phase one are not deemed to require assistance, those in phase two are involved with some form of intervention, and those in phase three are either viewed as being beyond assistance or have rejected the addiction model. The model reflects the relationship between substance-related discourse and the structuring of treatment modalities. The five stages that make up the three phases of the addiction model are outlined below:

Phase 1, Stage 1 - Gossop (1982) has argued that, "an important part of what is generally called the drug problem is the set of attitudes that society maintains towards drugs and drug taking" (Gossop, 1982, p.2). This is not a simple consequence of drug potency, but a result of a complex interplay of moral, social, political and historical factors. When individuals engage in substance use, their beliefs and experiences are mediated by group norms and expectations, set against a background of societal values about particular types of drug. This social categorisation is a determinant of what one may become addicted to - a list that includes alcohol, opiates and cocaine, but may extend to dieting, exercise, chocolate, sex, caffeine and cannabis.

People may use any substance without encountering any difficulties, while others using similar quantities of the same substances encounter problems that are

subsequently attributed to the drug. The relationship between the problem encountered and the substance used is not causally determinable. Therefore, stage one cannot be thought of in terms of specific substances, but refers to those individuals who do not attribute any life difficulties to the use of substances - a non-problematic form of substance use. So when Joe claims, "I take hash all the time and acid and speed for kicks. I love the feeling of being mellow and it gives you a right good buzz", the explanation is volitional and positive.

The point is that drug use is perceived by the user as controllable, enjoyable and irrelevant to the discourse of addiction. This is an attributional issue, in which the views of "experts" are irrelevant until they impose some sanction on the individual that renders their use problematic. For example, if the police arrest the user for possession or if the drinker's spouse leaves them for their repeated drunkenness, then their previously non-problematic use may be recast as the cause of their negative outcomes.

The major point to make about the first stage is that for many individuals, regardless of which substance or substances it is they use, they will never leave this stage. This is the stage that would be attributed for substance activity by most adolescent drug users (see Chapters 5 and 6). Although this is the first stage of a model of addiction, it is critical to the model that there is no assumption that all individuals must pass through it.

It should also be borne in mind that simply because an individual passes through the model for one form of substance use, there is no requirement that they must go through the model for all the substances, licit or illicit, they use. However, there are different social barriers to passing to different stages of the model in terms of the user's own expectations and the assumptions of those around the individual. Thus, there is a strong social value system surrounding heroin which does not surround chocolate such that, while it is possible for a heroin user to remain indefinitely in the stage of non-problematic use, the user and those around him or her are more likely to attribute life problems to the use of this substance. This may be a consequence of the myths that surround it, which make movement to the second stage more likely than is the case for chocolate, which is not surrounded by such a mythology.

Phase 1, Stage 2 - This is the stage when the user encounters problems with their substance activity, and when this connection is made in their substance-related discourses. What this may imply is that the unqualified pleasure associated with substance use in the first phase is tempered by unpleasant consequences that reduce the positive reporting of substance activity. This is the point when the concept of a cost-benefit pay-off is introduced, as at this stage and the fourth stage, discursive ambivalence and vulnerability to contextual influences on reporting are evident. What characterises this stage is a discourse marked by both positive and negative reporting of different aspects of substance use. Thus when Tommy says, "I like a good drink and there's nothing else to do anyway. I suppose I do have a drink problem but I reckon I could stop if I want to". What is interesting here is that in addition to both

positive and negative reporting, there is a real ambivalence about whether he sees himself as dependent or not.

The discourse at this stage is still primarily recreational and there are unlikely to be self-ascriptions of an addicted state, although this does not mean that addiction as a concept is necessarily alien. This discourse is ambivalent as it is not exclusively characterised by positive experiences, although such explanations do occur. The cost aspect of the pay-off may be based on financial considerations, physical consequences (including hangovers for alcohol), the risk of loss of control and fear of legal sanctions. These reflect the social aspect of a model in which it is a combination of social structures (such as the legal and clerical systems) and social norms (shaped by family and peer groups) that constitute the field in which discourses occur. This reflects the relationship between social structures and discursive acts.

It is also worth noting that there is a distinction between stages one and two in terms of the consistency of the discourses that are produced at each stage. At the first stage, the user has no problems with their substance activity, which results in a positive discourse, irrespective of the interlocutor or context. However, the individual at the second stage is more aware of the benefits and drawbacks of their substance use, and so is more susceptible to shifting explanation according to the context. This implies that the individual at this stage has access to different kinds of story about their substance activity, those emphasising the benefits and those emphasising the costs. The story that will become most salient in an interaction will be contingent on their perceptions of the interlocutor and of the functionality of the explanation. Thus, the

drinker on his way out to the pub with friends is likely to emphasise cameraderie, whereas the next morning is more likely to accord to his partner's view that it was a waste of money and the cause of his current physical ailments.

It is also important that stages one and two are linked, in that it is possible for an individual to fluctuate indefinitely between these stages without ever crossing the threshold into the phase of addicted-style discourse. Thus, as substance-related difficulties arise and are resolved, the person passes from the first stage to the second and back again, without any necessary change in behaviour. Thus, Malcolm, an alcoholic in treatment describes his drug use very much in this way. He reports, "I used to be on LSD between 18 and 25, but that's non-addictive, and I had a smoke or speed, but at 25 I think I just grew out of it and I just tripped once a week on a Friday night at the Mayfair". Here the report is of casual use, not leading to problems and that eventually simply dies out, irrespective of the ongoing alcohol problems he experiences.

Typical of this would be the club-goer who uses ecstasy every weekend and suffers from irritability and fatigue at the start of each new week. As she connects the two events, she makes the attribution that speed is having a negative effect on her work performance and relationships. She decides to reduce intake for a few weeks in an attempt to regain some composure on domestic and professional fronts.

Phase Two, Stage Three - The addicted phase: While there is the ease of movement between stages one and two, so that it is possible to move from one to the other and

back again, this is not the case for the shift from the second to third stages. While the barrier dividing stage one from stage two is permeable and possibly cyclical this is not the case for the transition from stage two to stage three. Here, there is a radical shift in discourse and in the significance of substance behaviour. Although the transition to stage three is not easily accomplished, the shift in the opposite direction is almost impossible. Although, the most obvious indicator of stage three is the self-ascriptions of addiction, there is a shift in the categorisation of substance activity and of the individual, such that "addict" becomes almost an existential marker. Thus, when asked why he takes drugs, Cameron replied that "I got some from a friend and I've been an addict now for 13 years". What is interesting here is the jump made in the explanation from experimentation to addiction, a word not used in the question.

It is the shift from stage two to stage three that is the critical point in the model, as it is the point at which the self-ascription "addict" is accepted and confirmed by an external, legitimating body. This has consequences in terms of the discursive dynamics of substance use available to the user. Certain discourses are no longer available to the person defined as an addict. When Maureen is asked why she cannot give up, she claims "because I couldn't stop. I tried to stop but I wasn't getting any help off the doctors. It was too hard." She perceives her use as an addiction, an addiction that she cannot overcome without outside assistance.

Self-determination and choice are, in part, removed from the individual who has participated in their categorisation as addict, as is their ability to renounce the addicted label from their own behaviour. The model is primarily a social discursive

rather than attributional. It is not only that the explanations have consequences for subsequent behaviour, but also that they act as complex social processes of characterisation. Addiction is seen as a socially mediated process which, while its acceptance requires the agency of user and legitimating body, its subsequent rejection is less likely to be based on the self-ascriptions of the user.

This raises the question of why a user would want membership of a group who are socially ostracised by the rest of society. In effect, the user participates in the sacrifice of their claims to self-determination in return for a dispensation, according to which their anti-social activities are, to some extent, excused. However, this pardon requires the individual to engage in reparation activities, whether this takes the form of detoxification, voluntary self-help or participating in medical treatments. This is a functional discursive decision that acts as a form of social structuring. The individual must participate in certain assumptions about their drug use as a precondition to their rehabilitation - that it is undesirable, that it makes them abnormal in some sense and that its treatment requires the agency of a third party. However, these assumptions are not inherent to drug use, but are essential for those who 'participate' in addiction, treatment or rehabilitation.

Traditionally, this problem has contained moral and medical components. The behaviour is perceived as indicative of weakness of character, or one that has its resolution in correcting a biopharmacological malfunction. These assumptions exist to different degrees, depending on the intervening authority (or the substance used), but typify the characterisation of "alcoholic" or "addict". The system in the UK is

characterised by the central role occupied by the general practitioner, supplemented in recent years by statutory and non-statutory specialist agencies (Spear, 1994). Each of these represent a tradition, with the medical component emphasising pharmacological interventions and expert agency, or on the 12-step model, introduced in the form of Alcoholics Anonymous in 1935 and Narcotics Anonymous in 1953. The distinction between services for alcohol and drugs is exemplified by the role performed by the prescription of substitutes which has had a powerful impact on the drug using community. The emphasis on substitute prescribing has become increasingly prominent since the association between intravenous drug use and the transmission of the HIV virus (Toon and Lynch, 1994). This has increased the pressure on health authorities to reduce illicit drug injection by prescribing non-injectible substitutes.

Although the role of substitutes is examined in Chapter 4, it may be useful to consider the role performed by prescribing in bringing clients to addiction services and in retaining them in treatment. The Dole and Nyswander (1965) model for methadone prescription to opiate abusers advocated high dose levels (a minimum of 60 ml per day) delivered on a maintenance basis as a means of reducing illicit opiate use and permitting therapeutic work to be done with the client. However, the successful impact of methadone prescribing on illicit heroin use (Ball and Ross, 1991), on retention in service (Caplehorn and Bell, 1991) and on legal problems, family relationships and employment records (McLellan et al, 1993) does carry with it certain difficulties and risks. Dole and Joseph (1978) found a net success rate of 8% for detoxification of clients from methadone prescriptions and that, even among this

group, "most persons with a long history of heroin use relapse after detoxification whether or not they had been rehabilitated" (Dole and Joseph, 1978).

However, methadone also acts as a powerful inducement for clients to make contact with addiction services, irrespective of their 'treatment' intentions. As Gary points out, "I've never had an incentive to come off before now, but now I'm getting things sorted out. I've got my own prescription, there's no need for me to go out looking for it any more, cause at the time that was the only thing I was bothered about, getting out my nut". The difficulty is that the stability offered by treatment comes at a price for the client.

As Strang and Gossop (1994) indicate, the British system operates largely through GP-mediated prescribing programs in which G.P.'s make decisions about quantity and duration. However this may be mediated by the individual's worker (contrasting with the American situation in which methadone prescription is centrally managed by the Drug Enforcement Agency (Platt, 1996)). In the British system methadone prescribing acts as an inducement to clients who are having health, legal or financial problems with opiate use. Habitual heroin use is often a risky, tedious and seemingly never-ending business and so the prospect of a substitute may be a significant lure - particularly one that is legally acquired, can be taken once a day and which can have a major impact on withdrawals (Hunt et al, 1985-1986).

In terms of the discursive model of addiction, a methadone prescription can be seen as a reification of addicted status. A methadone prescription also offers benefits in that it

represents a tangible commodity which, regardless of its therapeutic qualities, may be used, sold or swapped according to the client's needs (NIDA Research Monograph, no. 131 - "Impact of prescription drug diversion control systems on medical practice and patient care", 1991). Methadone treatment operates as an incentive to clients to participate in addicted discourse as their addiction is mediated by pharmacological agents, and its validity is legitimated. This same mechanism acts as a means of retaining clients in addiction services as the continuation of the addicted story is facilitated by the continued use of methadone. This serves as a prop for this view of 'addiction' and perpetuates its discourse.

This implies that the threshold between the problems encountered at the second stage and initiation of the addicted style of discourse indicative of the third stage is weakened by methadone prescribing. However, substitute prescriptions also act as a disincentive to rejecting and moving beyond the addiction story. As there are practical benefits for the opiate user who can engage in legitimised self-ascriptions of addiction, in terms of justifying their activities and through access to a methadone script, this is not discarded lightly. However, for many substance users there are problems with this form of treatment-based lifestyle that may encourage its rejection in favour of a more ambiguous attitude to treatment services and the story of addiction.

Phase Two, Stage Four - The Shadow of Addiction: This stage occurs within the phase of addicted behaviour and so movement back and forward from this stage to the third stage is common. Indeed, the cycling behaviour that was described as a typical pattern of movement in the first phase is replicated here with clients frequently

passing through the "revolving door" of treatment. Here, the client's categorisation as addicted remains constant but their discourse may shift in systematic ways. What this shift means is the fourth stage of the model, characterised by the breakdown of the addicted myth and lifestyle. The benefits conferred on the addict by "recognising" their problem also involves a price in terms of a loss of choice and an institutionalisation of behaviour that causes dissatisfaction in some substance users.

In the fourth stage, the individual continues to employ an addicted explanatory style, but this is no longer adequate to explain the range of his or her behaviours. Thus, Cameron's claim that "I'm coming at this as a hard core addict and that's where I'm stable, but I mean I enjoy it, but I don't know if I'll ever stop" suggests an acceptance of the addicted role, but one no longer inconsistent with a desire to continue using drugs. The fourth stage, is contextually defined, with variations in the style of explanation (in particular related to substance use) influenced by the context in which the explanations are given. This would explain the Davies and Baker (1988) finding that explanations given to academics differ from those provided to a fellow user. While the demand characteristics of context are the catalyst for shifts in explanation, this would only hold for those susceptible to contextual influence, in the second or fourth stages of the model. Those in the third stage use an addicted style of explanation that is resistant to contextual influence, but in the fourth stage, characterised by ambiguity, users are more vulnerable to context as a key to the appropriate form of explanation. Therefore, individuals employing the discourse of Stages 2 and 4 are more likely to shift their explanations according to the demands of the context.

Therefore, users within the phase of addiction are characterised by a consistent adherence to the story of their own addiction (stage 3) or fluctuate according to the context in which the explanation is given (stage 4). This difference manifests itself in differences in attitudes to treatment and, thus, in behaviours. From a clinical perspective it is those in the third stage who are less vulnerable to peer influence and so continued illicit use than those at the fourth stage. This is because their relationship to drug use is less clear, with an ambivalent attitude to the concept of addiction. This inconsistency occurs both across and within dialogues, as addicted and non-addicted explanations may even weave together within the same conversation. Thus, while at one point Garry claims that he uses drugs because, "I like them, I enjoy them", only seconds later he states "my tolerance is up and I'm feeling worse, so I want to cut down so that I end up being stable". Here, there is clear inconsistency between the pleasure associated with drug use and the problems of drug dependence and lifestyle.

The individuals in the fourth stage have not totally rejected the concept of addiction but it is not sufficient for all their discourses. However, explanations for substance use incorporate addicted self-ascriptions and so are within the addicted phase. This stage is characterised by dissatisfaction with the situation in which the users find themselves. Their addicted discourse is mediated by possibilities of achieving abstinence or even controlled use, and the extent to which they aspire to these objectives. In summary, then, the fourth stage is an uncomfortable one in which the user remains convinced of their addiction, but this is a necessary but not sufficient explanation for their behaviour. So when Garry later attempts to describe himself, he

says "it's maybe an illness for a junkie, but I don't class myself as a junkie, even though there's a need for it, know what I mean?" The temptation is to answer this rhetorical question with 'no, not really' as the inconsistency is what characterises this kind of discourse.

Phase 3, Stage 5 - In contrast, the advent of stage 5 is a major transition in the substance careers of those who reach this point, although there is nothing inevitable about the transition from the fourth to fifth stage. The fifth stage represents an irreparable breakdown in the applicability of addicted discourse. The means by which this breakdown occurs is either by a positive rejection of the addicted style of discourse by the user, which may be more predictive of an optimistic prognosis. If the rejection is initiated by the drug agency or court, then the outcome is less likely to be positive.

It is the former group for whom it is meaningful to suggest that they have "come out the other side" of addiction, and for whom the addicted style is significant only as a contrast to their current non-addicted status. Whilst these individuals are aware of the costs of substance use, these will be reported as costs they are no longer paying. The discourse of those who have rejected the concept of addiction, stage five positive, is likely to characterise their "escape" from the addicted life story. Thus, when Madeline claims that "it was pretty early on I became an addict, and I didn't have any money or anything and I started to really hate what it made you feel. That's when I decided it was time to stop." It is not that Madeline rejects the concept of addiction, but that she sees it as something she has come through.

In contrast, stage five negative occurs when the addicted script is rejected by the agencies who legitimised its attribution to the user. This is the point at which the court, the addiction service or the family abandons their expectations of addiction and its resolution in favour of negative global characterisations in which the user is portrayed as "hopeless". This is the point at which the paradigm of disease and treatment are abandoned. If the legitimising bodies will no longer participate in the individual's deployment of them, they cease to be functionally applicable for the user in that there is no longer a return in terms of excuse or tangible reinforcer for their employment. This is the category of 'down and out', street drinker and drug user for whom addiction is caught up in a web of social problems.

This can be represented as a group who have failed the system or have been failed by the system but are its unfortunate detritus - the proof that the addiction treatment services are not infallible. This unfortunate conclusion to an addiction career, more often evidenced for problem drinkers than for drug users, can only be resolved by the re-categorisation as addict by another legitimising body and a return to the third stage of the model. However, this would be an unusually fortuitous outcome and more commonly would be associated with a decline into a social underclass of homelessness, crime and incarceration.

Discursive Allocation to Stage

The method by which the individual's stage can be assessed is through analysis of their naturally occurring discourse in terms of seven dimensions. Each of these represents a characteristic of each stage of addiction's style of explanation. While these dimensions can be seen to have their roots in attribution theory, they represent overlapping schemata that can be used to characterise the drug user's explanations. They consist of five continua and two dichotomous states and are as follows:

1. Time - This is the tendency to use explanations for substance use that have primarily future, present or past temporal orientations. The significance of this is that explanations based far in the past are more likely to imply a clearly established causal structure and thus a more intractable and inevitable pattern of use, i.e. past explanations are more consistent with addicted self-ascriptions. Thus, when asked why she uses, Margaret replies by claiming, "when I was 14 my dad died. I think it all sort of started from that". The explanation to a present continuous question is answered with an event that occurred long ago.

2. Generalisability - This refers to the range of life events that are perceived by the user as being influenced or shaped by their substance-use activities. The more events that are explained with reference to substance use, the more likely the individual is to possess an "addicted" understanding of their present position.

Thus, Peter replies to the question 'how much does methadone help?' with "Basically I am not the same person I was a few years ago and that's why I want to come in here

and get myself sorted". What is interesting is, again, that Peter appears to be answering a question other than the one that is asked. While this is partly based on an assumption about shared knowledge, it also suggests that he sees his drug problems and their resolution as being critical to his status and identity.

3. Purposiveness - This is the extent to which the user perceives his or her activities as being purposefully chosen or beyond their control. Thus, Madeline contrasts when she first used with later experience in her report that, "I stopped enjoying it quite soon and it never comes back. You have to have it and you can't enjoy it when it's all about need". This is critical to understanding the perceived loss of volitional control that is associated with addicted styles of discourse. This is supported by Michael's comment that, "I've never admitted this before – but it's totally out of control, ever since I've been injecting anyway". This is central in terms of the substance user's perceptions of empowerment and their ability to initiate change.

4. Hedonism - This involves the extent to which explanations reflect a positive or negative evaluation of the user's activity, and the consequences of such a lifestyle. To the extent that the model can be envisaged in terms of costs and benefits, this reflects the role of the initial high and its subsequent reduction as tolerance increases with continued substance use. Thus, while Flora, a drug user in treatment claims, "you very quickly become addicted and you just basically take them to get squared up", Tommy, a young recreational user is at opposite end of the scale of hedonism with his assertion that, "I like the buzz and that's how I use".

5. Reductionism - This is the level of description used in explanation in which the principal distinction is between physiological and psychological causes. Extensive use of physiological explanations for use (for example, reporting use as caused by physical cravings or the easing of withdrawals) is characteristic of the addiction phase of the model. Thus, Cameron's claim that "I need it just to get myself squared up, to stop me rattling" in reply to the question "why do you take drugs?' is to reply to a psychological level question at a physical level. Such is not the case for psychological-level explanations such as "I take drugs because I'm bored" or "I drink because I want people to like me".

6. Contradictoriness - Contradictoriness is the extent to which the subject makes use of contradictory or competing styles of explanation both within a single conversation as the topic shifts, or between conversations as the discourse in one context differs from that in another. An example of the first instance comes from Colin who claims that "I'm dependent but I don't see myself as a junkie, not really, because I don't take anything that's put down in front of me which is too easy to take". In the study to be outlined in the next chapter, which involves several interviews with each user, we can locate contradictoriness both within and between discourses for the same individual. Within the present model incompatibility between explanations is regarded as a defining feature of stages 2 and 4.

7. Addiction - This involves the self-ascription of the term "addict" or its denial. The term is not used by the interviewer to avoid a cueing effect and so is not always present. Thus when Margaret replies to the question, 'how would you describe

yourself?' with "I still see myself as an addict because I am addicted to something. I cannot get by without my methadone" it is to classify oneself in a way that carries considerable baggage. However, when the user employs the term addict as either a self-referent or in denial of this, this is a significant act for their beliefs about their substance use.

The relationship between the stages and the dimensions is outlined in the table presented below, in which the individual's explanations are coded for the dimensions that are then transferred to the most appropriate stage:

Stage	**1**	**2**	**3**	**4**	**5+**	**5-**
Time	Present	Mixed	Past	Mixed	Present	Past
Generalisability	Low	Mixed	High	Mixed	Low	Mixed
Purposiveness	High	Mixed	Low	Mixed	High	Low
Hedonism	High	Mixed	Low	Mixed	Mixed/high	Low
Reductionism	Psych.	Mixed	Physiol.	Mixed	Psych.	Psych.
Contradictoriness	Low	High	Low	High	Low	Low
Addicted state	Absent	Absent	Present	Present	Absent	Absent

Table 2: The seven dimensions of the five-stage model

The procedure for the elaborated decision-making process then proceeds as follows.

First, the coder must decide which three of the remaining six dimensions are most prominent in the text as the model must include the level of contradictoriness. These are then coded and the individual transcript is assigned a stage. The model is used as a method of categorising the explanations of substance users that is sensitive to their attributions as reflected in their naturally occurring discourse.

The model employed in the third chapter was originally tested using an inter-rater approach based on four independent coders who each coded 20 randomly selected transcripts on a blind basis. All four had been involved in the development of the model and so it was possible that shared biases increased the concordance between their coding. The results, which were independently recorded and monitored, are reproduced in Table 3 below:

Subject	Coder 1	Coder 2	Coder 3	Coder 4	Consensus
Billy	1	1	1	1	4/4
Michelle	1	1	1	1	4/4
Tam	1	1	1	1	4/4
Anthony	4	4	4	3	3/1
Peter	3	3	3	3	4/4
Dianne	4	4	3	3	2/2
Steven	1	1	1	1	4/4
Ian	1	1	1	1	4/4
Brian	2	2	2	2	4/4
John	4	4	4	4	4/4
Alan	5	4	4	3	2/1/1
Mark	3	4	3	3	3/1
John	2	2	2	2	4/4
Flora	2	4	4	4	3/1
Patricia	3	3	3	3	4/4
John	4	3	3	4	4/4
Mark	2	1	2	2	3/1
Donna	4	5	4	5	2/2
Thomas	5	4	5	5	3/1
Paul	2	2	2	1	3/1

Table 3: Reliability of coding for pilot set of interviews

Of the 20 transcripts selected, 10 provoked complete agreement, with a further six producing agreement from three of the four raters. Of the remaining four, only one involved more than two categories being selected. As Davies (1997) points out, with 6 options, the chance of complete agreement are 216 to 1. Therefore, as there are 10

cases out of 20 where this occurs and 9 more where two categories are selected by the four judges, this implies a high degree of agreement and replicability.

Conclusion

This chapter is an attempt to incorporate some elements of the social-cognitive traditions of attribution theory (Chapter 1) and qualitative aspects of discourse analysis (Chapter 2) to produce a testable model for explaining substance users' discourse about their activity. The model attempts to account for the fact that substance use is not a simple product of psychological or physiological determinants but is a complex interplay of these factors. These interact in a social context mediated by social structures and institutions that affect not only behaviour but also the relevant forms of discourse.

The model is an attempt to incorporate this complex social dynamic in understanding the activities and explanations of drug users. This provides some guidance to contextual influences on explanations and attributions given by substance users and these may be powerful prognostic indicators on which to measure intervention and change. Having outlined this model, the next chapter examines a research investigation in which these methods were implemented in an applied context. The central feature of the investigation to be described in the next chapter, as with the other two research projects described in this thesis, is the attempt at providing a participative and empowering research strategy that retains prediction and systematicity at its core.

Chapter 4 - Explanation Changes in Drug and Alcohol Users

1. Introduction

The crucial variable is whether participants were in contact with addiction services at the point of first contact with the project. This is because, by accessing addiction services, clients are participating in a social activity where attributions of addiction are most prominent. Distinguishing participants on the basis of their contact with addiction services establishes a social context distinction that tests the categorisation of addicted and non-addicted explanations. However, the contextual basis for this distinction is the services that exist and the models of treatment they offer. For this reason, it is important to examine the historical context for the provision of treatment.

The current British approach to addiction dates back to the Rolleston Committee of 1926, incorporated in a Home Office memorandum of 1929, in which general practitioners were warned about the precautions to be adopted when faced with an addicted patient. This set the tone for a system in which general practitioners were central to public policy and they were given considerable discretionary powers (Strang and Gossop, 1994; Stimson, 1995). This situation persisted through the increase in illicit substance activity in the 1960's, although by this point many G.P.'s were expressing a reluctance to deal with users. As Spear (1994) claims, "United Kingdom drug laws aim to provide a framework within which doctors are free to use drugs in accordance with their clinical judgement, which may or may not accord with the consensus of medical opinion at that time" (Spear, 1994, p.26). Thus while Home

Office guidelines exist, most substitute prescribing is done at the discretion of the individual physician.

A major development in central control occurred with the Dangerous Drugs Act of 1967, as a result of which doctors were required to notify the Home Office of patients addicted to a range of substances. Under the existing 1973 regulations this contains 14 substances - cocaine, diamorphine, dipipanone, methadone, morphine, opium, pethidine and seven other powerful analgesics. This information is contained in the computerised Addicts' Index (although this has since been discontinued). The aims include the detection of addicts obtaining dual supplies of notifiable drugs, monitoring prescribing and the provision of statistics on notified addicts. In addition to monitoring, this reifies the addicted status of users by providing a means through which drug users can be classified. 'Addict' is not merely a convenient label but a legitimating process mediated by the notification process, as if a test of whether an individual is 'really' an addict. This is a structural manipulation of power in which 'addict' is given societal validation and through which the label begins to impact on subsequent behaviour (Tierney, 1996).

This system is serviced by the provision of substitute drugs, most commonly oral methadone (ISDD, 1994). With the recognition of an HIV risk through the sharing of injecting equipment, there has been a move away from the prescribing of injectible substitutes in favour of their oral equivalents (Farrell et al, 1994), in particular methadone mixture (Mitcheson, 1982). Clinicians have moved away from an abstinence oriented form of intervention in favour of an emphasis on control and risk

reduction (Robertson, 1994). The key distinction between the activities of community drugs teams and community alcohol teams has been the role of prescribing. Strang and Clement (1994) have argued that, "there is widespread evidence that the dominant activity and area of influence of the CDT worker is with regard to the provision or non-provision of substitute drugs to the opiate addict" (Strang and Clement, 1994, p.215). Another treatment has resulted from the development of Narcotics Anonymous (NA) in Britain. As with AA, the assumption is that the "addict" has crossed a thin line into a physical, psychological and spiritual illness that can be fatal unless arrested by total abstinence (Turner, 1994), as identified in Stage 3 of the model (see Chapter 3).

Evidence for the beneficial effects of methadone maintenance appear compelling (Platt, 1995; Ball and Ross, 1991; Caplehorn and Bell, 1991, Hubbard et al, 1989) in terms of reduced injection and illicit opiate use, retention in service and improved family and social relations. However, this form of treatment has never been fully accepted by clinical services (Platt, 1995), with many services providing low doses of methadone on a reduction basis (Stimson, 1995; Strain et al, 1993). Further, whether retention in service should be regarded as a positive outcome or as the perpetuation of an undesirable state is contentious (Hunt et al, 1985 - 1986; Spunt et al, 1986). In the attributional model the addicted phase, with which treatment is associated, is stigmatised and associated with loss of self-determination. This situation is beneficial only temporarily, as it becomes ambivalent and unsatisfactory. A methadone prescription may penalise the individual by binding them to the addicted role. The salvation from the daily grind of obtaining money, finding a dealer, avoiding arrest,

finding a vein and then repeating the cycle is a haven that is offered at a price (Hunt et al, op cit).

This type of behaviour is contingent on a treatment policy in which opiate agonists, such as methadone, are prescribed in preference to antagonists such as naltrexone. This offers the opiate user a range of options - the client may use the methadone to ease withdrawals, swap it, sell it, or some combination of these. The key is that a methadone prescription is of value to the opiate user, and so both its acquisition and its retention, are valuable. Indeed so great is the American Drug Enforcement Agency concern about sale (diversion) of prescribed opiates that the Medicaid Abusable Drug Audit System was implemented in 1993 to monitor and reduce abuses associated with this form of substance activity (Molinari, Cooper and Czechowicz, 1994). Although not all users abuse their methadone prescriptions, methadone is of sufficient value that stable strategies have developed for its diversion and sale (Weppner and Stephens, 1973).

The debate about the form of opiate substitute to be prescribed continues with emphasis on prescribing injectibles (Stimson and Oppenheimer, 1982) and whether diamorphine would be preferable to methadone (Marks and Palombella, 1990). However, although mediated by its form, the prescription of oral methadone has acted as a lure by which users have been attracted to services (Strang et al, 1994). This means that the barrier to leaving treatment should be higher for users receiving methadone than for other treatment groups. Methadone attracts opiate users more

quickly to treatment services and binds them more tightly and so the addicted style of explanation is more powerful for this group.

Predictions of the model

The investigation addresses the effects of substitute prescribing on the explanations provided. The first comparison is between users prescribed methadone, opiate users not prescribed methadone and users of other substances. Opiate users receiving a methadone prescription should be most likely to produce addicted style explanations and should be most resistant to change over time. The group providing the least addicted explanations would be opiate users not receiving methadone (and not attempting to obtain it). The reason for the last requirement is that the absence of a script cannot be assumed to be the absence of an attempt to obtain one. Thus the first hypothesis is that opiate users on methadone scripts are more likely to have addicted style explanations than opiate users not on scripts. The second is that opiate users on methadone are less likely to change stage over time than any other groups.

The third hypothesis emphasises the British system in which doctors are at liberty to dispense methadone to whomsoever they see fit. As these figures dominate the British drug and alcohol treatment system, individual psychiatrists can influence both treatment and street drug activities in the regions in which they work. Thus, the hypothesis is that there will be regional variations in patterns of drug use in the four sites in this study. As Stimson (1995) has argued, "there is a marked absence of methadone maintenance programmes in the U.K. Instead there is a catholic range of individually tailored unresearched treatments". These frequently fail the recognised

requirements of doses in excess of 60 ml of oral methadone and flexible prescribing programmes suggested by the literature (Ball and Ross, 1991; Hubbard et al, 1989; Ward, Mattick and Hall, 1992).

This also results in variations in access to substitute prescribing, and in the flexibility of treatment regimes. Thus, while some clinics do not punish patients for continued heroin use, others may do so by reductions in the quantity of methadone prescribed, increases in frequency of supervision or even discharge from the programmes. Regions with the highest threshold to treatment (where it is most difficult to obtain a methadone prescription) and with the most punitive regimes are those in which a script is most valued and clients are least likely to drop out of treatment. Therefore, the fourth hypothesis is that the discursive stage occupied by clients, and their movement from one stage to another, will be influenced by the local prescribing policy.

