Volume 10 issue 1 January/February 1995

DRUG links

The suggestion box is just one way of involving users - there are at least a dozen others
See page 9

isdd Institute for the Study of Drug Dependence

DRUG link

DRUGLINK is about 'disapproved' forms of drug use – seen legally, socially and/or medically as 'misuse'. *Druglink* does not aim to cover alcohol and tobacco use. *Druglink* is for all specialist and non-specialist workers and researchers involved in the response to drug misuse in Britain.

ISDD provides Britain's information service on the misuse of drugs and conducts research. ISDD's reference library is unique in Britain and an important international resource. Services include current awareness bulletins, publications and an enquiry service. ISDD is an independent charity grant-aided by the Department of Health.

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IN THIS ISSUE

CONSERVATIVES MAINTAIN COMMITMENT TO DRUGS ISSUE

In the face of tight public spending restrictions this issue of *Druglink* suggests the Government has maintained its financial commitment to drug services and increased its policy commitment – but are they keeping pace with British youth's commitment to drugs? Perhaps an added ingredient is needed – Simon Polley's review points to the many ways drug users can become part of the solution as well as part of the problem.

ARTICLES

REGULARS

Cover: Mike Ashton

DARE drug lessons trialed in England as doubts grow in USA

Drug Abuse Resistance Education (DARE) – the USA's favourite drug education programme – is being trialed in Britain as in the USA questions are raised over its ability to reduce drug use. This latest US import involves uniformed police teaching 17 weekly one-hour lessons in primary schools. Its aim is to equip pupils to resist peer pressure to use drugs before they grow too far beyond adult influence.

Inspector David Scott of the Nottinghamshire police was the driving force behind the first UK trial of DARE in a Mansfield middle school. The programme was slightly truncated and anglicised but stayed close to the US original. With support from local businesses it has been extended to other schools.

The evaluation compared pupils' responses with those of pupils in schools not in the DARE programme, using measures taken before and shortly after the trial. On several measures there were improvements but the researchers were disappointed that such a resource-intensive programme produced "no clear or generalisable" gains in knowledge and attitudes about drug use.[1] Their findings are echoed in US research, a recent review of which has raised hackles among DARE's many enthusiasts.

DARE is practised in half the USA's school districts and spreading rapidly, supported by the US Justice Department with a $1.75 million grant approved by the US Congress. But a review of DARE evaluations by the Research Triangle Institute has concluded that DARE has little if any impact on drug use.[2]

> Interactive teaching had three times the impact of DARE

The review was limited but dramatic in its findings. A shortage of follow-up studies meant only measures of short-term effects on drug use were included and the ages of the children made measuring impact for drugs other than alcohol, tobacco and cannabis impractical. But within these limits, the researchers found that the impact on drug use was so small that for alcohol and cannabis it may have been zero. The review's restriction to short-term outcomes leaves open the question of whether the impact might be greater as children later encounter drugs such as heroin and cocaine.

DARE's teaching style relies heavily on police officers as classroom experts answering pupils' questions. Other more interactive education programmes have three times the impact on drug use that DARE has, estimate the researchers, and much greater positive effects on social skills and attitudes. Even on knowledge, where DARE did best, it lagged behind. The review cautions that displacement of interactive teaching by programmes like DARE could have a negative impact on drug prevention. In Mansfield too the evaluators called for DARE to become more "interactive".

The US review is so controversial that its sponsors, the US Department of Justice, decided not to include it in its own research publication series.[3] Dr Herbert Kleber, who chairs DARE's scientific advisory board, dismissed the findings as based on "old studies of an old curriculum".[4]

US police say DARE is effective in ways other than reducing drug use and have no plans to reduce their commitment to the programme. Their description of the collateral benefits is echoed by the evaluators in Mansfield. Unlike the impact on the pupils' knowledge, the benefits for the police and the school were "manifest", said their report.

For both the DARE pilot showed they were "doing something" positive to combat drug misuse. The police officers involved were "very clear" that it developed the relationship between the pupils and the police which spilled over to their siblings and parents, promising to help create a more "police-friendly" community. The school too benefited in terms of community relations and credibility.

Several UK police services now acknowledge the limitations of enforcement and are turning to demand reduction. Police services including Hampshire, Manchester and Humberside are thought to be considering DARE. Others may follow as they look for ways to develop their drug prevention work in schools, one of the tasks for police in 1995/96 identified in the Government's *Tackling Drugs Together*.

The US researchers suggest programmes based on pupil participation deliver the greatest benefits but this teaching style may be at odds with police culture. Their final warning is that no matter how good the programme, its chances of changing adolescent drug use behaviour "should not be overstated."

1. Whelan S. and Moody D. *DARE*, Mansfield. North Nottinghamshire Health Promotion, August 1994.
2. Ennett S. T. *et al.* "How effective is Drug Abuse Resistance Education? A meta-analysis of Project DARE outcome evaluations." *American Journal of Public Health*: 1994: *84*(9), p. 1394-1401.
3. "Police officials challenge criticism of DARE program." *Drug Enforcement Report*: 25 October 1994.
4. "DARE has grown into biggest anti-drug program but critics grow too." *Narcotics Control Digest*: 12 Oct. 1994.

Dealing in steroids to be made drugs act offence

Acting on the advice of the Advisory Council of the Misuse of Drugs (ACMD), supplying anabolic steroids is to be made an offence under the Misuse of Drugs Act, announced Michael Howard last November. If Parliament approves, steroids will be a class C drug meaning suppliers could face five years' imprisonment plus an unlimited fine. Simply possessing steroids will not be an offence

In his statement, the Home Secretary said, "these measures will help to stop the activities of the unscrupulous illicit suppliers and traffickers which feed anabolic steroid misuse". That may be the case but the risk is that the unscrupulous dealers will continue regardless.

Pat Lenehan of the Drugs and Sport Information Service told us of "one dealer who takes a paternalistic view of what he does and tries to make sure that people get good quality drugs and know how to use them. He said he would probably stop dealing now and that would leave those who are more organised and greedy and not really bothered about those who are using".

Already the Government is looking to extend the scope of the legislation by including more performance-enhancing substances under the banner of anabolic steroids. In a written answer to Tom Pendry MP, Home Office Minister Michael Forsyth named beta 2 agonists and peptide hormones as two substances the ACMD would be considering in January.

❑ Two steroid dealers have gone to the European Court of Human Rights over attempts to prosecute them for dealing both under the Medicines Control Act and through the VAT laws.

The penalties for avoiding VAT are more punitive than those under the Medicines Act, but the dealers' case is that it is unfair for them to be charged with illicitly dealing in drugs and evading VAT.

Druglink's debt to its readers

Behind the scenes at ***Druglink*** a few of you – its readers – have been helping ISDD get it right by giving their time as members of ***Druglink***'s Advisory Group. Selected initially at random from the readership each year, they give us feedback on what has been done and leads to what might be done in the future.

Much of what you see in ***Druglink*** reflects their influence, such as changes to this year's layout to improve legibility, and the extra space in feature opening pages for the editor to flag the significance of the article. Their work has led directly to initiatives ranging from major supplements, such as one on the work of the Advisory Council on the Misuse of Drugs, to those small but important points, such as labelling the rose on the CONNECTIONS page – always intended to signify thanks, but doing so less than clearly.

Most of all, they have sharpened our awareness of how what we do impacts on our readers, and the need to take care over what we put into and how we alter what is, after all, your magazine. ***Druglink***'s readers as well as its staff have reason to be grateful to them. The 1994 Advisory Group can finally relax and enjoy the fruits of their work. Now is a good time to record our gratitude to:

Maureen Anderson Leicester Drug Advice Centre
Colin Chapman London Borough of Redbridge Education Department
Alison Chesney Cranstoun Projects
Jill Davis Coventry Community Drug Team
Philip Fleming Northern Road Drug Advice Centre and **Tony Miller** formerly of the Centre (jointly)
Dawn Hart and **Russell Webster** Standing Conference on Drug Abuse (jointly)
David Hicks Northern Regional Drug and Alcohol Service
John Marsden National Addiction Centre (formerly of Turning Point)
Phil Williams Cheshire police
Sharon Withnell Anglia and Oxfordshire RHA

'Radical' change risks crisis of confidence in SCODA

The representative body for drug services in England and Wales enters the new year bereft of staff, facing widespread disquiet over its ethical values and independence from government, and yet to resolve the key issue of extending membership. For drug services, SCODA's upheavals could not have come at a worse time. In the coming months a strong independent voice will be needed to help shape government drug strategy and respond to the review of services (see centre pages).

The Standing Conference on Drug Abuse (SCODA) was set up in 1973 by voluntary drug services to represent their interests and those of their clients. Now SCODA's management believes radical change is needed. Its chair and new chief executive say the plans are supported by many in the drugs field and grounded in the views expressed through an "unprecedented" consultation exercise. They aim to address long-standing criticisms of SCODA's performance and responsiveness.

Both highlighted a letter sent to SCODA's chair in January 1994 by Anne Hooper on behalf the drug and alcohol services lobby, ADSA. It called for a "radically different" SCODA which recognised the close relationship between prevention and treatment. At the time Anne Hooper and at least one other ADSA member were also on SCODA's management committee.

SCODA's management committee has the backing of its major funder, the Department of Health. Resignations and redundancies mean staff who might have challenged the direction of change have gone. SCODA's remaining problem is to carry current members with it yet attract new groups of members.

To get a feel for the views of the drugs field ***Druglink*** spoke to seven of the 11 chairs of regional drug workers' forums and all five chairs of the national forums, to SCODA's chair and chief executive, and to the former staff's union representatives. A dossier including letters between SCODA and the Department of Health and staff meeting minutes helped document events.

Talking to forum chairs four issues came up repeatedly:
· membership extension and whether the interests of the voluntary sector and problem drug users will be safeguarded;
· SCODA's independence;
· the loss of valued staff;
· the ethics of the recruitment of the chief executive.

During the interviews it became clear that the case for change at SCODA is strong. This much is common ground across critics and supporters of current plans and even among the staff who became casualties of the change process. How change is being achieved deeply disturbs many and is the focus of this report.

The membership crunch

SCODA's management committee aims to extend SCODA's brief beyond treatment and care to represent drug services whose primary aims include education, prevention and community safety as well as implementing the extension to statutory drug services approved last year.

In the process it will be aligning its vision with that of its major funder, the Department of Health (DoH). Relevance to DoH concerns could increase SCODA's ability to fine tune policy and improve its chances of survival. "If services as in *Tackling Drugs Together* [government's draft strategy for England] are expected to participate in a wider community-based response to drug misuse ... it is right that their representative body should reflect that shift", explained a DoH spokesperson.

