

□ A more principled objection might be that it is immoral to pay drug users cash which they would in all likelihood spend on drugs. This would be a peculiar position to adopt when drugs and free needles are already being handed out as an incentive to make contact. Set against it is the fact that, if we were not paying drug users, many would raise the cash by victimising the local community. The link between acquisitive crime and illicit drug use has been well established in recent years.³

Are we morally secure in ignoring the rise in burglary rates due to injecting drug use, not to mention the health risks from needle sharing? Might we be more righteous in the long run if we were to offer financial incentives to drug users to encourage contact with services? If they use those incentives to further their drug use, so what? — they were going to continue using and sharing anyway. These are not new moral dilemmas. In educational work it has long been argued that a harm-minimising strategy should override moral fastidiousness.

□ Another argument is that the contrast with outreach work is false — that the aims of outreach work are not to bring drug users into existing services, but to create an entirely new type of service operating out in the community and responsive to the needs of that community.

This may be a sensible objective for outreach work. But it is not how new outreach services have recently been justified. Demands for these services clearly originate in the threat of an epidemic of HIV disease. The case has been persuasively made that the objectives of abstinence-orientated drug services have to give way to the priority of curbing HIV infection. Opportunities to encourage safer drug use (ie, no longer sharing needles) can only occur if drug users are brought into contact with the advice, persuasion and resources available at services such as needle exchange schemes.

By definition, the *sine qua non* of harm-reduction services is their ability to contact those at greatest risk. Outreach work may be justifiable in its own terms — but it becomes an important part of the response to HIV only to the extent to which it succeeds in reaching those parts which other services have not.

THERE IS NOTHING new about offering drug users payment to cooperate with drug services. It is a well-established tradition in research in America. In north-west England a recent series of user interviews in the evaluation of Lifeline's comic earned participants £10 an hour. The system worked without any serious problems.

The idea of economic incentives ought to appeal to those of a Thatcherite persuasion — though this is probably the reason why it will get a 'no' from people who only need to think that it smacks of capitalism, to know that they oppose it.

A final argument in favour of at least attempting this incentives approach is that it would be very cheap to launch. If it proved unsuccessful, the experiment would have cost very little. The idea could be introduced on a pilot basis for a few months with only one or two thousand pounds in the kitty. Perhaps the best way to test the validity of arguments for and against this strategy would indeed be to launch it on just such a pilot basis, and see what happens next. ■

Facts
Practical
Skills
Narrowing in
Status quo
Rigid
Product

Learning
about drugs
can be analysed
as a shifting
balance between
training and
education

Meanings
Theoretical
Issues
Opening out
Critical
Flexible
Process

TRAINING

EDUCATION

LEARNING

SKILLS or ISSUES?

The nature of drug training

THE TERM 'training' makes me feel uncomfortable, evoking images of dogs being trained to sit, or soldiers trained to kill. It implies obedience, and that there is a 'right' and a 'wrong' way of doing things. In reality, what's called 'training' often lies somewhere on a continuum between training and education, and not at either extreme. In the drugs field, as elsewhere, learning processes have to be an appropriate mix between training and its opposite and contradictory concept, education (see diagram).

□ Training is about looking at facts and providing practical skills for dealing with them. It is more rigid than education, often being based on the status quo and promising an end-product, ie, the trained or skilled worker: "Training involves a *narrowing down* of the consciousness to master certain techniques or skills." (Peter Abbs, *Guardian*, 5 January 1987.)

□ Education, on the other hand, looks at the meanings behind the facts and the issues that arise from them, as well as the facts themselves. Ideally it should be a critical, flexible process valid in itself whether or not there is an end-product such as practical skills or qualifications: "Education is an *opening out* of the mind which transcends detail/skill and whose movement cannot be predicted". (*op cit*.)

From these definitions it is clear that what many people bring to a learning event on drugs is their experience of training, not education. This may be their experience of the British school system, which increasingly fits the criteria for training rather than education, or of professional training in, for example, social work, teaching or medicine. As a result they expect to be provided with the facts about drugs and drug users and the practical skills to deal with them — end of story.

Education by itself is as useless as training by itself in helping people to cope through their learning about drug problems. It can be so woolly that it never tackles the issues it discusses in a practical sense. Certainly it is bad practice to send someone away from a learning event without some enhancement of their skills.

If education is emphasised rather than the

Is it drug training workers need — or drug education? Decide for yourself what learning about drugs should really be about.

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training product, people may initially feel de-skilled and *less* able to cope, because they feel their existing knowledge base and skills are inadequate, and no new skills have been learnt. They may feel personally challenged or criticised. However, their competence will eventually be enhanced as they discover how to adapt their *existing* skills to the issues that emerge during the learning experience — learning *how* to solve their problems rather than just what the solutions are.

Indeed, many educational models assume that learning is a process filled with tension and conflict. It seems essential, then, that this experience should be conducted within a context of maximum safety and support and with evaluation and follow-up built in. This is particularly true, for example, of the new courses we are organising for drug workers in Scotland. These workers are increasingly having to work with HIV-positive clients, and need help with sexuality and sexual counselling, pregnancy counselling, bereavement and loss.

THE BEST SKILLS to help people come to terms with the many facets and complexities of the 'drug problem' may be those of education itself — to be flexible and critical, to examine the issues, and to maintain an open mind. After all, the 'drug problem', like education itself, is a phenomenon the movement of which cannot always be predicted. ■

I have refrained from giving in-depth examples of training and education in the drugs field. Readers should consider for themselves whether the model described makes sense. If you are a participant, do you feel you are experiencing a balanced approach that meets your needs? If you are a helper, are you clear where you and your course stand on the education/training continuum, and how you fit this to the needs of the course participants?

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