Specifically, clients in Edinburgh (where the CDPS operates a low threshold and non-punitive policy) should be more flexible than Glasgow where traditionally there has there has been restricted access to treatment services (Greenwood, 1992). There should be less movement around the third stage in Glasgow than in Edinburgh as clients are more likely to value their script and so less likely to voluntarily drop out of treatment. Ayrshire has a more liberal prescribing regime than in the city, Glasgow, this area borders. Finally, Newcastle does not have long waiting lists before assessment, but there is a highly regulated system in which breach of clinical contract is dealt with severely. The hypothesis is that there will be greater change in stage and

discourse in Ayrshire and Edinburgh, than in Glasgow or Newcastle. However, differences between the four sites in demographic, cultural and substance profiles are likely to result in different explanation profiles in each. The coding frame for discursive stage is provided in Appendix 1.

The fifth hypothesis relates to the internal dynamics of the model and is based on clinical assessments of users in treatment from their key workers (the keyworker monitoring form is given in Appendix 2). Keyworker assessment of client outcome tests the predictive aspect of the model as shifts in explanations should predict clinical outcomes. Therefore, this hypothesis assesses the consistency of shifts in explanations from one interview to another and is an assessment of outcome, where discursive patterns are compared against measured behaviour. These behavioural outcomes are assessed by self-reports of substance use and life events, and evaluation criteria from the user's key worker.

Method

The study outlined in this chapter was funded by the Scottish Office and was undertaken by the Centre for Applied Social Psychology at the University of Strathclyde. Therefore, the results described here result from the combined efforts of members of the unit, in particular Professor John Davies, Maria Crugeira and Fiona McConnachie. This also applies to the five-stage model, which has its foundations in the research opus of Professor Davies, and emerged through the efforts of Maria Crugeira, John Davies and myself. Both the data presented here and the methods and theory tested have been reported elsewhere. However, all the data analyses presented

in this chapter are original as they involve a re-analysis of the data presented to the Scottish Office. As a consequence, it is hoped that this presentation complements the work already done by Professor Davies and his colleagues.

The study involved accessing individuals who were using a range of illicit substances or alcohol in each of the four location sites. This was done through contacts with problem substance services and, consequently by snowballing techniques, to make contact with those who had no form of contact with treatment services. In two of the sites, most of the contacts were obtained through large, regional addiction services - Northern Region Drug and Alcohol Service (NORDAS) in Newcastle and the Community Drug Problem Service (CDPS) in Edinburgh. In these sites, this initial contact was supplemented by utilising networks of "street" services and then also attempting to contact individuals who had no form of contact with any form of treatment intervention service, although they may have been accessed through the outreach workers of such services. The situation in Ayrshire was sufficiently dispersed that the most appropriate way of obtaining a sample was to use two of the drug problem services - the Bridge Centre in Ayr and the Townhead Centre in Irvine, an alcohol detoxification unit, Ailsa House and the local councils on alcohol. From this it was possible to attempt to snowball from contacts obtained in each of these services to obtain the out of contact clients required for the study.

The situation in Glasgow was more problematic in that in the duration of the study a centralised prescribing service, the Glasgow Drug Problem Service (GDPS) was set up to manage the treatment of substance use, through local street agencies, in the city.

Therefore, the approach at the start of the project was to enlist local agencies in the project along with an addictions rehabilitation and detoxification unit, Parkhead Day Hospital, in the east of the city. In total, six drugs projects - Blackhill and Provanmill, Easterhouse, Gorbals, Drumchapel, Possil and P.A.R.C. - and the Glasgow Council on Alcohol provided both direct client contacts and names and addresses of people who we could contact for our non-agency cohort. A substantial part of conducting such a project proved to be maintaining and managing the contacts with the 27 agencies or community groups involved in the four sites over a period of 18 months.

Once contact had been made with an agency, attempts were made to fit the research around the ethos of the treatment programme and the requirements of the client. Recruitment was done on a casual, non-aggressive basis and in the spirit of a qualitative and participative research project. When individuals had been contacted they were assured about the confidentiality of the information both from legal and clinical services, and were given a brief outline of the project and its objectives. Participants were also informed that they would be contacted on at least one further occasion if they agreed to take part but that this contact could take place at a time and in a venue suitable to them. The interview generally lasted for between 10 and 15 minutes, although no time restrictions were placed on clients who were at liberty to reveal as much or as little as they felt was appropriate. While the initial topics were guided by the researcher (and generally revolved around current substance use and perceptions), the remainder of the dialogue would be determined by interactional forces. Thus, in an attempt to replicate natural discourse as closely as possible in such an artificial set of circumstances, agenda setting was mutual rather than led by the

researcher on the basis of an interview schedule. As a result the attributions and explanations given by the participant should more closely resemble those from their everyday conversations.

The principle employed in the interviews was that natural attributions are couched in everyday discourse and so to attempt to elicit this style of explanation it is critical that the interaction resembles as closely as possible what may be construed as a representative conversation about substance activity for the participant. While the use of tape recording appears only to accentuate the extraordinary qualities of the interview, it creates less of a barrier to natural speech than does note-taking or tick box completion. Thus, all of the normal dynamics of everyday interaction (turn-taking, patterns of eye contact, topic shifts) can be retained throughout the interview after a brief period of acclimatisation. Therefore, while the tape recorder was placed in front of the participant to avoid any suspicions of underhand practice, this was felt to be the most sensitive recording device in a project in which the authenticity of the interaction was regarded as paramount.

On completion of each initial interview, clients were asked if they felt that they were happy with what they had said and if they were still willing to be re-interviewed on at least one further occasion, which none of the clients refused to do. As clients were not required to give more than their first names if they were uncomfortable about so doing, minimal information was taken from each client, usually about where they could be contacted and by what means (telephone, letter, etc.). The aims of the project were to contact each client on three occasions separated by a minimum of six-

month intervals. It was recognised from the outset that with only one full-time researcher working in all four sites that there would be some loss of subjects at each stage of the project, but it was important to maximise the numbers at the first stage. This meant the emphasis could be placed on obtaining a high number of clients with second and third interviews (rather than a high percentage of retest participants). The project is thus open to the criticism that those retained over the three interviews may not be representative as they may be the most stable, or clinically dependent. However, it was felt that for such a qualitative procedure, the crucial aspect was to maximise the number of contacts to facilitate the development of the qualitative model and to test its explanatory and predictive capabilities

Subjects

In total 275 substance users were successfully recruited to the first stage of the project - 97 in Glasgow, 49 in Edinburgh, 59 in Newcastle and 70 in Ayrshire. Of these 174 were in contact with clinical services at the start of the project, while 101 were not in contact with services at the start of the project, although they may have been known to outreach workers or been on waiting lists for some form of clinical assessment. Of the latter group, 52 had no contact with clinical services at any point during the project and 49 made contact with clinical services at some point between their first and subsequent interviews. Therefore, the initial sample consisted of 174 people who had contact with services at the start of the project (in September 1993) and 101 who had had no form of service contact. This group consisted of 200 males and 75 females, of whom 30 were recruited in Glasgow, 16 in Edinburgh, 9 in Newcastle and 20 in Edinburgh.

Project Results and Discussion

The first point to make about the data relates to the self-reports of substance use among the sample at the time of the first interview, and the stage of theoretical model they were assessed at, categorised in terms of their geographic location. The figures expressed for substance use are in terms of the mean quantity used on each occasion of use. The figures are for all clients, not merely those who characterise themselves as users of a particular substance:

	Glasgow	**Edinburgh**	**Newcastle**	**Ayrshire**
Prescribed methadone (ml)	23.49	47.04	21.61	38.71
Prescribed valium (ml)	6.32	28.26	8.39	4.07
STAGE	2.63	3.42	3.14	3.51

Table 1: Reported substance activity at Interview 1 (all subjects)

The first point to make about these findings relates to the marked variations in the use of prescribed drugs between each of the locations. Although not included in the table, it is worth noting that there appear to be generally low levels of heroin reported by participants in the study. This may result either from low actual activity or a reluctance to reveal this form of substance use. Similarly, there are no significant differences in the use of illicitly acquired methadone between the sites. Mean current use ranged from 26.0 ml in Ayrshire to 28.76 ml in Glasgow supporting the notion that the overall use of illicit opiates does not markedly vary between the four sites. It is most useful to use the first interview for these comparisons as this is the time at which the largest data sample was available. Again, there do not appear to be marked differences according to location in the alcohol consumption patterns of the sample.

However, there is a danger in interpreting the use of prescribed drugs according to location as there are different proportions of the client group who have clinical contact in each of the sites. Therefore, these comparisons are most usefully made, as in the table below, by comparing the clinical groups only in terms of their reported substance activity at first interview:

	Glasgow	**Edinburgh**	**Newcastle**	**Ayrshire**
Prescribed methadone (ml)	37.61	47.26	26.56	39.27
Prescribed valium (ml)	10.40	30.36	10.21	4.13
STAGE	3.30	3.46	3.41	3.53

Table 2: Substance activity among the clinical sub-group at first interview

The first issue that arises here is the disparity of distribution of methadone dose among clinical clients at each of the four locations, with the mean amount of methadone prescribed to clients in Edinburgh higher than in any of the other three locations. These differences achieve statistical significance in the comparison between Edinburgh and Newcastle ($p < 0.01$) but not between Edinburgh and either of the other sites. However, clients in Edinburgh do receive significantly higher levels of diazepam than in Newcastle ($p < 0.05$), in Ayrshire ($p < 0.001$) or in Glasgow ($p < 0.01$). Similarly, at the time of the second interview, in comparing clients in clinical contact in Glasgow ($n = 52$) with those in Edinburgh ($n = 33$), clients in Edinburgh (mean = 37.84ml) receive greater amounts of prescribed diazepam than those in Glasgow (mean = 13.02; $p < 0.01$). They also receive significantly higher levels of methadone (Glasgow mean = 37.83 ml, Edinburgh mean = 55.93 ml; $p < 0.05$). Furthermore clients of the Edinburgh clinics also receive higher levels of

prescribed temazepam at the time of the second interview (mean = 13.88 ml) than do clinical attenders in Glasgow (mean = 6.00 ml, $p < 0.05$). Thus, there would appear to be grounds for inferring a different background to clinical intervention in the predicted direction with higher prescribing of both oral methadone and benzodiazepines in Edinburgh than occurs in Glasgow. Therefore, the difference in methadone dose levels and frequency of prescribing creates a different treatment background against which the substance activity and explanations of participants must be understood.

Similarly when comparisons are made between prescribing practices in Edinburgh and Newcastle for the clinical samples included in the study, the significant difference in methadone prescribing is repeated at the second interview. Participants attending clinical services in Edinburgh (mean = 55.94 ml) received higher average prescriptions of oral methadone than those in Newcastle (mean = 25.96 ml; $p < 0.01$), and higher prescriptions of diazepam at both first interview ($p < 0.05$) and at second interview ($p < 0.001$). However, when comparisons are made between levels of prescribed drugs in the clinical samples in Edinburgh and Ayrshire the only significant differences relate to the prescribing of valium, with higher levels reported as being prescribed in Edinburgh at both first ($p < 0.001$) and second interview ($p < 0.001$). In contrast, and again consistent with the predicted outcomes, there are no significant differences in the amount of prescribed drugs between Glasgow and Newcastle at the first or second interviews. The data from the third interviews are not included as the loss of subjects prevents meaningful comparisons by location.

The final two sets of comparisons in terms of the levels of prescribed drugs received by clients in each of the locations involve the differences between Ayrshire and, Glasgow and Newcastle. In the first comparison there are no significant prescription differences at any of the three data collection points between clients in Ayrshire and those sampled in Glasgow, although clinical participants in Glasgow receive higher mean amounts of diazepam on prescription on all three occasions. However, when comparisons are made between Ayrshire and Newcastle, it is noticeable that clients in Ayrshire receive significantly higher mean prescriptions of methadone at first ($p < 0.05$), second $p < 0.05$) and third interview ($p < 0.01$). However, there are no differences in the amounts of prescribed temazepam or diazepam at any of the three data collection points. Thus the overall pattern appears to support the hypothesis that, for participants in the study who are in contact with clinical services, the highest levels of methadone prescription are given in Edinburgh. However, patterns of prescribing of both methadone and benzodiazepines, vary significantly from one location to the other.

As the use of street drugs was generally reported in terms of financial quantities it was felt that this restricted the viability of the reported amounts used. The standard unit for heroin purchase, a £10 or £20 bag, varies in purity and dealers are less likely to be able to accurately cost in street terms their own use - and so simple dichotomous responses for current consumption of each illicitly acquired substance are reported below. In other words the table below indicates the proportion of respondents who are engaged in each form of substance activity according to their location:

		Glasgow	Edinburgh	Newcastle	Ayrshire
Heroin	Int 1	23 (23.7%)	6 (12.2%)	18 (30.5%)	17 (24.3%)
	Int 2	19 (23.7%)	5 (14.3%)	9 (36.0%)	11 (19.0%)
	Int 3	8 (22.9%)	2 (40.0%)	7 (50.0%)	4 (16.7%)
Alcohol	Int 1	28 (28.9%)	5 (10.2%)	22 (37.3%)	13 (18.6%)
	Int 2	25 (31.2%)	2 (5.7%)	5 (20.0%)	3 (5.2%)
	Int 3	15 (42.8%)	-	4 (28.6%)	1 (4.2%)
Methadone	Int 1	7 (7.2%)	12 (24.5%)	6 (10.2%)	16 (22.9%)
	Int 2	6 (7.5%)	6 (17.1%)	3 (12.0%)	15 (25.9%)
	Int 3	1 (2.9%)	1 (20.0%)	1 (7.1%)	5 (20.8%)
Diazepam	Int 1	2 (2.1%)	18 (36.7%)	4 (6.8%)	9 (12.9%)
	Int 2	7 (8.7%)	16 (45.7%)	4 (16.0%)	14 (24.1%)
	Int 3	2 (5.7%)	2 (40.0%)	1 (7.1%)	7 (29.2%)
Temazep'm	Int 1	26 (26.8%)	18 (36.7%)	17 (28.8%)	25 (35.7%)
	Int 2	18 (22.5%)	11 (31.4%)	13 (52.0%)	21 (36.2%)
	Int 3	9 (25.7%)	2 (40.0%)	5 (35.7%)	8 (33.3%)
Cocaine	Int 1	1 (1.1%)	1 (2.2%)	6 (10.2%)	3 (4.3%)
	Int 2	-	2 (5.7%)	2 (8.0%)	2 (3.4%)
	Int 3	-	-	-	-
Speed	Int 1	20 (20.6%)	4 (8.1%)	15 (25.4%)	16 (22.9%)
	Int 2	17 (21.2%)	2 (5.7%)	6 (24.0%)	7 (12.1%)
	Int 3	-	-	-	-

Table 3: Street use of illicit substances by location

The above table indicates the proportions of individuals in each of the four locations who have reported using illicit drugs at each of the interview points. The first point to make here is that this represents self-report of substances that are not prescribed to that individual, so there is no overlap between the reports of substances in this table

and the previous two tables, both of which referred to drugs that were prescribed for that individual. However, it is interesting to note that the highest prevalence of use of illicit methadone is reported in Edinburgh where the greatest amount of methadone is prescribed, at least at the first interview (where the largest sample is available). However, this pattern is even more pronounced with regard to the illicit use of valium with only 2.1% of the total sample in Glasgow reporting current diazepam use while this is the case for 36.7% of the sample gathered in Edinburgh. At first interview more people report using illicit valium in Edinburgh (18/49) than in the other three locations combined (15/226) in spite of the fact that Edinburgh accounts for only 49 of the 275 participants recruited to the investigation.

In contrast, clients from Edinburgh report the lowest prevalence of heroin use and alcohol use of clients in any of the four sites investigated in the study. The report of 10.2% using alcohol and 12.2% using heroin at the first interview contrasts strongly with the situation in Glasgow where 23.7% report heroin use and 28.9% alcohol use at the time of the first interview. Here there seems to be an inverse relationship between the prescribing policy with regard to opiate substitutes and benzodiazepines, and the use of alcohol and heroin by participants.

With regard to the second hypothesis, the first comparison involves the stage attributed to individuals at each interview and their contact with treatment services. It would be hypothesised that those who had not had clinical contact should be at the first or second stage, while those who had had clinical contact should be at the third stage or later. As the stages to some extent represent divisions along a continuum this

was tested using a t-test yielding the following outcomes for each of the three interviews. It is important to note that the data presented here involve the retention of Stage 5 explanations, which were dropped from the analysis conducted by Professor Davies' group for the Scottish Office report. Table 4 below gives the mean stage by clinical contact:

	Mean stage for no clinical contact	**Mean stage for clinical contact**	**t-value**	**Significance**
Interview 1	1.88	3.43	10.60	$p < 0.001$
Interview 2	1.74	3.57	9.52	$p < 0.001$
Interview 3	2.25	3.55	3.09	$p < 0.01$

Table 4: Stage of clients according to clinical contact

Here there would appear to be clear support for the ability of the theoretical model to distinguish between those who have made contact with clinical services and those who have not. Indeed, when this information is broken down for the first interview data, 45 of the 57 individuals who have not ever had any form of clinical contact are categorised in the first two stages of the model. In contrast, only 14 of the 218 participants who have had clinical contact are mis-categorised as being in the first or second stage. Indeed of this 14, four were to make some form of agency contact during the course of the study and so for this sub-group the discourse they provided may have predicted their change in clinical status. Thus, there would appear to be clear support for the theoretical model's ability to differentiate between those who do make clinical contact and those who do not on the basis of the explanations they

provide for their substance related activity. However, this does not require the complexities of the theoretical model in many of the transcripts examined. Thus, in response to the question of why he uses, Rab, an occasional user of hallucinogens and stimulants, explains that, "I like the buzz – its part of going out, just like you having a few pints, I'll have an eccy (ecstasy) or a dab (amphetamine)". This contrasts with Laura, who receives a methadone prescription and who describes herself as an addict. She replies to the same question with, "At the beginning I was getting a kick off it, but now I get nothing off it, I just need the meth to hold me together".

However, the key aspect of this comparison may be the relationship between the individual determinants of the stage decision model, namely the dimensions of the model and the clinical contact the individuals had with addiction services. This is outlined in the table below, although in this instance, it was necessary to use chi-squares as each of the dimensions is coded according to discrete labels rather than a continuous scale. The following table is for the first interview only:

DIMENSION	**Agency contact**	**No agency contact**	**Significance**
Addiction	Yes - 200 (91.7%)	Yes - 18 (31.6%)	$p < 0.001$
Contradiction	Yes - 115 (52.8%)	Yes - 26 (45.6%)	n.s.
Generalisability	High - 158 (72.5%)	High - 17 (29.8%)	$p < 0.001$
Hedonism	Low - 36 (16.5%)	High - 38 (66.7%)	$p < 0.001$
Purposiveness	High - 25 (11.5%)	High - 31 (54.4%)	$p < 0.001$
Physiological Reductionism	Present-185 (84.9%)	Present- 17 (29.8%)	$p < 0.001$
Time	Present - 13 (6.0%)	Present- 37 (64.9%)	$p < 0.001$

Table 5: Dimensions of the model by agency contact at the first interview

Here it is apparent that all but one of the dimensions successfully differentiates between those who have made agency contact and those who have not at the time of the first interview. The dimension that is not a marker for clinical contact, contradictoriness, would not be expected to do so. As contradictoriness is expected to be high in second and fourth stages, that is for one stage indicative of clinical contact and one not associated with agency contact. Perhaps the most salient indicator for the social component of the model is that, at first interview, 91.7% of those in treatment with addiction services used the self-ascription of addiction while this was true for only 31.6% of those with no contact with treatment services.

The key issue appears to be that users in contact with treatment services frequently deploy the 'addict' term while those not in contact with treatment services tend only to do so as evidence that they do not have a problem. Thus Laura also claims that "once that first needle goes in that's you – a junkie". This contrasts markedly with the explanations provided by many of the non-treatment sample (and many of the young people interviewed in the Easterhouse and Edinburgh studies. Thus is summed up in Karen's claim that "I use happy drugs that you can't get hooked on – like speed and blow (cannabis). I'll never be a junkie". At second interview the contrast is even more dramatic with 151 (91.0%) using addicted self-ascriptions but only 6 (19.4%) of those not in contact with services making this attribution.

While it may be argued that this form of explanation is a post hoc rationalisation used to justify treatment rather than explaining the individual's use, this argument is

consistent with a social model of addiction, in that it incorporates social response and legitimation within the concept of addiction. However, when the evidence from the other dimensions is equally striking in contrasting the explanatory styles of those with clinical contact and those with no treatment contact, the evidence for the model becomes more compelling. Thus, the fact that a reductionist style of explanation in which physiological underpinnings of use are cited by 185 (84.9%) of those with clinical contact but only by 17 (29.8%) of those with no service contact at the first interview provides equally compelling support. This is summed up in Katherine's Claim that "I've not had any smack (heroin) since Christmas there. I've been trying to stop but it's hard. I'm rattling all the time".

Similarly, at the second interview 146 (88.0%) of those with clinical contact provide reductionist explanations which have a physiological base which is the case for only 5 (16.1%) of those with no clinical contact. To this extent the results support the hypothesis that the theoretical model is a useful diagnostic indicator of the individual's socially founded substance related explanations which has the sensitivity to distinguish between participants who either have some form of clinical contact or who are not in contact with treatment services. However, it may be difficult to tell for drug users the extent to which this relates to treatment or to the specifics of methadone prescribing. The patient's dissatisfaction with this is summed up in Laura's claim that, "I wanted off, I wanted detoxed, but nobody seems to be asking me about that, they just keep firing me methadone scripts".

The next important hypothesis, which in part attempts to address this question, relates to the success of the model in predicting successfully clinical outcomes for each of the clients. This task has proved problematic for clinicians throughout the time that alcohol and drug misuse have been treated in a systematic manner. In this investigation, the indicator of outcome employed was, for participants who had clinical contact throughout the study, treatment variables assessed by their keyworkers. What this involved was the keyworker completing a brief questionnaire for each client who had taken part in the study and with whom they maintained some form of contact or had seen in the last six months. In the analysis below the results from their interpretations of the changes in their clients' situation are compared with the stage the client is assigned to in second interview, and the coder's prediction of their likely stage at the third interview.

In total, 84 interviews were conducted - 21 in Glasgow, 7 in Edinburgh, 19 in Newcastle and 37 in Ayrshire, of whom 65 were in treatment at the point of the last contact while 19 were not. In terms of keyworkers' perceptions, 19 had shown a marked improvement since the time of the first research interview, 33 had shown a slight improvement, 24 had shown no change in their overall situation, with8 reported as having deteriorated in the period of the study.

The first point to make here is that a range of markers for change in clinical situation was gathered from the participant's key worker. In addition to an overall assessment of whether the client had improved or deteriorated, keyworkers were asked about whether the contact was ongoing, whether the client was involved in criminal activity,

how long they had been in treatment and the client's injecting status. The way in which the direction of movement was calculated using the stage model was achieved in two ways - first, by subtracting the stage the client was at first interview from their stage at second interview, and secondly by performing the same calculation on their actual stage as calculated from each of the relevant interviews. In this way it is possible to assess not only their actual stage at the time of the clinical assessment but also any shift there may have been in their attributed stage from the first interview to the second. These provided the criteria against which the ratings derived from keyworkers were compared:

	KEYWORKER Marked improve	**ASSESSMENT** Slight improve	No change	Deterioration
Assessed change Backward move	1	5	7	2
No change	15	20	11	4
Forward move	3	7	6	2
Predicted change Backward move	3	1	5	2
No change	11	24	14	6
Forward move	5	7	5	-

Table 6: Keyworker assessment of clinical change by theoretical assertion of change

However, as indicated in the model above, the attempt to indicate change in their assessed stage and in the coder's prediction of subsequent movement showed no association with the keyworker's interpretation of their clinical change, as assessed using chi-squares. However, this raises issues of what constitutes a positive change

for substance users in that the move to Stage 4 of the theoretical model is based on an ambivalent concept of contact with treatment services and addiction attributions. In contrast, for most addiction workers, continued contact with services is regarded as a positive outcome per se. However, even with the more specific indicators, there does not appear to be a statistical relationship between criminal involvement and change in either the individual's stage or the coder's predictions of their likely subsequent movement within the model.

The same would appear to be the case with the keyworkers' reports of continued injection, an indicator not only of risk behaviour but also a useful short-hand indicator for severity of dependence. Again, there does not appear to be a significant or even directional relationship between the participant's keyworker's assessment of this and their change in stage or prediction within the model. However, one of the main difficulties would appear to be that the application of the theoretical model is not particularly sensitive to movement from one interview to the next. Fifty of the 84 cases for which there are clinical assessments (59.5%) show no movement in their assessed stage from the first stage to the second while 55 of them (65.5%) have the same prediction after the second interview as after the first. This is evidenced by the fact that there is a correlation of 0.84 ($p < 0.001$) between the stage at interview one and the stage at interview two and of 0.82 ($p < 0.001$) between the stage predicted after the first and second interviews.

Theoretical Discussion

This project attempted an innovative approach to examining the explanations of substance users in the context of minimally prompted, naturally occurring discourse. The investigation had both methodological and clinical implications and it is perhaps by examining these in turn that the most helpful interpretations of the results can be offered. The fact that the categorisation of participants into the stages of the theoretical model appears to predict whether or not the client has contact with treatment services implies that the model has at least some utility in differentiating meaningful classes of substance activity and its relationship to treatment services. However, this would appear to contrast with the inability of the model to predict movement in substance related behaviour on the basis of explanations given at the interview time. There are likely to be two main reasons for this failure - the contentious relationship between verbal report and observed behaviour and the contextual limitations of the data gathering process used in the investigation.

With regard to the first of these issues, it is a long-established problem for social researchers that there are frequently low correlations between reported "attitude" and behaviour (Eagly and Chaiken, 1993; Fishbein and Ajzen, 1975). The problem has traditionally been framed in a form that what people would like to do and how they present themselves (as occurs in an interview or questionnaire context) may fail to account for the practicalities and vicissitudes of everyday life (see Chapter 2). In the present study, this problem involves the attribution of clinical improvement by the participant's keyworker compared to explanations for substance-related activity taken from the users themselves at a different time point. In effect, this means there are two

sets of, possibly conflicting, impression managements which may have mutually evolved as a consequence of the clinical relationship.

This difficulty is compounded in the reported study in that there were six monthly gaps between interviews, periods in which any number of life variables may shift, particularly in a group as chaotic as problem substance users. This is most poignantly observed in the rate of loss of subjects - a standard operating difficulty in conducting research on a participant group whose movements and lifestyles are highly unpredictable. Thus, it is likely that unless the explanations given are highly prominent in the activities of the individual that their life salience may have altered dramatically in the six months between interviews. One difficulty in conducting a research project such as this is that to give a sufficient period for changes in substance-related explanations to naturally occur is also to permit a shift in life circumstances that precludes rational interpretation of discourse. Thus, unless one could examine gradual shifts in explanations related to specific life events then one is likely to be faced with major discontinuities that are problematic to attribute. It may also have been beneficial to gather some self-reported quantitative data at the second and third interviews, after the open interview, to provide some standard measures against which the open interview could be compared. This approach was subsequently adopted in the young people's studies undertaken in Edinburgh and Easterhouse (see chapters 5 and 6).

However, the problems associated with interviews separated by six-month gaps may also revolve around the willingness of individuals to participate in and to make sense

of the research procedure. This refers not only to the possible biasing effects of such a high attrition rate, where it may be the more stable clients with whom contact is maintained, but also that those who were more positive about the research project who were retained. The core of this argument is that it is likely that, to the extent that individuals' attributions are context-bound, they are context-bound in a way that is contingent on the definition of the interview situation (this reflects the debate on deconstructing texts outlined in Chapter 2).

This is the point of the Davies and Baker (op cit) paper in which the overall attributions about the context of the research event flavour the explanations by altering their immediate discursive salience. Yet, translated into the current study, this is likely to influence the interpretation of second and third interviews. Given that most of the participants were aware of having spoken to the interviewer before and had some recollection of its content, this repeat may well have determined a significant aspect of the follow-up interview context. While this does not invalidate the procedure, it does reduce the likelihood of test-retest variability by creating a continuity of context.

The second aspect of this methodological examination concerns the reports of substance-related activities as a consequence of the shifts in clinical contact. There are clear disparities in self-reports of substance activity, and differences in stages and dimensions, in each of the locations assessed in the study. Thus, there may be aspects of clinical context critical to the interviewees' attributions. These would include the prescribing regime, the extent to which the clinic imposes punitive sanctions on

clients for continued illicit use and the extent to which the interviewer was perceived as a part of the clinical set-up. Thus, while clinical contact is treated as a dichotomous variable for practical purposes in the investigation, it is in fact a complex range of social phenomena that are further complicated by the way the clients perceive their relationship to the clinic. This will also influence the way in which the interviewer is regarded as a part of reflexive activity on the part of both interviewer and interviewee (see Chapter 2).

Barriers to accessing treatment services may be critical in this portrayal of addiction as a socially mediated phenomenon, in that institutional boundaries are an integral aspect of the social modelling of addicted explanations. While one of the problems here relates to statistical power, in that the group sizes for each of the locations may not have been sufficient to detect differences because of attrition of subjects at second and third interviews, the homogeneity of services within each area also cannot be assumed. What this means for the model is that the barrier between stages two and three, the transition to addicted styles of explanation, is likely to vary as a function of the ease with which services, in particular those associated with substitute prescribing, are accessed by substance users. Although, the likely regional patterns of this have been discussed, what has not is variation between services within each of the regions. Thus, even if there is one key prescribing figure, a centrally based psychiatrist, the picture is confounded by the prescribing practices of local general practitioners. In other words, there is complication in attempting to characterise the regional picture. Therefore, institutional mediation in the form of variable prescribing practices, makes this form of prediction, especially difficult.

In this way, there are difficulties in defining the social context as shaped by the addiction services, in part as a consequence of prescribing practices but also as a result of the type of service provided in each of the establishments. Thus, in confirming the point made by McLennan et al (1993) about the effectiveness of services, the provision of ancillary services not only alters the effectiveness of methadone in retaining individuals in treatment it also influences the type of discourse that is available to describe substance related activity. Thus, as most of the interviews with participants in contact with services occurred in the agencies, it seems likely that they would be shaped by the context of the treatment service. This includes the same physical location, the formal and rationalised context and the same topic areas. Therefore, the interaction may be shaped by the style of explanation normally used in that treatment institution which may favour addicted-style explanations.

However, this raises another problem for the theoretical model and, more specifically, for the method employed to test it. One of the key dimensions for the model is contradictoriness, both within and between stages, as a means of allocating participants to stages. Thus, it is anticipated that individuals in stages two and four should have more inconsistencies in their discourse, both within and between interviews. This suggests that explanations high in inconsistency are most susceptible to contextual influences and are most likely to vary as a consequence of context. The argument would be that a person who employs an addicted style of explanation when talking to a judge but not when talking to peers is displaying the contextual variability and inconsistency indicative of the fourth stage. On the other hand, the committed and confirmed addict will consistently talk about addiction, irrespective of their

interlocutor, displaying consistency characteristic of the third stage. However, as participants with clinical involvement were interviewed in clinics on each occasion, and those with no clinical contact were interviewed outside addiction services, there was little opportunity for this contextual susceptibility to appear.

The difficulty in attempting to conduct a large number of interviews in each of the sites involved in the study is that it was frequently only possible to contact clients when they attended for their clinical appointments. There would have been both ethical and practical difficulties in attempting to interview users with no institutional contact in a clinical location. As a consequence most of the participants who were interviewed on more than one occasion were interviewed in the same location, which has meant that it was not possible to assess contextual variability. This means there may be a routinised explanatory style for clients faced with keyworkers, which is rationalistic and justificatory, which may not be the case for the discourse they produce when surrounded by peers. The difficulty in practical terms for the research project was the failure to access clients in this second context in which the variability of the discourse may have become apparent. It may have been better to select a smaller sample that could more easily be accessed on a number of occasions in a variety of locations.