Before SCODA can extend in this way it may need to convince current members that their interests will be safeguarded. At stake for many is not just a national lobby for their voluntary sector services, but the closest thing Britain has to a national voice for problem drug users, mirroring its members' traditional client advocacy role.

This they see threatened in two ways. First, statutory members will not have the independence from government which allows the voluntary sector to speak out for its clients. But this is less an issue than

> A 'hit man's come in from the DoH now he's got the job'

admitting groups whose primary concern is not the welfare of drug users but preventing drug use or crime. An attempt to create an all-embracing organisation which speaks with a single voice will be resisted by those who see this as stifling the natural diversity of perspectives in a multidisciplinary field. From their point of view the interests of those in prevention and treatment are and should be kept distinct.

For SCODA's chief executive Roger Howard the divisions are overstated. He says last year's consultations showed support for broadening the organisation to reflect the work being undertaken by drug services. Treatment services are, he points out, already "up to their armpits" in education, reducing crime and broader community-based work. Many educators also advise young people about drugs, and debates such as between abstinence and harm reduction cut across the sectors.

SCODA's chair Jane Goodsir promises structures to "safeguard existing members" and says she is "determined" to maintain SCODA's client advocacy role. To develop these structures the next AGM on 2 February will be asked to set up a constitutional review group to report in the Autumn. Membership extension may be put on hold pending the group's report. The move may help bring doubters on board but will prolong the limbo SCODA has been in since January 1994 when extension to statutory agencies was also put on hold.

DoH 'pulling the strings'?

SCODA's credentials as an independent voice for drug services took a sharp knock on 1 November when Roger Howard was appointed chief executive. The post was advertised and filled without intervention from the Department of Health but the common perception is that it perpetuates a SCODA compliant to government. For over six months from April 1994 Mr Howard had been commissioned by the DoH as a management consultant to promote change in SCODA. Backed by a letter from SCODA's chair instructing staff to cooperate, he described his role as SCODA's "*de facto* acting director".

One forum chair said his members saw the appointment as a "hit man's come in from the Department of Health and now he's got the job", another doubted "Roger will bite the hand that has fed him", and another saw the Government's hands "pulling the strings". SCODA's former staff do not see how it can now speak for drug users' interests if that means opposing government action.

Jane Goodsir says SCODA may be politically realistic but its response this month to the draft government drug strategy will prove it is robustly independent. Even during the consultancy she says the department ensured SCODA made progress but CDCU and DoH members of the consultancy steering group were not prescriptive about where that should lead. A Department of Health official, "disappointed" that this was how it was seen, also denied controlling SCODA.

continued on page 8 ▶

Department of Health pressure on SCODA increased in 1994 but started well before. Following ministerial ire at the previous year's high-profile community care lobby, SCODA's campaigning role had been compromised by mid 1993 when ex-director David Turner told staff they would now be seeking to "moderate", not overturn, government policy.

The department's concern over performance and SCODA's ability to represent the field date back at least to a DoH review in 1991. In this they echoed several member agencies, frustrated by a seeming lack of responsiveness on SCODA's part. By June 1993 David Turner saw clear signs that the DoH was "warning SCODA of the need to make rapid changes".

In 1994 the department showed a new willingness to wield its muscle as SCODA's major funder to force the pace of change. The plan put to SCODA's chair in January was to make a 'hands-on' consultancy a condition of its grant to SCODA for 1994/5 and withhold over £40,000 to pay for it. As before, the DoH's concerns were over "lack of credibility" in the field and SCODA's "limited membership", meaning it was not effectively representing drug services or their clients.

During the January 1994 AGM secret discussions between management committee officers and the DoH clarified the department's proposal. As these were taking place the meeting blocked a major step towards the DoH's objectives for SCODA by voting to postpone admitting statutory services to membership. By February Jane Goodsir says the DoH's message to SCODA was 'get your act together' within a year or face withdrawal of funding.

The consultancy was imposed but not unacceptable to SCODA's management committee. A core of members shared the department's impatience; several also shared the Government's new policy agenda. In December 1993 the committee was already looking to community partnerships and community safety as providing a new focus for the agency's work.

SCODA's chair and other officers decided to go with the consultancy. By the full committee meeting on 28 February 1994 the discussion was not whether to accept the DoH's condition but how. Next day SCODA's director of 17 years, David Turner, announced his resignation, the first casualty of the consultancy.

For leading committee members,

continued on page 8 ▶

£6 million for drug education and prevention in England

On 14 December the Department for Education (DfE) announced that nearly £6 million would be available in 1995/96 for drug prevention, including school drug education. Forty per cent of this must be found by local authorities. The announcement followed the launch of a draft DfE circular to schools on drug prevention (see below).

This is the first national drug grant from the department since funding for health education coordinators ended in 1992/93. Underspends in other areas allowed the grant to exceed most people's expectations, but it is less than the peak spend on the earlier initiative. This reached £7.3 million in the early '90s with just 30 per cent to be found locally.

The revival in funding will underpin education's contribution to the English drug strategy. £1.6 million was allocated to 16 "innovative" drug education or prevention projects. The surprisingly high sum may reflect the quality of the bids, which had to be in well before the funding announcement; initially only about 10 projects were to be funded.

In-service training

The bulk of the funding – £4.3 million – is to support in-service training of teachers, seen in the DfE's draft circular as the main way to give teachers information and confidence to "deliver clear and consistent messages about drugs". Funding is available to all education authorities. Despite having to find 40 per cent themselves, just one out of 109 declined.

How far this new funding can recover ground lost since April 1993 is debatable. The money has been allocated to authorities according to the number of maintained schools in their areas. Gloucestershire tops the chart with £131,400 while inner London boroughs such as Lambeth and Southwark get just over £16,000.

> Teachers may look to drug services and police for help

Local authorities are "expected" to devolve the grant to schools rather than pooling it for a central initiative. Health educators warn this risks each school doing its own thing without the resources to assess the training on offer or to buy enough to really make a difference. One council agreed with local heads that money devolved to them would be handed back for the authority to manage on their behalf. Another made clear its intention to vet schools' spending plans. Both have satisfied departmental scrutineers.

The fragmented market created by local management of schools has opened education to moral and economic entrepreneurs. Without controls the temptation may be to go for a cheap off-the-peg programme. In Bury police and education officials expressed concern over a trust being set up by a former drug squad officer to offer free drug lessons to schools. Teaching is to be done by volunteers after a week's training. The education authority is advising schools to use only recommended agencies but has neither the financial nor the legal clout to enforce this.

Other elements of the government's strategy will help steer schools in approved directions. Additional to the draft DfE circular, the DfE has asked the School Curriculum and Assessment Authority to develop more detailed guidance on drug education. A DfE-funded digest of materials will help schools assess the education packages on offer, and the official watchdog OFSTED will be monitoring schools' responses to drugs. In 1995/96 OFSTED will make a specific study of drug education.

Question over resources

Education Secretary Gillian Shephard sees the funding as one of a set of initiatives aimed at maximising use of existing resources. Her package has received support from educationalists relieved that the Department for Education is taking an interest in drugs, and in a way which reflects professional consensus over good practice.

Their main concerns are over resources. Gillian Shephard has stressed that "every school in the country has a responsibility to consider its response to drug misuse". As drug misuse slips down the age scale, England's 20,000 primary as well as its 4000 secondary schools are seen as drug education targets. Spread across all England's 24,000 schools each would get just £180 – enough to release a teacher for less than two days' training.

Before the funding announcement, Ruth Joyce – member of the Advisory Council on the Misuse of Drugs and Cambridgeshire's drugs education adviser – said she feared lack of resources could mean schools were "set up to fail". There is to be a five-year break from major educational reforms but she warned the draft circular makes "considerable demands", especially on small schools.

For her area the funding amounts to almost twice what she expected. On its own it is not enough, she says, to overcome her fears. If it can be supplemented by funding from the pot for governors and other sources she is "cautiously optimistic" about the outcome.

Teachers reeling from recent educational upheavals are now being asked to grapple with one of the hottest topics in education. Speaking for Labour in the Lords on 1 December, Baroness Jay welcomed the funding but cautioned that "inhibiting and regressive" messages from ministers over sex and HIV education had made teachers "extremely wary of the whole area of personal and social education". Drug services and police may be looked to for help as many areas no longer have access to a local drug education specialist.

Nigel de Gruchy, general secretary of the National Association of Schoolmasters/Union of Women Teachers, has challenged whether education can help young people resist drugs, the DfE's main objective. The research evidence is on his side: attitudes may be changed and knowledge improved – legitimate objectives in their own right – but a lasting reduction in drugtaking behaviour has rarely been demonstrated from the education programmes so far tested.

DfE says tell children about the attractions as well as the risks

Under the ambitious banner 'Drug Proof', on 8 November the Department for Education launched its draft drug prevention circular to schools.[1] Out for consultation until March, it covers drug education and the school's response to drug-related incidents. Three conferences in January and February will help finalise the guidance. The process suggests a willingness to listen; already the draft reflects expert opinion in some key areas.

In the influential *Times Educational Supplement*, drug education expert Ian Clements said the guidance: "will be especially welcomed in highlighting that drug education should be contained in a properly planned health education programme with the emphasis on skills, knowledge, informed choice, etc. Equally important is the recognition that young people need accurate information about drugs which gives a realistic account of their attractiveness, as well as any negative implications ... The advice that 'one-off' sessions and 'scare tactics' are not a good idea and that using ex-users could glamorise drug use should finally spell the end of these types of ineffective and dangerous approaches."[2]

His disappointment is the low profile given to the youth service – in many areas "crucial" to drug education and early intervention.

By stressing that "No school can afford to ... think its pupils are not at risk," Gillian Shephard aims to remove the "stigma" attached to schools which develop a drug policy. Such policies should, she said, be seen as a "positive marketing tool" for the school, not a sign that it has a problem.

The draft circular does not oblige schools to develop drug policies but the encouragement is strong. Larger schools, it's suggested, might identify a member of staff to coordinate the

response to drugs across the school. But all maintained schools – primary and secondary – are expected to have considered the need for a drug policy or reviewed their existing one by the start of the spring term 1996. The official education watchdog OFSTED will include drug policies or the lack of them in its inspections.

In its advice on handling drug-related incidents, the draft circular says teachers cannot guarantee confidentiality to pupils. Schools are expected to notify police when illegal drugs are found or when pupils suspected of having drugs refuse to volunteer the substance.

The assertion that to avoid legal liability heads must inform police if they believe cannabis is being smoked or drugs supplied in school is simply wrong, says Simon Kirkham of Release. Heads must take action to stop the activity but that need not involve the police.

Given this guidance, it may be as well that the draft advises schools to tell pupils of confidential sources of advice outside school. Funding for early intervention (see opposite) should expand help for pupils unwilling to risk disclosure to teachers.

1. Department for Education. *Drugs prevention and schools*. Draft circular. November 1994.
2. *Times Educational Supplement*: 25 November 1994.

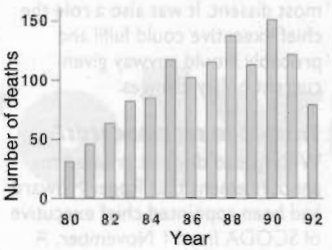
Government claims credit as solvent deaths fall by a third

Latest figures for UK solvent deaths are the lowest since 1982. Data for 1992 published by St George's Hospital Medical School, show that 79 people died from solvent misuse, down from 122 in 1991.[1]

Announcing the figures on 7 December, John Bowis, Minister for Health, attributed the fall to the success of the 1992 Government solvent campaign aimed at parents: "the results...show that parents have taken notice of the messages in what was a hard-hitting campaign". The report's authors agreed. Because the fall in deaths was greater in children than adults, they said the statistics supported "the view that the campaign aimed at parents had an effect".

The evidence for this is only circumstantial. No evidence is offered that parents actually spoke to their children about solvents as a result of the campaign or if they did that any warnings had an effect.

Evidence from John Balding's latest résumé of his surveys of drug use among teenage schoolchildren may offer another reason for the fall in solvent deaths.[2] Solvents are seen as 'kids' stuff' which young people leave behind once they can access 'grown-up' drugs[3] – and now more have that access.



Balding's work suggests fewer young people are using solvents and more are using cannabis, amphetamine, LSD and ecstasy, all increasingly available to the younger age groups associated with solvent misuse. Use rates for all these drugs among all categories of children rose from 1989-93, except solvents where the overall trend was down from a point well before the 1992 solvent campaign. Balding concludes, "unlike the other drugs studied ... no obvious increase in the use of solvents is predicted".

1. Taylor J. C. *et al. Trends in deaths associated with abuse of volatile substances 1971-1992.* St George's Hospital Medical School, 1994.
2. Balding J. *Young people and illegal drugs 1989-1995: facts and predictions.* University of Exeter, 1994.
3. Ives R. "The rise and fall of the solvents panic." ***Druglink***: 1986, *1*(4), p.10-12.

Pre-Xmas grant announcements bring some cheer

Funding announcements for 1995/96 to help make the new English drug strategy a reality, and the uprating of other grants roughly in line with inflation, gave a pre-Christmas sign that the Government remains committed to support for drug services.

English health service allocations for drug misuse (£8,847,000), AIDS and drug misuse (£11,555,000) and pharmacy-based needle exchange schemes (£2,868,000) were all uprated by roughly 3.2 per cent. These funds remain ringfenced so must be spent as intended by the Department of Health.

Another £3,478,000 is unallocated but £660,000 may be needed to fund the structured methadone maintenance pilot, leaving up to £2,818,000 for other purposes. Most if not all of this will help reimburse authorities for their methadone prescribing costs. In 1994/95 the methadone grant was £2,700,000.

The methadone pilot is one of the new funding initiatives linked to the *Tackling Drugs Together* green paper for England. Another £260,000 will be spent in the current financial year making a total of about £920,000. The money will fund eight programmes for 12 months each and pay for their evaluation. Among the successful bids are two GP programmes and Kaleidoscope in Kingston – further endorsement for a project whose fight to retain 70 of its clients has been reported in *Druglink*.[1]

On 5 December Virginia Bottomley announced £1 million for 1995/96 to develop "early intervention services" for young people embarking on drug use, another green paper commitment. Discussions with health and local authorities and the voluntary sector will help the Department of Health decide how to target the funding.

> Drug problems may be growing faster than the money

From 1994/95 the general health service HIV/AIDS treatment and care allocation was no longer ringfenced. Reflecting the rise in AIDS patients, that has been increased 10 per cent to £181 million. The HIV prevention grant is ringfenced and will increase from £47.6 to £49 million in 1995/96.

Community care '£200m short'

Despite the stringent revenue support grant settlement in the November budget, local authorities' community care funding will be as planned in 1995/96 and 1996/97. The ringfenced special transitional grant is £735.9 million this year falling to £647.6 million in 1995/96 as more is merged into the overall personal social services allocation.

The Association of County Councils estimates that in 1995/96 this will be £200 million less than needed.[2] On 14 December an Audit Commission report said authorities were already exhausting their community care budgets for 1994/95 and recommended "eligibility criteria", widely reported as a means to ration care.

Some councils are already doing this. By December Camden Social Services had written to drug and alcohol residential services warning that cash shortages meant it was introducing a "quota" for funding places and would establish a "waiting list" of people it could not immediately fund, potentially including those assessed under 'fast track' arrangements.

The specific grant to help local authorities develop voluntary sector services for drug and alcohol users will increase from £2.4 to £2.5 million in 1995/96. The same level of spending is anticipated for the next two years. To qualify local authorities must meet 30 per cent of their bids. The AIDS/HIV grant will rise from £12.9 to £13.4 million in 1995/96 and then to £13.7 million.

A new wave of GEST funding for drug education will pump an unexpectedly high £6 million into school-based and other drug prevention activities in 1995/96 (more on page 6).

It all amounts to the maintenance of existing funding for drugs work and modest new funding in some sectors. But there must be a question mark over whether the upratings have kept pace with 'inflation' in the drug problem. Notifications of opiate and cocaine addiction rose by 13 per cent in 1993 following a 19 per cent rise the previous year and indicators of youth drug use are continuing to increase.[3] Constraints on general local and health authority budgets will restrict the extent to which they are drawn on to supplement the specific drugs allocations which – especially where they are not ringfenced – may be raided to support other client groups.

1. See *Druglink* issues November/December and May/June 1994.
2. *"Spending cuts will hit services."* Community Care: *8-14 December 1994.*
3. Balding J. *Young people and illegal drugs 1989-1995: facts and predictions.* University of Exeter, 1994.

❑ **Last November the Harris polling agency asked a representative sample of 1006 adults their views on the "best option" for dealing with problem drug users.[1] 82 per cent thought they "should be sent to treatment centres for support and rehabilitation in the community" compared to 9 per cent who opted for hospital treatment and 4 per cent prison. Turning Point commissioned the survey. It says the results show the British public views problem drug users sympathetically and thinks they should be helped not punished.**

1. **Turning Point.** ***A question of attitude*. 1994.**

❑ On 1 December the report on policing from the Advisory Council on the Misuse of Drugs (ACMD) emerged from HMSO where since June copies have been awaiting a release date from the Home Office.[1] Unlike previous reports there was no high-profile launch with ministers and no government press release, adding to the impression that its advice was not wholeheartedly welcomed. As previously reported,[2] in it the ACMD advocated "harm reduction" policing prioritising the drugs which cause most harm and supporting other harm reduction services.

1. Advisory Council on the Misuse of Drugs. *Drug misusers and the criminal justice system part 2: police drug misusers and the community.* HMSO, 1994. Available from ISDD.
2. *Druglink*: 1994, *9*(5), p. 6.

❑ **Drug testing is becoming big business in the UK with companies such as Hoffman-la Roche considering a bid for the new prison testing programme in England. The Army is to introduce compulsory drug testing requiring soldiers to produce a urine specimen with no warning. Those who fail to comply or produce a positive test will normally have to leave the service. The Navy too is considering compulsory testing.[1] In Scotland the BioGenerics company is marketing its "Catch and Cure" programme for parents concerned about drug use by their children. On offer are urine and saliva testing kit and hair testing for those who refuse a urine sample.**

1. ***Hansard*: 13 December 1994.**

❑ A US government report[1] on the costs and benefits of addiction treatment reached conclusions similar to those of the RAND institute and the state of California.[2] The researchers from the Rutgers Centre of Alcohol Studies concluded that – with the exception of drug affected infants, where the data was inadequate – all the populations studied showed "high cost-benefits ratios" for treatment interventions.

1. White House President's Commission on Model State Drug Laws. *Socioeconomic evaluations of addictions treatment.* December 1993.
2. See *Druglink*: 1994, *9*(6), p. 8.

▶ *continued from page 5*

The facts of how the consultancy came about and was managed show government influence increased sharply in 1994, continuing a process that started years before (see panel). But concluding that SCODA was forced to toe the official line would be too simplistic. The reality may be closer to a complex alliance between the Government in the form of the Central Drugs Coordination Unit (CDCU) and the DoH, 'modernisers' on SCODA's committee, figures in the drugs field, some themselves on SCODA's committee, and the consultant, author of the *Across the Divide* report which informed the CDCU's work.

From summer 1993 Jane Goodsir describes a management committee increasingly taking a grip on the organisation but plans put to the January 1994 AGM did not envisage the severity of the changes soon to emerge from the DoH consultancy. The DoH's intervention would have given some committee members a way to force changes they felt were needed but had yet to accomplish, without taking all the blame for the blood spilt in the process – and by the end there was lots. Jane Goodsir denies using the DoH to deflect the blame.

Shock over sackings

Roger Howard took over in time to see through the restructuring plan which emerged during his consultancy. It included making all SCODA's core (non-project) staff redundant. Administrative and financial staff were later spared but by Christmas deputy director Hugh Dufficy and the remaining four core staff working on drug issues had been forced out through contested 'redundancies', a project worker had accepted redundancy, and another had resigned in protest.

SCODA's rationale is that the three new posts which might have been available to these staff were so different from those that went before that advertising was the only way to fill them with the best people available. Staff could apply and were guaranteed at least one interview. None took up the offer. Claiming a "great injustice", they say the management was determined to get rid of them and never assessed them for redeployment.

Their departure – with barely more than the legal minimum payoff – has accentuated controversy among member agencies and the wider drugs field. With little notice, agencies suddenly found themselves deprived of support from staff they had worked with for years.

The personal reaction of Roy Hughes, formerly on SCODA's management committee, was typical of several forum chairs. He was "extremely disturbed" at the loss of experienced staff which his forum members found an "essential link". Such a major step should, he argued, have been put beforehand to the membership. Esther Saunders, two of whose forum members were among those dismissed, complained "everyone else has lost their jobs and he [Roger Howard] has gained one".

The shock of the sackings to those outside SCODA is palpable enough but nothing like the shock to staff. As late as 16 August the deputy director told them they would have first crack at the restructured posts. Nine days later they were presented with the redundancy plan.