This problem may be inherent to carrying out research into substance use if the researcher is a non-using professional irrespective of the choice of measuring instrument. Users frequently reject the empathy of non-users on the grounds that it is impossible to understand addiction without having actually experienced it. As a result,

there may be difficulties in implementing a participative technique based on empowerment. In the same way that an ethnographic study would actually involve the researcher in adopting the lifestyle of the using group, so a qualitative approach that uses unstructured interviewing and supportive discourse is in danger of appearing patronising or unrealistic. The problem is that if the participants do not accept the researcher at face value, then they are likely to produce a style of narrative and explanation that is defensive and consistent with the narrative they may produce for other non-peers who pry into their lives. The question of empowerment (see Chapter 2) may be difficult to achieve in research projects in which the status and authority of the researchers are unclear.

Thus while the investigation may have more face validity than the methods of Kelley (op cit) or Heider (op cit) (see Chapter 1), this may not have been sufficient to remove the artificial and stilted aspect of the encounter. Indeed, one problem may be that certain attributional ("why") questions make sense only in the concept of a scientific enquiry, and not in the day to day routines of a person whose life is so deeply entrenched in the activities being examined. Thus, to a heavy user the question "why do you inject in your groin?" has a meaning that "why do you use drugs?" does not. The more specific question has a clear frame of reference, in which the unspoken questions involve why not other possible injecting sites or alternative modes of ingestion are provoked. In contrast, the global question, with no obvious terms of reference does not have a clear frame of reference. It is not that the latter question does not make sense, but that it is too global to be explanatory for any individual action or choice. Furthermore, the question may be perceived as a moral one ('why

are you doing something that decent people do not do) rather than as 'scientific', which may provoke a defensive reaction.

For this reason, the research conducted in the following two chapters focuses precisely on these issues of how to ask questions of individuals about their substance use and who the most appropriate people are to ask. While the emphasis in this chapter has been on ways of asking questions that produce responses representative of the participants' natural discourse, the remaining two chapters look at other aspects of interactional dynamics. The emphasis is on considering the formatting and the context in which the research question is asked. Furthermore, the studies involve a change in the participant group from adult drug users to adolescent samples whose substance experiences are likely to be more limited and for whom the impact of drug use on self-concept is less likely.

Implications of the study

However, to conclude the current investigation it may be useful to pass comment on a number of practical implications of the research into the explanatory style of substance users in the four sites examined. The first issue with clinical relevance is that there do appear to be clear differences in the discourse of substance users according to their clinical status. While the investigation has not managed to demonstrate the predictive capability of the theoretical model, the clarity of both stages and dimensions suggests that this approach may be of some utility. As has been pointed out in the introduction to this chapter, a qualitative investigation of this

sort is essentially exploratory and the establishment of the dimensions and their relationship to the stage concept may require some modification for different substance-using populations. However, the model has face validity to the extent that it was constructed on the basis of pilot interviews and so reflects the variations in explanation typically employed by users.

While the study may have underestimated the complexity of the relationship between treatment, on the one hand, and social dynamics and context, on the other, the attributional objective of this study remains valid. It is important to recognise that drug users' discourse is strategic and intentional, reflecting both current goals and motivations, and historical antecedents that frame their explanations for drug use. It is not enough to recognise that drug effects are mediated by social and psychological factors, it is also inherent in any attempt to model substance activity to incorporate this social dynamic of use. In this respect, the most salient resource available to the researcher and the clinician alike are the interpretations and expositions of the users themselves, whose co-operation and motivation are essential components of both treatment and research (Prochaska and DiClemente, 1982). What the current study has attempted to do is to provide a systematic way of coding and interpreting this discursive repertoire without imposing the academic's linguistic register on the participants.

Thus, the emphasis that has been placed on regional variations and on the social construction of 'addiction', is the attempt to make sense of a negotiable process riddled with rhetoric and inconsistency. The substance user must make sense of their

own activities, activities proscribed by statutory institutions and regulated treatment providers, particularly with respect to substitute prescribing. It is imperative that treatment agencies recognise the role they play in creating, defining and perpetuating 'addiction' and 'addicts', in their attempts to provided services for their client groups. Social investigators must also recognise the key role played by the legitimating power of drug agencies and services who may perpetuate a myth of addiction that may do little more than serve their goals.

This is not a politically motivated attack on treatment services, but is a qualitative analysis of the role played by agencies in rationalising addiction and for providing a framework for this story to have meanings and outcomes. One of the difficulties with adult drug users who are well established in their substance patterns is that their exposure to treatment over a period of years means that they may have a repertoire of standardised responses that are available whenever they are faced with a new keyworker, consultant or researcher. The last point is also a significant one in that many of the locations that were used to obtain participants in this study have been "over-researched" by individuals involved in this type of work. What this may mean is that many potential participants are cynical about research and are reluctant to engage in participative forms of enquiry. While this may not have hampered the current investigation, it has been a significant factor in influencing the decision to utilise adolescent samples who are likely to be early in their substance careers for the subsequent investigations of substance research methodology. The danger is that participants may feel that they are being exploited by the researcher, and it is important to emphasise their stake in the investigation.

Conclusion

The study was a principled and systematic assessment of the five-stage model for socially mediated explanations of substance use outlined in Chapter 3. The researchers examined patterns of self-reported substance activity and explanations in samples gathered from those with contact with treatment agencies, and those with no such contact in four locations - Glasgow, Edinburgh, Newcastle and Ayrshire. The data gathered revealed significant differences in patterns of substance activity in the four locations, and also differences in the stages according to whether the individual was in contact with treatment services. Drug users in contact with treatment services used explanatory strategies consistent with those predicted by the model. They were unlikely to explain use in terms of pleasure, favouring explanations based on addiction, physical need and loss of control. However, the 'addict' population contained a sub-group ambivalent about their status, who mirrored the inconsistency of reporting shown by the non-treatment group in Stage 2.

Furthermore, in six of the seven dimensions underpinning the theoretical model differences were found, indicating that substance-related explanations derived from minimally structured interviews can successfully be used to categorise the clinical involvement of drug and alcohol users.

However, the study did not support the hypotheses that explanations given at the first interview would successfully permit prediction of explanations at the second interview, nor was the prediction significantly associated with the outcome indicator

employed - the summary of the progress reported by their keyworker. While, there are a number of potential explanations for this failure, both theoretical and practical, these are not sufficient to abandon the attempts to model the reporting and understanding of substance related difficulties with a qualitative and principled method. The goal of this investigation - to combine a qualitative methodology with quantitative outcomes - remains an accessible target for drug researchers. This may also be based on attempting to locate the explanations given by the user for their substance activities in terms of the context of the explanation. This may involve examining demand characteristics (a topic that will be examined in the following chapter) or the wider social context in which the explanation occurs. This would consist of the socio-cultural, moral and legal contexts in which substance use occurs (which will be the focus of Chapter 6). However, the critical feature of this research undertaking is that it must be reflexive and critical in the consideration of the political role assigned to both the researcher and the research subject, at every stage of the research process.

Ch 5 - Investigating substance-related reports in young people

Background

The emphasis of the research presented in this thesis has been on methodological issues that surround asking questions about illicit drugs. This has involved assessing the problems surrounding the interpretation of responses, both in terms of their validity and in providing an empowering and meaningful context in which the research interaction can occur. The criticism of much traditional research carried out in this area is that insufficient attention has been paid to the demand characteristics of the research context and so to the meaning of the results. While some attention has been paid to the reliability of self-reports in this area (Barnea, Rahav and Teichman, 1987), almost none has been paid to the question of validity, and the ways in which the context of the investigation shapes the responses elicited. Oetting and Beauvais (1990) argue that adolescent self-report of substance activity is both valid and reliable, but at best their justifications for this claim are weak, based on anecdotal rather than empirical foundations.

The problem is that there is often an uncritical approach to the methods of social science research in investigating substance activity in young people. In particular, this relates to the use of self-report questionnaires in which it is generally assumed that most people will tell the truth, although specific populations, particularly those with behavioural or personality problems, will understate their substance use in an attempt to appear good or normal (Winters, 1990). What the current investigation aims to do is to examine a specific population, whose substance activity cannot be predicted at

the outset of the project, and to examine variations in their substance-related attitudes, perceptions and behaviours in a variety of research contexts.

The reason for studying young people is that they are a group whose substance use is given prominence by both researchers and policy makers and who have been widely assessed in recent years in both Britain (Coggans et al, 1991) and the US (Johnson, O'Malley and Bachman, 1985). Similarly, they are unlikely to have deeply entrenched views on illicit substances and so one may infer, in terms of the methodology of the previous chapter, that young people may be most susceptible to contextual variation in their reporting. Furthermore, the practical opportunities for this type of research are fuelled by the increasing prominence accorded drug education both within the school environment and through the media. The current investigation was designed to examine the effectiveness of a particular approach to drug research and education, and to examine the effects of such an approach on the reported attitudes to substance use among this group. However, the investigation retains the methodological emphasis on assessing the variability of reporting on drug attitudes and behaviours as formed the focus of the previous chapters.

The work reported in this chapter was carried out as part of an evaluation of Fast Forward's Peer Research programme and the leaflet that was produced as a result of its findings entitled "Bolt Ya Radge" (Fast Forward Positive Lifestyles Ltd, 1995). The research project originally carried out by Fast Forward had two main objectives - to investigate the informational requirements of 12 to 16 year olds in the Edinburgh area about drugs and health and to use this to develop drug educational materials for

this group. As a consequence, the evaluation that forms the basis of this chapter had two clear phases. First, an assessment of the validity of the original research project and its salience for young people was carried out. Second, an examination of the success of the application of research findings was also used as a way of examining research strategies and their impact on drug-related reports in young people.

However, the key to the project was the attempt to protect the integrity of the participative and empowering ethos that had characterised the original work conducted by the Fast Forward team in their peer research project and to assess its impact on reporting style and content. This provided the opportunity to examine some of the critical methodological issues surrounding research into substance awareness, attitude and activity in young people. However, it is relevant to preface this discussion with a clarification of what the group meant by the term "peer". This was defined by Fast Forward as "an approach which empowers young people to work with other young people, and which draws on the strength of positive peer pressure. By means of appropriate training and support, the young people become active players in the educational process rather than passive recipients of a set message" (Fast Forward in-house publication, 1995).

Tobler (1992) has argued that peer education is a particularly effective approach to drug education and reports that it shows a definite superiority in a range of outcome measures. Klepp et al (1986) have argued that this is because peer educators serve as potent role models through their demonstration of non-use, while Carr et al (1994) claim that young people can more profitably discuss drug issues with people of their

own age than with adults. However, Carr et al also warn that 'peer' is the new in-word within youth services and should not be regarded as a panacea in what remains an inordinately complex task.

The significance this has for the mixed qualitative/quantitative research approach is the active and participative role afforded the researcher who is required to perform a meaningful and active role in the research process. This is the application of reflexive research principles in a practical context (see Chapter 2). This approach challenges the role distinction between researcher and researched, and attempts to break down some of the disparity in status and knowledge between the two. As in the Scottish Office project(see Chapter 4), the objective was to examine the functionality of participants' discourse rather than to score its 'accuracy'.

Fast Forward's working definition of "peer" as equivalent in status rather than age is consistent with the model advanced by Shiner and Newburn (1996). They argue that the term 'peer' should not be taken too literally as even those who are obviously older may be equivalent in status. This permitted the incorporation of a number of qualitative assumptions about the way research should be conducted to be included in an innovative approach to evaluation.

The aim was to make the evaluation consistent with the objectives of the original research and educational activity. This emphasised a number of the key aspects of the YAP scheme evaluated by Shiner and Newburn. Their approach was to make drug use appear unfashionable and unpleasant, using methods that emphasised credibility.

Shiner and Newburn argued that the key to success for peer-based approaches is that it be based on "a complicated balance of age, experience and message content". Among the central concepts Fast Forward sought were shared ownership, not only for the research, but also in devolving responsibility for research and education to its likely recipients. This reflects the challenge to the expert status of the research discussed in Chapter 2. Thus, the overall approach can be characterised as a qualitative investigation that can be regarded as multi-perspectival, reflexive and responsive-rhetorical (Shotter, 1993).

The multi-perspectival approach requires the employment of a range of research methods and data collection techniques to increase the outlooks and values that may be incorporated in the research and its reporting. Secondly, to be reflexive it is necessary that the investigators challenge whatever assumptions they may bring to the project. In this case, this was achieved by blurring the boundary between researched and participant and by involving participants in as many stages of the research process as was possible. Finally, the research approach was responsive-rhetorical in that it provided a framework in which the discursive forms of the participants were preserved, without trying to sanitise them for academic reporting. In sum, the aim of both the original research and the evaluation was to involve as many young people in an investigation that was challenging and empowering. This permitted a critical analysis of the ways in which information is gathered about drug use and awareness in young people. As with the other studies described in this thesis, the aim was to provide a clear and systematic characterisation of the meanings and understandings of the participants.

Background to the drug education effort

The Fast Forward project must be understood in the context of previous drug education and primary prevention attempts that have occurred, primarily through the education system. The Fast Forward initiative, and the evaluation reported here, are important for their challenge to the way in which drug education has been managed in Scotland (and throughout the UK). As Hammersley et al (1990) have pointed out much of the work done in this area has occurred against a media background emphasising negative stereotypes about drugs and drug users, generally classed under the banner of "fear arousal" approaches to drug education. However, in spite of research findings (Schaps et al, 1981) indicating that such approaches are ineffective, if not actually counter-productive, school-based approaches to drug education have often adopted a similar "just say no to drugs" approach. These have been based on alternatives to drug use and teaching life skills that are thought to decrease the likelihood of initiating use (Davies and Coggans, 1991). The conclusion drawn in a study of 3,375 American school children was that educational approaches based on either the provision of information or fear arousal had little or no effect on drug-using behaviour (Schaps et al, op cit).

However, as Davies and Coggans (op cit) point out, the determination of efficacy for drug education packages is far from clear, and further raises the issues of outcome criteria mentioned in the previous chapter. Finnigan (1988) argued that drug education messages based on fear arousal appeal to the general public, but de Haes and Schuurman (1975) argue that a life skills approach had more beneficial effects on both

substance use and attitudes. However, the definition of 'beneficial', in addition to the most appropriate measurement instruments, are contentious. As much of this outcome data is reliant on self-report the risk may be that drug education teaches the child the appropriate response to give in a questionnaire rather than recording actual changes in behaviour. However, this at least clarifies what are generally regarded as the three areas of significant outcome in drug education - the impact on knowledge, attitude and behaviour in the area of substance use.

The approach to drug education in recent years has been influenced by the harm reduction philosophy. This is a recognition of both the ineffectiveness of earlier attempts at primary prevention and changes generally in the drugs field in response to the advent of HIV and AIDS (Clements, Cohen and O'Hare, 1988). This shift of emphasis reflects a recognition of the widespread availability of illicit drugs to young people and the consequent need to adopt a realistic perspective in attempting to educate in this area. As Hirst and McCamley-Finney (1994) argue, "young people are aware of the presence of drugs in their social worlds and, in the main, they treat this matter of factly and find ways of coping with, or responding to it as a matter of course" (Hirst and McCamley-Finney, 1994). The argument here is that drugs are a routine feature, if not a particularly important one, of the lives of many young people, and that this is the context in which drug educators must act, without recourse to stereotypes or tabloid headlines.

In contrast, Bukstein (1995) argues that the extent and frequency of young people's drug use is considerably overstated, particularly with regard to abuse or dependence

(in terms of DSM-IV criteria). The danger here is that research is inconsistent both with regard to absolute frequencies and perceived trends, with Bukstein's argument being contrasted against Wright and Pearl's (1995) claim that 14 - 15 year olds' exposure to illicit substances significantly increased between 1969 and 1994. Similarly, Parker, Measham and Aldridge (1995), in their review of the literature, point out that the prevalence of illicit drug use for 15 to 20 year olds ranges from 10% to 35% in national surveys and from 5% to 50% in local surveys. The huge variability in these results does not make the task of the drug educator easier in terms of targeting the intervention or in understanding the audience. This variability of reported drug use is compounded by methodological problems in which a range of sampling techniques, interview or questionnaire styles and contextual biases vary from one investigation to the next.

With regard to the other main outcome areas, Coggans et al's (1991) National Evaluation of Drug Education in Scotland suggested that drug education has some positive impact on drug knowledge, but that drug knowledge and awareness among young people is generally poor. Wright and Pearl (op cit) suggest that television is the main source of drug information for many young people. An area that is perhaps even more problematic falls under the general heading of attitudes to drugs, a term that tends to be a catchall for the beliefs and values reported by young people in this area. In this category, Dowds and Redfern (1992) argue that around two thirds of young people believe that taking cannabis is very serious and that 86% believe that people who take drugs need help rather than punishment. The difficulty here is that such opinions are likely to be framed by a range of demand characteristics making their

measurement and interpretation highly problematic. It is difficult to gauge what relevance to accord such attitudinal reports compared with the self-reports of experience or knowledge.

Thus the current situation in Britain employs a life skills model in which self-esteem and informed choice are regarded as key concepts in preventing drug-related harm. Furthermore, O'Connor (1995) has outlined some further useful directions for work in this area which include the locating of drug education within a wider context of "healthy" behaviour promoted within a school context, the development of a community prevention approach and the development of a clear and pragmatic programme of interventions. Similarly, O'Connor argues in favour of a peer education approach which is well received by young people and which may offset some of the problems of credibility that may be associated with the use of teachers as drug educators.

However, one of the main conclusions of the O'Connor report was that "despite the fact that drugs education has been a compulsory element of the science National Curriculum since 1988, little is known about the overall quantity and quality of provision" (O'Connor, 1995). The problem this creates is that, in a context in which young people are bombarded by media images of drugs and alcohol, their own sources of information are far from clear.

It is in this context that Gerstein and Green's (1993) observation that there are numerous methodological issues about evaluation in this area that need to be clarified,

that the current research project is located. The method evaluates the techniques used in the original research project in a manner consistent with the participative ethos developed by Fast Forward. This meant that the evaluation attempted to augment and extend the original research and to address some of the issues brought to the fore by the original project. While this goal was restricted by time and resources and by the need to complement the ongoing work of the Fast Forward project, the evaluation consisted of two phases. The first was a research investigation of the methodology of the original project incorporating a replication of the original instrument. This was followed by an action evaluation of the leaflet resulting from the research project, conducted alongside the piloting of the leaflet.

It was in the first part, the methodological assessment and replication, that key theoretical issues were examined concerning aspects of investigating drug awareness and activity in young people. The central methodological issue, originating in the peer aspect of the project, was reflexive and concerned the impact of the researcher on the dynamics of the encounter and on the responses of the participants.

The effectiveness of peer techniques

As has previously been mentioned the use of "peer" researchers is a recent and contentious development in the drug education field, not only for young people but also among existing groups of users (Herkt, 1992). In the US, a number of peer projects have been undertaken in which current and former users are employed as 'educators' to attempt to change the behaviour of injecting drug users (Broadhead, 1995; Friedman, 1993). In response to an ACMD (1993) report, many agencies have

taken up peer approaches as part of their drug prevention and harm reduction programmes. Indeed, Hunter, Ward and Power (1997) found that around half of the agencies accessed in their study were implementing peer intervention strategies.

Among the key issues here have been the questions of what constitutes a peer and what impact such a perception is likely to have on the type of responses given to particular types of attitudinal, knowledge and behavioural questions about drugs. Shiner and Newburn (1996) have argued that there are three key components in peer credibility – the deliverer, the message and the experience of the provider. To examine this the investigators were all aged between 20 and 23 years of age and so in the same age range as Fast Forward's peer investigators – in other words, significantly older than the target population. They adopted either a formal or an informal approach, both in terms of their dress and their demeanour while working with the young people, as a means of manipulating the status component (specified by Fast Forward as their critical determinant of peer identity).

Furthermore, the context of the encounter was varied in terms of their previous contact with Fast Forward, the physical context of the exchange and the use of an open interview schedule either before or after a questionnaire. The manipulation of context was an attempt to examine the effects of measurable situational variables on discourse and attributions. In many ways, this represents an extension of the Davies and Baker (1988) paper discussed in Chapter 3 to work with young people.

The first of these was also conducted to assess the salience of the original project for those who had taken part. This allowed an examination of any differences in drug awareness or experience, and in attitudes between those who had been involved in the original project and those who had not.

However, there is also a methodological issue here about the priming effect of having participated in previous research. It was possible to compare results for the original study with the results for the evaluation replication, for the group who had taken part in both, as well as comparing this group with those who had not taken part in the original investigation. However, we also examined any differences between the groups on the basis of their drug education experiences (including that with the Fast Forward) in both the interview and the questionnaire. This was made possible as those who have participated previously will have completed a questionnaire, but not been involved in an open interview on the same topics.

The second opportunity afforded by the evaluation concerns differences in responses between a questionnaire and a one-to-one interview. It has been traditional to assess impact and behaviour with self-completion questionnaires, yet it is well-established (Presser and Schuman, 1981) that self-report questionnaires involve numerous artifacts. Therefore, it may not be a particularly useful or accurate means of assessing behaviour or attitudes. Thus, in the evaluation, participants were asked to take part in both an interview and to complete a questionnaire, the order being reversed on a random basis so that half of the participants received the questionnaire first while the other half were interviewed first. It is not that interviews are more "valid" or

"accurate" than questionnaires, but that each is subject to its own set of demand characteristics. Therefore, by collecting both, the biasing of any one method is more likely to become apparent and it is possible to examine the interaction of data collection method with contextual variables.

The other interesting aspect of questionnaire-based research that this design permitted was an examination of the potential priming effect of a fixed format instrument on naturally occurring explanations. Thus, one of the items raised by Fast Forward for examination concerned a perception on the part of a large number of the young people that their message was along the lines of "just say no to drugs". This appears to have occurred in spite of attempts to provide an impartial presentation about illicit substance use. However, this may be true of all formal presentations about drugs - that as soon as a written paper and pencil element is introduced, traditional stereotypes about illicit drugs are reinforced. This, in turn, may provoke a negative and moralistic set in the young people, irrespective of the content of the questions. Therefore, the research attempted to assess differences in reporting styles both in questionnaires and using a minimally scheduled interview as the criterion. The hypothesis assesses the artifactual impact of questionnaire completion on reports of substance use, awareness and attitude in an interview context.

The other major assessment involved in the design of the replication concerned the impact of physical location on report. This is a test of the Davies and Baker (1988) effect examined in the previous chapter and assesses the suggestion that explanations and self-reports which are salient in one context may be less salient in a different

situation. In the current investigation two locations were used - schools and youth clubs - which it was hypothesised would vary in their informality and the extent to which the young people would feel comfortable in making positive or negative statements about illicit drugs. This is likely to be emphasised by the Fast Forward finding reported above that young people are more likely to interpret any educational intervention in a school context as hostile to drug use, as a consequence of their expectations. The issue here is not to attempt to prove that the young people make erroneous attributions but to test the dynamics of an encounter that may be critical to the impact of different styles of intervention.

Fundamentally the study assesses the possibility that paper and pencil surveys of drug education may be misleading and may influence the results obtained. Furthermore, this effect may be perpetuated through the impact of research on subsequent drug education, policy and evaluation. By manipulating aspects of the research encounter - the presentation style of the researchers, the physical context, the young people's previous experience, and the format of the instrument - light may be shed on the processes that occur (and whose veridicality is taken for granted) when young people are asked questions about illicit substance activity. While the use of peer educators is an attempt to consider the credibility aspect, the current investigation is a more systematic assessment of criteria that influence the self-reports of young people in this area. Again, by combining qualitative and quantitative methods, the objective is to involve participants as active players in the understanding of the research process and its outcomes.

Method

Design: The project was carried out as a piece of action research, as the evaluation examined theoretical issues in the context of applied field work (by Fast Forward), which was continuing as evaluation data were being gathered. For this reason, it was necessary to implement a research design that enhanced the original work of the Fast Forward research project. This allowed the immediate incorporation of the results into the ongoing activity of piloting the leaflet the research had inspired, "Bolt Ya Radge". For this reason the research team attempted to access the same schools and youth clubs that had been contacted by Fast Forward. If willing to participate, they were surveyed using a questionnaire including but not restricted to the instrument used in Fast Forward's original research project. It was anticipated that the young people attending either type of facility would overlap with the cohort tested in the original research project and so within each location there would be a naturalistic categorisation of those with and without previous contact with Fast Forward.

A number of interviewers (to test for individual interviewer effects) were used to manipulate the formality of the interviewer (one of the key contextual manipulations of the study). However, all the interviewers were equivalent in age and status to those used in the original study by Fast Forward. They approached young people in either the school or the youth club setting and requested their participation in the investigation. The two elements of formality tested were dress - either smart, formal wear or casual clothes - and interactive style. The latter was to be either friendly and conversational, or business-like with no general chatting to precede or to follow the research procedure.

The interview was tape-recorded and semi-structured. It investigated the three areas of traditional inquiry - attitudes, awareness and behaviour, and was carried out either before or after the completion of the questionnaire. This was an examination of the demand characteristics of questionnaire completion in assessing both differences in the style and content of responses to similar questions in a less structured format. It was also an analysis of order effects in which the priming effect of completing a questionnaire (such as that employed by Fast Forward) could be assessed in the discourse produced in the subsequent interview. In other words, it was anticipated that those who were interviewed after they had completed the questionnaire would exhibit the impact of questionnaire on completion on subsequent natural discourse.

However, this formal research project constituted only part of the evaluation and although it can be represented as an autonomous investigation, it occurred only as the first phase of the larger evaluation. Although the primary emphasis will be on context effects comment will be made on the other phases of the evaluation.

The second aspect of the study, the evaluation of the "Bolt Ya Radge" leaflet, produced as a consequence of the original research project, was evaluated in two phases. Immediately after the original investigators piloted it, the young people were given a questionnaire assessing both their views on the leaflet and their drug-related experiences and perceptions. This was followed up two weeks later by returning to the clubs in which the same young people completed a questionnaire assessing their views on the brochure, along with a section on their recollection of it (in the absence

of the leaflet itself). The final aspect of the evaluation was a number of minimally structured interviews with participants in the Fast Forward peer research projects concerning their perceptions of the project, and drug education in general.

Thus the overall design involved a research project investigating four variables that represent demand characteristics of drug research that are rarely questioned and assessed, as the first phase of the evaluation. These were the impact of previous contact with peer research methods, the physical location for the research, the formality of the investigators and the impact of minimally structured interviews alongside questionnaire methods. This was followed up by an assessment of the impact of the leaflet produced on a group of young people, both immediately after receiving it and two weeks later. Finally, throughout the period of the evaluation, unstructured interviews were carried out with a number of participants to contextualise the investigations and to gain access to the perspectives of those involved.

Procedure

The procedure was largely shaped by the approach that had been employed in the original Fast Forward project for two reasons. The first was an attempt to make the evaluation as compatible and consistent with the ethos of the original project and, second, as a means of facilitating access to the agencies and schools used by Fast Forward. Therefore, for the first phase of the evaluation (the context study), agencies who had already participated in the original project were contacted and asked if they

would be willing to take part. If agreement was obtained, all of the researchers made contact with the young people either directly or through the mediation of the youth worker or teacher (whose decision this was). Those who agreed to participate were told that their involvement would be anonymous and of around 10 - 20 minutes duration. At each session, the investigators all adopted the same degree of formality with participants, although the order of interview and questionnaire would be alternated within each session. The agencies varied in the proportion of young people who had already taken part in the original Fast Forward sessions.

For the interviews, the procedure was to tape record the session for later transcription so that, while a number of key topics were to be covered, the researcher could engage the young person in a natural form of discourse. This would not have been possible in a totally structured interview or one in which the researcher is attempting to record the responses while the interview is taking place. Although many of the young people were initially suspicious of talking into a tape recorder, this was not a significant problem with many of the young people appearing to "forget" about the tape recorder after a few minutes. With regard to the questionnaire, this was done on a self-completion basis with assistance only being provided to clarify any difficulties that the young people were having with the form.

Participants

The methodological investigation involved a total sample of 77 young people, 40 of whom were male and 37 female. In terms of their age distribution, 12 were between

the ages of 11 and 13 years, 48 between the ages of 14 and 15, and 17 between the ages of 16 and 18 years. In terms of their previous experiences 44 had been involved in the earlier Fast Forward investigation while 33 had not. With regard to the location in which they were contacted, 52 of the encounters were conducted in youth clubs and 25 in schools. Finally, 31 were assessed in formal conditions and 46 in informal conditions while 44 were the questionnaire first and 33 the interview first. There were only four refusals to participate by young people who were approached and, at some youth clubs, young people were queuing up to take part in the study.

In the evaluation of the "Bolt Ya Radge" leaflet produced by Fast Forward following the research project, 400 questionnaires were distributed immediately after the leaflet had been distributed, 296 in schools and 104 in youth clubs. For the follow-up evaluation of "Bolt Ya Radge", 238 of the original 400 were re-assessed two weeks later which represents a retention rate of 59%.

Results

Methodological study

The first set of results concerns the responses to the questionnaires in the methodological investigation, initially surrounding the self-reports of drug use. These results are reported in two ways - first, in terms of the number of young people who report having tried a particular substance and, secondly, in terms of the number of drugs reported as having been tried. This permits a comparison with the reports of substance activity in the unstructured interview, both as a direct comparison and in

terms of order effects on self-reported substance activity. While the emphasis will largely be placed on contextual manipulation, it is necessary first to examine the results in their descriptive form as a means of describing response patterns to each of the sets of questions about substance activity, drug awareness and attitudes to substance activity.

Firstly, in terms of the experience of specific substances, the young people reported having tried each of the following substances (in the table below, the sums that do not come to 77 represent missing values):

Table 1: Reported substance use in self-completion questionnaires

Substance	**Have tried**	**Have not tried**
Cannabis	55 (72.4%)	21 (27.0%)
Solvents	31 (42.5%)	42 (57.5%)
Magic mushrooms	17 (23.2%)	56 (76.7%)
LSD	25 (34.3%)	48 (65.8%)
Ecstasy	6 (8.5%)	65 (91.7%)
Amphetamines	22 (29.7%)	52 (70.3%)
Tranquillisers	22 (30.1%)	51 (69.9%)
Painkillers	16 (22.2%)	56 (77.8%)
Cocaine	2 (2.9%)	67 (97.1%)
Astralight	2 (2.9%)	67 (97.1%)
Heroin	-	69 (100%)
Other drugs	2 (2.7%)	73 (97.3%)

The first point to note relates to the high reporting of cannabis use implying that, at least for this drug, there is not a general disinclination to report use, irrespective of

the questioning format, a finding consistent with other research investigations of this sort (Miller and Plant, 1996). This does not however imply that such a prohibition exists for no drug as the perceptions of acceptability and harm may well be substance specific. It is also important to note that reporting of "hard" drug use, of cocaine and heroin, is minimal in a cohort in which the level of report of having used a wide range of substances is relatively high.

The distinction between 'good' and 'bad' drugs is made explicit in several of the unstructured interviews. One interviewee is asked what the bad ones are and reports "jellies, heroin and cocaine" but when asked about her own use and its costs says "hash you can get for a fiver and ecstasy for a tenner and its no problem". However, a more meaningful comparison can be made between the reporting of number of drugs between the questionnaire and the interview, with the following number of drugs reported as having been tried by each of the participants:

Table 2: Number of drugs reported used in interview and questionnaire

Number of drugs reported in …	**Questionnaire**	**Interview**
0	18 (23.4%)	21 (35%)
1	13 (17.1%)	25 (41.7%)
2	12 (15.8%)	8 (13.3%)
3	9 (12.2%)	3 (5.0%)
4	6 (6.8%)	3 (5.0%)
5	7 (9.2%)	-
6	5 (6.6%)	-
7 or 8	6 (7.8%)	-

While there is a marked disparity between the mean number of drugs reported in the interview and in the questionnaire ($p < 0.001$) this may reflect differences in the salience of the cues in each of the assessment formats, regardless of the accuracy of either. It is likely that the tick-box format of a questionnaire facilitates overstatement while the voluntary response frame of the interview may encourage understatement – on some occasions the issue may never arise or the topic of conversation changes. What may be of more importance however is that there is a highly significant association between the number of drugs reported in the interview and the number of drugs reported in the questionnaire, as having been tried ($r = 0.561$: $p < 0.001$). Thus while there is a disparity according to data collection method, this is not random, with young people who tick the most boxes in a questionnaire also likely to volunteer most reports of substances tried in an interview context. While this provides support for the cueing argument, it also implies that the threshold to substance reporting is consistent within individuals.