Whatever the ethics of the dismissals, concern over how SCODA can now service its current members, let alone a wider constituency, is real enough. By the end of December SCODA was left with its new chief executive plus three project staff and admin and financial support. One of the project staff is on maternity leave and the other two are tied to work programmes managed jointly with other agencies.

Recruitment to the three new core posts was disrupted when advance notice from the Department of Health of likely grant cuts led to a decision to put a hold on the Policy and Practice post, the only one to ask for drugs field experience. It may be March before the other two posts are filled.

The decision was announced in response to a letter from the DoH received the day before appeals from two staff against redundancy. For one it undercut the clearest of the grounds for appeal – that the 'new' post was virtually the same as the policy job they were doing.

Staff representatives see it as the latest in a series of 'dirty tricks' that do not bode well for how SCODA will relate to member agencies, and evidence of an unholy alliance between SCODA and the DoH. Jane Goodsir says the Policy and Practice post was chosen because it was the one over which there was most dissent. It was also a role the chief executive could fulfil and probably would anyway given current policy changes.

Trusted to set standards?

Widespread disquiet greeted the announcement that Roger Howard had been appointed chief executive of SCODA from 1 November. A single ad in the *Guardian* had produced just 18 returned forms. Four candidates were interviewed, none from drug treatment or care services, SCODA's core constituency.

Even those who suspect Mr Howard is the best person for the job are worried about what his appointment says about the ethics of an agency bidding to lead across the drugs field. Their concern is that someone brought in to restructure an organisation, including advising on the chief executive's job description, person specification and remuneration should then be allowed to personally benefit from their advice by applying for the job.

It "rang alarm bells" as far away as South Wales said the area's drug forum chair. "It doesn't feel good", commented N. E. Thames's chair. "Normal practice would be for a consultant to disbar himself" thought the Residential Services Forum chair. In December *Private Eye* got in on the act, querying the propriety of the appointment.

SCODA staff representatives saw it as indicative of deep failure of values and ethics. "They've cut SCODA open, taken out its guts – its values and principles – and stitched it up again. It looks the same from the outside, but it isn't. People might not suspect." With all that has happened, they ask how SCODA can now be trusted to lead and set standards for the drugs field.

It's a view Roger Howard says will be fiercely contested by the management committee. Asked whether he should have stepped aside, he pointed out that he was not applying for a post at an organisation which had hired him as a consultant. His contract was with the Department of Health, not SCODA. Decisions over the job were taken by SCODA's management committee and bore the marks of "lots of people's fingers", not just his. The salary, though £11,000 more then David Turner's, was based on comparable salaries.

Jane Goodsir stressed SCODA's equal opportunities and recruitment practices were followed and applications processed outside SCODA. She had assured staff that "independent advisers will be recruited" but was unable to point to any specific way this had been done. The selection was done by four of SCODA's management committee with no external observer present.

This year's two annual general meetings – in February and planned for the Autumn – will be the test of whether SCODA's management can carry its membership with it. The challenge facing them can be encapsulated by an amalgam of the concerns expressed: 'What kind of organisation is it that lets the government take over, sacks its experienced staff, and fails to see anything wrong with a consultant getting the job they advised on?'

In SCODA's favour is the fact that the need for such a body is still keenly felt. Dissatisfaction with the old SCODA was strong and the need for change is common ground; many will be able to find something to like among current proposals. A chief executive closely aligned with current policy trends will be seen as an asset by those who favour those trends. Jane Goodsir has the kudos of her years at Release. It may still be an uphill struggle.

Mike Ashton

▶ *continued from page 5*

and probably too for the Department of Health, their director – a voluntry sector enthusiast – was an obstacle to change, moving to widen SCODA's base too slowly for their liking. With lukewarm support from his committee – and faced with the alternative of sacking other staff to meet the financial shortfall and playing second fiddle to a consultant backed by the power of the Department of Health – he jumped.

Roger Howard was added to the list of potential consultants at the request of a SCODA management committee member, but other aspects of the consultancy show the department led the process.

The consultant was selected by SCODA's chair and two Department of Health civil servants and hired by the department. Arrangements were made which meant that legally he held no sway over SCODA's resources but on 12 April Roger Howard told staff he was the "de facto acting director/chief executive". He reported to a steering group of SCODA committee members and civil servants chaired by Department of Health, which made recommendations to SCODA's management committee.

The recommendations must have been difficult to ignore. As well as withholding the consultancy fee from SCODA's grant the DoH made it clear that the balance would only be paid "subject to satisfactory progress" during the consultancy.

Further evidence of the Government's hand on SCODA came with last October's green paper on drug strategy. This had community safety at its core and said Government had asked SCODA to explore "full representation of service providers across ... education, prevention, treatment and care services" and "accreditation of members" who deliver standards set by SCODA.

These proposals appeared in a draft statement of purpose for SCODA issued in the summer, having been among those suggested to SCODA by the Central Drugs Coordination Unit (CDCU) which drafted the green paper. CDCU director Sue Street served on the steering group for the SCODA consultancy so could influence whether SCODA took on board the CDCU's proposals, though Jane Goodsir said she did not do so.

The statement also stressed that SCODA will not represent a particular set of organisations but the "collective wisdom" of those involved in the wider drugs field – reminiscent of the DoH's desire for SCODA, in Roger Howard's words, to be a "body of informed opinion".

How involved can you get?

A tour de force round what could be one of the big ideas of the '90s – involving users in running your service from frontline to boardroom.

- *13 ways to involve users*
- *2 common models in depth*
- *5 major snags – knowing what they are is half the battle*

by
Simon Polley
Drug Development Officer of Northern and Yorkshire RHA and head of the Regional Service Development Centre

SUMMARY

A service's users may go far beyond drug users. User involvement is the process by which services systematically learn from their users to achieve a more effective service. Common problems include disempowering users unaccustomed to the bureaucracy and jargon of service management, assuming one user can represent all users, dealing with intoxication, and retaining control if users drive services in unacceptable directions. Two approaches are examined in detail – management committees and user satisfaction surveys.

ANYONE WHO USES a health and social care service has some right to be involved in what happens to them. No one wants to feel left out: purchasers worry that they don't know what's really going on in the agencies they finance; service managers struggle to oversee the diverse and complicated actions of their staff; fieldworkers complain that decision-makers ignore their suggestions and complaints; and as for service users...

What options do they really have to praise, criticise or change the services they receive? As a service user, you might hope your views would be noted during your interaction with agency staff and fed into the decision-making structure. Most people know that in practice this is a hit-and-miss process; there are too many variables to guarantee that any one user's views will make a difference – even if they are heard. Power does not always corrupt – but lack of it certainly demoralises.

It would be foolish (and offensive) to see users as inarticulate or unwilling to contribute – but naive to assume that without assistance they can make clear, structured comments about the service they received. The right words, the

THE USERS

- ❑ Individuals who contact an agency because they use alcohol and/or other drugs.
- ❑ Those who have previously contacted the agency for these reasons.
- ❑ Carers for the above.
- ❑ The relations and friends of the above.
- ❑ Those who take part in education and training offered by the agency.
- ❑ Those who use the literature produced by the agency.
- ❑ Other workers who may need the agency's advice, information and support.
- ❑ Any member of the community in the agency's catchment area.

ADVANTAGES OF INVOLVING THEM

- ❑ **Higher quality** User information is essential in helping us ensure that the service we deliver is of the quality we intend.
- ❑ **Positive outcomes** The involvement of individuals in responding to their needs and agreeing ways forward is likely to maximise positive outcomes.
- ❑ **Better targeting** As information and intelligence about the clients' needs increase, service delivery can be more tightly targeted for effectiveness and efficiency.
- ❑ **Higher morale** Staff who deliver services which are wanted, in ways which produce positive outcomes, are likely to feel more rewarded and relate better to service users.
- ❑ **Wider support** Agencies which involve users at several levels will in the process also actively recruit people interested in lobbying for and helping the agency.

WAYS OF INVOLVING THEM

- ❑ **Working feedback** Users' comments through their contact or key-worker, and this is fed into team meetings and planning sessions.
- ❑ **Complaints procedures** How an agency provides opportunities for and responds to specific complaints expressed by service users.
- ❑ **Management committees** Users invited to join management in running or reviewing an agency (in detail on page opposite).
- ❑ **Satisfaction surveys** Questionnaires actively encouraging user comments on the service they receive, its setting etc (in detail on page opposite).
- ❑ **Suggestion/comment boxes** Passive resource where users can record suggestions, criticisms, appreciation.
- ❑ **Planning groups** Users invited to join in the discussions of professionals involved in planning services.
- ❑ **Development surveys** Questionnaires seeking user views on development options for an agency and guide future change.
- ❑ **User councils** Autonomous groups of users feeding their views on service provision to the agency's management.
- ❑ **Resource production** Users co-producing leaflets and campaign materials with agency staff.
- ❑ **Service delivery** Deliberate employment of users to carry out tasks, especially outreach type work.
- ❑ **Service research/studies** Involving users in planning what research to do and refining how to do it, and/or in carrying it out.
- ❑ **Outcome determination** The users formally rate their satisfaction with the results of contact with the agency in terms of goals achieved, improvements in quality of life etc.
- ❑ **Focus groups** Interviews are conducted with different groups of users over a period, each set of interviews/discussions providing information on a particular aspect of services.

appreciation and the criticism, often come later, sometimes well after contact has ceased.

To deal with this and other practical problems, systems are required. Such systems go under many names: client satisfaction; patient feedback; consultation; and others. For convenience, we employ the term 'user involvement' to cover this multitude of approaches. User involvement may be simply defined as *the processes by which services learn from those they serve.*

Many alcohol and other drug agencies have experience of user involvement – some successful, some dispiriting. In early 1994 the Regional Service Development Centre in Leeds began a review of some experiences in the north of England, distilling them until we felt we had a clear idea of the different approaches. To identify the most workable approaches we needed to define terms such as 'user' and ask: Why user involvement? What is its purpose?

Why user involvement?

To involve service users, you first need to know who they are. The obvious answer is an alcohol or other drug user who has contacted the service. As we probed further we found agreement that family members involved with the drug-using client could also count as users. Then the man who rang up to ask how to identify crack cocaine was also a user, so was the personnel officer who wanted to know about drug policies in the workplace, and the GP with an urgent referral...

So a service's users may include varied groups which go far beyond the person using the drugs. They can be people who have used the service, those who are now using it, even those who *may* need the service in the future (see *The users* panel). This is the agency's constituency over time and geography – those it serves.

But why should these people be involved in what a drug agency does, how it does it and how that might change and develop? After all, agencies already have an array of guides to what they should be doing: research, their own professional expertise and experience, the specifications of the purchasers, and national guidance.

We might feel that involving users is 'right' or 'fair', but there must be more tangible, positive, reasons to devote resources to this source of guidance. What might user involvement offer an agency? The various anticipated outcomes (see *Advantages of involving them* panel) amount to a more effective service as the primary benefit of user involvement.

Five common snags

If we know who the users are, and agree they should be more involved, what are the options for how we go about it? Obviously different subgroups of 'users' may require different approaches if they are to be properly involved. For brevity, the options discussed here are limited to service users who have, or have had, a substance-related problem themselves.

During our work we identified more than a dozen models of user involvement being employed or considered by agencies, from the humble suggestion box to giving users a hand on the reins of management power (see *Ways of involving them* panel). Some are used with others to generate user involvement at different levels or for different purposes.

Each of these models (and there are probably more) has its advantages and disadvantages. To examine some of these we looked at experience with two approaches to user involvement in detail – management committees and satisfaction surveys (see opposite). Many of the pros and cons can be identified from an agency's own experiences, or learned from other agencies. These need to be explored before choosing and implement-

continued on page 12 ▶

Users on the board

Inviting service users onto management committees is a controversial tactic on which agency staff had very mixed opinions. 'User members' offer committees access to new experiences and may give users a real sense of involvement. Their input may be crucial to understanding the cutting edge of the agency's activities. Many agencies surveyed believed the idea might benefit both parties if done properly, but felt the problems were difficult to overcome. Views on these fell into four groups, which relate to the 'user profiles' presented on page 12.

Representativeness Staff questioned how an opiate user could be representative of a client with alcohol-related problems. This prompts questions about how users get on to committees – are they elected democratically by the body of service users, or chosen by agency staff/management? The first option requires such a body to be properly constituted and supported so it is capable of electing representatives. The second may lead to 'suitable' users being chosen: angry, challenging and 'difficult' users might not get a look in, yet their views may be more pertinent to service development. It also has to be asked whether management committees which have their own internal problems could function with constant challenge at this level.

Current or former users? A second problem was familiar to agencies with experience of service users on committees. Users still in treatment had been known to attend 'under the influence', devaluing their contribution in some eyes. An alternative is to recruit only former service users who are substance-free. However, doubts were raised about their ability to represent current service users. Some ex-users were known to have less than sympathetic attitudes to those still drinking or taking drugs; others might be convinced that their own approach to overcoming problems was the path for all current clients.

(By now, the ideal 'user member' on a management committee needs to be an articulate, non-disruptive substance-free current service user who can represent the needs of all the various diverse populations requiring services from the agency – a being so unusual as to risk being representative of no one!)

Dwindling enthusiasm When first approached many users were enthusiastic, but experience was that often this was short-lived and attendance dwindled (often true of committee members in general). Committees became frustrated at the absences and tended to abandon user representation. This is linked to...

Men in suits Current service users told staff that they found the prospect of sitting in meetings with a group of 'businessmen in suits' a daunting one. Such perceptions, whether well-founded or not, seemed to be a factor in some users' decisions not to get involved.

◀ *Drug and alcohol* ▶ *workers in the north of England had mixed feelings about two of the most common models of user involvement*

The scary part comes when we succeed – the loss of our power

Measuring satisfaction

User satisfaction surveys are a common approach to user involvement and potentially one of the most misleading and useless. What are the snags?

False positives Satisfaction surveys often produce results which reflect well on the agency. This may be because the service *is* good; more often, the results mask dissatisfactions. Put yourself in the user's shoes and ask questions such as:

- Do I want to be too critical of someone doing their best to help me?
- Do I believe my feedback is confidential?
- If I give a negative response, what will happen to the treatments/facilities offered here?
- Am I in any position to judge at the moment?

Another issue is how satisfaction ratings relate to outcomes. Should we ask if the user is satisfied with the *services*, or satisfied with their *outcome*? The first may be positive, the second negative. Is it OK to be nice to people but do them no good?

The lack of detail in surveys and the way they guide responses can also produce misleadingly high ratings. Responses may reflect satisfaction at a superficial level – the way staff behaved or the buildings; underlying opinions may not be voiced, especially if the survey is badly constructed. Users may express satisfaction with a drop-in service but really mean they are pleased to have such an option. Probing may reveal specific complaints or suggestions about opening hours, facilities, and so on. Clients asked, 'Did you like the apples and the bananas?' may answer 'Yes', but really have wanted to complain about the oranges.

Under-resourcing Effective surveys need resources – for printing instructions and forms, distribution, staff time for this and for explanations to users, administration, software for analysis, time to interpret and write up, and time to repeat the whole thing with amendments. Agencies saw this as valuable work, but did not have the resources to pursue it as well as they'd like.

Response rates were often low. Surveys sent through the post had a low return rate, but having them filled in on site threatened anonymity.

Commitment to act Neither staff nor clients had guarantees that survey results would be acted on. Surveys conducted because it was the 'done thing', or because of political pressures, might then be filed into obscurity. Commitment to debate the results from managers, committees and purchasers should be a prerequisite.

These snags can be overcome, but only with commitment, clear thinking and enough resources. With these the exercise may become valid and reliable. For example, clear design, reply-paid envelopes, and evidence that responses make a difference, can increase response rates.

Satisfaction surveys might be complemented by 'development surveys'. These ask users to rate potential *changes* to the service. Offering users a chance to prioritise a set of realistic developments gives them a legitimate say in the process.

◀ *continued from page 10*

ing any particular model(s). But before venturing down *any* of these routes, it is important to look more generally at how things can go wrong. User involvement implies a relationship between user and agency, and relationships, however dynamic, are often unequal. What should we look out for if we do commit ourselves to user involvement?

1 The 'disempowered' user One potential source of friction is the gulf between the intense, often inward-looking world of health/social care services and the communities outside. Users catapulted into this world are immediately placed under stress. They may become depressed or furious at an apparent (or real) lack of action. The power to comment, criticise or praise is not much of a power if nothing you say makes any difference. They may unintentionally be disempowered by professionals who have spent 15 years in this environment – and if they have no power, the anticipated benefits for the agency will fail to materialise.

How does this happen? Most users do not mark their time by management and review meetings, where ideologies sometimes seem to overcome common sense – and where planning and financial cycles dictate that by the time you've thought of something, it's too late for another year.

They do not necessarily share or accept the prioritisation of resources that services have to consider. After all, frustration with the pace of change, and with the chronic inability to pay for something which seems badly needed, is evident enough even in paid professionals – and at least they get status and money to compensate for the angst.

The language or jargon of any service can also confuse and block outsiders. We "address core needs assessment and share the conclusions in a non-directive manner" rather than decide what we think people need most and tell them.

2 The 'selfish' user Most of us want what we think is best for ourselves – what's best for others comes later, even more so when they may take resources or opportunities away from us. It is unrealistic to expect a teenager injecting heroin to be interested in responses to older drinkers, if those responses do nothing to improve services to injecting heroin users. Exceptions are where there are shared facilities or aspects of service that affect both groups – such as home visiting or evening clinics.

Acknowledging the users' personal motivations should improve user involvement in the long run, not disable it. Some people in the field still say "drug users just want more drugs" as if this is an argument against bothering to consult anyone. Even if it is true of an individual, it is still a legitimate expression which needs to be recorded. Good models of user involvement can identify and deal with this issue within the context of wider ones. The 'selfish' user leads us on to a third issue.

3 The 'representative' user We cannot truly be representative of anyone but ourselves. All we can show is that there are some things we have in common, but this should not be overestimated. A black Nigerian woman should no more be expected to speak for all black communities than a white Yorkshireman be expected to speak for men in general.

This also holds true when considering the substances used. Dividing these into two camps – alcohol v. drugs – can distort user involvement. The generalisation that drinkers have different concerns to drug users suggests that 'drug users' – encompassing people taking solvents, amphetamines, street heroin, tranquillisers, travel sickness tablets and steroids – all have the same needs. They don't. Elevating a service user into a 'representative' slot to satisfy a service's user involvement ambitions can be destructive for both user and agency.

4 The 'intoxicated' user To state the obvious, alcohol and other drugs affect mental states. Some professionals argue that users who are in treatment or still markedly dependent on a substance may not be in the best state to make decisions about services. From this point of view, ex-users (ex- to the agency and/or ex- to the substances) are the best source of feedback.

Relying on ex-users might allow for distancing and rational judgement but – as many smokers know from their contacts with reformed smokers – ex-users are not always the most tolerant in their judgements about those who still have a substance problem: "This model worked for me, so it will work for you".

User involvement needs to allow for this by looking for comments and suggestions at the start of, during, and after agency contact. Returning briefly to the idea of communities and other professionals also being users, information might be fed in even *before* contact: "What do you think *should* be available if a substance use problem arises?"

5 The 'empowered' user The scary part comes when we succeed in user involvement – the loss of our power. What if the users do not get demoralised and go home? What if – through turning up at all the meetings, starting radical user councils, and filling in all the forms in triplicate – they start to drive the agency in a direction which the purchasers cannot support politically, and which the staff do not think is in the users' best interests?

Taking power back from users may be more taxing than giving it to them in the first place, so most approaches to user involvement make sure that the reins are only loosened, not handed over. While this may be uncomfortable for some, it is pragmatic and needs to be honestly acknowledged. Users will not thank us for pretending that they can change things when they can't.

The evident pitfalls may at first depress initiates into user involvement, but are not presented here as arguments against it. Most of us have no wish to revert to the time when feedback was a rare letter of thanks or a report on the latest overdose death. Service users are the reason we have services (and jobs) at all, not an awkward element that disrupts what we do.

One positive note may be the growth of 'consumer audit', which by its name and nature moves user involvement towards 'professional acceptability'. To see user involvement as a required part of service audit is to take it seriously, not to relegate it to something we will do if we have time and if anyone is particularly interested (or vociferous).

RECOGNISING THE potential problems in advance gives us a chance to make user involvement work, to get somewhere – like checking the map before you set off, not when the road has disappeared and the wheels are spinning on mud. The Regional Service Development Centre is now supporting a number of agencies in developing their own approaches to user involvement. We believe that if we foresee and then actively seek to avoid the pitfalls, the journey will be well worthwhile for all concerned. ❍

The survey of services on which this article was based was conducted jointly with Richard Cyster and Jacqui Chamberlain. The Regional Service Development Centre welcomes enquiries and comments from others interested in user involvement. Phone 01132 448277 or write to the RSDC at Unit 51, 36a Call Lane, Leeds LS1 6DT.