Furthermore, there are indications that higher levels of drug reporting are associated with more negative attitudes towards drug education in both interview and questionnaire contexts. In the interview there is a correlation of -0.34 ($p < 0.05$) between reported drug use and positive attitudes to drug education and in the questionnaire a correlation of -0.32 (ns) between reported drug use and attitudes towards drug education. In both research formats, those who report the higher levels of drugs experienced are also likely to have the more negative attitudes about drug

education. Similarly, the table provided below indicates associations between reported drug education experiences and the number of drugs tried by the participants:

Table 3: Association between drug use and attitudes to drugs and drug education

Association	**Kendall's tau**
Total number of drugs reported (interview) and attitudes towards drugs	**tau = 0.27** **$p < 0.05$**
Total number of drugs reported (interview) and attitudes towards drug education	**tau = -0.28** **$p < 0.05$**
Total number of drugs reported (questionnaire) and attitudes towards drug education	**tau = -0.25** **$p < 0.05$**

The finding here is that among those individuals who have tried the most drugs there appears to be more positive attitudes to drugs and, conversely, those with the most negative attitudes towards drugs are those who have experienced the fewest substances, on average. The reverse appears to be the case with regard to drug education with those who have experienced most drugs also exhibiting the least positive attitudes to drug education and those who have the least drug experience the most positive attitudes to drug education.

However, there were a number of other factors that appeared to predict the extent to which individuals displayed positive attitudes to drugs, the most prominent of which are outlined in the table below:

Table 4: Predictors of reported drug attitudes

Reported drug attitudes	χ^2
Positivity of drug attitude as a function of gender	$p < 0.001$
Positivity of drug attitude as function of old and new centres	$p < 0.05$
Positivity of drug attitude as a function of age	$p < 0.05$
Positivity of drug attitude as a function of order of presentation (interview or questionnaire first)	$p < 0.05$

What this table demonstrates is that while males reported markedly more positive drug attitudes than females, more positive drug attitudes were also expressed by older participants. However, beyond demographic variables, those young people who attended youth clubs or schools previously visited by Fast Forward expressed more positive attitudes than did those who had no contact with Fast Forward.

The final result here, which relates to the contextual aspect of the study, was that participants who completed the questionnaire before the interview expressed significantly more negative attitudes towards drugs in the interview than those who had taken part in the interview first. Therefore, the questionnaire appears to have cued participants to report more negative attitudes about drugs in the interviews. This satisfies the hypothesis that the participation in an unstructured interview can be influenced by the context established in the research format. This suggests two points of note about research questionnaires. First, that they have an impact on the subject (however 'neutral' the researcher attempts to make them and, second, that veridicality of results can never be assumed in this kind of social research.

A number of other order differences were found as a consequence of the data collection methods. These are reported in Table 5 below:

Table 5: Young people's responses as a consequence of methodological variations

Association	**Kendall's tau**
Order: Total reported drug use in the questionnaire and positivity of drug attitudes as expressed in the interview	Questionnaire first : ns Interview first : $p < 0.01$
Order: Total reported drug use in the questionnaire and attitudes towards Fast Forward expressed in the interview	Questionnaire first : ns Interview first : $p < 0.05$
Context: Total reported drug use in the interview and positivity of drug attitudes expressed in the interview	Formal context : $p < 0.01$ Informal context : ns
Context: Total reported drug use in the interview and drug knowledge demonstrated in the interview	Formal context : ns Informal context : $p < 0.05$
Context: Drug knowledge demonstrated in the interview and attitudes towards drug education	Formal context : ns Informal context : $p < 0.01$
Context: Total reported drug use in the questionnaire and attitudes to drug education expressed in the interview	Formal context : ns Informal Context : $p < 0.05$

For participants who completed the interview first, the total quantity of drug use reported in the questionnaire was associated with positive attitudes towards drugs, an association that did not occur when the questionnaire was completed first. The second order effect was that for those who completed the interview first their total drug reporting in the questionnaire was inversely related to their attitude to Fast Forward. In other words, if a participant completed the interview first, when they subsequently completed the questionnaire, the more drugs they reported having used the more likely they were to have a negative report of Fast Forward. This relationship did not exist for those who completed the questionnaire before the interview. These secondary

order effects suggest that the dynamics associated with reported attitudes and behaviours are highly complex and may be mediated by the method of data collection.

With regard to the attempts to manipulate the context of reporting, four main effects were found. In the formal context, reports of drug use in the interview and positive drug attitudes were positively associated, not in the informal condition. In the informal condition, there was a positive association between the number of drugs experienced and drug knowledge, a finding not replicated in the formal context. Again only in the informal condition, there was an association whereby the more the young people knew about drugs the more negative were their attitudes to drug education. Finally, in the informal condition, there was a negative correlation between the number of drugs experienced and attitudes to drug education that did not occur in the formal condition.

The final set of results arising from manipulations of context and order are perhaps more difficult to interpret as they involve partial analyses of the data. The derived relationships involve only small subsets of the sample and are based on the comparative non-significance of the opposite effects. These are reported in Table 6 below:

Table 6: Young people's responses as a function of data collection method, order of completion and context:

Reported drug use	χ^2
Order (questionnaire to interview) : Reported drug use when responding to the questionnaire as a function of context	4.16 ($p < 0.05$)
Context (informal) : Reported drug use when responding to the questionnaire as a function of age	7.30 ($p < 0.01$)
Order (interview to questionnaire) : Reported drug use when responding to the interview as a function of age	5.31 ($p < 0.05$)

When the questionnaires are distributed prior to the interviews there was a context effect - more people in the informal context reported no drug use than in the formal context, an effect not found when the interviews were first. Similarly, in the informal context, reported drug use was associated with age - older reported greater drug experience in the questionnaire than younger participants - which was not the case in the formal context. The final significant relationship is that when interviews were conducted before questionnaires, there was a gender difference in the reporting of drug experiences. Males were more likely to report a drug experience in the interviews than were females, a difference that did not occur if the questionnaires were distributed first. While the impact of each of these specific effects may be limited, they are indicative of the complex social dynamics that may differentiate drug research by data collection methods.

The next comparison is between drug experiences and attitudes to drugs, for participants in the original Fast Forward project and those who took part in the evaluation, between which there is a gap of 6 - 12 months, and a difference in

participants. For reports of having ever tried a drug, the following table outlines reports of substance activity:

Table 7: Reports of drugs tried in original and evaluation reports

Drug taken	Fast Forward research	Evaluation study
Cannabis	56%	72.4%
Solvents	32%	42.5%
Magic mushrooms	16%	23.3%
Ecstasy	8%	8.5%
Amphetamines	21%	29.7%
Tranquillisers	20%	30.1%
Painkillers	22%	22.2%
Heroin	3%	-
Cocaine	-	2.9%
Astralight	2%	2.9%
LSD	28%	34.2%

Several drugs are more frequently reported in the evaluation study than in the original Fast Forward study, most significantly cannabis which varies from 56% in the Fast Forward study to 72.4% in the evaluation research, and tranquillisers which have increased in frequency from 20% to 30.1%. Similarly, there are differences in the reporting of solvents, amphetamines and LSD.

However, a more startling set of differences occurs in the responses to three attitudinal items between the original research investigation and the evaluation study, presented in the table below:

Table 8: Attitudinal reporting in the Fast Forward and evaluation studies

Item	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
Cannabis should be legalised	FF : 31.5% Eval : 63.3%	28.8% 15.6%	21.9% 20.8%	11% -	6.8% -
Raves encourage young people to take drugs	FF : 35.1% Eval : 62.3%	23% 7.8%	16.2% 29.9%	14.9% -	10.8% -
Drugs like hash lead on to harder drugs	FF : 28.4% Eval : 49.4%	28.4% 15.6%	23% 35.1%	10.8% -	9.5% -

Irrespective of the valence of the item, respondents in the evaluation gave universally positive responses. The immediate reaction by the researchers - that this was a coding error - was investigated to no effect. This may be the result of a methodological artefact such as an acquiescence set but cannot readily be explained.

Evaluation of "Bolt Ya Radge"

The remainder of this results section consists of a summary of the second half of the evaluation study, the investigation of the efficacy of the leaflet produced as a result of the original research study. Of the 400 young people who completed a questionnaire (see Appendices 3 and 4) after being given a copy of the leaflet, 238 replied to the item concerning how good they thought the leaflet was. Among this group, 150 (63%) reported that they thought it was "good" or "very good", 23 (9.7%) that it was "quite good", 59 (24.8%) that it was "all right" and 4 (1.7%) that it was "crap". Furthermore, 86 young people reported that they found it "informative", 82 that it was "funny" and 36 that it was "interesting". In total there were 601 comments about the leaflet of which only four were negative in tone. However, when asked whether they felt that the leaflet had changed how they felt about drugs, 223 (61.8%) felt that it had not, 136 (37.7%) that it had with 39 people not responding. On the other hand 254 (70.8%) of the respondents felt that the leaflet had been useful to them. Furthermore, 226 (57.9%) of the young people felt that leaflets were a good way of attempting to reduce young people's drug taking.

The questionnaire also included 13 drug knowledge items that the respondents were required to give true/false responses to, and the correct answers to which had appeared in the leaflet. For all but one of the thirteen items the correct response is the most commonly given response. The table below gives a breakdown of the number of correct responses by gender:

Table 9: Number of correct responses to knowledge items in "Bolt Ya Radge" evaluation

Total number of correct items	**Male**	**Female**
0 – 2	12 (5.8%)	5 (3.3%)
3 – 5	37 (17.7%)	26 (17.1%)
6 – 8	91 (44.7%)	67 (44.1%)
9 – 11	60 (28.9%)	48 (31.6%)
12 – 13	8 (3.9%)	6(3.9%)

The majority of respondents have at least half of the items correct (mean score of 7.26 correct responses). As with all knowledge assessments of this sort, there may be some debate not only about the accuracy of the answers (e.g. "speed can rot your teeth"), as a result of the substance-related experiences the young people have in their lives. Thus, while the question with the lowest level of correct responses, "Is alcohol a stimulant?", is technically accurate, in practical terms for adolescents alcohol may serve to activate and stimulate at least socially, irrespective of its effects on the central nervous system.

The final section dealt with the young people's own experiences with drugs, for which the table below indicates their self-reports of the number of drugs they have both tried and those that they frequently use. Again, alcohol is the most commonly reported substance with 90.1% of the sample reporting that they drink either "sometimes" or "often", followed by tobacco (42.8%) with the most commonly used illicit drug being cannabis (reported as used sometimes or often by 34.9%) of the respondents.

Table 10: Number of drugs reported as tried in the leaflet evaluation questionnaire

	EVER TRIED		**FREQUENT USE**	
Number reported	**Male**	**Female**	**Male**	**Female**
0	6 (2.9%)	8 (4.8%)	94 (44.8%)	91 (54.8%)
1	55 (26.2%)	45 (27.1%)	57 (27.1%)	30 (18.1%)
2	41 (19.5%)	44 (26.5%)	30 (14.3%)	34 (20.5%)
3	49 (23.3%)	28 (16.9%)	19 (9.0%)	9 (5.4%)
4	24 (11.4%)	11 (6.6%)	5 (2.4%)	-
5 or more	34 (16.2%)	30 (18.1%)	5 (2.4%)	2 (1.2%)

Thus while the figures for the number of drugs tried appears high, this is inflated by the inclusion of alcohol and tobacco. Indeed, the only other drug that has even been tried by more than one in five of the respondents is solvents (20.1%), while only 8% of the respondents report that they use temazepam either sometimes or often. The percentage for amphetamines is 7.8%, LSD 5.7%, ecstasy 6.2% and cocaine 2.5%. Furthermore, there do not appear to be marked differences by gender, with a slightly higher number of males having tried more than two drugs and a slightly higher number of females having tried 5 or more, although neither of these differences approach statistical significance.

A follow-up assessment of those who took part in the original evaluation of the questionnaire was conducted two weeks after the first piloting and assessment, leading to 238 of the original 400 participants completing a follow-up questionnaire (a retention rate of 59%). Of the 238, only 27 (11.7%) did not know where the copy of "Bolt Ya Radge" they had been given two weeks earlier was, and only 24 (10.4%)

said that they had discarded it. Thus the remaining 77.9% of the sample had either retained it or given it to a friend. Furthermore, when asked for a second time what they thought of it, 62.0% reported that they thought it was either good or very good (compared to 63.7% immediately after distribution) with only 2.2% thinking it was poor (compared with 1.6% at first impression). Again the most prominent comments made about it were that the leaflet was funny (44.8%) and informative (34.5%) compared to figures in the original assessment of 41.2% and 22.0% respectively.

Of equal importance is the delayed impact on young people's perceptions on likelihood of using drugs, with the follow-up yielding a decrease in those who thought it would reduce the likelihood of their using drugs from 45.6% in the immediate evaluation to 35% at follow-up. On the other hand there was a slight increase in the number of young people who felt that it had changed what they thought about drugs from 37.7% immediately after reading the leaflet to 39.6% at the follow-up assessment. Thus, the young people regarded it as something worth retaining, in spite of its dull photocopied presentation, and that it was entertaining, informative and had some impact on the young people's attitudes to drugs.

Finally, the knowledge test based on the issues raised in the initial survey was repeated in the follow-up questionnaire as a means of assessing the impact of specific aspects of the leaflet over time yielding the following total scores out of a possible 13:

Table 11: Number of correct responses in original survey and follow-up:

Number of correct items	Initial survey	Follow-up
0 - 1	8 (2.3%)	9 (4.1%)
2 - 3	20 (5.6%)	20 (9.1%)
4 - 5	53 (14.6%)	35 (15.9%)
6 - 7	112 (31.0%)	56 (25.4%)
8 - 9	91 (25.2%)	61 (27.7%)
10 - 13	78 (21.6%)	39 (17.7%)

This represents a mean decrease in number of correct responses from 7.3 at the time of the initial survey to 6.9 at the time of the follow-up, which is not statistically significant. Although the young people did not consult the leaflet when they first completed the questionnaire, they had just read it. All the answers were contained in the leaflet, whereas at second assessment point, they would only have recently seen the material, had they chosen to read it in their own time. Thus, whether this consistency in number of correct responses represents a high degree of retention or reading the leaflet in the interim period, it still represents a success for the brochure which appears, in some form, to have remained salient for a number of the young people involved. At this point the number of drugs experienced was also assessed but, as indicated in the table below, there does not appear to be any marked difference in the number of substances that have been used by the young people in the follow-up sample.

Table 12: Number of drugs reported as having been used at initial evaluation and follow-up:

Number of substances	Initial survey	Follow-up
0	3.7%	6.1%
1	26.5%	23.4%
2	22.5%	27.3%
3	20.4%	19.5%
4	9.5%	7.8%
5	5.3%	3.9%
6 or more	11.7	11.6%

As can be seen from the above table there do not appear to be any marked differences in the number of drugs that are reported as having been tried by the respondents to the follow-up from those reported by the young people who completed the original questionnaire.

Discussion

(1) Methodological Assessment

This study should be seen as an attempt to address two main issues - the first is a research methodology question about the ways in which data should be gathered, and an investigation of the problems associated with traditional paper and pencil tasks. The second assesses the ways the participant is characterised and categorised in substance misuse research. The reason for emphasising the mixed design of each of the studies in this thesis is an attempt to increase the understanding of data collection methods on research outcome. It is only by examining the relationship between research and participant, delineated by the experimental design and procedure, that

biasing effects of traditional research methods may come to light. The general emphasis is therefore placed on the ways in which the interaction is established (whether by the presumed relationship of participant to investigator or by the format the inquiry takes). This evidence can then act as a means of assessing the efficacy of interventions in the areas of drug assessment and policy.

In this case the questions concern the relationship between drug awareness, drug attitudes and drug education in young people. This was initiated by the original Fast Forward project in which questionnaires were interpreted in the context of group discussions, allowing the evaluation to adopt a similarly dynamic role. The first area, then, to consider is the replication of the original empirical investigation, assessing the contextual dynamics of the research interaction. This represents the main point at which the evaluation was able to combine an analysis of Fast Forward's work with an examination of the dynamics surrounding the issue of how to ask young people about drugs and drug education.

The first point to make about the use of both a questionnaire and an interview is the direct comparison of the number of drugs that are reported as having been tried in each of the contexts. More young people report using no drugs in the interview (35% in the interview compared to 23.4% in the questionnaire). Similarly, while none of the young people report using 5 substances or more in the interview, 18 (23.6%) report doing so in the questionnaire, resulting in an overall disparity in the mean number of drugs reported ($p < 0.001$). This may well reflect the salience of the cues rather than concerns about disclosure (Davies and Best, 1996), as there were candid

reports of drug activity. One participant, when asked how they funded their drug use replied, "From my mum, I steal it, I sell my stuff and from my pocket money". The point is that one categorises and lists while the other retains the element of social accounting and narrative.

This does not mean that one is correct while the other is wrong, but rather reflects the different demand characteristics of two different data collection methods. The most obvious determinant of this is the increased cue for specific substance reporting in a questionnaire, while conversational dynamics may shift topics or emphasis in a manner far more consistent with the local dynamics of a specific interaction. A second explanation for this may be the perceived anonymity of the questionnaire context, in which the young person may feel less judged about their drug use than in a face to face encounter with a stranger, particularly when this stranger is holding a tape recorder.

It may also be the case that the face-to-face encounter reduces exaggerated reporting, particularly if the interviewer is perceived as being a knowledgeable peer. However, the critical point is that the results demonstrate that different methods produce different reporting, most easily assessed in numbers of drugs used, indicative of different response dynamics, irrespective of their underlying cause. For whatever reason, the data provided indicate that young people are sensitive to the context of the question and do not access some immutable reality. This further challenges the naïve assumption that responses are either 'true' or 'false', indicating that young people,

like adults, construct their responses partly as a result of the question and partly as a consequence of their interpretation of the context.

While the lack of interpersonal restraints associated with anonymous completion of a questionnaire may lead to both under-reporting and over-reporting, varying on an individual basis, another problem with this type of questionnaire item relates to the ways drugs are categorised. Thus, while painkillers and tranquillisers can be abused, many young people will have used both of these drugs medicinally, while other drugs would not be reported because they have only been taken on a one-off basis or because they do not fall within the young person's conception of "drugs". What this implies is that while an interview may yield more of the dynamics of drug activity, a questionnaire may misrepresent by over-literalising as well as over-reporting levels of substance activity. In contrast, the unstructured method allows the interviewee greater ownership as they interpret 'meaning' and 'relevance' in addition to demand characteristics. It is interesting that under-reporting is often regarded as the norm in questionnaire analyses, yet the compensating effect of over-reporting is rarely considered. Furthermore, the reliability of reporting may be substance specific, as young people may employ differing thresholds according to their perceptions of the social acceptability of certain patterns of drug use.

The conclusion here is that the reporting of substance activity is a complex affair whose veridicality cannot be assumed or measured according to logical positivist principles. The use of a range of data collection methods may help to uncover some of the dynamics under-pinning drug reporting, although it cannot be assumed to

automatically improve the accuracy of this reporting. However, the key to improving the quality and validity of research, particularly that which uses a questionnaire design, may be attempting to find ways of understanding the contextual dynamics of the completion of the questionnaire. The high correlation between the number of drugs reported in the questionnaire and the interview implies that responses are not arbitrary. However, there is a danger of over-emphasising the role of self-reports of substance activity which, while of importance, must be considered in the wider context of what substance activity means. Thus, the more open forms of investigation – like unstructured interviews – may provoke an experiential reality that is less accessible to closed methods and inconsistent with objective measures like urine and hair testing (see chapter 3).

Thus the association between higher levels of drug reporting and negative attitudes towards drug education in both interview and the questionnaire may be informative in this regard. In contrast, there is a positive association between the number of drugs used and their attitudes towards drugs. This implies that the attitudes expressed by young people are neither disinterested nor arbitrary, rather they constitute a structured representation of the young person's own experiences. Thus, while it is logically consistent that the young person who takes drugs will wish to avoid cognitive dissonance by expressing positive attitudes about drug taking, the converse may be true for the abstainer. What this may suggest is that the attempt to access attitudes on drug use may be predictive of the young person's substance using experiences. This implies that reporting of substance activity is influenced not only by the number of drugs actually used, but by perceptions of the acceptability of drug use. Yet, these

factors also contribute to the young person's decision to take drugs or not, and it is here that both the educator and the researcher's responsibility lies.

The relationship between substance use and attitudes to drug education may be of greater concern to educators, in that drug education may have greatest impact among those who are unlikely to use drugs, a risk that would be compounded by traditional tick-box evaluations. Thus, if drug education is conducted on groups whose substance use is not high, and drug education appeals to abstainers more than users, then the positive evaluation of a drugs education package is contingent on a majority of non-users in the cohort. This may be contingent on the continued perception that drug education attempts to persuade in favour of abstinence and so, for cognitive consistency, those who use drugs and have this perception of drug education will be negative about drug education. The point is that it is not the accuracy of the young people's perception that drug education is abstention oriented, but the fact that such a perception may exist. From a harm reduction perspective, the target group for education are those who currently use, yet if this is the group who are most negatively disposed to drug education in schools, then the efficacy of drug education is considerably reduced. It is not sufficient that drug education packages serve only to support the belief structures of those who were unlikely to use illicit drugs in the first place. From a drug educator's perspective, it is not satisfactory to retain abstinence among those who have no drug experience while ignoring the group already using, as lost to the aims of drug education.

However, neither of these relationships is simple and there are a number of intervening factors that are likely to shape the type of reports made by individuals. As was mentioned in the previous chapter, this is not a "true-false" dichotomy, rather it reflects a complex interplay of demand characteristics of the research situation and the social context in which the research occurs. Thus, the extent to which positive drug attitudes were expressed is also a consequence of age (younger participants expressed less positive drug attitudes than did older participants) and gender (more positive attitudes were expressed by males than by females). The gender issue is a particularly interesting one in the light of no differences in drug use by sex, as this may imply a differing set of social dynamics where it is more acceptable to present positive drug views for males. With regard to age, a cynical perspective may imply that younger children, with less experience and fewer personal encounters with drugs are more likely to uncritically accept the negative perception of drugs expressed in the media and in abstinence-oriented drug education. However, this perception may dissipate with increasing age, increasing the likelihood of drug-related encounters.

The result that is perhaps most important from a methodological standpoint is that participants who completed the questionnaire before being interviewed, expressed significantly more negative attitudes towards drugs in the interview than those who had completed the interview first. What this may imply is that the use of a fixed choice schedule may cue negative expectations about substance use in young people and may act as a trigger to a negative style of responding. The issue here again is that, in response to questionnaire items, individuals do not possess clear and exact

"true" responses, but rather the response is a consequence of the demand characteristics and context of the inquiry.

What may be happening is that the questionnaire serves to crystallise and formalise what may be ambivalent feelings and so polarise response sets among respondents who want to appear consistent. Although one may debate the aetiology of such an effect, this result acts as further evidence that responses to questions of this nature are mediated by the methodologies involved in their presentation. Thus the answer to questions asked can never be either true or false in any absolute sense as the response cannot escape the mediating effect of the question that framed and contextualised it. This does not imply that such questions should not be asked, but rather that the responses should be viewed as being more complex, sophisticated and contingent than is currently the case. It is only by characterising the participant as an active player making sense of the encounter (see Chapter 3) that categorical responses can be imbued with relevance and meaning.

It should be borne in mind that, while the evaluation attempted to assess methodological issues, no attempt was made to bias items in the questionnaire to cue negative attitudes towards drugs, yet this appears to have occurred. In one sense the most significant conclusion to draw from this finding is that authorial attempts at impartiality and "objective" framing of questions do not in themselves constitute a guarantee that this will be a perception shared by respondents. Thus, while one possible explanation is that young people associate drug education with the expectation of negative framing for drugs, this is a disincentive to express positive

drug attitudes and perceptions. The positivity of drug attitudes expressed by young people are variable, and variable in subtle ways. While this is not a condemnation of either questionnaires or interviews as methods of assessing young people, it would suggest that researchers adopt a far more critical perspective concerning the methods they employ.

Another conclusion that follows from the sensitivity of responses to methods, involves the implications for the characterisation of the participant group. The fact that such variations arise should be seen as indicative of the interpretive powers of the young people who, in the course of the encounter, make sense of the situation they find themselves in and respond accordingly. The current investigation has attempted to use a mixed methodological approach as a recognition of the fact that the attempt to capture self-reports as if they were inevitable and unavoidable productions is problematic. The problem is that attitudes and beliefs do not have a structure that is so simplistically represented and because it is only by involving the participant in an activity that makes sense for them that meaningful social results can be attained. Reports of drug prevalence make no sense out of this context (see Chapter 6).

Thus in the correlation results reported in Table 5, it should not be surprising that individuals who express positive attitudes to drugs are also those who report the greatest levels of substance activity. What is perhaps more surprising is that these effects are mediated also by the order of presentation and the context. What appears to be happening here is that if the interview is completed first and the individual expresses positive drug attitudes here they are more likely then to justify this by

reporting higher levels of drug activity, a report that does not happen in reverse. A plausible explanation for this relationship not occurring with the reverse order of presentation is that if the questionnaire is first, then there has been no obvious interpersonal cue for reporting style in the interview. On the other hand, if the interview is first, then the individual has a salient, socially legitimated agenda that acts as a cue in the questionnaire. However, the key issue is not whether this specific explanation is accurate, but that interpretive dynamics influence responses in this context in subtle yet powerful ways. This has considerable salience for the impact of group discussions or question and answer sessions on the self-reported substance use of young people.

Similarly, for the four context effects that were found, total reported drug use in the interview was found to be associated with both positive drug attitudes in the formal context and with the levels of drug knowledge demonstrated in the informal context. Similarly, in the informal context only, there is a positive association between the total drug use reported in the questionnaire and the attitudes to drug education expressed in the interview. While there are a number of ways in which these differences may be explained, what is important is that the manipulation of context creates different response dynamics for the participants. The task here is not to speculate as to the specific causes of these individual effects, which are not easily explained or tested, but to make overall strategic points about the contextual variations that may influence the style of responses.

The effects of formality are unlikely to be as clear-cut as order effects as the perceived formality of the interviewer rests on the recognition and interpretation of social cues by the young people participating. The problem of interpreting these findings is confounded by the fact that the same individuals were used in both conditions and, as the young people encountered an interviewer only once, it may be that this particular experimental manipulation was not salient. However, it is interesting to note that the only significant result involving the formal condition is the association between drug use and drug attitudes. What may be occurring here is that this response is based on the need for cognitive consistency, an impression management more salient if the young person feels that they are being judged. The only result from this table that offers a plausible explanation is the association between drug reporting and attitudes to drug education that occurred in the informal setting alone. Here, it may have been the case that those who reported drug use feel comfortable disparaging drug education in what they perceive to be the less threatening environment.

Exactly the same issue arises in attempting to interpret the findings presented in Table 6 in which the interactions of at least two of the experimental manipulations are examined. However, the interpretation of these results is made easier by the focus on levels of reported drug use. Thus, when the questionnaires are presented first, more people in the informal context report no drug use in the questionnaire than in the formal context, but not when the interviews are conducted first. This implies that the apparent inconsistency of formality, with an informal style but a formal instrument, may be confusing. It may disrupt the young people's expectations and may make

them less likely to report substance use. An important conclusion about the use of questionnaires may be that they are perceived as formal instruments, so their presentation in an informal manner may arouse the suspicions of the young people who may then become more guarded in their responses. This would imply that the researcher should be consistent - if they are to use an informal approach then a questionnaire may be inappropriate, but that if they use a formal style this may be more suitable than an unstructured interview.

The last part of the methodological assessment concerns differences in substance reporting and attitudes in the original study and the evaluation. The most salient difference being in the higher levels of substance activity reported in the follow-up assessment than in the original Fast Forward data. With the exception of cannabis (with 16.4% more reported having used in the evaluation than in the original study), differences in reporting levels for the main drugs used by young people are between 5 and 10%, with the order remaining consistent. While the samples overlap but are not identical, there are likely to be two main methodological artifacts of using the same sample divided by a time period of up to one year. The first, and more obvious, is that the young people have had significantly more time in which to experiment with drugs by the time of the second investigation. The second effect of the test-retest approach is that suspicions about reporting an illicit activity are less likely to exist for a group who have seen that the reporting of substance activity has not been disclosed or punished. A final possibility is that repeated exposure to this type of research leads to an ease and familiarity which may have made both the discussion of substance activity and the actual use of the substances less socially unacceptable. This is not to

suggest that participation in such a project encourages substance activity. However, an education package that emphasises a value free approach to substances may have removed some of the taboos around substance activity and its discussion yielding higher levels of report at the second encounter.

This may also explain the marked increase in the positive reporting of drug attitudes to one of the items in the drug attitude evaluation but cannot explain the strong acquiescence set in which none of the young people record disagreement with any of the three attitudinal items. For this outcome no obvious explanation can be offered other than the responses of young people to questions of this sort are neither predictable nor simplistic. The final comment to make about substance reporting is that, in the current study, this has proved to be a useful marker for comparison with research methods and reported attitudes, but cannot be taken as indicative of problem use or dependence (see Chapter 6).

(2) Evaluating "Bolt Ya Radge"

While emphasis was placed on the methodological component of the investigation concerning social dynamics inherent in researching substance activity, the leaflet produced by the Fast Forward peer research study merits some comment. The approach employed a participative style that provoked positive comments from participants, immediately and two weeks after initial presentation. This may indicate that the leaflet has successfully targeted and involved its audience. As with the research project, the Fast Forward initiative represents a means of engaging young

people in this type of informed discussion about substances without appearing pompous or detached from the range of drug-related encounters they are likely to have. The efficacy of the methodological study has relied on the reflexive and participative approach employed by Fast Forward in their original work.

This is emphasised by the retention of much of the information contained in the brochure over the two-week time lapse between the original distribution of the leaflet and second assessment. It is also supported by the accuracy with which the young people could state where the leaflet was and what stories it contained. This represents a vindication for an action approach in which the needs of young people are prioritised and through which they are permitted a stake both in the "Bolt Ya Radge" production and in the processes central to the drug education process. The key may be to ensure that the attempt to inform young people about illicit substances loses its curricular and educational quality and that it steps beyond the classroom to meet the issues that arise in situations and contexts encountered in daily life. Thus, that many young people reported on both occasions that the leaflet was both funny and informative, is a challenge to the ways in which information should be conveyed to ensure that it is assimilated and accepted.

From the perspective of the evaluation, the research project derived a similar conclusion - young people must be engaged in the process of researching adolescent substance activity for their responses to be viable and meaningful. It is not only the case that simply enquiring about prevalence and attitude is insufficient, but it is also likely to be misleading without an attempt to understand the social context in which

substance use occurs. To complete a questionnaire about substance use is not a disinterested nor objective task for a young person, concerned about censure as well as the social dynamics associated with either reporting substance activity or abstinence as they are likely to be. Thus, while it is always tempting to discard differences in reporting of prevalence of substance activity as either artifactual or as reflecting a sampling bias, it is perhaps more useful to think of this area of responding as being socially mediated. This is a consequence of the interpersonal dynamics of the research interaction and the demand characteristics of the interview or questionnaire schedule. Thus, the lower levels of reporting of drug use among the sample involved in the evaluation may reflect its perceived irrelevance to the task of commenting on the leaflet. So the young people's failure to engage in the task would then reflect their own attempts at agenda setting when they may think there is something more interesting to do.