DRUG link
PHOTOCOPIABLE
FACTSHEET

11 DRUGS – THE BASIC FACTS

INFORMATION FOR PARENTS, TEACHERS, ETC. FROM ISDD

This briefing concentrates on the risks of drug misuse. But it's worth remembering that most people who use drugs do not come to serious harm.

HEROIN

White powder which can be swallowed, injected, sniffed or smoked.

Small amount makes people relaxed and content. Large amount causes sleep. Stops pain. Lasts several hours.

Short-term health effects

Can make people feel sick. Makes concentration and quick reactions difficult.

Long-term health effects

Damage to veins and skin and risk of infections like HIV and hepatitis if injected. Easy to become dependent with regular use. Withdrawal effects can be very unpleasant.

Law

Illegal to have unless prescribed by a doctor. Illegal to sell or give away.

Slang

Junk, smack, skag, H.

SOLVENTS

Glues, aerosols and gases (like lighter fuel), the fumes of which can be inhaled to get 'high'. Lasts about half an hour. Like being very drunk.

Short-term health effects

Risk of accidents and death (like vomiting while unconscious). Gases (aerosols, lighter fuels) and cleaning fluids can cause death through suffocation or heart failure.

Long-term health effects

Tiredness, poor performance at school and in sports. Possible lasting damage to body (liver, kidney, brain) but this is rare.

Law

Legal to have but illegal to sell to known or suspected young solvent misusers.

CANNABIS

Smoked in a cigarette or pipe, by itself or with tobacco. Can be eaten. Usually makes people feel relaxed and talkative. If someone's anxious or depressed, it could make them feel worse. Makes people more sensitive to sounds and colours. Lasts 20 minutes to several hours.

Short-term health effects

Makes concentration and quick reactions difficult. Will affect driving.

Long-term health effects

Possible lung damage if smoked.

Law

Illegal to have. Illegal to sell or give away.

Slang

Dope, puff, weed, blow, draw, blunts, smoke.

ECSTASY

Swallowed as a pill or capsule. In small doses produces effects similar to LSD. In higher doses, the effects are more like those of amphetamine.

Short-term health effects

Possible sweating, dry mouth and throat and raised blood pressure. Bodily coordination may be affected. Users say the drug makes them feel 'in tune' with their friends and surroundings.

Long-term health effects

If used repeatedly, person may become anxious, panicky or confused. A number of deaths have been caused by the drug. Evidence of liver damage.

Law

Illegal to have. Illegal to sell or give away.

Slang

E, plus many others based on the colours and shapes of the capsules (doves, burgers, etc).

STEROIDS

Swallowed as a pill or caspule and also injected. Used by some athletes and body builders to increase muscle size and aggression, by others to improve appearance.

Short-term effects

Users report that the drugs make them feel more aggressive and they can train harder.

Long-term effects

Used over a long period of time (which you have to in order for anything to happen), these drugs affect both men and women in different ways. Women may become more 'masculine' (eg deeper voice and smaller breasts) and these effects may not be reversible, even after the drugs have been stopped. In men, the reproductive system may be temporarily affected. Young people using these drugs regularly over a period of time, may stunt their growth. In rare cases, users have died of liver cancer caused by steroids.

COCAINE (inc. CRACK)

Sniffed, injected or smoked (crack). Effects very similar to amphetamines, except that cocaine only lasts for up to an hour and crack wears off even more quickly and the feelings with both are more intense.

Law

Illegal to have unless prescribed by a doctor. Illegal to sell or give away.

Slang

Charlie, coke (cocaine); rock, wash, base (crack).

LSD

Swallowed as a liquid on blotting paper. Effects very dependent on situation and mood. Can make things look and sound very different, and make people feel very differently about themselves and about the world in general. Lasts for 8-12 hours.

Short-term health effects

Makes concentration and quick reactions difficult. Some takers become very upset ('bad trip') which may last for days afterwards. May 'trigger' mental disorder in a few people who are on the verge of a mental breakdown.

Long-term health effects

Can re-experience part of a trip a long time afterwards.

Law

Illegal to have. Illegal to sell or to give away.

Slang

Acid, trips.

AMPHETAMINES

Usually sniffed as a powder and injected. Makes people more awake and lively. Lasts several hours.

Short-term health effects

Helps concentration for a short while. Feel tired afterwards.

Long-term health effects

Lose appetite for food. Can become very anxious and jumpy if repeated doses are taken every few hours leading to acute paranoia. Feel depressed and very hungry after stopping, so can be difficult to give up.

Law

Illegal to have unless prescribed by a doctor. Illegal to sell or give away.

Slang

Wizz, speed, sulph.

INJECTING DRUGS

This is the most dangerous way of using drugs. People will try to inject all kinds of drugs including heroin, amphetamines and sleeping pills. Anybody who uses any injecting equipment which has been used by somebody else runs the risk of becoming infected with HIV. Apart from HIV, those who inject drugs may catch hepatitis which affects the liver, and may also damage their veins or poison their blood. Also those who inject are more likely to overdose.

Your nearest source of more detailed drug information is:

isdd

Written by Harry Shapiro.

DRUGLINK FACTSHEET 11 • DRUG FACTS (Extra/replacement copies £1.50. Send cheque payable to ISDD plus A4 self-addressed envelope to: Jan Hodgman, ISDD, 32-36 Loman Street, London SE1 0EE)

The Department of Health's

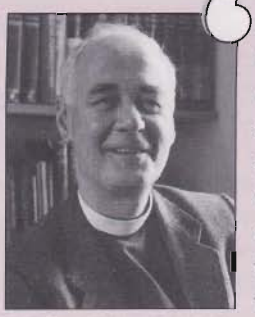
Task Force to Review Services for Drug Misusers

A progress report

by

John Polkinghorne

Chairman of the Department of Health's
Task Force to Review Services for Drug Misusers



The Reverend Dr John Polkinghorne

"On 21 April 1994 Dr Mawhinney, then Minister for Health, announced that he intended to commission a wide-ranging review of the effectiveness of treatment services for drug misusers in England. I know that this announcement has caused a great deal of interest in the drugs field and, perhaps, some concern. The purpose of this article is to introduce the Task Force established to undertake this review, of which I am Chairman, and to explain how we intend to go about our work."

Terms of reference

To conduct a comprehensive survey of clinical, operational and cost effectiveness of existing services for drug misusers; to review current policy in relation to the principal objective of assisting drug misusers to achieve and maintain a drug-free state, and the secondary objective of reducing harm caused to themselves and others by those who continue to use drugs; to make recommendations where appropriate and to report to Ministers.

Membership

The Task Force is made up of people from a wide range of backgrounds, some with professional expertise in the provision of services for drug misusers and some from other professional areas, chosen to bring, in the Minister's intention, "a fresh perspective" to this important area. Dr John Strang, the Chief Medical Officer's consultant adviser on drug misuse is our medical adviser. Sue Street, Director of the Central Drugs Coordination Unit and Sarah Paul from the Prison Healthcare Directorate are both observers on the Task Force. The Secretariat for the Task Force is provided by the Department of Health. Whatever our backgrounds, we are all aware of the misery and harm that drug misuse can inflict on individuals, their families and the community as a whole. The full membership of the task force is:

The Reverend Dr John Polkinghorne President of Queens' College, Cambridge (chair)
Dr Michael Farrell Consultant Psychiatrist in drug dependence at the Maudsley Hospital
Dame Margaret Fry Non-executive member of South and West Regional Health Authority
Dr E Josse General Practitioner
Mr James Kay Director of Healthwise, Liverpool and member of the Advisory Council on the Misuse of Drugs
Mr Denis O'Connor Deputy Chief Constable of Kent
Ms Rosemarie Ramsay Lawyer, and Vice Chairman of Brixton Drugs Project
Miss Esther Rantzen Member of the Health Education Authority
Mr Robin SeQueira President of the Association of Directors of Social Services and Director of Social Services, Dorset County Council
Mr Tony Shaw Chief Executive of Southampton and South West Hampshire Health Commission
Mr Tony Sheehan Nurse and Chair of the RCN Substance Misuse Forum
Mr David Taylor Audit Commission
The Rt Reverend William John Westwood Bishop of Peterborough

Programme of work

Dr Mawhinney has left the Department of Health, and the findings of our review will now be submitted to Mr John Bowis, Parliamentary Under Secretary of State for Health, who has assumed overall responsibility for drug misuse at the Department. We are due to report our findings in January 1996.

The Task Force held its first meeting on 1 June and we have now met five times. Our early meetings were spent in familiarising those who, like myself, are new to this specialist field with the issues, and then in considering the areas on which we should focus our work. We are acutely aware that drug misuse is a complex and challenging area for study. We have only a finite time in which to produce our response to Ministers, and a finite budget within which our work must be contained. Nevertheless, I am determined that we should do justice to the issues we address, and that the findings of our review should result in clear advice to purchasers about what constitutes a sound investment of resources, thus producing measurable benefits for individuals and for society as a whole.

If we are to succeed, it is essential that our recommendations be based on sound information, as quantitatively reliable as possible. To achieve that we must depend on the help and cooperation of services themselves. The NHS Executive has written to health authorities, local authorities and NHS trusts, asking them to encourage services to participate in this review. The programme of work we are commissioning will seek to encompass every aspect of service provision. I very much hope that those services which are approached to be part of our sample will cooperate fully with the people undertaking work on our behalf.

Census of drug services

The first, and now completed, piece of work was a comprehensive survey of drug services undertaken for us by Professor Suzanne MacGregor of Middlesex University. The data from this 'census' has been compiled on a computer database, and will provide us with invaluable quantitative information about services, the activities they undertake, staffing, numbers of clients and funding arrangements. For example, we should be able to interrogate the database for information on the numbers of services providing treatment and care for young people, or for amphetamine users; whether a service offers HIV or hepatitis C testing; the numbers of services which are involved in prescribing and which drugs they prescribe; whether services have a waiting list for treatment; and so on. This service directory will provide essential information to underpin all the other studies the Task Force is putting in hand.

Information collection

Much of our work will be commissioned from researchers experienced in the drugs field, and some from management consultants. In order to examine service provision itself, we shall be asking drug users themselves for their views of the services available to them. We shall also form a view, from the findings of this work, about where there may be gaps in service provision, and we shall make recommendations about how these gaps might be filled in the future. Task Force members are also keen to hear the views of people working in the field. In addition to the written evidence from key individuals and professional bodies which we have now received, we are expecting to undertake a programme of visits to a range of services. We shall also invite a small number of people to present oral evidence to us over the forthcoming months.