The conclusion here is that reporting of substance activity, attitudes and awareness cannot be regarded as simple arithmetical indices reflective of universal states that the young people can choose to either report accurately or inaccurately. Rather, they are socially mediated constructions whose salience and meaning is negotiated in the course of the research interaction as a consequence of a wide range of social agendas. While the current research has attempted to examine the mechanisms that underpin some of these contextual influences on reporting in a systematic manner it may be more important to attend to the ethos of this type of research rather than the specifics of the conclusions. As with the previous study, the objective was to make sense of the

way people respond when they are asked questions about drug activities and attitudes by researchers, a theme that will be further explored in Chapter 6.

Conclusion

The investigation was an evaluation that continued the participative theme of the original peer research project conducted by Fast Forward. This was done by incorporating their questionnaire in the research protocol, by utilising similar peer researchers, by contacting as many of the original participants as could be contacted and by working with the Fast Forward team on the evaluation of "Bolt Ya Radge". This was done not only to increase the validity of the research but also to enhance the participative quality of the investigation. That such importance was accorded this reflects the researchers' belief that for drug research and education to progress meaningfully it is necessary to involve and engage young people at every stage of the applied procedure.

The success of the Fast Forward peer research project and the evaluation have relied on trusting the young people to perform the role of educators in an area where the only relevant forms of drug education are those that are likely to impact on the drug-related encounters they will have. The method employed in the project reflected the resources available and the context in which it was carried out. As a consequence of the peer-based strategy Fast Forward used, the participative approach (in which qualitative methods could be implemented alongside quantitative ones) was applicable

as a means of attempting to further our understanding of the dynamics of a research encounter that relates to substance use.

From the evaluation perspective, the project presented the opportunity to examine research methodology in a systematic and measurable, yet reflective way. Thus the impact of both the context (in terms of the formality of the interviewers) and style of the encounters (interviews and questionnaires randomised in order) support the findings from previous chapters (3 and 4) that a more critical perspective be adopted to designing research projects of this sort. This demands an agenda which attempts to access meaning and value systems that have personal relevance to the young people and which accounts for their active role in making sense of the research procedure. It is not surprising therefore that the results demonstrate that not only are young people's attitudinal reports influenced by their own behaviours, but that so are their response to what would traditionally be referred to as knowledge or perception issues. This is because people make sense of their own actions and do so in ways that are most readily understood in an interpersonal format.

The overall conclusion of this investigation is that the most profitable route for drug researchers and educators is to adopt a more participative perspective in which young people are involved at each stage of what is a complex process. This represents a duty of the researcher to empower and engage the young people and to ensure that their views are not distorted by simplistic research methods which lead to misleading representations of a complex research issue and a thoughtful and interested participant group.

Chapter 6 - Investigating substance activity in young people

This chapter continues the theme of examining methodological issues in assessing substance-related behaviour within a paradigm of participative and qualitative investigation. This study is conducted as a piece of action research in which significant practical issues helped to shape its conception and its presentation. To this extent, the major theoretical development involved concerns the use of a qualitative and reflective procedure for a study with immediate ramifications for its participants and for the management of drug issues in the area in which the study was carried out. Although part of the project involves a type of prevalence research the authors, and those who funded the investigation, were always conscious of the importance of framing this type of information in its context. This context is one in which the role of drug use for young people could be explored and their understandings and meanings for substance activity could be expressed.

The investigation was funded by the Greater Easterhouse Initiative in Glasgow and managed through the local drugs agency, the Easterhouse Drugs Initiative. Greater Easterhouse is a large post-war housing estate in the South-East area of Glasgow which has experienced a wide range of social difficulties in recent years, one of which has been high levels of substance activity (particularly with regard to the misuse of opiates) among the adult population. There have also been wide-ranging concerns expressed about perceived substance misuse among adolescents although these concerns and the reports that informed them have been largely anecdotal and imprecise. Thus, the remit for the current investigation was primarily to assess the

extent and profiling of substance activity among 12 to 19 year olds in the Greater Easterhouse area. This study emphasises the importance of local factors (see Chapter 2) in explanation, as Easterhouse has a local culture and value system that defies generalisation (even to other parts of Glasgow).

However, the funders were also concerned about the type of drug-related problems that young people in the area were encountering and the strategies they were using to overcome them. This reflected a failure on the part of the drugs agency to engage young people, and the hope that if drug issues could be examined proactively, then many of the problems encountered by adults in the area could be avoided. It was felt that if a research project could be developed which was sensitive enough to detect differences in substance use according to gender, age and location within the area then a more targeted and appropriate form of service could be delivered. The key to this would be that drug services could be developed that were compatible with the needs of young people.

This is the first concession to a participative approach to service delivery, in that the purchasers were concerned to assess what kind of education or intervention the young people would actually want. This is a critical development in that it avoids the assumption that the model used with adult substance users can simply be amended for young people. The specific targeting of drug services for young people has been complicated by the fact that few adolescent users exhibit signs of physical dependence (Bukstein, 1995) and so the medical model may not always be the most appropriate

one. In other words, for a group who are unlikely to fit the 'addicted' role, the question of what type of service is most appropriate is a complex one.

Furthermore the investigation was also interested in examining the ways in which young people could develop a voice within the field of professionals involved in drug education and intervention. This would allow their interests and needs to be directly serviced according to their perceptions and requirements of what is valuable and useful for them. Thus, although the original project reported here is only a six-month pilot research investigation, its ultimate objective was to facilitate action and co-operation from existing professional bodies in the area and from the young people who ultimately have the greatest stake in service provision and development. Thus within the context of a prevalence investigation, the study developed a perspective and context for data collection in which the views of the participants were central. This is a recognition that research is located in a social and political context and it is through this recognition that such an applied piece of work can have focus and relevance (see Chapter 2).

This is, in part, a recognition of the problem encountered in the previous chapter where discrepancies in substance activity in samples of young people are difficult to attribute. Variations that occur may be explained in terms of sampling biases, the demand characteristics of the research context, the framing of the target questions, and the individual, social and political sequelae of the responses for those who participate (see Chapter 5). The type of reporting of prevalence data that is employed must be consistent with the social context of drug explanation and it is with this

proviso that the current investigation attempted to analyse substance misuse. This was undertaken in the context of young people's understanding, as well as a formalised context of the drug interventions and education provided locally.

Prevalence of adolescent substance use

The national context of substance activity is described by Parker, Measham and Aldridge (1995) as one in which the number of young people found guilty of drug related offences has been rising for several years, and where the types of drugs being "misused have changed in such a way that while cannabis remains a key drug, many of the supply and possession charges revolve around the use of dance drugs, particularly among 17 to 20 year olds" (Parker, Measham and Aldridge, 1995). Similarly, Wright and Pearl (1995) have argued in a cross-sectional study of 14 to 15 year olds, that young people's exposure to illicit drugs has increased significantly between 1969 and 1994. Along the same lines, Balding (1994) has argued that cannabis use has trebled among 15 to 16 year-olds between 1989 and 1993 for the leaf preparation of cannabis, and there has also been a significant increase in the use of cannabis resin. Balding has also argued that half of all 15 to 16 year old boys in the United Kingdom may have experimented with cannabis and that over 80% of all young people in this age group will report that they know at least one other young person that takes drugs.

In a study carried out as part of the National Evaluation of Drug Education in Scotland, Coggans et al (1991) assessed substance use in a sample of second to fourth year secondary school pupils (aged from around 13 to 16 years). They found that the

reports for at least having tried each substance on one occasion were 74% for alcohol, 36% for tobacco, 15% for cannabis, 12% for solvents, 7% for magic mushrooms, 6% for temazepam, 6% for LSD and 4% for amphetamines. In contrast, less than 1% of the sample claimed to have tried a class A drug, such as heroin or cocaine.

However, there would appear to be considerable variation in the prevalence reported in studies of this sort. For example, Swadi (1988) reported that cannabis has been used by approximately 11% of 11 to 16 year olds, compared with 15% of 13 to 16 year olds by Coggans et al (op cit) and 7% of 15 to 16 year olds by Plant, Peck and Samuels (1985). In a similar finding, Parker, Measham and Aldridge (op cit) report in a review of the literature that the prevalence of illicit drug use among 15 to 20 year olds is between 10 and 35% in national samples and between 5 and 50% in localised samples. These enormous variations may reflect a range of methodological artifacts, sampling differences (in particular, the age ranges involved) and response sets. However, it is nonetheless problematic for policy makers in this area when they are faced with marked inconsistencies in the levels of adolescent substance activity according to the particular study they examine.

This difficulty is compounded by the debate among researchers and academics about how this information should be interpreted with, for example, Bukstein (1995) arguing that the extent and frequency of young people's drug use is grossly over stated and that few young people experience what he refers to as the "gateway" effect of drugs. This concept is an important one as it refers to the potentiating effect of recreational use of "soft" drugs for more problematic and dangerous substance use,

although this concept has been hotly debated. In many ways this touches on one of the key issues that surround the risk associated with adolescent use in that, for many parents, teachers and drug professionals, it is not only the risks associated with the immediate behaviour that is regarded as a cause for concern. It is the possibility that there is a correspondence between substance use or experimentation as an adolescent, and substance abuse or addiction in adulthood, along with many of the social and lifestyle problems that are often assumed to accompany a drug-centred life routine.

Again, the literature here offers no consensus with authors such as Coffield and Gofton (1994) arguing that soft drug use poses no problem to young people many of whom can control their own use, and that it is more likely to be alcohol or tobacco that cause problems for young people. This claim is supported by Hirst and McCamley-Finney (1994) who suggest that young people have a matter of fact approach to drug use, which is not a central part of many of their lives and that they find ways of coping with any difficulties they may encounter as they arise. This would be consistent with Stages 1 and 2 of the addiction model presented in Chapter 3 of this thesis.

However, this presents a radically different picture to that presented by the studies of Robins and McEvoy (1990) and Robins and Przybeck (1985). They argue that early alcohol use and early illicit drug use, particularly before the age of 15 years, predicts progression to adult drug use, especially at more severe levels. Along similar lines, Mill and Noyes (1984) advocate a type of gateway argument in which they claim that

adolescent substance use starts a career in which increasing numbers of drugs are used by young people.

At this point the argument is complicated by the extent to which prevalence can be regarded as an indicator of problem use in young people, a relationship that is not entirely clear. However, the Advisory Council on the Misuse of Drugs (ACMD) argue in the 1994 "Tackling Drugs Together" paper that not only do 42% of 16 to 19 year olds admit to having taken drugs at some point they also argue that drug misuse among young people is widespread and that it can lead to serious health problems, although quantifiable data are not reported in support of the second claim. The problem is that studies which suggest relationships between adolescent drug use and adult criminality or addiction are predominantly retrospective and may be compromised by their methods of data collection.

The problem is compounded by the reluctance of young people to access drug services and the difficulty of fitting the substance activities of young people within the (psychiatric) classifications for adult misuse or abuse (Bukstein, op cit). This issue is also complicated by methodological concerns and while Oetting and Beauvais (1990) argue that adolescent self-reports of substance use are both reliable and valid, this is not a view that is universally shared. Winters (1990) has argued that certain populations, especially extremely antisocial youth, have a widespread tendency to "fake good" in their responding, more so than would be expected from even a clinical sample. Again, however, there is insufficient evidence to draw clear conclusions about the accuracy of self-reports in this area, although it seems likely that this will be

influenced by the specific research methodology employed and the perceptions of participants about what will be done with the responses.

This emphasises the role performed by the young people's perceptions of drug use and their interpretations of the problems that are associated with it in delineating not only what is recorded as problematic use but also the ways in which prevalence is recorded. This is consistent with Davies and Coggans' (1991) claim that adolescent addiction and dependence pose far less of a problem than does the social context of adolescent drug use, by which they are referring to the sanctions and prohibitions that are incurred by young people whose substance activity is detected. The reliance of research on the paper and pencil format is challenged by Davies (1996) who argues that self-report is "likely to reflect the context in which the account is obtained and the motives of the person involved rather than any direct scientific account of fact or truth" (Davies, 1996). The critical point here is that reports of substance use are never neutral or disinterested, and so it is important to account for the context in which the reports are taken and the social dynamics of the research encounter in attempting to interpret or explain the results obtained.

However, the context refers also to the motives and agendas of the researchers who are attempting to gather information, a context which is most obviously manifested in the role performed by the research with regard to drug education or service intervention. The problems with attempts at intervention are typified by the current study in which drug agencies are unable to shake off the image of refuges for intravenous opiate users and as prescribing services. As a consequence, they have

difficulties in providing services that match the needs of young people who, as has been previously pointed out, are unlikely to perceive their own drug use as problematic. Therefore, they are unlikely to feel the need to engage any service that attempts to deal with addiction or dependence. Furthermore, if the model outlined in Chapter 3 is accurate, there are considerable risks in attempting to bring young users into drug treatment, as this may facilitate a shift from non-problematic drug explanation to explanations for drug use that are based on addiction.

Drug education and it effectiveness

In contrast, with regard to drug education, there is a well-established literature that critically examines the efficacy of drug education in the classroom context. Most famously, Schaps et al (1981) reviewed in excess of 100 drug education programmes and found that 74 had no effect on average self reported drug use, intentions to use drugs or attitudes towards drugs. While 45 of the programmes had a positive (reducing) effect on drug taking, 7 actually appeared to have a detrimental effect on this behaviour. Similarly, Kinder, Pape and Walfish (1980) claimed that most of the drug education programmes they examined were ineffective. A further problem arises from the inadequate evaluation of drug education packages, a point emphasised in O'Connor's argument that "despite the fact that drugs education has been a compulsory element of the science National Curriculum since 1988, little is known about the overall quantity and quality of provision" (O'Connor, 1995).

This perceived failure, however, may be a consequence of both unrealistic objectives and the methods and philosophy used in a number of the existing projects. For

instance, a Health Advisory Service (1996) publication has claimed that much of this failure can be attributed to programmes that aim for total prevention and complete abstinence. O'Connor (op cit) has also argued that the use of scare tactics has proved to be an ineffective approach while Davies and Coggans (op cit) have argued that the most effective approaches have been those that have emphasised non-prescriptive, non-moralising and factually accurate approaches. Finally, Coggans and Watson (1995) have suggested that multi-media and multi-strand approaches are more likely to be effective than those that rely exclusively on one method. However, to date, no method has been devised that adequately provides accessible and useful information that is credible to young people.

It is this context that creates a compounded difficulty for applied research projects such as the one undertaken in Greater Easterhouse. Inaccurate and contentious literature and methods for estimating prevalence are compounded by uncertainty over the most appropriate intervention and education strategies. As in Easterhouse, the public perception appears to be one of widespread concern but no consistent or clear indication of the most suitable means of addressing this concern. For this reason, the current investigation attempts to address both of these issues by shifting the rationale and the methodology of prevalence research to increase its participative and qualitative components and to examine the use of alternative strategies for data collection with an adolescent target audience. Again, the study aims to address methodological issues while undertaking applied research in a local context.

Peer-based approaches

The harm reduction approach to reducing drug-related problems has involved attempts at community access of social networks to achieve group-mediated changes in risk behaviour (Stimson et al, 1994). One of the few UK projects that has used this approach with adult drug users is Klee and Reid's (1995) attempt to employ peer leaders as part of a strategy to prevent amphetamine users from moving to more problematic forms of use. As Rhodes and Stimson (1998) argue, peer models make two assumptions – first, that peers make effective advocates for change and, second, that by changing group norms it is possible to influence individual substance behaviour.

Tobler (1992) has argued that peer education is a particularly effective approach to drug education and reports that it shows a definite superiority in a range of outcome measures. Klepp et al (1986) have argued that this is because peer educators serve as potent role models through their demonstration of non-use, while Carr et al (1994) claim that young people can more profitably discuss drug issues with people of their own age than with adults. However, Carr et al also warn that 'peer' is the new in-word within youth services and should not be regarded as a panacea in what remains an inordinately complex task.

In this context, the peer approach employed in the Fast Forward evaluation has potential benefit. The method appropriate to both of the adolescent peer studies in this thesis mirrored YAP's aim of "take people from the street, train them up and return them to the street" (Shiner and Newburn, 1996). Again, the method was influenced

by the definition of peer used by both Fast Forward and YAP, in which peer status is based more on credibility, experience and status than on chronological age.

Peer participative research in an applied context

It is also important to establish the local context of adult substance activity as the backdrop against which the current investigation exists, as this constitutes many of the parameters and definitions in terms of which the perceptions and activities of the young people must be set. Firstly, Glasgow has a long-established problem drug culture (Frischer et al, 1993), a culture particularly strong in the post-war housing estates built on its periphery, of which Greater Easterhouse is one. Glasgow's drug situation has been well documented (Hammersley, Lavelle and Forsyth, 1990; Sakol, Stark and Sykes, 1989) as one in which the use of "downers" predominates - in addition to opiates, benzodiazepines such as temazepam are widely used and often injected, while the misuse of opiate agonist-antagonists such as dihydrocodeine and buprenorphine is also common. However, in contrast to Edinburgh, Glasgow has not experienced high rates of HIV infection (Stimson, 1995) with a study by McKeganey (1990) suggesting that risk behaviours in the city have markedly reduced since the late 1980's.

However, Greater Easterhouse is an area in which the local community drugs agency has encountered widespread misuse of opiates among the adult population but has experienced only anecdotal reports of the problems associated with adolescent substance misuse. While these reports have tended to emphasise both problem behaviours and high prevalence rates, this has not been reflected in the number of

young people approaching drug services for intervention or assistance. While a number of suggestions have been advanced for this, the goal of the present investigation is to utilise a range of participative research styles in accessing young people to address three primary questions.

The first of these concerns the extent and patterns of substance activity in the target group of 12 to 19 year-olds throughout the area, along with variations shaped by age and gender. The second relates to the perceptions of substance difficulty young people encounter - if they experience certain substance encounters as problematic how do they go about resolving this and to what extent does drug education and formal service provision have a role to play in this. Thirdly, the project is also prospective in that it is geared to assessing the needs of young people with regard to illicit substances so that the drugs agency may attempt to provide the most appropriate form of service for the needs of the young people in the area. However, for all of these objectives, the ethos of the research is participative with the views of the young people valued by involving the young people in the process of investigation. This last aspect of the investigation has been done by using what may loosely be termed a "peer research" approach (Best, Mortimer and Davies, 1995) in which young people were involved as both researchers and participants. This is an attempt to increase the validity and credibility of the project for the young people who were the focus of the investigation by using peer research methods alongside the peer intervention methods discussed previously.

Method

Design. The study design was dominated by the goal of attempting to access as wide a range of young people in the investigation as possible. To achieve this a decision was made to use methods that may be less threatening than the traditional classroom based format of questionnaire assessment, although it was recognised that ultimately a questionnaire would be the only way to gather quantitative information within the time allocated for the project. As the project was of only six months duration it was critical that the researchers developed a sound working knowledge of the area and its social geography. Therefore, the initial phase of the study was designed as a research-outreach combination in which the key was the development of a process of information exchange between the researchers and the participants. The researchers themselves were selected on the basis of their involvement in previous peer-based research projects and for their enthusiasm and willingness to work in this area.

The use of three female researchers all under the age of 24 years was an attempt to replicate the equivalence of the status criterion implicit in peer based approaches (see Chapter 5). It was regarded as a critical determinant in the perceived viability of a project that attempted to reflexively engage young people that the contact points were both physically and socially accessible to the potential participants. For this reason the principal investigator was not involved in the direct participant contacts, all of which were carried out by the three peer investigators. The emphasis in the initial stage of the investigation was on creating an environment in which the young people felt at liberty to speak of their drug perceptions and experiences in a context that attempted to minimise the aspects of social judgement.

This was within a design in which the research-outreach component of the project was intended not only to provide the basis for the subsequent questionnaire but also to act as the major interpretive frame for all of the derived data. This replicates the qualitative method used in the study outlined in Chapter 4 in which the method is defined and refined as a part of the data collection process. This first phase of the study, which lasted for twenty of the 25 weeks of the study, used an outreach approach to accessing young people. Participants were recruited in youth clubs, in social clubs, in shopping centres and around the streets of the area in an attempt to equate the environment of the research encounter with one that would be familiar to the locations in which they may have drug-related encounters. This is an attempt to counteract the effects of formal contexts in developing performance anxieties and formalised demand characteristics. However, this combined with a research methodology that allowed the researchers to develop a high profile in the area so that many of the local young people would become familiar with their presence. It was hoped that this would have a positive effect on the credibility of the researchers as well as provoking interest among the young people.

The design of the interview had both a theoretical and a practical base. It was important from a practical perspective that the contacts were informal and brief enough that they did not appear incongruous or inappropriate, and that the young people did not feel that their opinions and beliefs had been invaded. From a theoretical perspective, it was important to use the interview to provide drug use and context information against which the questionnaire results could be compared. The

other objective was to allow the young people a platform on which to discuss their own understandings and meanings for substance use.

This could be done in terms of their values and beliefs about drug use and to allow them to explain their understandings of the role to be performed by schools, drug agencies and other outside bodies in prevention efforts. For this reason, the emphasis was placed on a minimal number of fixed questions around which the interviewers were instructed to explore in a manner consistent with the development of the interaction. It is important to differentiate between interview and questionnaire as the development of an interview represents a social dynamic. The needs of both participants are addressed and, for this reason, it was emphasised to the interviewers that the encounters should be seen as exchanges of information rather than as formal, spoken questionnaires. This also allowed the young people to frame their views in conversational contexts in which they were active participants and joint owners.

However, the attempt to elicit interest and involvement in the issue of drug awareness and drug services for young people was not restricted to young people. Attempts were made to involve all interested parties and professional groups with a stake in drug services or drug education in the area. One of the difficulties with an area like Greater Easterhouse is that it is in fact many separate areas with perceived identities of their own and so the attempt to develop a strategy throughout such an area involves attempting to break down local issues of territoriality. This is manifested not only in local rivalries but that is sustained and reified by community groups and services that operate in each of these small areas, of which Greater Easterhouse has eleven.

Thus, it was also the task of the researchers to attempt to gain the co-operation and participation of local community action groups, neighbourhood watch schemes and housing co-operatives. This attempt to initiate enthusiasm and participation was regarded as essential to the success of a qualitative, participative and applied piece of action research. For this reason the design of the study was such that no voices were to be excluded although the primary role was to be performed by the young people of the area. While not specified in the research contract, it is important that the management of such a study be locally vindicated and owned, so that the conclusions and recommendations are more acceptable to all local people.

For the reasons outlined above, the interview phase of the study was not only the greatest time commitment of the project, it also represented the most valuable source of information in terms of the breadth and richness of data collected. However, a traditional approach to data collection was also utilised at the end of the project both as a means of increasing the range of influence of the study and as a way of creating an immediate comparison and secondary database. This allowed the design to be a mixed methodology, with data against which both the quantifiable data of the main investigation and the contextual explanations and understandings of the interviews could be framed. For this reason it was decided that while the interview data were being analysed, the initial results should be incorporated into a questionnaire (see Appendix 5) to be distributed in a number of secondary schools and youth clubs in the area. Again it was important that this questionnaire was reasonably brief so that it was both a minimal imposition on the young people and that it did not incur the fatigue

factor that is normal when young people are asked to complete lengthy questionnaires. This questionnaire was to be distributed to 200 young people in the target age group.

Procedure. The initial weeks of the survey were occupied with the researchers attempting to make informal contacts with the representatives of all interested agencies. They also adopted a high profile by accessing and speaking to young people in locations such as shopping centres, local public parks and around the streets of the area.

If these initial contacts were received enthusiastically, the young people were asked if they would be interviewed for around five or ten minutes by the researcher either immediately or at a time convenient to them. The interview was conducted in an informal way with the interviewer taking notes if the participant was willing, supplemented on completion of the encounter with the interviewer's summation. The exchange would conclude with a discussion of the views of the young person on service needs and they would be asked if there was any information or advice that the researcher could provide for them. While the interviewers attempted to cover a number of core areas, the young people were given a say in the development of the discourse and no attempt was made to pressure them to speak about areas that they may have found threatening or unsatisfactory.

The interviewers' remit was to access as many young people, distributed across the appropriate age range and geographic locations, of both sexes as could be managed in the limited time available. For this reason, a wide range of snowballing and outreach

approaches were used, with the onus on maximum coverage rather than strict adherence to any form of formalised protocol. It was felt that a two minute encounter with a young person from which no notes or records could be taken was still of benefit to an action project one of whose goals was the initiation of interest and debate about drug issues and education among young people. No limits were placed on the interaction, as any information that was obtained was regarded as valid, constrained only by the willingness and enthusiasm of potential participants. For this reason, the interviewers were instructed that, although direct quotations were valuable where they could be obtained easily, this process should be regarded as secondary to the garnering of exchanges and information relevant to the development of a participative research outreach project.

The final stage of the process was to use the initial phase of analysis of the interview data as the basis for the development of the instrument to be used in schools and youth clubs in the final stage of the study. The decision to use a purpose-made questionnaire was based on the belief that this was most consistent with the interview stage to ensure a continuity and comparability between the two forms of data collection. As the time permitted for the entire process of instrument design, distribution, completion and analysis was only six weeks, it was felt that the most appropriate strategy was to distribute it in those schools and youth clubs that had been most supportive of the project as a whole. The questionnaire was only 3 pages in length and piloting established that it took only around 10 minutes to complete, a time period that was felt to be appropriate for this type of undertaking. As the interviews had been conducted opportunistically and anonymously, it was not possible to

establish the extent of overlap from interview to questionnaire phases of the project, although this had been one of the original project objectives. However, anecdotal reports indicated that the extent of overlap was not high.

Subjects. In total, 147 unstructured interviews were carried out with young people in the Greater Easterhouse area in the first phase of the investigation. This group consisted of 84 males and 63 females with an average age of 13.5 years and a range of between 10 and 17 years. In the second phase of the study, 200 questionnaires were successfully completed (three were wasted), 101 by males and 96 by females, with three respondents not completing the item on their gender. This group had a mean age of 14.3 years and, as with the interview phase, participants came from all parts of the Greater Easterhouse area.

Results

The first, and possibly the most important finding of the entire project, concerns the willingness and enthusiasm of young people to participate in this type of project. In contrast to the dilemma with which researchers of adult substance misuse are often faced about whether to offer financial inducements for participation, the only restriction on numbers was the time available to the interviewers in the six months the project had to run. Indeed, on several occasions, the researchers were detained at youth clubs beyond their normal closing time as they attempted to deal with the queue of young people who wished to relate their drug experiences and attitudes to an outside body, other than their school guidance teacher or parents. As one 14 year-old girl said, "Aye you hear a lot at school and on the telly and that, but you don't get a

chance to say what you think". It would be hoped that this level of commitment may not only have a beneficial effect on the accuracy of what is said as young people contribute what they want to say rather than what is required of them, it may also fulfil a participative requirement of the project. To the extent that the study had as an objective the stimulation of interest among young people this enthusiasm for participation and ownership is a vindication of both the methods employed and the overall strategy of the research.

However, in terms of the actual reporting that occurred in each of the contexts, the prevalence data for the interview and the questionnaire are presented in the table below.

Table 1: Substance activity reported in questionnaire and interview

SUBSTANCE	QUESTIONNAIRE Ever used	Currently used	INTERVIEW Ever used	Currently used
Alcohol	171 (91.9%)	121 (65.1%)	105 (71.4%)	56 (38.1%)
Inhalants	31 (16.7%)	5 (2.7%)	0	0
Cannabis	99 (53.2%)	68 (36.6%)	74 (50.3%)	45 (30.6%)
Speed	51 (27.4%)	17 (9.1%)	34 (23.1%)	13 (8.8%)
LSD	66 (35.5%)	25 (13.4%)	47 (31.9%)	24 (16.3%)
Ecstasy	41 (22.0%)	25 (13.4%)	32 (21.8%)	12 (8.2%)
Valium	21 (11.3%)	6 (3.2%)	6 (4.1%)	5 (3.4%)
Temazepam	63 (33.7%)	32 (17.2%)	46 (31.3%)	10 (6.8%)
Heroin	5 (2.7%)	3 (1.6%)	0	0
Cocaine	8 (4.3%)	3 (1.6%)	0	0

The most obvious conclusion to draw from a methodological point of view is that while absolute levels of reporting are higher in the questionnaire (replicating the findings of the Fast Forward study - see Chapter 5), the ordinal distribution is similar for the two forms of data collection. Thus, while most drugs are reported as having been tried and currently used by more people in the questionnaire, the rank ordering of drug use is remarkably robust across the two methods of data collection.

The most obvious difference is in the reporting of inhalant use, which does not occur in the interviews but is reported as having been tried by 16.7% of the questionnaire sample. It is possible that this is on the grounds that without the cue given by a tickbox in a questionnaire, the respondents may not have felt that this was relevant to a discussion on drugs. However, the main conclusions would appear to be that the use of questionnaire methods has yielded higher prevalence rates in respect of a wider range of drugs than has the interview approach. However, the failure to report solvent use in interviews may be a consequence of the question being framed as 'what drugs have you used?' In this case, the respondent has the opportunity to exclude solvents (along with alcohol and tobacco) and report on their illicit use, a categorisation not possible with the tickbox format, in which solvents were included.

The other main conclusion is that the levels of substance reporting are considerably higher than those cited in the literature (Balding, 1994; Parker, Measham and Aldridge, 1995; Miller and Plant, 1996). In addition to alcohol and cannabis, the other main drugs reported in each data collection format, would appear to be temazepam, LSD, ecstasy and amphetamines. The types of drugs reported as being used also reflect what is perceived as being locally available by the young people. Among the older groups, the reply that "I've had jellies, acid, hash, speed, but not E, it's the worst" would seem to indicate what is generally available. The most important of these findings may be the relatively high levels of reporting of temazepam use, a use that would appear to be both functional and strategic. The fact that the use of temazepam correlates significantly with the use of amphetamines ($r = 0.56$; $p <$

0.001), with the use of acid ($r = 0.71$; $p < 0.001$) and with the use of ecstasy ($r = 0.68$; $p < 0.001$), suggests that it represents a central aspect of substance use for young people who use illicit substances in the Easterhouse area. While this is not to imply that this pattern exists for all young people, there would appear to be evidence of polydrug activity among a proportion of the young people sampled.

The concern about the use of benzodiazepines is further extended when the young people were asked about how much they would use on each occasion of use, with the mean amounts reported being 93.3mg of diazepam (Valium) and 89.0 mg of temazepam, levels well in excess of the recommended therapeutic doses for adults. One 16 year old girl, from the Barlanark estate, said that she and her friends took "E, speed, beans (temazepam), acid and hash, but some of them just at the dancing. That's what's around – but there's no pressure to take them". Temazepam is perceived as a street drug that is readily available and accessible (as they cost only £1 each), a worrying fact given their associations with disinhibition and violence. This also does not account for the potential cumulative effects of combining these drugs with other illicit substances or alcohol.

With regard to the association between the use of temazepam and the use of alcohol, the first point to make is that while there are 15 young people who have drunk alcohol but not had temazepam all 63 people who have had temazepam have also experienced alcohol. Similarly, all five of those interview respondents who regard themselves as current temazepam users are also current drinkers, although this relationship does not hold in reverse. Therefore the correlation between current use of alcohol and current

use of temazepam in the questionnaire is 0.27 ($p < 0.001$), which is not as high as the correlations for temazepam with certain other illicit drugs. The reason for this is that while temazepam use is almost a perfect predictor of drinking, many young people drink who do not use temazepam, so alcohol consumption is not a good predictor of temazepam use. This last point is of particular importance as it suggests that drug use is not a gradual decline into polydrug activity, but may also be a phase of experimentation and curiosity in which preferences are explored. One 15 year-old girl reports that she regularly mixes "hash (cannabis), bevvy (alcohol) and jellies (temazepam) or speed and bevvy" but because she only does this at the weekend she does not see it as a problem.