Written evidence

In August we invited written evidence on a range of treatments and issues including but not limited to:

- Approaches to rapid withdrawal (detoxification)
- Methadone maintenance
- Types of rehabilitation
- Self-help groups
- Approaches to gradual withdrawal
- Sale/exchange of needles and syringes
- Support and counselling

Other areas on which we suggested evidence might be given included:

1. The aim(s) of drug misuse services in general
2. How to address gaps in service provision
3. Services for young people
4. Services for non-opiate users
5. Women and drug services
6. Ethnic minorities and drug services
7. Services for prisoners
8. Access and referral to services
9. Entry criteria applied by services (if any)
10. Reaching misusers not in touch with services
11. The role of the General Practitioner
12. The role of other professionals: nurses, probation officers, social workers, youth workers, teachers, etc
13. The training of drug misuse workers
14. Issues for purchasers
15. Issues for providers

Focus on outcomes

The Task Force has selected a range of outcome measures against which the success of treatment will be judged. These include abstinence from drugs, reduction in drug use and risk-taking behaviour, improvement in physical health and psychological wellbeing, improved social functioning (in relationships, employment, education/training etc) and a reduction in criminal activity.

The outcomes on which we wish to focus are:

Drug use

1. Abstinence from drugs
2. Near abstinence from drugs
3. Reduction in the quantity of drugs consumed
4. Abstinence from street drugs
5. Reduced use of street drugs
6. Change in drugtaking behaviour from injecting to oral consumption
7. Reduction in the frequency of injecting

Physical and psychological health

1. Improvement in physical health
2. No deterioration in physical health
3. Improvement in psychological health
4. Reduction in sharing injecting equipment
5. Reduction in sexual risk-taking behaviour

Social functioning and life context

1. Reduction in criminal activity
2. Improvement in employment status
3. Fewer working/school days missed
4. Improved family relationships
5. Improved personal relationships
6. Domiciliary stability/improvement

National Treatment Outcome Research Study

A major part of our review will be a study looking at the progress of up to 1000 clients coming into services over a three-month period early next year. The National Treatment Outcome Research Study (NTORS) will be conducted by the National Addiction Centre in London, under the supervision of Dr Michael Gossop. Dr John Marsden, who until recently worked as research manager at Turning Point, will be working with him.

The progress of clients will be followed for the full length of the study, whether they remain in treatment or not. The following treatments will be represented in the sample:

- residential rehabilitation;
- inpatient drug dependence unit treatment;
- outpatient/community-based methadone reduction treatment;
- outpatient methadone maintenance.

These particular treatments have been selected because they are thought to be capable of providing particularly large samples of clients to provide statistically reliable evaluations. Treatments involving smaller entry numbers of clients will have to be surveyed by more qualitative methods. Services participating in, and funded by, the Department of Health's recently announced pilot oral methadone maintenance programmes will be asked to include their clients in this study.

Outcome study extended

The Task Force will receive a first report from the National Treatment Outcome Research Study in November 1995, providing information on the progress of clients over the first six months. We recognise that this is early days to measure clear outcomes from treatments for drug misuse, but I am confident that it will offer significantly improved information than we have at present on the initial effectiveness of various interventions. In recognition of the limited information that this exercise will give us in the time available, I asked the Minister for the study to be extended, beyond the life of the Task Force, and I am glad to say that it will now continue until at least November 1996. This will enable a comprehensive judgement of the longer-term effects of treatment to be made. A further report on the progress of clients will be made to the Department of Health.

Many of the treatments to be included in the National Treatment Outcome Research Study are relevant mainly to people dependent on opiates. The Task Force has therefore considered how it should address the issue of the effectiveness of service provision for other aspects of drug misuse. We are clear that we need to examine services for non-opiate users, including those who use amphetamines and crack/cocaine, the particular challenges posed to services by young people, the role of GPs in the care and treatment of drug misusers and drug misuse in pregnancy. We shall be looking at the role of and effectiveness of community-based services and of needle exchange schemes. With the Prison Healthcare Directorate's help we shall be looking at the care and treatment of drug users in prison. We shall also be considering appropriate training for people working in drug services.

International literature reviews

A further aspect of our work is to benefit from what has been learned by people working in this field in other parts of the world. A series of international literature reviews have been commissioned by the Department of Health, and these will be available to inform us on various aspects of drug misuse and service provision. The reviews and their authors are:

Detoxification and gradual withdrawal	Dr Herb Kleber
Needle and syringe exchange	Dr Don Des Jarlais
Residential rehabilitation	Dr Rob Hubbard
Methadone reduction treatment	Dr Charles O'Brien
Maintenance approaches to treating drug misusers	Dr Richard Mattick
Reaching drug misusers not in touch with services	Dr Robert Booth
The consequences of drug treatment for criminal behaviour	Dr Peter Reuter

Government Drugs Strategy

You will see, from this brief outline, that the Task Force has ahead of it a prodigious work programme. We know that the results of our labours are keenly awaited by many individuals and organisations, including the Department of Health and the Central Drugs Coordination Unit. The recently published draft Government Drugs Strategy for the period 1995-98 commits the Department of Health to address a number of issues following the outcome of our review. In particular the strategy requires the Department to:

- ensure that cost-effective and appropriate services are accessible to those experimenting with drugs and problem drug misusers;
- identify what further steps need to be taken to ensure that young people have access to adequate and effective early intervention services;
- continue to encourage a range of initiatives which minimise the risks and damage of drug misuse both to communities and to individuals who are not drug-free eg. syringe and needle exchange schemes and advice on safer sex;
- ensure that purchasers have access to appropriate sources of advice and consultancy to inform purchasing decisions.

I expect the next twelve months to be a challenging and interesting time for members of the Task Force. We believe our work to be important, and we are seized of the responsibility that has been placed on us by the Minister to make this review relevant, the findings appropriate, and the outcome a better provision of high quality, demonstrably effective services for the future. I hope you will support us in our work, and that over the forthcoming months my team and I will have the opportunity to meet with many of you providing services and to learn from your knowledge and experience.

Shape up or pay up

Make your services fit for a culturally diverse society – or release funding for those who can

DRUG SERVICES FACE a growing challenge to become more culturally appropriate, one few have really addressed. Established services, overwhelmingly staffed by, managed by and run for the white population, have failed the black community. We need to change in the four main areas described below – or stand aside for those who *can* deliver culturally appropriate services.

Transforming existing agencies

The vast majority of resources are tied up in established white services. Over the last few years we have employed more black drug workers, but we have used them to avoid our responsibility to transform our agencies. Posts in established agencies for work in black communities may be viable, but only if the workers are empowered to create new relationships with community groups and to promote organisational change. Black workers should not be expected to assimilate.

Creative recruitment methods and equal opportunities procedures must be explored and developed. We should review our entry criteria, giving due weight to the skills, contacts and experience people from black communities can bring to the organisation and creating training opportunities so these can be harnessed. We should support black workers to support each other through black drug worker's forums or through mentoring schemes, where new workers or students are supported by experienced black workers. More urgently, we must re-educate ourselves right to the top of our organisations. An opt-out by senior management ensures institutional racism continues and limits the value of work done by other staff.

Embracing local communities

One way to drive change is to organise our agencies so they promote participation by community groups. This is not about token places on management committees. It is about opening up our organisations and letting people question how we work. We should invite community representatives to planning days to reflect the views of those we fail to reach. We should be more open about our budget-setting and encourage a debate on our priorities. We should invite community groups to 'audit' our services, including those groups with uncomfortable messages to deliver. And we must be prepared to listen and adapt, otherwise we simply create frustration and anger.

Developing culturally sensitive services

We should question whether black drug users will come to agencies with a strongly Eurocentric image or which project a clear drugs or HIV profile. Outreach or satellite services are one way round this problem. The youth service has shown flexibility in using part-time working to create culturally diverse services. As drug use spreads, the only way we can keep pace may be for these workers to work with us or act as gatekeepers to our services. They may even provide our services for us. This requires trust and skills-sharing but will mean we can build on the commitment and privileged access of community members.

We should also question treatment approaches. I feel uncomfortable about prescribing methadone to young heroin users from communities where drug use is still in its infancy. Does this reflect our lack of imagination? With apparent success, Asian youth workers in east London have been taking young users and dealers away on residential courses to discuss the damage drug use does to their communities.

Black staffed and managed agencies increasingly provide some sanctuary against the apathy of other services. They can also create new models of drug services, become advocates for their communities, and catalysts for change. They must not become our new excuse for not changing. Nor should we look to them to come in and 'sort out' our problems.

> We have failed to provide culturally sensitive services

Purchasing and funding strategies

Currently funded agencies have the resources and contacts to ensure they continue to corner funding and the power to dominate small community groups. Many have shown their unwillingness or inability to change. The health and social care market provides a vehicle for questioning this status quo. Purchasers should promote partnership and fund more creative service delivery options. This may require more sophisticated ways of measuring a service's performance. Services which campaign, raise issues and facilitate the work of other services can add value across a district or borough. Measuring only direct client contacts misses what may be their main contribution.

As providers we could support community groups where they are better placed to offer services, by not bidding against them or by bidding in partnership. Large providers could agree to make savings of say 2 per cent to release money for such groups to work in hard to reach communities. A small percentage top-sliced from our budgets could have major benefits for small community groups when there are no new monies.

We have failed to provide culturally diverse and sensitive services. We may be creative and politically correct in explaining this to our purchasers; it would be more ethical to openly tackle theseproblems. If we don't, then purchasers should act decisively to force us to change – or fundamentally reconsider the funding and provision of services. ❍

from
Matthew Southwell
Drugs and HIV Services Manager for the City and East London Community and Family Health Services.
This article is based on a presentation to the Asian Drug Project conference Breaking The Silence, 8 July 1994.

No big deal

Court-ordered treatment in practice

From October 1992 courts have been able to 'sentence' drug and alcohol dependants to treatment. Two researchers pool their results to assess how this controversial power has worked out in practice. What they found was unexpected

by
Maggy Lee
ISDD Research Unit
Sarah Mainwaring
Leicestershire Probation Service

SUMMARY

Two studies have assessed the practical impact of the provision introduced in 1992 allowing courts to make it a condition of a probation order that drug dependants undergo community-based treatment. Courts rarely used this option and it had little impact on the volume or type of work done by drug services. There was evidence that probation services are 'unnecessarily' proposing treatment conditions in less serious cases where the offender would not have been imprisoned.

THE 1991 Criminal Justice Act gave judges and magistrates the option of requiring treatment for drug or alcohol dependence as an add-on to the standard probation order. These 'conditions of treatment' may involve residential or non-residential contact with a drug or alcohol agency up to the length of the probation order. Treatment can be specified or simply to be directed by anyone "having the necessary qualifications or experience". Drug services, medical and non-medical, were in line to receive referrals under the new system.