The results would appear to support experimental and strategic use more than a decline into problematic drug use, a suggestion that is supported by the failure to uncover clear demographic patterns in the self-report of use. The only statistically significant difference in levels of reporting was in the amount of cannabis reported as being used on each occasion with young males using higher mean quantities ($t = 2.25$; $p < 0.05$). Cannabis appears to be readily available and is widely used, both in adult and adolescent populations. Indeed, the girl quoted above also says, "hash is the only one I couldn't do without, I have to have that every night".

There are only mild associations between age and number of drugs ever used ($r = 0.22$; $p < 0.05$), and between current use and age ($r = 0.20$; $p < 0.05$). The fact that, within the age range assessed, there do not appear to be substance specific differences in the pattern of use does not support a "gateway" argument. The pattern

of substance use described in the sample assessed implies a strategic pattern of use in which many of the young people are aware of the availability and effects of a wide range of the drugs that can be accessed in Greater Easterhouse.

On the other hand, the number of drugs the young people report as having been tried and the number of drugs reported as currently used vary markedly in both data formats. This suggests that some use is experimental and does not lead to regular drug activity. The regularities in patterns in both formats also suggest clear structuring of responses, albeit mediated by the format and context.

Similarly, prevalence reporting appears to be related to certain types of attitudes expressed in the questionnaires. Table 2 below outlines the mean number of drugs used by the young people who completed the questionnaire divided by median split on the basis of their agreement or disagreement with each of the attitudinal items presented to them. All of the data in the table below refers to those who completed the questionnaire and excludes those who opted for the middle - "don't know" option in the attitude items listed.

Table 2: Mean numbers of drugs currently used and having ever been tried as a function of expressed drug attitudes in the questionnaire

Item	**Response**	**Total mean current use**	**Total ever used (mean)**
Teachers know nothing about drugs	**Agree**	2.07 (n = 44)	4.09 (n = 44)
	Disagree	1.31 (n = 79) t = 2.45; p < 0.05	2.56 (n = 79) t = 3.09 p < 0.01
School is not the right place to be taught about drugs	**Agree**	2.23 (n = 39)	4.00 (n = 39)
	Disagree	1.37 (n = 120) t = 2.80 p < 0.01	2.64 (n = 120) t = 2.81 p < 0.01
If you take drugs you are a drug addict	**Agree**	0.85 (n = 20)	1.80 (n = 20)
	Disagree	1.73 t = -2.79 p < 0.05	3.23 t = - 2.17 p < 0.05
It is dangerous to take acid	**Agree**	1.31 (n = 108)	2.60 (n = 108)
	Disagree	2.04 (n = 41) t = -2.34 p < 0.01	4.07 (n = 41) t = -3.23 p < 0.01
Cannabis is good for you	**Agree**	2.33 (n = 53)	4.15 (n = 53)
	Disagree	1.19 (n = 83) t = 4.25 p < 0.001	2.35 (n = 83) t = 4.33 p < 0.001

What this table demonstrates is that there are marked differences in the attitudes of young people about drugs, these are consistent with their own drug-related experiences. For instance, those who believe that school is not the right place to be taught about drugs are also likely to report having ever used more drugs ($p < 0.01$) and that they currently use more substances on average ($p < 0.01$) than those who do believe that school is the right place to be taught about drugs. Similarly, those who agree with the statement that it is dangerous to take acid report having tried fewer drugs ($p < 0.01$) and report currently using less substances ($p < 0.01$) than those

who disagree with the statement. Finally, those who agree with the statement that cannabis is good for you report having experienced more drugs ($p < 0.001$) and currently use more drugs ($p < 0.001$) than those who disagree with this statement.

This behaviour-attitude consistency (see chapter 5) is also evident in the interviews with, for example, one 13 year-old who had only ever had alcohol, saying "acid really worries me because I've seen folk freak out on it" and that "I don't see the point because you just get full of it and fall about". This contrasts with a girl from the same youth club who regularly takes ecstasy and reports "E's are brilliant when you're dancing and its far better for you than drink". The consistency in interviews from behaviour to attitude is more readily consistent with the Stage model outlined in chapter 3 but the sense making activity is retained in a less obvious form in the questionnaire format.

There are equally strong associations between the levels of reported drug use in the questionnaire and the attitudes expressed by the young people about drug education and the most appropriate sources of advice and information available to the young people in the area. Firstly, those who report that they would definitely speak to their parents if they had a problem with drugs or alcohol report lower levels of substance activity both in terms of the number of drugs they have ever tried ($t = -2.75$; $p < 0.01$) and in terms of the number of drugs they report currently using ($t = -3.99$; $p < 0.001$), than those who would not talk with their parents.

Similarly, as indicated in the table below, the levels of drug experience reported by young people are associated with what they regard as the most appropriate sources of drug education. Those who have used higher numbers of substances ($p < 0.001$) and those who are currently using a wider range of substances ($p < 0.001$) are those who feel that school teachers are the least suitable providers of drug education, even in a classroom context. As one 14 year-old boy said, "It was alright, but I know it all, I'd heard it all before". Conversely, it would also appear that those young people who have tried the widest range of substances are more likely to feel that other young people are the most suitable providers of drug education ($p < 0.01$) although this disparity does not quite achieve statistical significance for reports of current levels of substance activity ($p < 0.06$).

Table 3: Mean number of substances recorded in the questionnaire as a function of who they regard as the most suitable sources of drug education

Educator	**Ever used** Suitable	Unsuitable	**Current use** Suitable	Unsuitable
Teacher	1.79 (n = 47)	3.33 (n = 130) t = -4.0; $p < 0.001$	0.87 (n = 47)	1.79 (n = 130) t = -4.26; $p < 0.001$
Drug worker	2.65 (n = 110)	3.36 (n = 67) ns	1.39 (n = 110)	1.81 (n = 67) ns
Ex-addict	2.99 (n = 143)	2.62 (n = 34) ns	1.54 (n = 143)	1.47 (n = 34) ns
Young people	3.78 (n = 51)	2.57 (n = 126) t = 2.92 $p < 0.01$	1.92 (n = 51)	1.40 ns
Police	2.42 (n = 43)	3.08 (n = 134) ns	1.33 (n = 43)	1.62 (n = 134) ns

In addition to asking the respondents about who they felt were the most suitable sources of information on the subject of drugs the young people were also asked what they felt were the most important areas that they needed information about. Again, the

responses that were elicited proved to be associated with the young people's self-reports of substance activity, as indicated in Table 4 below. The first point to make about these results is that in all but one of the ten comparisons shown in the table it is those with least drug experience who are most likely to want information on the following practical issues surrounding drugs. Mean reported levels of current drug use are higher among those who do not want information on long-term effects ($p < 0.05$), health risks ($p < 0.001$) or the legal situation surrounding drugs ($p < 0.01$).

Table 4: Mean drug activity by desired areas of drug information

Information area	**Ever used** Wanted	Not wanted	**Current use** Wanted	Not wanted
Long-term effects	2.80 (n = 88)	3.22 (n = 87) ns	1.34 (n = 88)	1.92 (n = 87) t = -2.24 p < 0.05
Health risks	2.48 (n =97)	3.67 (n = 78) t = -3.23 p < 0.01	1.12 (n = 97)	2.26 (n = 78) t = -4.29 p < 0.001
Legal situation	2.17 (n = 52)	3.37 (n = 123) t = -3.41 p < 0.01	1.08 (n = 52)	1.86 (n = 123) t = -3.54 p < 0.01
Side effects	2.66 (n = 106)	3.55 (n = 69) t = -2.31 p < 0.05	1.48 (n = 106)	1.86 (n = 69) ns
Safe use	2.99 (n = 83)	3.03 (n = 92) ns	1.64 (n = 83)	1.62 (n = 92) ns

Similarly, a lower average number of drugs have been tried by those who want information on health risks ($p < 0.01$), on the legal situation ($p < 0.01$) and on side effects ($p < 0.05$). Thus, the strongest predictor of the individual's perceptions of drug attitudes and those to drug education would appear to be the individual's history of substance involvement. However, from the interviews it is obvious that it is the effects that provoke the most interest, particularly for drugs like ecstasy with one girl

saying "I don't take it any more because of the girl that died. I would need to know more about what's in it".

Discussion

The following discussion attempts to cover the main implications for drug research, drug education and drug intervention that arise from the research, interpreting them with reference to the more qualitative aspects of the interviews that were carried out throughout the project. The first point to make concerns the interpretation of the prevalence data that, although varying according to the method of data collection employed, constitute very high levels of substance activity and availability.

The key principles of the argument here match those of both the young people interviewed and the writings of Hirst and McCamley-Finney (1994), which are pragmatism and participation. Here it is important that a distinction is made between use and experimentation on the one hand, and problem use and abuse on the other. While there may be ethical grounds for objecting to substance activity among adolescents, this does not automatically equate to the health difficulties that would be associated with adult substance misuse. The crucial issue is that drugs are readily available – as one interviewee put it, "there's never a problem getting the drugs, if the dealer is willing to sell to you", and that many young people will use them.

In this respect, the first important point to make is the disparity in both questionnaire and interview data between reported levels of having experienced a substance and

being a current user of it. The fact that, in the questionnaire, six substances are reported as having been tried by at least 20% of the respondents, yet only alcohol and cannabis are reported as currently used by that proportion. This suggests that a substantial amount of the drug use in the area is experimental and may not be related to frequent use. Thus, the 15 year-old who reports that she uses ecstasy and speed does not use cannabis because "I hated hash the one time I tried it because it was horrible and smelly and I don't like smoking". Therefore, neither experimentation nor patterns of use are predictable and inevitable determinants of polydrug problems in this group.

Thus it is no surprise that in the interviews, when asked about their use of temazepam, several young people echoed the views of the young female who said, "I tried them but I didn't like the effect so I haven't had any since". The point here is that far from being ensnared by dependence, many young people are aware of the availability of substances and have experimented with them, but do not use them on a regular basis. This would be compatible with the suggestion that the use of temazepam may be functional in more than one way. While it may be combined with alcohol for an immediate sedated effect, it may also be used strategically as the effects of ecstasy or amphetamines wear off, to allow the user to come down gently or sleep without experiencing the "crash" that is normally associated with stimulant rebound effects.

The point is that the discourse young users provide about their substance activity is functional ("I do it because I like the feeling I get when we go out") and intentional.

No young person described their reasons for use in terms of craving, addiction or dependence and so their behavioural reports are consistent with Coffield and Gofton's (1994) argument that young people believe they can control their use. It is also consistent with the drug explanations that characterised non-problem use in the predictive model outlined in Chapters 3 and 4.

This position is supported by the range of substances that are used by young people in the area - the most common being alcohol, cannabis, LSD, amphetamines, ecstasy and temazepam. With the exception of alcohol and temazepam, the other drugs are regarded by the young people as "happy" drugs and are categorised as radically different from what they perceive as problem substances, the "hard" drugs, methadone, heroin and cocaine, which have been tried by under 5% of the sample. Similarly, the reported pattern of use for young people would be that while cannabis use may occur on a daily basis, the use of stimulants or hallucinogens is context specific. They are more likely to be associated with clubs or parties - and so their use is not seen as an autonomous behaviour with which problems may be associated.

As Bukstein (1995) has argued, it is not only the case that young people rarely perceive their substance use as problematic but that, as here, it would be very rare for their pattern to satisfy DSM-IV criteria for abuse or dependence. However, in a cross-sectional study like this it is not possible to make judgements about any predictive or 'gateway' effects. The key to the combined study is that while the quantitative figures appear alarmingly high for prevalence rates, the young people's

understanding of use and availability is critical in developing a 'problem' model for the area.

An interesting variant on young people's perceptions of substance use and addiction surrounds the use of cannabis - the illicit substance that is reported as most commonly used in both questionnaire and interview formats. The first issue that arose from the interview data is that several participants were not aware of the fact that cannabis use was illegal. This appears to be a consequence of its availability and its prevalence of use among both adults and adolescents, and a perceived lack of police interest in its prohibition or prevention. The second issue concerns young people's conceptions of addiction, with one 15 year old female describing the problems she was having with sleep patterns and mood changes when cannabis abstinent - what would be regarded clinically as mild withdrawal symptoms - but concluding by saying "but you can't be addicted to cannabis, can you?". While a number of interviewees expressed concerns about the health effects of certain drugs – in particular, temazepam and ecstasy, none of these concerns were voiced about cannabis, even by non-users.

A number of important pointers for drug intervention and drug education arise from this example - the first being that young people also watch the television and read newspapers and so are well aware of certain parts of academic debates about the addictiveness of particular substances. On the other hand, this may be interpreted in terms of a local context in which cannabis use is so rife and, apparently so non-problematic, that it appears impossible to young people that it would be illegal. This issue supports the use of a combined methodology as the local context shapes young

people's drug awareness. This consists of both external and general influences, including the popular media and the school-teacher's conception of what constitutes addiction, as well local factors that shape availability and acceptability of individual drugs, on a substance-specific basis. It is this combination that shape the ways individuals interpret their drug encounters and develop particular styles of drug explanation.

This also brings into focus the meaning of attempting to assess substance prevalence in a group of young people where the pressures to deny or admit to certain forms of substance activity are likely to be influenced by the perceived dynamics of the social context. This, in turn, has an influence on, and is influenced by, the local social desirability of certain behaviours, whose criteria may be specific to the interactional context. Although this study cannot pick this up, one of the reasons that Easterhouse may show such high levels of substance use is that, in addition to actually higher levels of use, there are fewer taboos about reporting than in other parts of the city or country. The fact that higher levels of prevalence are reported in the questionnaire context than in the interview may relate to demand characteristics, although sampling issues (such as the higher mean age of participants in the questionnaire) are also likely to be influential.

However, the main conclusion from such a disparity must not be the attempt to prove which of the methods is most accurate, but the pressures associated with each methodology that leads to the difference in the first place. It is, in an investigation such as this, a futile task to attempt to assess which method is more credible, but

crucial to recognise that even the most apparently simple question in an area such as adolescent drug use is complicated by the fears, expectations and beliefs of the respondents and their interpretation of what it is the researcher wants to hear. This is compounded by their ease with the task, their beliefs about its purpose and, in the interview, their perceptions of and attraction to the interviewer.

Thus, while school based prevalence surveys are open to the accusation of systematic under-estimating, this is not only because young people fear punishment but also because they think abstinent-style discourse is what is required of them in that context. Indeed, this is a problem for all adult researchers who investigate adolescent substance activity - the young people may interpret their motives as associated with "just say no to drugs" and assume, that when asked by adults, it is important that they play the appropriate role by decrying drugs as bad. As with the Fast Forward evaluation, it is unfortunate that the design was not able to assess the extent to which questionnaires provoke more polarised opinions than interviews. It is reasonable to infer that an open conversation allows the respondent greater freedom to qualify responses than would the tickbox method commonly used in questionnaires.

While this is one motive for using peer researchers, it is also important to recognise that young people are aware of a number of agendas when they participate in drug research projects and may answer according to their perception of this dynamic. This is not to accuse young people in this context of Machiavellian manipulation, but only to suggest that the type of experience they are likely to relate may not only be the path of least resistance, but also that which they feel may be most valued in the context in

which the debate occurs. If that is the case then there is a powerful pressure, when reporting prevalence, to report accordingly.

However, this is not to suggest that there is no value in gathering this information as all reports of this nature are underlaid by a series of indeterminable social influences (the deconstructionist view of this is outlined in Chapter 2). However, for practical purposes, the suggestion is that this represents a caveat against over-emphasising data in ways that misrepresent the subject. As Hirst and McCamley-Finney (op cit) have argued, drugs are a part of the everyday reality for a number of young people in areas such as Greater Easterhouse and it is important to know which drugs young people report using and with what frequency. Thus the social pressure and dynamics around reporting may well be substance-specific as well as context-specific.

The fact that these results should not be treated as absolutes is as much a consequence of their being immediately out of date and the inability to gain a sufficiently comprehensive sample (such research will always exclude a number of hidden populations) as the social constructions underlying prevalence estimates. However, the interview schedule offers the young people who report substance activity an opportunity to explain their own understandings and meanings for the substance use in which they engage. The problem with aggregated data of the form questionnaires provide is that it represents a tyranny on each of the individuals who takes part as their understandings of their own narratives are subsumed in an attempt to explain the collective. This experience of being over-simplified by questionnaires is not unique to either young people or drug surveys.

One assumption common to both the fear-arousal and the informational approaches to drug education is that by telling young people the risks about drugs they are less likely to engage in such risky behaviour. Yet the two most negative experiences of temazepam use - "my big brother took jellies and ended up in hospital" and "I know a girl who took beans and jumped out of a window" both come from young people who reported that they used temazepam on a regular basis. There are two points here - the first is that this educational strategy is based on a rationalistic fallacy (people do not always act as a consequence of rational principles whether they are aware of them or not)., Secondly, young people's attitudes and behaviours towards drugs are more complex and involved than can be explained by such group-style explanations. It is even a problem in writing a report like this that it is always easier to present the summary information given by quantitative methods, than to present the myriad of views offered by the young people in the interviews.

Thus, one conclusion that such a finding implies is that it is not possible to dissuade young people from experimenting with drugs simply because there is the possibility of negative consequences. Most young people are well aware that substance activity may lead to side effects and the over-stating of the risks associated with the types of drugs most commonly used by young people serves only to reduce the credibility of the drug educator. It would appear that the level of knowledge among many young people in the area is high and so precludes any straightforward health or moral message as the level of drug awareness among both users and non-users is such that their own experiences will predominate.

This situation is emphasised by the contrast between the media portrayal of the drug dealer and the experience reported by a number of the young people in the project - while the dealer is commonly seen as a blight on society and a great moral danger, to many of the young people they represent a major obstacle to obtaining the drugs they want. The image of the dealer is summed up by the 14 year-old who pointed out that "drug dealers are ordinary people and they will only sell to you if they know you". Similarly, a report that arose in the interviews was that dealers would not sell to younger children and that, at the ages of 12 to 14 years it was not easy to obtain drugs for this reason.

Thus, the image of the dealer in the area is of a familiar figure who, far from peddling evil and death, is perceived as a responsible individual who will not sell to young children and as providing a service to those he or she knows. While this perception may not be palatable to many involved in drug education, this is the social reality for a number of the young people in the area, a reality of sufficient import to discount media mythologies about drugs and drug dealers. Furthermore, it is only by asking the young people in the area, that this aspect of their drug understandings can be accounted for without assumptions that may be outdated and damaging to the credibility of both researcher and educator.

This raises the issue of the impact of personal experience of substance activity on young people's attitudes to illicit drugs and to drug intervention and education. As is demonstrated in Table 2 of the results section, there are clear differences in drug

related attitudes between those who have experienced a greater number of drugs and those whose experience and use is minimal. The fact that this is more closely associated with attitudes to drugs and drug education than either age or gender is a finding that cannot be ignored for two reasons. First, the fact that there is such homogeneity of attitudes and drug-related behaviour across gender implies a pattern of activity in the area that is more likely to be associated with youth culture in general than to do with the specific activities of certain peer or gender groups. This is not to suggest however, that all young people do use drugs but that the classification of those who do and those who do not does not seem to occur on the basis of simple demographic characteristics. Secondly, with regard to age, while the questionnaire results suggest little differentiation in the patterning of drug use according to age, the interview transcripts imply that those in younger age groups are more likely to accept traditional stories about drugs being bad and people who use drugs being "stupid" although at all age groups this is inversely associated to the individual's own substance related experience.

It is an interesting consequence of the portrayal of drug misuse in the popular media and in certain approaches to drug education that a number of the young people who themselves reported using a number of licit and illicit substances were disparaging in their references to "junkies" in the interview. The reason for this apparent paradox is that the image of the "junkie" is that of the intravenous opiate user, a form of substance use that none of the sample reported (even the few young people who reported having smoked heroin). What this means is that, for a sub-section of the participants, the stereotype of the drug addict can be sustained irrespective of

the range of "recreational" drugs they may be using. To this extent the fear-arousal approach to drug education would appear to be potentially counter-productive in that the young people can both retain a negative stereotype of substance abuse while engaging in a range of substance activities that may or may not be problematic but which only proscribe opiate injection. This only tends to magnify the contrast between "bad" drugs and "good" or "happy" drugs, a contrast that is commonly advanced as indicative of the non-problematic status of adolescent drug use by young users.

It is, however, important to return to the classification of reported attitudes to both substance activity and to drug education on the basis of the individual's own experiences of substance use. The most striking of these findings is that young people who have the most drug experience are also likely to hold the most positive views about illicit substance activity, which may make sense in terms of relating a narrative that is consistent. They also report the most negative attitudes about drug education. One of the specific findings was that those who think teachers are suitable providers of drug education are also those who have experience of less drugs and use, on average, fewer drugs than those who do not hold this view.

The danger with this finding is that, in conducting evaluations, the positivity of the evaluation is inversely associated with the substance-related experiences the young people have had. This would imply that in areas where substance use is low the most traditional drug education strategies would appeal most to the young people. However, it may also be the case that this occurs because it acts as a vindicator of

their current behaviour and so is effectively preaching to the converted. In contrast, the same message may have an alienating effect on young people whose substance activity is most pronounced, in other words the group who are most in need of any harm reduction strategies to be implemented.

It is also noticeable that the young people who report the highest levels of substance experience and activity are also those who are most supportive of a peer based approach to drug education. The use of a peer-based approach in this investigation does not imply a universal support for such an approach, and this study supports Shiner and Newburn's (1996) suggestion that the emphasis on age in peer approaches is a cause for concern. They argue that while person-based credibility is important (part of which is age) emphasis should also be placed on the experiences of the speaker as a source of credibility and crucially that the message is perceived as credible. The last point is critical - the source of drug education becomes irrelevant if the message is not one that is credible to its recipients. Therefore it is essential that the use of a peer based approach be accompanied by an emphasis on a message that is compatible with the experiences and the values held by the young people the education attempts to target.

The peer-based approach that was utilised in the current investigation was successful because it did not attempt to convey a message. The reason that young people were willing to queue to speak to one of the researchers was, at least in part, that there was no educational message and that it was an opportunity for the young people themselves to be heard without being lectured to. The problem is not the

quantity of drug education, nor even of information, but rather with the way in which the information is presented, part of which is the association between learning about substances and the formal educational curriculum.

The enthusiasm generated among the young people is a sufficient goal in itself for a project of this sort and this is perhaps an objective that drug educators would also be advised to bear in mind. In the interviews, the most common responses to enquiries about drug education in schools were of cynical indifference and of frustration about how poor and inappropriate the quality of provision was. Thus the curious situation that has arisen is one in which young people report that there has been both too little and too much drug education provided.

Drug educators must therefore be more reflexively conscious of their own performance in terms of defying stereotypes about the roles they can meaningfully fulfil. The point is not that drug education is futile nor that all of its ills will be resolved by the use of peer educators. However, a more pragmatic approach that centres on assessing the needs and perspectives of young people and attempts to incorporate these within the intervention planned will have a greater possibility of making a positive impact on young people. The questionnaire and interviews clearly demonstrate that young people have access to a wide range of sources of information on this subject. This means, in effect, formal intervention or informational provisions are in competition with alternative sources of information which include parents, siblings, friends and other young people, dealers and so on.

As a consequence, the message offered in schools or by drug agencies must be meaningful for the life experiences the young people have. It must provide compelling evidence, either by its presentational style or by its content, that it has something to offer beyond dire warnings of the consequences of use. One of the reasons drug education is not successful with users is that young people perceive drug education to be primarily geared towards abstinence, whether this belief is accurate or not, and so for young people who are currently using the perception is that it has nothing to offer.

Thus it is the efficacy of drug intervention and education that requires the implementation of both a reflexive and a participate philosophy in which the key issue is to engage the young people in an endeavour that they perceive as both relevant and compatible with their life goals. To this extent, research of substance activity among adolescents must learn the same lesson as it is only by invoking the co-operation of young people that research projects can claim to produce information that is meaningful and useful. Ultimately, the key to both peer education and peer research projects is that young people are included in a task that they perceive to be worthwhile and whose objectives are compatible with their own.

Conclusion

The study was an attempt to implement a combined participative research study of substance activity among adolescents with an outreach project whose objectives were to assess the service and informational needs of young people in the Greater

Easterhouse area. The study afforded another opportunity to examine understandings and behaviours for a contentious activity, drug use, in a non-clinical population. While both interview and questionnaire methods revealed that alcohol and cannabis were the most commonly used substances, there was widespread use of temazepam, ecstasy, amphetamines and LSD, throughout the age range and among both sexes.

While the prevalence rates appear high most young people did not perceive their substance use as problematic and in many ways the key to the study is a quotation from the 15 year old who claimed that "young people see drugs as a pleasure not a problem". While this conclusion may not rest easily with a number of drug educators the important conclusion is that drug activity is neither shocking nor the preserve of a radical minority. Any attempt at intervention or education must be developed in a context in which, for a substantial number of young people in Greater Easterhouse, substance misuse is an accepted feature of daily life.

This has implications for research, education and intervention in that young people are not drug naive and so all interventions occur against a backdrop of competing sources of advice, information and moral interpretations for substance activity. Therefore, any such attempts at influencing young people must engage their enthusiasms and interests and provide a forum in which their beliefs and attitudes have a role to perform and where they are seen as valid and active participants. Service providers and educationalists alike must recognise that many young people in areas such as Greater Easterhouse do like taking substances that are illegal and

do not perceive there to be negative consequences, at least none that do not justify the alleviation of boredom and offer of excitement that drug use provides. What is necessary is not simply a harm reduction approach but an accessible form of service that allows young people a voice and a source of dialogue and information compatible with their needs and the substance related choices they must make on a daily basis.

Overall discussion and conclusion

The thesis had two prime objectives – to undertake a methodological examination of responses to questions about drug behaviours and understandings, and, second, to develop a method that is sympathetic to the research participant. The main conclusion from qualitative literature is not a methodological issue but a philosophical one – the research participant is most likely to provide useful insights and explanations if the forum for this exposition is sympathetic and person-centred.

The examination of attribution theory and social accounting approaches that constituted the first two chapters were, in effect, ways of setting the agenda for the objectives of the data collecting components. The problem is not that either attribution theory is inherently flawed and pernicious nor that discursive models are exclusively self-indulgent and abstract, but that the strengths and limitations of each form the basis for the strategies adopted. The aim was to follow attribution theory in developing methods that are systematic and enumerable, but to do so in ways that integrate the subject. Each of the data studies attempts quantification within a framework and design that gives breathing space to the needs of the participant.

This question is particularly important for an area like drug and alcohol research for two reasons. First, in spite of the fact that many of the effects of substances (including euphoria, craving, withdrawal and dependence) are all experienced at a psychological level, the preferred model for science and intervention has been pharmacological and medical. Secondly, this is an area in which the accuracy of information has always been debated, with various attempts at 'objective' measurement used to validate the

self-reports of a socially unacceptable behaviour. For these reasons, there are both academic and practical benefits to developing models of explanation that attempt to re-integrate the subject and which challenge the scientific and positivistic characterisations of drug experimentation and addiction that dominate the literature.

The aim of the early chapters was to consider a number of the assumptions that underlie traditional and alternative research methods in this area and the ways in which each may have created a particular type of reality. The greatest difficulty is that in an applied area such as researching substance activity, research does not occur in a social vacuum. It is integrally linked to social policy and service, and education provision, which means that any biases incorporated in the research body are reproduced and magnified in the daily treatment of the original participant group in the research. In this way the activities of research are self-replicating to the extent that the findings of research projects are based on a particular set of assumptions that then manifest themselves in social policy through the frequently unquestioning nature of social research methodology.

This is, however, a political dispute that manifests itself in the ownership of knowledge in particular areas of inquiry. With regard to substance misuse and drug education, it is the methodology of the social sciences, in particular that of social psychology that is dominant, a dominance that is reflected in the distribution of research funding in this area. For this reason the discussion of the relative merits of attribution theory and discourse analysis utilises excerpts from interviews with academic psychologists as an overt discussion of the methods used in a number of

social drug studies. It is important in this context to give a voice to the debates that exist within the academic discipline about the politics of research and the ownership issues that ensue. These include what status the researched have in defining their participation and the most acceptable and appropriate ways in which the academic should gather the explanations and attributions of subjects and use these in papers in journals in which behaviour is consequently explained.

The issue that underlies this dispute, common to a number of areas of applied social research, concerns the extent to which the subject is regarded as an accurate reporter of his or her own behaviour and its determinants, particularly those that may be termed intra-psychic. What the debate attempted to demonstrate was that these apparently theoretical issues have enormous practical importance for the role played by social research and the inevitability of political involvement in research and those who act on its findings. Thus, one of the advantages of utilising a methodology based on participation and reflexiveness is that it obliges the researcher to reject the myth of impartiality in favour of a critical examination of the research activity. This examination of methodological issues reflects concerns about the demand characteristics of research questions outlined in Davies and Best (1996, see Appendix 6).

This, however, does require a shift in methodology to one in which increased emphasis is placed on methods other than simple quantification and researcher-led protocols to empower the participants and to provide a platform for voices that may otherwise not be heard. The focus of the first two chapters was on the specific

manifestation of this problem in interpreting and explaining natural explanation and how this can be done in a manner that is both scientifically rigorous and which allows the participant a stake in the research process. The conclusion is that it is not sufficient to use an alternative method as all research methods are inherently artificial and constraining. Therefore, each method must be critically examined in terms of the specific goals and contexts of the research context, however politically infused this may appear to be.

This reflexivity is required at each stage of the research endeavour to ensure that the integrity of the participants' contribution is retained. In an area as applied as drug and alcohol research, this is integral to the process of interpreting behaviour and discourse for informing social policy. For this reason, the discussion of methods used to interpret natural explanation must be considered in the light of protecting the face validity of applied research in this area, in addition to its own academic merits.

Therefore there are two questions concerning the treatment of drug users' (or young people's) drug related explanations that are examined - the first concerns the accuracy of self-reports in this area and the second relates to how these reports, irrespective of their accuracy, should be dealt with. However, these considerations are not independent to the extent that the criteria employed for testing the accuracy of the information gathered may also imply a methodology in which summary representations are introduced to characterise groups of respondents - which is the key to both descriptive and inferential statistics.

While it is inevitable that some method of summarising the responses of groups of participants be employed, this must not compromise the meaning or significance of their productions. Thus, particularly when dealing with the attributions individuals give for their own behaviours, it is important not to exclude local context effects in favour of psychological or social overview foundations for explanation. Thus there is a need for a critical and reflexive compromise in which the need for summary statistics does not lead to an abuse of the interests of the participants. Similarly, the specific and local factors that influence behaviour should not be discounted, particularly as this can never occur in a politically neutral context.

With regard to the theory posited for drug users' explanations in the third chapter, the key point was to attempt to preserve the salience of immediate contextual demand characteristics in shaping explanatory theories. In other words, the model outlined in the chapter can be seen as an attempt at preserving the significance of context in a generalisable and testable theory of drug behaviour and explanation. This can also be seen as an attempt to develop a qualitative approach to understanding everyday explanation that retains the properties of testability and predictiveness and which allows for the incorporation of social and political determinants in a theory of individual explanation. However, the emphasis on the local context of explanation that contrasts with the traditional assumptions of research objectivity and the dichotomous assumption that there is no other status than truth or lie for the explanations of the substance user.

The importance of this chapter is that it attempts to use a debate that is alive within the field of academic research, which combines both theoretical and methodological issues, with an area of applied work that is relevant to both clinical activity and research within the field of substance misuse. The study develops a theory that has clinical applications and which is sensitive to a range of interpersonal dynamics that are accorded relevance in both daily and clinical encounters. Thus, instead of regarding variance in response that results from the demand characteristics of a research or clinical encounter as noise whose impact is unsatisfactory but also irrelevant, the model uses this contextual variation in responding as an integral and predictable feature of such interactions. Thus the methodological focus on demand characteristics of the research encounter also serves to increase the applicability of the project to the clinical context in which contextual variance in responding may be a significant determinant of various outcome measures for treatment and intervention.

With regard to the testing of this model that is outlined in Chapter 4 the crucial point is that this again combines the action research focus with a practical assessment of drug reporting in four sites, each of which appears to represent a different context for substance reporting.

The model successfully distinguishes between substance users with no form of agency contact and users who are involved with drug treatment services. That this difference occurs not only for the overall assignation to stages but also to each of the dimensions of which the stages consist constitutes further support for the discursive model advanced in both of these chapters. However, the results not only represent a

vindication for the discursive attributional model outlined in Chapter 3, they also provide support for a critical and reflexive model of both research and clinical interview in which the interviewer is regarded as an active participant in a creative and generative process. Thus it is not sufficient to employ a method that is sensitive to discursive aspects of explanation and reporting, it is also critical that this is done in such a way that predictions are possible for clinical applications.

This theme is developed in Chapters 5 and 6 in which the dynamics of substance attitudes and reporting are explored among young people. Here again the emphasis is on utilising live issues in applied substance research as an appropriate forum for the examination of methodological questions concerning self-reports, in particular the effects of interviewer characteristics and physical location on the type of reports that are given. It is just as important in examining research dynamics with young people as with adult subjects that it is not only prevalence of various forms of substance activity that is considered but also the associated expectations, attitudes and beliefs surrounding the discourse of substance activity that are explored. However, the main finding of each study, that more negative drug attitudes are expressed in the interview if it follows the questionnaire, suggests an important demand characteristic of this type of research.

The overall conclusion from this thesis would be that the researcher must always be cautious in attempting to generalise out from a given context. This context consists not only of the social, political and personal factors that influence the subject population, but also those that frame the research. Whether qualitative or quantitative,

the research method moulds and shapes the data, and the results obtained will always reflect the process of collection. This is particularly true and problematic for social research in which the participant will often have a view on what is happening and will be influenced by what he or she perceives the purpose of the task to be.

This interpersonal dynamic, behind which lie an innumerable range of external contextual factors, is the key to the critical and reflexive emphasis of the thesis. What this means, particularly in an area as contentious as drug research, is that the researcher can never escape his or her role in the materials derived. The use of peer researchers is one explicit attempt to recognise and work with this limitation, a limitation that is particularly acute for a subject population like drug and alcohol users. The challenge faced when working with this group relates not only to credibility but to allaying suspicion about what is to be done with the information they provide, a key concern that again makes the role of the researcher more visible than those who want to assume the role of dispassionate observer would want.

In researching this group, the final conclusion would be that meaning can be derived, but that this meaning is always contingent. It is contingent in the practical sense that it relies on the good will of participants but secondly that it cannot be definitive. The model developed, in which qualitative and quantitative methods can be married to produce context-driven data, is an attempt to go some way to addressing these problems. It does not represent a solution, as much as a recognition of these concerns.

References

Abramson, L., Alloy, L. & Rosoff, R. (1981) Depression and the generation of complex hypotheses in the judgement of contingency. Behaviour Research and Therapy, 19 (1), 35 – 45.

Advisory Council on the Misuse of Drugs (ACMD) (1988) AIDS and drug misuse, part one. London: HMSO.

Alloy, L. & Abramson, L. (1979) Judgement of contingency in depressed and non-depressed students: Sadder but wiser? Journal of Experimental Psychology (General), 108, 441 – 485.

Alloy, L. & Abramson, L. (1982) Learned helplessness, depression and the illusion of control. Journal of Personality and Social psychology, 42 (6), 114 – 126.

Annis, H. (1986) Is in-patient rehabilitation cost-effective? Con position. Advances in Alcohol and Substance Abuse, 5, 175 - 190.

Antaki, C. (1993) A brief introduction to attribution and attributional theories. In: Antaki, C. and Brewin, C. (eds.) Attributions and Psychological Change. Academic Press: London.

Antaki, C. (1994) Explaining and arguing: The social organisation of accounts. Sage: London.

Armistead, N. (1974) Reconstructing Social Psychology. Harmondsworth, Penguin: London.

Austin, J. (1961) How to do things with words. Clarendon Press: Oxford.

Balding, J. (1994) Young People and Illegal Drugs, 1989 - 1995. Schools Health Education Unit. University of Exeter: Exeter.

Ball, J. and Ross, A. (1991) The Effectiveness of Methadone Maintenance Treatment. Springer-Verlag NY Inc.: New York.

Barnea, Z., Rahav, G. and Teichman, M. (1987) The reliability and consistency of self-reports on substance use in a longitudinal survey. British Journal of Addiction, 82 (8), 891 - 898.

Barthes, R. (1974) S/Z. Jonathan Cape: London.

Beck, A, Rial, W. & Rickels, K. (1974) Short form of depression inventory: cross-validation. Psychological Reports, 34 (3), 1184 – 1186.

Becker, H. (1961) The outsiders: studies in the sociology of deviance. London: McMillan.

Bernstein, R. (1971) Class, Codes and Control, Vol. 1. Routledge: London.

Best, D.W., Mortimer, R.M., and Davies, J.B. (1995) Fast Forward Evaluation Report. Fast Forward Positive Lifestyles Ltd.: Edinburgh.

Billig, M. (1987) Arguing and Thinking: A rhetorical approach to social psychology. Cambridge University Press: Cambridge.

Bonaiuto, M. & Fasulo, A. (1997) Rhetorical intentionality attribution: Its ontogenesis in ordinary conversation. British Journal of Social Psychology, 36, 511 – 536.

Broadhead, R., Heckathorn, D., Grund, J., Stern, S. & Anthony, L. (1995) Drug users versus outreach workers in combating AIDS: preliminary results of a peer-driven intervention. Journal of Drug Issues, 6, 274 – 287.

Brown, R. (1986) Social psychology: The second edition. Free Press: New York.

Bryant, K.J., Rounsaiville, B.J. and Babor, T.F. (1991) Coherence of the dependence syndrome in cocaine users. British Journal of Addiction, 86 (10), 1299 - 1310.

Bukstein, O.G. (1995) Adolescent Substance Abuse - Assessment, Prevention and Treatment. John Wiley and Sons Inc.: New York.

Cahoone, L. (1996) Introduction. In: Cahoone, L. (ed) From Modernism to Postmodernism: An Anthology. Blackwell, Cambridge, Ma.

Caplehorn, J. and Bell, J. (1991) Methadone dose and retention of patients in methadone treatment. Medical Journal of Australia, 154, 195 - 199.

Carr, E., Levin, L., McConnachie, G., Carlson, J., Kemp, D. & Smith, C. (1994). Communication-based intervention for problem behaviour. Baltimore: Paul Brooks.

Clements, I., Cohen, J. and O'Hare, P. (1988) Beyond 'Just Say No'. Druglink, 3 (3), 8 - 9.

Coffield, F. and Gofton, L. (1994) Drugs and Young People. Institute for Public Policy Research: London.

Coggans, N. & Watson, J. (1995) Drug education: Approaches, effectiveness and delivery. Drugs: Education, Policy and Prevention, 2, 211 – 224.

Coggans, N., Shewan, D., Henderson, M., Davies, J. and O'Hagen, F., (1991) National Evaluation of Drug Education in Scotland: Final Report. Scottish Education Department: Edinburgh.

Culler, J. (1983) Barthes. Oxford University Press: New York.

Cummings, N.A. (1991) Inpatient versus outpatient treatment of substance abuse: recent developments in the controversy. Contemporary Family Therapy, 13 (5), 507 - 520.

Daniels, M. and Coyle, A. (1992) 'Health dividends': The use of co-operative inquiry as a health promotion intervention with a group of unemployed women. Paper presented at the 2nd Annual Conference on the Promotion of Mental Health, University of Keele.

Darke, S., Hall, W., Wodak, A. Heather, N. and Ward, J. (1992) Development and validation of a multi-dimensional instrument for addressing outcome of treatment among opiate users: the Opiate Treatment Index. British Journal of Addiction, 87, 733 -742.

Davies, J.B. and Baker, R. (1988) The impact of self-presentation and interviewer bias effects on self-reported heroin use. British Journal of Addiction, 82, 907 – 912.

Davies, J.B. and Coggans, N.D. (1991) The facts about adolescent drug use. Cassell Education Ltd.: London.

Davies, J.B. (1992) The Myth Of Addiction. Harwood Academic Publishers: London.

Davies, J.B. and Best, D.W. (1996) Demand characteristics and research into drug use. Psychology and Health, 11, 291 - 299.

De Haes, W. and Schuurman, J. (1975) Results of an evaluation study on three drug education models. International Journal of Health Education, 18, Supplement.

Denzin, N. and Lincoln, Y. (1994) Handbook of Qualitative Research. Sage: London.

Departmental Committee on Morphine and Heroin Addiction (1926) Report. HMSO: London.

Derrida, J. (1974) Of Grammatology. Translated by Gayatri Spivak. John Hopkins University Press: Baltimore, US.

Derrida, J. (1979) Living-On: Border-lines. In: Deconstruction and Criticism. Seaburg Press: New York.

Dole, V. and Nyswander, M. (1965) A medical treatment for diacetylmorphine (heroin) addiction. Journal of the American Medical Association, 193, 646 - 650.

Dole, V. and Joseph, H. (1978) Long-term outcomes of patients treated with methadone maintenance. Annual Journal of Academic Sciences, 311, 907 - 912.

Dowds, L. and Redfern, J. (1994) Drug education amongst teenagers: a 1992 British Crime Survey analysis. London University, Research and Planning Unit, Paper 86.

Eagly, A.H. and Chaiken, S. (1993) The Psychology of Attitudes. Harcourt Brace Jovanovich: Orlando, Florida.

Edwards, D. and Potter, J. (1992) Discursive Psychology. Sage: London.

Eiser, J.R. (1978c) Discrepancy, dissonance and the 'dissonant' smoker. International Journal of the Addictions, 13, 1295 - 1305.

Eiser, J.R. (1982) Addicion as Attribution: Cognitive Processes in Giving up Smoking. In: J.R. Eiser (Ed.) Social Psychology and Behavioural Medicine. Wiley: Chichester.

Eiser, J.R., Sutton, S.R. and Wober, M. (1977a) Smokers, non-smokers and the attribution of addiction. British Journal of Social and Clinical Psychology, 16, 329 - 336.

Eiser, J.R. and Gossop, M. (1979) 'Hooked or sick': Addicts' perceptions of their addictions. Addictive Behaviours, 4, 185 - 191.

Eiser, J.R. (1994) Attitudes, Chaos and the Connectionist Mind. Blackwell: Oxford, UK.

Farrell, M., Ward, J., Mattick, R., Hall, W., Stimson, G., Des Jarlais, D., M. Gossop and Strang, J. (1994) Methadone maintenance treatment in opiate dependence: A review. British Medical Journal, 309, 997 - 1001.

Fast Forward (1995) Bolt Ya Radge. Fast Forward Positive Lifestyles Ltd: Edinburgh.

Fine, M. (1994) Working the hyphens: Reinventing self and other in qualitative research. In: Denzin, N. and Lincoln, Y. (Eds.) Handbook of Qualitative Research. Sage: London.

Finnigan, F. (1988) Stereotyping in addiction: An application of the Fishbein-Ajzen theory to heroin using behaviour. PhD thesis, Strathclyde University: Glasgow.

Fishbein, M. and Ajzen, I. (1975) Belief, Attitude, Intention and Behaviour: An Introduction to Theory and Reading. Addison-Wesley: Reading, Ma.

Foucault, M. (1972) Birth of the Clinic. An Archaeology of Medical Perception. Translated by A.M. Sheridan: London.

Foucault, M. (1972) The Archaeology of Knowledge and the Discourse of Language. Translated by A.M. Sheridan. Pantheon Books: New York.

Foucault, M. (1975) Discipline and Punish: The Birth of the Prison. Translated by A.M. Sheridan. Pantheon Books: London.

Friedman, S. (1993) Going beyond education to mobilising subcultural change, Encouraging Peer Support for Risk Reduction. Netherlands: National Committee on AIDS Control.

Frischer, M., Leyland, A., Cormack, R., Goldberg, D., Bloor, M., Green, S., Taylor, A., Covell, R., McKeganey, N. & Platt, S. (1993) Estimating the population prevalence of injection drug use and infection with human immunodeficiency virus among injection drug users in Glasgow, Scotland. American Journal of Epidemiology, 138 (3), 170 – 181.

Garfinkel, H. (1967) Studies in Ethnomethodology. Prentice Hall: Englewood Cliffs: NJ.

Gasche, R. (1987) The Tain of the Mirror. Harvard University Press, Cambridge, Ma.

Gawin, F.H. and Kleber, H.D. (1986) Abstinence symptomatology and psychiatric diagnosis in cocaine abusers. Archives of General Psychiatry, 43, 107 - 113.

Gawin, F.H., Khalsa, H.K. and Anglin, M.D. (1989) Subjective symptoms of cocaine withdrawal. NIDA Research Monograph No. 442. National Institute on Drug Abuse, Rockville, Maryland.

Gergen, K.J. and Gergen, M.M. (1991) Toward Reflexive Methodologies. In : F. Steier (Ed) Research and Reflexivity. Sage: London.

Gerstein, D.R. and Green, L.W. (1993) Preventing Drug Abuse: What Do We Know? National Academy Press: Washington.

Goffman, E. (1971) Relations in Public: Microstudies of the Public Order. Harmondsworth, Penguin: London.

Gossop, M. (1982) Living With Drugs. Ashgate: Cambridge.

Greenwood, J. (1992) Persuading general practitioners to prescribe - good husbandry or a recipe for chaos? British Journal of Addiction, 87, 567 - 575.

Gubrium, J.F. (1994) Phenomenology, ethnomethodology and interpretive practice. In: Denzin, N. and Lincoln, Y. (Eds.) Handbook of Qualitative Research. Sage: London.

Habermas, J. (1984) The Theory of Communicative Action. Vol. 1: Reason and the Rationalisation of Science. Beacon Press: Boston, Ma.

Halliday, M.A.K. (1987) Spoken and written modes of meaning. In: R. Horowitz and S. Jay-Samuels (Eds.) Comprehending Oral and Written Language. Academic Press: San Diego, Ca.

Hammersley, R., Lavelle, T. and Forsyth, A. (1990) Buprenorphine and temazepam abuse. British Journal of Addiction, 85 (2), 301 - 303.

Hammersley, R., Lavelle, T. and Forsyth, A. (1992) Predicting initiation to and cessation of buprenorphine and temazepam abuse amongst adolescents. British Journal of Addiction, 87, 1303 - 1311.

Harre, R. (1988) Accountability within a social order: The role of pronouns. In: C. Antaki (Ed.) Analysing Everyday Explanation: A Casebook of Methods. Sage: London.

Hart, H. & Honore, A. (1959) Causation in the law. Oxford University Press: Oxford.

Health Advisory Service (1996) Children and Young People. An NHS health Advisory Service Thematic Review. HMSO: London.

Heider, F. (1958) The Psychology of Interpersonal Relations. Wiley: New York.

Heritage, J. (1984) Garfinkel and Ethnomethodology. Polity Press: Cambridge.

Herkt, D. (1992) Peer-based user groups: the Australian experience. In: N. Heather, A. Wodak, E. Nadelmann and P. O'Hare (Eds.) Psychoactive Drugs and Harm Reduction: From Faith To Science. Whurr: London.

Hilton, D. & Slugoski, B. (1986) knowledge-based causal attribution: The abnormal conditions focus model. Psychological Review, 93, 75 – 88.

Hilton, D. (1988) Contemporary Science and Natural Explanation. Harvester Press: Brighton.

Hirst, J. and McCamley-Finney, F. (1994) The Place and Meaning of Drugs in the Lives of Young People.

Health Research Institute Report, No. 7. Sheffield Hallam University: Sheffield.

Holstein, J.A. and Gubrium, J.F. (1994) Phenomenology, ethnomethodology and interpretive practice. In: F. Steier (Ed) Research and Reflexivity. Sage: London.

Home Office (1929) Memorandum as to duties of doctors and dentists. HMSO: London.

Howard, K., Bell, J. and Christie, M.J. Measuring Heroin Use in Methadone Maintenance Programmes. Drug and Alcohol Review, 14(1) 27-34. 1995.

Hubbard, R.L., Marsden, M.E., Rachal, J.V., Harwood, H.J., Cavanaugh, E.R. and Ginzberg, H.M. (1989) Drug abuse treatment: A national study of effectiveness. University of North Carolina Press: Chapel Hill.

Hunt, D., Lipton, D., Goldsmith, D., Strug, D. and Spunt, B. (1985 - 1986) 'It takes your heart': The image of methadone maintenance in the addict world and its effects on recruitment into treatment. International Journal of the Addictions, 20, 1751 - 1771.

Hunter, G., Ward, J. & Power, R. (1997) Research and development focusing on peer intervention for drug users. Drugs: Education, Prevention and Policy, 4(3), 259 – 270.

Iguchi, M., Griffiths, R., Bickel, W., Handelsman, L., Childress, A. and McLellan, A. (1990) Relative abuse liability of benzodiazepines in methadone maintenance populations in three cities. Problems of Drug Dependence, NIDA Publication Number ADM90 - 1663. NIDA : Rockville, Ma.

ISDD (1994) Drug Misuse in Britain. ISDD: London.

Janesick, V.J. (1994) The dance of qualitative research design: Metaphor, methodolatry and meaning.

Jaspers, J., Hewstone, M. & Fincham, F. (1983) Attribution theory and research: The state of the art. In: J. Jaspers, F.Fincham and M. Hewstone (eds.) Attribution Theory: Conceptual, Developmental and Social Dimensions. Academic Press: London.

Johnson, L., Bachman, J. and O'Malley, P. (1985) Monitoring the Future: Questionnaire responses from the nation's high school seniors. Institute for Social Research, Ann Arbor, M1: Washington.

Jones, E. & Harris, V. (1967) The attribution of attitudes. Journal of Experimental Social Psychology, 3, 1 – 24.

Jones, E.E. and Nisbett, R.E. (1971) the actor and the observer: Divergent perceptions of the causes of behaviour. In : E.E. Jones, D.E. Kanouse, H.H.Kelley, R.E. Nisbett, S. Valins and B. Weiner (Eds.) Attribution: Perceiving The Causes of Behaviour. General Learning Press: Morristown.

Jorgenson, J. (1989) Where is the 'family' in family communication research: Exploring families' self-definitions. Journal of Applied Communications Research, 17, 27 – 41.

Jorgenson, J. (1991) Co-constructing the interviewer / Co-constructing 'Family'. In: F. Steier (Ed) Research and Reflexivity. Sage: London.

Kelley, H. (1967) Attribution theory in social psychology. In: D. Levine (ed.) Nebraska Symposium on Motivation, Vol. 15. University of Nebraska Press: Lincoln.

Kidorf, M., Stitzer, M. and Brooner, R. (1994) Characteristics of methadone patients responding to take-home incentives. Behaviour Therapy, 25, 109 - 121.

Kinder, B.N., Pape, N.E. and Walfish, S. (1980) Drug and alcohol education programs : A review of outcome studies. International Journal of Addiction, 15, 1035 - 1054.

Klee, H. & Reid, P. (1995) Amphetamine-misusing groups: a feasibility study of the use of peer group leaders for drug prevention work among their associates. Home Office Drug Prevention Initiative Paper 3. HMSO: London.

Klepp, K., Perry, C. & Jacobs, D. (1986) Onset, development and prevention of drinking and driving among adolescents. European Journal of the psychology of Education, 2(4), 421 – 441.

Kovacs, C. & Beck, A. (1978) Maladaptive cognitive structures in depression. American Journal of Psychiatry, 135 (5), 525 - 533.

Lalljee, M., Watson, M. & White, P. (1983) Some aspects of the explanations of young children. In: Jaspers, J., Fincham, F. & Hewstone, M. (eds) Attribution Theory and Research. Academic Press: London.

Lloyd-Bostock, C. (1983) Attributions as social phenomena. In: Jaspers, J., Fincham, F. & Hewstone, M. (eds) Attribution Theory and Research. Academic Press: London.

Mackie, J. (1974) The cement of the universe. Oxford University Press: London.

Marks, J. and Palombella, A. (1990) Prescribing smokable drugs. Lancet, 335, 864.

McAllister, P. and Davies, J.B. (1992) Attributional bias as a function of clinical classification. Drug Issues, 22, 5.

McArthur, L. (1972) The how and what of why: Some determinants and consequences of causal attributions. Journal of Personality and Social Psychology, 22, 171 - 193.

McKeganey, N. (1990) Being positive: Drug injectors experiences of HIV. British Journal of Addiction, 85 (9), 1113 - 1124.

McLellan, A., Arndt, I., Metzger, D., Woody, G. and O'Brien, C. (1993) The effects of psychosocial services in substance abuse treatment. Journal of the American Medical Association, 269, 1953 - 1959.

McLellan, A., Arndt, I., Metzger, D., Woody, G. and O'Brien, C. (1993) The effects of psychosocial services in substance abuse treatment. Journal of the American Medical Association, 269, 1953 - 1959.

McLennan, A., Luborsky, L., Woody, G., O'Brien, C. and Kron, R. (1981) Are the 'addiction-related' problems of substance abusers really related? International Journal of the Addictions, 169, 232 - 239.

Miller, D. & Norman, S. (1975) Actor-observer differences in perceptions of effective control. Journal of Personality and Social Psychology, 31, 503 – 515.

Miller, D. & Ross, M. (1975) Self-serving biases in the attribution of causality: Fact or fiction? Psychological Bulletin, 82, 213 – 225.

Miller, F., Smith, E. & Ulleman, J. (1981) Measurement and interpretation of situational and dispositional attributions. Journal of Experimental Social Psychology, 17, 80 – 95.

Miller, P. & Plant, M. (1996) Drinking, smoking and illicit drug use among 15 and 16 year olds in the United Kingdom. British Medical Journal, 313, 394 – 397.

Miller, W.R. and Hester, R.K. (1986) In-patient alcoholism treatment: who benefits? American Psychologist, 41, 794 - 805.

Mills, C. & Noyes, H. (1984) Patterns and correlates of initial and subsequent drug use among adolescents. Journal of Consulting and Clinical Psychology, 52 (2), 231 – 243.

Mills, G. and Noyes, H. (1984) Patterns and correlates of initial and subsequent drug use among adolescents. Journal of Consulting and Clinical Psychology, 58, 385 - 394.

Mitcheson, M. (1982) Drug Addiction. In: Oxford Textbook of Medicine. Rev. Ed. Oxford University Press: Oxford.

Molinari, S.P., Cooper, J.R. and Czechowicz, D.J. (1994) Federal regulation of clinical practice in narcotic addiction treatment : Purpose, status and alternatives. Journal of Law and Medical Ethics, 22 (3), 231 - 239.

Moolchan, E. and Hoffman, J. (1994) Phases of treatment: A practical approach to methadone maintenance treatment. International Journal of the Addictions, 29 (2), 135 - 160.

Nelson, C., Treichler, P.A. and Grossberg, L. (1992) Cultural Studies. In: l. Grossberg, C. Nelson and P.A. Treichler (eds.) Cultural Studies. Routledge: New York.

Nisbett, R., Caputo, C., Legant, P. & Marecek, J. (1973) Behaviour as seen by the actor and as seen by the observer. Journal of Personality and Social Psychology, 27, 154 – 164.

Nisbett, R.E. and Wilson, T.D. (1977) The halo effect: the evidence for unconscious alterations of judgements. Journal of Personality and Social Psychology, 35, 250 - 256.

Nolimal, D. and Crowley, T.J. (1990) Difficulties in a clinical application of methadone-dose contingency contracting. Journal of Substance Abuse Treatment, 7 (4), 219 - 224.

O'Connor, L. (1995) Drug Education in Schools - Getting It Right. Paper presented to the London Drug Policy Forum Conference. 24 March 1995. London Drug Policy Forum : London.

O'Doherty, F. and Davies, J.B. (1987) Life events and addiction: A critical review. British Journal of Addiction, 82, 127 - 137.

Oetting, E. and Beauvais, R. (1990) Adolescent drug use: Findings of national and local surveys. Journal of Consulting and Clinical Psychology, 58, 385 - 394.

Olesen, V. (1994) Feminism and models of qualitative research. In: F. Steier (Ed) Research and Reflexivity. Sage: London.

Orvis, R., Cunningham, J. & Kelley, H. (1975) A closer examination of causal inference: The role of consensus, distinctiveness and consistency information. Journal of Personality and Social Psychology, 32, 605 – 616.

Parker, H., Measham, F. and Aldridge, J. (1995) Drug Futures: Changing Patterns of Drug Use Amongst English Youth. ISDD Monograph No. 7, ISDD: London.

Parker, I. (1992) Discourse dynamics: critical analysis for social and individual psychology. Routledge: London.

Parsons, T. (1937) The Structure of Social Action. Glencoe, III: The Free Press.

Peterson, C. & Seligman, M. (1984) Causal explanations as a risk factor for depression: Theory and evidence. Psychological Review, 91 (3), 347 – 374.

Plant, M., Plant, M., Peck, D. & Setters, J. (1989) The sex industry, alcohol and illicit drugs: Implications for the spread of HIV infection. British Journal of Addiction, 84 (1), 53 – 59.

Plant, M.A., Peck, D.F. and Stuart, R. (1982) Self-reported drinking habits and alcohol related campaigns amongst a cohort of Scottish teenagers. British Journal of Addiction, 77, 75 - 90.

Platt, J.J. (1995) Heroin Addiction: Theory, Research and Treatment, Vol.3. Krieger Publishing Co.: Malabar, Florida.

Potter, J and Wetherell, M. (1987) Discourse and Social Psychology: Beyond attitudes and behaviour. Sage: London.

Potter, J. & Edwards, D. (1992) Discursive psychology. Sage: London.

Prochaska, T.O. and Di Clemente, C.C. (1982) Transtheoretical therapy: Towards a more integrative model of change. Psychotherapy: Theory, Research and Practice, 20, 161 - 173.

Pruitt, D. & Insko, C. (1980) Extension of the Kelley attribution model: The role of comparison-object consensus, target-object consensus, distinctiveness and consistency. Journal of Personality and Social Psychology, 39, 39 – 58.

Rabbitt, P. and Abson, V. (1990) Do older people know how good they are? British Journal of Psychology, 82 (2), 137 - 151.

Rhodes, T. & Stimson, G. (1998) Community intervention among hidden populations of injecting drug users in the time of AIDS. In: M. Bloor & F. Wood (eds) Addictions and Problem Drug Use: Issues in Behaviour, Policy and Practice. Jessica Kingsley: London.

Robertson, R. (1994) The arrival of HIV. In: J. Strang and M. Gossop (Eds.) Heroin Addiction and Drug Policy: The British System. Oxford University Press : Oxford.

Robins, L.N. and McEvoy, L. (1990) Conduct Problems as Predictors of Substance Abuse. In: L.N. Robins and M. Rutter (Eds.) Straight and Devious Pathways from Childhood to Adulthood. Cambridge University Press: Cambridge.

Robins, L.N. and Przybeck, T. (1985) Age of Onset of Drug Use as a Risk Factor in Drug and Other Disorders. In: C.L. Jones and R.J. Battjes (Eds.) Etiology of Drug Abuse: implications for Prevention. Nationals Institute for Drug Abuse, Department of Health and Human Services. NIDA: Rockville, MD.

Robins, L.N., Davies, D.H. and Goodwin, D.W. (1974) Drug use by U.S. Army enlisted men in Vietnam: A follow up on their return home. American Journal of Epidemiology, 99, 235 - 249.

Rogers, C. (1961) On Becoming A Person. Houghton-Mifflin: Boston, Ma.

Rose, A. (1982) Occasions and forms of anthropological experience. In: J. Ruby (Ed.) A Crack In The Mirror: Reflexive Perspectives in Anthropology. University of Pennsylvania Press: Philadelphia.

Rose, D. (1989) Black American street life. University of Philadelphia Press: Philadelphia.

Rotter, J. (1966) Generalised expectancies for internal versus external control for reinforcement. Psychological Monographs, 80, No. 1.

Ryle, G. (1949) The concept of mind. Penguin: London.

Sakol, M., Stark, C. and Sykes, R. (1989) Buprenorphine and temazepam abuse by drug takers in Glasgow: An increase. British Journal of Addiction, 84, 439 - 441.

Sallis, J. (1992) Doublings. In: D. Wood (Ed.) Derrida: A Critical Reader. Blackwell: Cambridge, Ma.

Schaps, E., Bartolo, R., Moskowitz, J.M., Palley, C. and Chugrin, S. (1981) A review of 127 drug abuse prevention program evaluations. Journal of Drug Issues, 11, 17 - 24.

Schon, D. (1993) The Reflective Practitioner. Basic Books Inc.: USA.

Schuman, H. and Presser, S. (1981) Questionas and Answers in Attitude Surveys. Academic Press Inc.: London.

Schustack, M. & Sternberg, J. (1981) Evaluation of evidence in causal inference. Journal of Experimental psychology (General) 110, 101 - 120.

Schutz, D. (1982) Life Forms and Meaning Structures. Routledge and Kegan Paul: London.

Sedlak, A. (1979) Developmental differences in understanding plans and evaluating actors. Child Development, 50, 536 - 560.

Seligman, M. (1975) Helplessness: On depression, development and death. Freeman: San Fransisco.

Seligman, M., Abramson, L., Semmel, A. & von Baeyer, C. (1979) Depressive attributional style. Journal of Abnormal Psychology, 88, 242 - 247.

Semin, G.R. and Manstead, A.S.R. (1983) The Accountability of Conduct. Academic Press: London.

Shiner, M. & Newburn, T. (1996) Young people, drugs and peer education: An evaluation of the Youth Awareness Programme (YAP). Drug Prevention Paper, No. 13. HMSO: London.

Shotter, J. (1993) Conversational Realities: Constructing Life Through Language. Sage: London.

Silverman, D. (1973) Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction. Sage: London.

Slugoski, B., Lalljee, M., Lamb, R. & Ginsburg, G. (1993) Attribution in conversational context: Effect of mutual knowledge on explanation-giving. European Journal of Social Psychology, 23, 219 – 238.

Spear, H.B. (1994) The early years of the 'British system' in practice. In : J. Strang and M. Gossop (Eds.) Heroin Addiction and Drug Policy : The British System. Oxford University Press : Oxford.

Spunt, B., Hunt, D., Lipton, D. and Goldsmith, D. (1986) Methadone diversion : A new look. Journal of Drug Issues, 16 (4), 569 - 583.

Steedman, P.H. (1991) On the relations between seeing, interpreting and knowing. In: F. Steier (Ed) Research and Reflexivity. Sage: London.

Steier, F. (1991) Research and Reflexivity. Sage: London.

Stimson, G.V. and Oppenheimer, E. (1982) Heroin Addiction: Treatment and Control in Britain. Tavistock: London.

Stimson, G., Eaton, G., Rhodes, T. & Power, R. (1994) Potential development of community oriented HIV outreach among drug injectors in the UK. Addiction, 89, 1601 – 1611.

Stimson, G. (1995) AIDS and injecting drug use in the United Kingdom, 1987 - 1993: The policy response and the prevention of the epidemic. Socials Science and Medicine, 41 (5), 699 - 716.

Storms, M. (1973) Videotape and the attribution process: Reversing actors' and observers' points of view. Journal of Personality and Social Psychology, 27, 165 – 175.

Stott, D.H. (1958) Some psychosomatic aspects of causality in reproduction. Journal of Psychosomatic Research, 3, 42 - 45.

Strain, E.C., Stitzer, M.L., Liebson, I.A. and Bigelow, G. (1993b) Methadone dose and treatment outcome. Drug and Alcohol Dependence, 33, 105 - 117.

Strang, J. and Clement, S. (1994) The Introduction of the Community Drug Teams across the UK. In: J. Strang and M. Gossop (Eds.) Heroin Addiction and Drug Policy: The British System. Oxford University Press: Oxford.

Strang, J. and Gossop, M. (1994) Heroin Addiction and Drug Policy: The British System. Oxford University Press: Oxford.

Strang, J., Ruben, S., Farrell, M. and Gossop. M. (1994) In: J. Strang and M. Gossop (Eds.) Heroin Addiction and Drug Policy: The British System. Oxford University Press: Oxford.

Swadi, H. (1988) Drug substance use among 3,333 London adolescents. British Journal of Addiction, 83, 935 - 942.

Tackling Drugs Together (1995) A Strategy for England, 1995 - 1998. HMSO: London.

Taylor, S. & Fiske, S. (1978) Salience, attention and attribution: Top of the head phenomena. In: L. Berkowitz (ed.) Advances in experimental social psychology, Vol. 11, 249 – 288. Academic Press: San Diego, Ca.

Tierney, J. (1996) Criminology: theory and context. Prentice Hall: Hemel Hampstead, UK.

Tobler, N. (1992) Drug prevention programmes can work: research findings. Journal of Addictive Diseases, 1992, 11(3), 1 – 28.

Toon, P. and Lynch, R. (1994) Changes in Therapeutic Communities in the U.K. In: J. Strang and M. Gossop (Eds.) Heroin Addiction and Drug Policy: The British System. Oxford University Press: Oxford.

Turnbull, W. (1986) Everyday explanation: The pragmatics of puzzle resolution. Journal for the Theory of Social Behaviour, 16, 141 – 160.

Turner, D. (1994) The development of the Voluntary Sector: no further need for pioneers? . In: J. Strang and M. Gossop (Eds.) Heroin Addiction and Drug Policy: The British System. Oxford University Press: Oxford.

Ward, J., Mattick, R. and Hall, W. (1992) Key Issues in Methadone Maintenance Treatment. New South Wales University Press: Sydney.

Weiner B. (1975) 'On being sane in insane places': A process (attributional) analysis and critique. Journal of Abnormal Psychology, 84(5), 433 – 441.

Weppner, R.S. and Stephens, R.C. (1973) The illicit use and diversion of methadone on th street as related by hospitalized addicts. Journal of Drug Issues, 3 (1), 42 - 47.

Winters, K. (1990) The need for improved assessment of adolescent substance involvement. Journal of Drug Issues, 20, 487 - 502.

Wright, J. and Pearl, L. (1995) Knowledge and experience of young people regarding drug misuse, 1969 - 1994. British Medical Journal, 309, 20 - 24.

PAGE NUMBERING AS ORIGINAL

APPENDIX I

CODING MECHANISM

1) ID :
2) SEX :
3) LOCATION :

4) PRESCRIBED DRUG USE : i) METHADONE
ii) DIAZEPAM
iii) TEMAZEPAM
iv) OTHER

5) STREET DRUG USE : i) HEROIN
ii) METHADONE
iii) TEMAZEPAM
iv) DIAZEPAM
v) ECSTASY
vi) LSD
vii) SPEED
viii) COCAINE
ix) CANNABIS
x) ALCOHOL
xi) SOLVENTS
xii) OTHER

6) INJECTION :
7) OVERALL ASSESSMENT :

Circle the appropriate number

8) PURPOSIVENESS :

1 2 3 4 5
HI LO

9) HEDONISM :

1 2 3 4 5
HI LO

10) GENERALISABILITY 1 2 3 4 5
HI LO

11) TIME : 1 2 3 4 5
PRESENT PAST

Tick beneath all that are appropriate

12) REDUCTIONISM :
PSYCHOLOGICAL PHYSIOLOGICAL SOCIOLOGICAL

13) ADDICTION :
14) CONTRADICTORINESS :
15) STAGE :
16) What stage do you predict this subject will be in at next interview :

AMOUNT

FREQUENCY

Appendix 2

CLINICAL ASSESSMENT OF CHANGE

CLIENT :

THERAPIST :

LENGTH OF CONTACT :

IS THE RELATIONSHIP ONGOING :

1) CHANGE IN LEVEL OF STREET DRUG USE :

2) CHANGE IN LEVEL OF PRESCRIPTION :
(REASON)

3) CHANGE IN FREQUENCY OF INJECTION :

4) CHANGE IN LEVEL OF DRUG-RELATED CRIMINALITY :

5) OVERALL ASSESSMENT OF FUNCTIONING :

OTHER COMMENTS :

APPENDIX 3

Drug Information Questionnaire

(This will be completely confidential - DON'T tell us your name!)

Age: ☐ Sex: male ☐ female ☐ Date of Birth.....

Have you ever met the people from Fast Forward at your youth club or school?

no ☐ If not then go to the next page.

yes ☐

What do you think of the people who spoke to you? .....

How old do you think they were? .....

Do you think they were drug workers? yes ☐ no ☐

Do you think they were drug users? yes ☐ no ☐

Did you see them as being much more experienced with drugs than you? yes ☐ no ☐

Who do you think should provide drug information? .....

What did you think it was all about? .....

d they advise you not to take drugs? yes ☐ no ☐

I they approve of you taking drugs? approve ☐ disapprove ☐ neutral ☐

they encourage you to take drugs? yes ☐ no ☐

Ve would now like you to tell us what you think of the leaflet "Bolt Ya Radge"

hat did you think of the leaflet? .....

id you like any of the stories? (which?, why?) .....

e you now more or less likely to take drugs? more ☐ less ☐ same ☐

as it changed how you think about drugs? (why?) .....

e leaflets like this a good way to give drug information? yes ☐ no ☐

t useful to you? (why?) .....

uld your friends like it? (why?) .....

you think leaflets can reduce people's drug taking? yes ☐ no ☐

ch young people should it be aimed at? (what age?) .....

t did it tell you about drugs? .....

t advise you not to use drugs? yes ☐ no ☐

ld the characters approve you of taking drugs? approve ☐ disapprove ☐ neutral ☐

encourage you to take drugs? yes ☐ no ☐

What do you think of the following statements?

	Agree	Disagree	Don't Know
Taking Speed can rot your teeth (1)	☐	☐	☐
Cannabis can make you very talkative (2)	☐	☐	☐
DFs is another name for temazepam (3)	☐	☐	☐
Jellies are less addictive than heroin (4)	☐	☐	☐
Eggs is another name for ecstasy (5)	☐	☐	☐
Ecstasy can make you sleepy (6)	☐	☐	☐
Alcohol is a stimulant (7)	☐	☐	☐
Crack is usually taken by injection (8)	☐	☐	☐
Temazepam (Jellies) is a depressant (9)	☐	☐	☐
You can die the first time you buzz gas (10)	☐	☐	☐
You can be jailed if you are caught with acid (11)	☐	☐	☐
Hendo would give good, clear advice on drugs (12)	☐	☐	☐
Injecting temazepam is extremely dangerous (13)	☐	☐	☐

Which of these did you find in the leaflet? (which number(s)?) .....

Have you ever tried?

	Never	Used to	Sometimes	Often
Alcohol	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Solvents	☐	☐	☐	☐
Cannabis	☐	☐	☐	☐
LSD	☐	☐	☐	☐
Speed	☐	☐	☐	☐
Magic Mushrooms	☐	☐	☐	☐
Astralight	☐	☐	☐	☐
DFs	☐	☐	☐	☐
Jellies	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐
Heroin	☐	☐	☐	☐
Ecstasy	☐	☐	☐	☐

ENDIX 4

Drug Information Questionnaire 2

(This will be completely confidential - DON'T tell us your name!)

Age: ☐ Sex: male ☐ female ☐ Date of Birth.....

What did you think of the leaflet, "Bolt Ya Radge"? .....

Did you like any of the stories? (which?, why?) .....

Are you now more or less likely to take drugs? more ☐ less ☐ same ☐

Has it changed how you think about drugs? (why?) .....

Are leaflets like this a good way to give drug information? yes ☐ no ☐

Was it useful to you? (why?) .....

Did your friends like it? (why?) .....

Do you think leaflets can reduce people's drug taking? yes ☐ no ☐

Which young people should it be aimed at? (what age?) .....

What did it tell you about drugs? .....

Did it advise you not to use drugs? yes ☐ no ☐

Would the characters approve you of taking drugs? approve ☐ disapprove ☐ neutral ☐

Did it encourage you to take drugs? yes ☐ no ☐

Where is your copy of "Bolt Ya Radge" now.....

APPENDIX 5

Young People and Drugs in Easterhouse

A. Background Details

A1. Date of birth ___/___/19___ **A2.** Initials _____

A3. Where do you live?

Easterhouse Ruchazie
Garthamlock Barlanark
Queenslie Other (specify) _____

A4. Sex : Male Female

A5. Are you : At school At college
Unemployed On a training scheme
Working Other (specify) _____

B. Drug Experience

B1. Could you please tick the boxes to indicate your experiences of drugs

	Have you ever used?	Do you currently use?	How much would you use on each occasion?
Alcohol			
Inhalants (e.g. glue)			
Cannabis			
Speed			
Acid			
Ecstasy			
Valium			
Temazepam (Jellies)			
Heroin			
Cocaine			
Other (specify)			

B2. Have you ever worried about your drug use : Yes No
If so, what did you do about it? _____

B3. If you ever had any problems with either alcohol or drugs who would you be most likely to speak to and who would you definitely not speak to (tick boxes):

	Would definitely speak to ...	Might speak to	Would definitely not speak to ...
Parents			
Brothers or sisters			
Friends			
Teachers			
Drug workers			
Doctor			
Other (specify)			

C. Drug attitudes

C1. How much do you agree with the following statements :

SA = Strongly agree **A = Agree** **? = Don't know**

D = Disagree **SD = Strongly disagree**

	SA	A	?	D	SD
I have received enough drug education at school					
Teachers know nothing about drugs					
School is not the right place to be taught about drugs					
I need everything I need to know about drugs					
You can't talk to adults about drugs					
If you take drugs you are a drug addict					
It is dangerous to take acid					
Cannabis is good for you					
Drugs like ecstasy and speed are safer than alcohol					

C2. Who do you think should carry out drug education in schools (tick as many as you think are appropriate):

Teachers	Drug workers	Ex-addicts	Other young people	Police

C3. Where do you think drug education should be given to young people (tick boxes):

In schools	In youth clubs	In drugs agencies	Through T.V. or radio	Other (specify)

D. Drug knowledge

D1. How much information have you received about drugs from each of the following sources :

	None at all	A little	Quite a lot	A lot
T.V. programmes				
School				
Leaflets				
Parents				
Youth club				
Drug workers				
Phonelines				
Newspapers				
Friends				
Other young people				
Other (who?)				

D2. Do you think you have everything you need to know about drugs :

Yes Don't know No

D3. Would you like to know more about any of the following things?

Long term effects	Health risks	Legal situation	Side effects	How to use safely

D4. Have you heard of the Easterhouse Drugs Initiative? Yes No

D5. Where is the Easterhouse Drugs Initiative?_____

_____

D6. Do you think the drugs agency (Easterhouse Drugs Initiative) :

	Yes	No		Don't know
Provides a good service for young people				
Is a place where young people can go				
Is a place you would go if you had drug problems				
Is just the same as social work				

D7. Would you like to know more about drug services for young people or to get involved in drug work with young people. If so, please talk to Alison or Michelle, who will give you more information

THANK YOU FOR FILLING IN THIS FORM.

APPENDIX 6

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DEMAND CHARACTERISTICS AND RESEARCH INTO DRUG USE

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Health research makes frequent use of verbal reports; and such reports are usually assumed to be the surface method is postulated, using a social perceptual analogy, in which psychophysics provide the notion. It is our the assessment of subject criterion, and permits an examination of signal-strength in terms of the researcher's motivation. Data are evaluated in terms of their "robustness", a measure which derives from the variability of response in different contexts, and under different elicitation procedures. The method requires few assumptions to be made about the "truth" or "falsity" of verbal reports. It focuses on the types of social activities that are performed by utterances and thus on the contextual variability revealed by asking questions in different situations and in different ways. This procedure does not presume a direct correspondence between verbal reports and mental representations.

KEY WORDS: Methodology, verbal reports, signal detection, criterion, drugs.

INTRODUCTION

Our intention is to place the research emphasis on the motivational factors that underpin the production of a particular report given in a particular context and the effect this may have on subsequent behaviour - seeing discourse as performative behaviour with consequences for both interlocutors (Austin, 1962), rather than searching for a series of connections between posited intra-psychic phenomena with which to connect verbal report to observable behaviour. The goal here would be to make applied researchers sensitive to the motivated nature of report and the crucial role context (both physical and discursive) plays in shaping this.

VERBAL REPORTS OF SOCIAL PERCEPTIONS, VIEWED AS PSYCHOPHYSICS

The assumption that reports of internal events and the internal events themselves correlate perfectly bears a very close resemblance to one of the main assumptions of classical psychophysics. It was precisely because classical methods failed to explain

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variability in verbal reports that signal-detection theory evolved (Corso, 1967). Data clearly showed that subjects did not produce the same verbal report in response to the same stimulus, over repeated trials. Consequently, the new psychophysics distinguished between the detectability of the stimulus (d-prime) and the criterion (beta) for response.

In a simple signal detection (SD) experiment, "subject criterion" is varied by attaching costs and benefits to various types of verbal response. This clearly alters the subject's motivation, and hence his/her willingness to report "Yes I see it" as opposed to "No I don't." For example, if a subject is rewarded with money for *hits*, a lax criterion is adopted where the subject says "Yes" to almost everything, including apparently perceiving stimuli which were not even presented. On the other hand, if *false positives* are severely punished, a strict criterion is adopted, with the subject apparently failing to detect all but the most blatant signals.

Since the intention of this section is to convince the reader of the applicability of some of the concepts, if not the mathematcal detail, of the SD model, it is worthwhile quoting from McNicol's (1972) primer of signal detection. He writes (p 10), "another interesting feature of signal detection theory, from a psychological point of view, is that it is concerned with decisions based on evidence which does not equivocally support one out of a number of hypotheses. More often than not, real-life decisions have to be made on the weight of the evidence and with some uncertainty, rather than on evidence which clearly supports one line of action to the exclusion of all others." And also (p 11), "Essentially, the measures allow us to separate two aspects of an observer's decision. The first of these is called *sensitivity*, that is, how well the observer is able to make correct judgements and avoid incorrect ones. The second of these is called *bias*, that is, the extent to which the observer favours one hypothesis over another independent of the evidence he has been given".

Whilst McNicol was referring primarily to sensory evidence and perceptual decisions, the underlying ideas have obvious applicability beyond that limited sphere; note the reference to "real-life decisions" and the observer who favours "one hypothesis over another". The fit between the philosophy of SD and, for example, the social worker under pressure not to "miss" any cases of child abuse, confronted with ambiguous information; or the psychologist seeking evidence to support a theory of stress, who unwittingly adopts a method most likely produce "hits", is compelling, and has far-reaching implications.

CRITERION ISSUES IN VERBAL REPORT

Verbal reports vary according to the motivational state of the subject. From the standpoint of the respondent, motivational state amounts to criterion for response. However, whilst in the area of psychophysics, variance explained due to the motivational (criterion) state of the subject is clearly separated from other sources of variance such as signal strength, no analogous development has taken place with respect to "classical" methods of attitude measurement or other methods of treating verbal data. Thus, if, as Higgins and Bargh (1987) suggest, even subtle priming manipulations can influence attitude reporting, then more emphasis should be placed on interpreting and understanding the role specific contextual factors will play in shifting the motivational state of the subject and, consequently, his/her verbal behaviour. The next stage in the development of a new verbal report methodology

therefore requires procedures which separate criterion for response from the surface meaning of what is said. People, after all, say things for reasons, and knowing those reasons is essential to comprehending what they mean.

It is suggested here that a loose analogy may be drawn between searching for a light or a sound (a "signal") amongst background "noise" in an SD experiment, and searching for a memory (or an attitude, an intention or whatever) in a sea of cognitive background noise. We believe that such an analogy suggests new ways of thinking and proceeding. In the SD experiment, as noted above, criterion is manipulated by attaching rewards or punishments to the *hit* and *false positive* cells. Adapting this directly to verbal reports such as statements about attitude, or about events that happened recently, suggests a rather bizarre procedure. We should, by analogy, encourage the subject to remember (detect) certain things on some "trials" by providing rewards; and on other trials we should punish "false positives", and in this way develop a separation of criterion (in this case motivation) from "what actually happened", or what the "real" attitude is, an experimental approach that may be seen as compatible with a functional perspective on attitudes (Katz, 1960).

Nonetheless, the analogy is useful. For example, giving evidence in a court of law, as opposed to recounting the same incident to friends at home, might be expected to produce accounts which differ in emphasis and mode of expression, since the rewards and punishments contingent in each situation differ. Consequently, it might be observed that a drug user attributes an illegal act to "addiction" when in the courtroom, but gives an account characterised by volition and bad luck when reporting the same event in a less threatening situation. If this were observed to be a general phenomenon, one might infer a common context-based motivation shift on the part of drug-using defendants: in the courtroom the criterion for reporting "addiction" becomes more lax and consequently the number of false positives (reporting "addiction" where there is no "addiction") increases. Further, if one accepts Eiser and Gossop's (1979) notion that addiction explanations are socially generated and have significant consequences for those who self-attribute in this way, not only is the explanation seen as contextually motivated, its *variance* between contexts is also likely to be predictive of future behaviour.

Similarly, recalling life events in an uncued manner ("Tell me anything important that happened to you in the last month?") as opposed to a check-list approach ("Read through the following list, and tick off any events that have happened to you in the last month?") produces markedly different results. In recent research by Shibli (1992) in which drug users reported life events, the uncued method produced a mean of 7 events, whilst the check-list produced a mean of 49. In such circumstances the question "which is the right answer?" is of limited worth. In psychophysical terms the two approaches can be seen to differ in terms of signal strength. The check-list specifically defines the "signals" which the subject must search for while the free recall method gives no such clues, so there is less certainty. It goes without saying that people are generally more likely to find the things you want if you tell them what to look for; whether the objects are hard-boiled eggs, memories about hard-boiled eggs, or attitudes towards hard-boiled eggs.

In psychophysical terms, the absolute "truth" can never be revealed by methods using verbal report; one can only view any given set of results within the context of the methods used to produce them, and the criterion state of the subject. One can, however, say with some certainty that the higher *hit* rates produced by certain methods must

inevitably be accompanied by higher *false positive* rates. Thus, if the psychologist designs a "conducive" situation and uses explicit cues (e.g. questions which define the types of reporting required, as in life-event check lists or stress inventories, for example) in order to increase positive responses, the false positive rate must also rise as a consequence of the resulting criterion shift. In other words, the more you get right, the more you will get wrong. Thus, for example, with respect to reports about serious crimes, staged reconstructions will produce more correct incidences of testimony than naturally occurring recall, but also recall of events that did not occur. In the area of stress research, questionnaires filled with explicit examples of stress-related behaviour for people to tick off, will correctly identify more instances of stress, and elicit more reports of stress where no stress is present.

A THEORY OF SOCIAL CRITERION

Certain key concepts and procedures in SD theory have to be transposed to meet the needs of a proposed Social Criterion (SC) model, as follows:-

Criterion for Response (Beta)

In the SD experiment, this is generally manipulated by a) attaching rewards to hits, and/or punishments to false positives, thus manipulating motivation in a very obvious way, and b) varying the probability of occurrence of the signal, and thereby manipulating the subjects' *expectations*. These various conditions necessitate many repeated trials.

Within the proposed SC theory, many repeated trials threaten to destroy the social reality of the interview. We have to make do therefore with fewer repetitions but there must be at least two. On the basis of two repetitions, exact estimates of criterion cannot be made: but we can at least observe the direction of any shift. One possible manipulation would be to attempt to change subject motivation between the repetitions, and thereby change the criterion for response. This could be done by using different interviewers, different schedules, different physical environments or providing different information; in short, by varying the two data collection exercises in any number of ways, *according to a clear theory- led hypothesis*. The aim at the outset would simply be to have two data collection points, and to provide contextual cues for a criterion shift. The hypothesis requires the experimenter to have a theory about the two contexts such that he/she can predict the direction of criterion shift as revealed in the verbal reports. If the verbal reports shift in the *direction* predicted, the experimenter has data which are consistent with the hypothesis, and thus on the type of reports a given context is more or less likely to elicit. This approach contrasts with Katz's (op cit) taxonomy of attitudinal functions in that the present model does not necessitate the positing of an intra-psychic mediation between context and account. Rather it assumes that certain contexts (for example, an interviewer style) increase the likelihood that certain reports will be produced (that is, it focuses on social rather than individualised and psychological loci of explanation). If the shift does not accord with the prediction, then the experimenter has not understood those aspects of contextual change that influence subject motivation.

For example, in the context of an interview with drug users conducted by a known drug user in a pub, drug users gave accounts of themselves characterised by fewer drug-related problems, less intense patterns of use, and more control, than in the context of an interview conducted by a suit-wearing psychologist in a formal setting (Davies and Baker, 1987). Applying the proposed SC theory to this study requires a hypothesis that, in the latter context, a more lax criterion will be adopted with respect to the reporting of "addiction" problems. This derives from evidence supporting the theory that drug users' motivation is more defensive in formal settings involving establishment figures than in less formal settings involving members of their own peer group.

Signal Strength

There is no way of manipulating signal strength in a way that would please a hard-line SD theorist. However, the interviewer has the option of bringing certain issues into salience (as, for example, in the case of check-lists or forced-choice agree/disagree questions; or other forms which explicitly describe the "signal" to be detected); or of not bringing them into salience (as in open-ended methods). To the extent that the subject is more certain that a particular type of signal is the one to be looked for, its strength relative to other signals may be said to be enchanced. Within SD theory, the notion of "salience" would probably be seen as a criterion issue, but within the context of the proposed model, criterion issues involve subject motivation (see above) whereas signal strength is here conceptualised as a function of the researcher's motivation. In sum, signal strength here represents the degree of salience attached to particular issues as a function of the research methodology adopted by the person carrying out the study.

Defined in such a way, signal strength refers to the emphasis given to particular issues within the data-collection methodology. From this point of view, data collected by different methods can be used to assess the impact of high versus low levels of signal on the nature of the reports obtained. Where contrasting methods produce basically the same data, one must conclude that the subject's motivation (criterion) is constant across methods, independent of the technique used. Thus someone suffering a recent bereavement will recall that event regardless of the method used, indicating high salience for the subject; on the other hand, events that are only recalled in response to specific prompts or closed format lists may be assumed to be of lower subjective salience, assuming no other shifts in the context of responding.

For example, a check-list survey of life stress, in which people tick off selected stressful events from a list provided by the experimenter might be combined with a second round of data collected by less structured means. If the stressors reported are salient for the person in question, there will be a minimal difference in the topics reported, indicating that the internal "signal" is strong; whereas substantial differences between the methods reveal that there is a difference in the strength of the "signal" the data collection techniques constitute. In this latter case we would not conclude that the subject's motivation or attitude has changed (although it may have) but that the data itself are simply not robust across methods. Thus whilst assessment of social criterion shifts involves between-context comparisons (see above), signal strength is accessed by subject variability within context. Thus the drug user who explains his/her drug use in terms of (a) physical addiction in a tick-box dependence questionaire, but (b) in terms of a range of social and volitional factors in an open-ended interview, can be seen to be influenced by signals of varying potency in the two methods used.

Signal-to-noise Ratio

It is possible to go beyond signal strength and make some comments about signal-to-noise (s/n) ratio, although the applicability of the analogy at this point may be more limited. By varying the *contents* of the protocols we use, we can attempt to increase or decrease the salience of competing cognitions, and observe the effects of such attempts on verbal reports. If the analogy is accepted, s/n ratio can be specified as the number of "target" questions in relation to the number of "non-target" questions. A "target" question is one which is semantically identifiable as belonging to that subset of questions concerned with the topic of the research; and a "non-target" question is not so identifiable.

We can now speculate that the detectability of signals will be greater where noise is lower; and less where noise is greater. And as in the case of signal strength, data which remain more or less constant when s/n ratio is radically changed from high (e.g. a set of target-only questions) to low (a single target question in a set of non-target questions) may be assumed to detect something salient or "highly detectable" for the subject. To give a real example, a positive response to the question "I suffer from alchol problems" embedded in a set of questions focused specifically on a variety of alchol-related problems, will have less predictive value than will a positive response to the same question embedded in a set of questions on other topics, other things (i.e. criterion; signal strength) being equal.

IMPLICATIONS OF THE MODEL

Methodological

The model requires a more sophisticated approach to the design of data collection exercises than that which characterises traditional methods. Firstly, two episodes of data collection are required in contrasting contexts, which can theoretically be expected to alter subject motivation in predictable ways (prediction in this sense means *a priori* prediction on the basis of a hypothesis). This contradicts a certain received wisdom which requires all data to be collected in the same standard way to avoid bias. In fact, all such a method ensures is that whatever bias is present will remain undetected.

The contexts to be studied depend on the theory from which the prediction is being derived and it might involve something as simple as revealing at a second interview how the interviewer rated the subject at the first interview (see, for example, McAllister and Davies, 1992). Similarly, in the Scottish National Evaluation of Drug Education, (Coggans, Shewan, Henderson and Davies, 1991) data were collected in two contrasting ways (i.e. suit-wearing interviewers using a formal questionnaire versus fringed jacket/Doc Martens wearing interviewers using a questionnaire with street-credible language and cartoons). Data that remained unchanged under this manipulation were assumed to be robust; data that shifted were seen to be context-dependent. Thus, the data which were found to be robust across contexts can be thought of as more widely generalisable (i.e. more reliable) than data that were context-bound.

Secondly, given that two contexts have been specified, and that a prediction of their impact upon motivation (criterion) can be made in the light of some theory, then two methods of data collection are required at each interview. It makes sense to proceed from an initial less-structured approach to a more structured approach, rather than the

other way round, since the structured approach brings things to salience which might persist through any subsequent, less-structured (open-ended) line of enquiry.

Quantitative/Qualitative Issues

At the present time, quantitative and qualitative methods have polarised, and each has its earnest devotees. However, the realisation that quantitative methods may generate methodological artefacts has prompted some researchers to uncritically adopt qualitative methods for purposes to which they may not be ideally suited. Under the present model, the two approaches may be seen as prompting different criterion positions and/or offering different signal strengths; and the researcher could thus set up the two mothodologies as reference points, and use the difference between the data they yield as the outcome variable in a hypothesis testing exercise. This is not a version of relativism but a recognition of the contextuality of reporting and the localised epistemology that must be the foundation of interpreting the motivations which underpin the response provided in any given context.

AN EXAMPLE

Theoretical Base

Conceptions of the nature of addiction draw in large part from the verbal reports of problem drug users. The reports characterise addiction as being a state in which control of behaviour and volition are lost, and were behaviour becomes basically "drug driven". However, attribution theory provides a body of evidence indicating that in some circumstances explanations can be primarily functional rather than veridical. This body of theory suggests that reports of addicted behaviour from drug users may be functional, following the predictions of attribution(al) theory rather than being "true" statements. This theory is elaborated in "The Myth Of Addiction" (Davies, 1992), and serves as the basis for a study based on the above model (McAllister and Davies, op cit). The study can be re-interpreted within the social criterion (SC) framework, as follows:-

Hypothesis

On the basis of an attributional theory of addiction, it is predicted that drug users who receive information that a psychologist has *a particular view of them* will make attributional statements which are functional in terms of that (i.e. the psychologist's) view. Specifically, "addicted" types of explanation will be consequent upon the classification of a person's drug use by the psychologist as "heavy", and non-addicted styles of explanation will accompany the classification of their drug use as "light".

Criterion

A study is devised in which feedback is given to smokers about how the psychologist has categorised their smoking behaviour; and two contexts are devised to detect changes in their verbal reports. A group of smokers are interviewed at Time 1, and their attributions for smoking are noted. Data on their reported consumption are also

collected, but the "truthfulness" of these reports is irrelevant within this paradigm. The group is subsequently dichotomised in terms of their reported consumption into a heavy-smoking and a light-smoking group. At Time 2, the interview is repeated, but the heavy smokers receive the information that they have been classed as "heavy smokers", and these words are written on top of the protocol. The light smokers are similarly informed of their status, and the words "light smokers" appear on the top of the protocol. Attributions are then collected again. It is observed that smokers classified as "heavy smokers" shift their attributions towards a more addicted style (internal, stable, uncontrollable) and that those classified as "light smokers" shift towards a non-addicted style of explanation.

Signal strength

At each interview, two data collection procedures are adopted. One uses a standard questionnaire and rating scales for measuring attributions developed by McAllister. The other involves natural attributions elicited primarily from open-ended "why"-type questions. It is observed that the criterion shift described above is specific to the questionnaire format, but cannot be detected in the natural attributions.

CONCLUSION

The hypothesis of the study is that self-reports of the reasons for drug use are *not robust*. It is predicted that a change of context will result in a criterion shift on the part of subjects, and that their explanations will consequently vary in ways predicted by the theory. The data across contexts indicate that this is the case; the study therefore provides evidence at the *first* level (e.g. criterion) that such reports are not robust: and the hypothesis is confirmed at this level.

However, the strongest form of the hypothesis requires that the attributional changes detected are of substantive importance in the real world; and to that end, the shifts detected should ideally be revealed regardless of method; that is, the findings should be robust at the second (signal strength) level. This is not the case. The shift is revealed by a forced choice questionnaire that contains a number of items which are prescriptive in their construction, and which would probably never occur in natural discourse; but the natural attributions do not reveal a comparable shift. Consequently, the hypothesis is comfirmed at the first level but not at the second. This implies either that the theory, whilst demonstrable, is relatively unimportant; or that the methodology surrounding the natural attributions is insufficiently developed. The initial hypothesis is confirmed by the level one data, but not by the level two data; and therefore the data provide only qualified support for the theory.

Finally, it remains only to say that the above framework provides a structured overview for a whole data collection exercise. It does not replace or supercede normal methods of analysis, nor the need for psychometric statistics such as cluster analysis, Alpha, and so forth. What it does do is place these statistical procedures within a broader and more coherent framework that takes into account the motivational basis of verbal reports.

WHAT KIND OF SOCIAL PSYCHOLOGY

The proposed model represents a principled means of dealing with verbal data which derive from personal experience and phenomenology, and which change according to how people construe the advantages, threats, and opportunities of different situations they find themselves in. Data from studies conducted according to the above model may be evaluated in terms of their "robustness". "Robustness" indicates resistance of verbal answers to change under varying conditions. For example, reports which emerge from interviews with contrasting interviewers, and which emerge from open ended formats as well as from forced-choice inventories, are "robust". But if such reports are only obtained in a single context using specific prompt questions in a forced-choice format, they may be assumed to be less "robust", and the less willing one would be to generalise from them.

References

Austin, J.L. (1962) *How To Do Things With Words*. Cambridge, Mass: Harvard University Press.

Coggans, N., Shewan, D., Henderson, M. and Davies, J.B. (1991) *National Evaluation Of Drug Education in Scotland*. London: Institute for the Study of Drug Dependence, Research Monograph No. 4.

Corso, J.F. (1967) *The Experimental Psychology Of Sensory Behaviour*. New York: Rinehart and Winston.

Davies, J.B. (1992) *The Myth of Addiction*. Reading: Harwood Academic.

Davies, J.B. and Baker, R. (1987) The impact of self-presentation and interviewer bias effects on self-reported heroin use. *British Journal of Addiction*, 82, 907–912.

Eiser, J.R. and Gossop, M.R. (1979) "Hooked" or "Sick": Addicts' perceptions of their addiction. *Addictive Behaviours*, 4, 185–191.

Higgins, E.T. and Bargh, J.A. (1987) Social cognition and social perception. *Annual Review of Psychology*, 38, 369–425.

Katz, D. (1960) The functional approach to the study of attitudes. *Public Opinion Quarterly*, 24, 163–204.

McAllister, P. and Davies, J.B. (1992) Attributional bias as a function of clinical classification. *Drug Issues*, 22 (1), 139–153.

McNicol, D. (1972) *A Primer Of Signal Detection Theory*. Sydney: Allen and Unwin.

Shibli, S. (1992) Unpublished data from Ph.D. thesis, in progress. Centre for Applied Social Psychology, University of Strathclyde: 50 George Street, Glasgow G1 1QE.