Not all were enthusiastic. There were concerns over compulsory treatment and that offenders who'd 'failed' the court's treatment programme would end up with harsher sentences than before. These vied with predictions that the provisions would help keep drug users out of prison and stimulate better working links between drug agencies and probation services.

This article assesses what happened as the Act became a reality for probation and drug services in England and Wales. Its basis is research by ISDD[1] plus work done at Leicester University.[2] ISDD collected statistics from 12 probation services and interviewed probation/drug workers for about half the offenders placed on treatment conditions. The research at Leicester collected information on treatment conditions from 20 probation and 15 drug services.

Expectations unfulfilled

A crucial first question is, was this sentencing option used? Our research suggests the answer is, only rarely. Twelve probation services reported just 61 conditions of treatment for drug dependence in the first six months of the Act, ranging from 20 in the Inner London Probation Service to zero in Cambridge.

For treatment services too, the impact had been minimal. Nine English drug projects surveyed reported 28 referrals under conditions of treatment up to July 1993,[3] contrary to warnings before the Act came into force that services might need to prepare for an influx of new clients.[4,5]

Nor did things work out as expected in terms of the *type* of treatment the offenders' received. The need to flexibly adapt to the court's schedule meant that in many areas probation officers took the lead as the 'suitably qualified' person directing treatment, rather than drug workers. This accounted for 20 of the 61 treatment orders made by 12 probation areas. When the court was more specific about the treatment to be imposed, the picture was mixed: 18 orders specified residential and 23 non-residential treatment.[6]

In the Leicester research 24 out of 28 treatment order referrals were received by residential projects and just four by non-residential ones.[7]

This mixed picture probably reflects a mixture of forces. Favouring residential conditions is the fact that before the Act working relationships between some residential projects and some probation areas had been established through condition of residence orders,[8] easing the way for the conditions of treatment to be tacked on to existing practice.

Also residential care needs funding; specifying it in a formal treatment order makes this easier to get. Funding is usually not a requirement for non-residential treatment, so this can be arranged without the need for a formal treatment order. At the time of our research there was no evidence that probation referrals to street agencies had come with funding attached. These factors will tend to mean that residential treatment is specified in probation orders while the bulk of non-residential treatment is arranged less formally.

Alternative to custody?

For many people the key question is whether the Act has kept drug users out of prison – or has restricted the liberty of people who would not have been imprisoned in the first place.

The Advisory Council on the Misuse of Drugs argued that conditions of treatment should be "reserved for people convicted of relatively serious offences and then only when a custodial

sentence would be the alternative outcome".[9] But targeting serious offenders is not easy. Critics of the Act have warned that to get their recommendations accepted by the court, probation officers might 'play safe' in pre-sentence reports, proposing greater restrictions of liberty than are warranted by the offence.[10]

Such concerns may be justified. In both our studies, most drug using offenders placed on conditions of treatment had been convicted of property crimes rather than violence. In 16 cases we had probation's rating of the seriousness of the offence. Five were not thought highly serious or such as would make the offender 'at risk of custody'. Over half – 53 per cent – of 61 conditions of treatment for drug dependence were made in magistrates' courts, which deal with less serious offenses than crown courts.[11]

One of us recorded the outcome in 94 cases where a condition of treatment for alcohol or drug dependence was proposed by probation, but rejected by the court. Only 57 per cent went on to be given a custodial sentence.[12] The implication is that many probation clients were having a more restrictive order proposed for them than was necessary.

Based on these small-scale findings, it is debatable whether conditions of treatment are only being made in serious cases and as an alternative to custody.

The impact on drug services

Many drugs workers were against the introduction of conditions of treatment. They argued that a choice between treatment and prison was not a real choice, and insisted treatment be a response to need, not a penalty from the court. There were fears that if an offender's drug advice worker liaises with their probation officer, then the drug agency will no longer be seen as safely distanced from the criminal justice system. Clients would lose trust and be less open about their drug use.

> The potential to divert drug users from prison seems strictly limited

There were concerns, too, that forcing drug users into treatment risked setting them up to fail. Of 15 treatment agencies surveyed, five out of the six that refused to accept conditions of treatment cited the issue of the client's motivation as their main reason.[13] But most were prepared to play ball. As the Probation Inspectorate pointed out, many were prepared to accept such conditions if that seemed the only way to keep an offender in the community.[14]

How agencies would manage the flow of court referrals was also a concern in the run-up to the Act. Services were advised to negotiate a referral policy with probation and to "decide in advance what type and volume of work [they are] prepared to take on".[15] In practice, the need to respond to the court's schedule, or to other administrative concerns of the criminal justice system (for instance, the backlog of cases), could mean such arrangements were thrown out of the window. Pressure on drug workers to accept a condition of treatment increased if the offender was known to the agency.

In agencies which did accept clients on conditions of treatment, drug workers felt the Act had not made a big difference to their work – either in terms of the number of new clients or how they worked with them. Most orders did not specify the nature and duration of the treatment, providing flexibility for treatment to be varied without having to return to court. As one residential drug worker put it:

"There is no difference whether a client is on condition of residence or bail or new residential treatment ... it should be the same ... We don't want to offer one thing to one type of client and another thing to another, or else there would be complaints from residents of unfair treatment, ie, they need to go through the court to get the right type of treatment."

Some workers in street agencies did make special efforts to do home visits. The aim was to minimise the risk of courts declaring the offender in breach of their probation order because they had failed to attend the agency.

Credibility problem in court

Probation officers have warned that conditions of treatment would not be a 'credible' sentence for courts dealing with serious offenders – not 'punishing' enough or too 'woolly'. This may be one reason why in 57 per cent of cases courts rejected treatment conditions recommended by probation.[16]

To make them more credible, probation officers have argued for any additional requirements placed on offenders to be clear-cut and more stringent than a straight probation order. This might explain some probation areas' preference for probation orders to specify activities and group work. These may not involve drug treatment at all and are funded and controlled directly by probation, avoiding the uncertainty of work with new 'partners' in drug services.

As for magistrates and judges, many prefer the 'old style' condition of residence to the condition of treatment, though the rehabilitation programme may be the same. As one drug worker explained:

"We work with all clients under the same therapeutic community model. But the 'condition of residence' is perceived as more punitive than conditional treatment by many judges. The difference exists purely in [their] minds ... In court their emphasis is on restricting these people's liberty."

THE MESSAGE FROM our studies is clear: treatment conditions have changed little for the clients, the courts or drug services. They may have prompted closer links between probation and drug services, but joint work around drugs remains mainly in the form of joint training, secondments, and informal liaison, rather than implementing the new sentencing option.[17] Perhaps training and improved inter-agency relations will in the end benefit drug users in the criminal justice system. But the immediate potential of the Act to meet the welfare needs of drug users or to divert them from prison seems strictly limited.

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Mind your own business

One strand of national policy encourages offenders to own up to their drug problems – but do other strands give them overriding reasons not to? This probation officer's eye view suggests schemes to divert offenders into treatment could fail at the first hurdle

by
Chris Briton
Probation Officer with the Somerset Probation Service

SUMMARY

Official guidance exhorts probation officers to encourage all offenders to disclose any drug misuse. Such guidance is unrealistic as offenders fear that they will lose more then they gain by disclosure. At risk are their liberty, their sources of drugs, their relationships with parents and school, their children, their partners, and their jobs or welfare benefits. New drug testing provisions in prison will add yet another disincentive.

A LONG TIME ago – before my time – police court 'missionaries' hung around court buildings waiting to save intoxicated defendants. They seemed fairly sure that some people's offending was related to their drinking. Ninety years later these missionaries evolved into probation officers. We still hang around court waiting to pounce on any unsuspecting drunk but have now acquired a new, more eloquent cause: "to extricate offenders from the revolving door of drug misuse, crime and custody".[1]

Inebriated defendants are still our concern, but now they are only a part of a collection that includes heroin injectors, acid heads, dope smokers and an assortment of other folk devils. Time has seen new drugs manufactured, such as LSD and ecstasy, and the drug scene has become more varied and complex. To combat the various harms associated with drug misuse the new, modern, case management probation officer is encouraged to entice and cajole offenders to reveal all about their drug misuse.

Some offenders are very open about their drug misuse and have no difficulty with disclosure. Indeed, for a number, "there is seldom a reluctance to talk about drugtaking".[2] It is a part of their lifestyle and identity which they feel a need to portray publicly.[3]

Other offenders, probably the majority, are enormously reluctant to disclose their drug misuse. When I ask defendants about drug misuse while preparing pre-sentence reports, I am often met with a blunt and colourful retort: 'Mind your own business' is the common theme. Why do they say this? Why do I feel they don't trust me?

Reasons to keep quiet

Having suffered derision and ridicule in response to my questions about drug misuse, I decided to try a new approach. Instead of asking offenders about the drugs they used, how often, their cost, their effects, I began asking them what they believed might happen if they told me they were still using drugs. This they found little difficulty disclosing. Displayed opposite are some of their misgivings and apprehensions. Those highlighted were only part of a very long list of reasons for non-disclosure including social disapproval, labelling, lack of confidentiality, being forced into treatment, and being vulnerable.

With this litany of understandable reasons not to disclose, it's no wonder that the good intentions of probation officers and policy makers run up against a blank wall. From the offender's point of view, the disincentives simply outweigh the incentives.

Probation service areas in England and Wales prepare more than 200,000 pre-sentence reports annually. Officers are encouraged to ask "all offenders about the possibility of drug misuse. We believe this is good practice, even in cases where there is no obvious indications that drug misuse is an issue."[4]

What do we offer in return? Referral to a psychiatrist? Referral for a community care assessment? As the Probation Inspectorate recently asked, "How does the probation officer get to the point where the offender actually believes there may be some advantage in disclosing information?"[5] The idea of disclosure from everyone is attractive – it is also unrealistic.

National crime and drugs policy sets the environment within which the disincentives operate. Recent calls by high ranking police officers for the decriminalisation of the possession of some drugs were met with a swift rebuttal from the Home Office. The Government cannot be perceived to be 'soft on drugs', and currently that translates to not being soft on drug users. If the message to drug misusing offenders is that they will be prosecuted and perhaps dealt with more harshly by the courts, then few of them will take a risk in disclosing their drug misuse to a probation officer.

The Advisory Council On The Misuse Of Drugs may advocate disclosure and the Home Office, in its *National Standards for the Supervision of Offenders in the Community*, may also encourage more openness from offenders

8 Reasons to keep quiet about drugs

What offenders believed might happen if they told a probation officer they were still using drugs

1 LOSING YOUR LIBERTY

There was fear that courts might respond to disclosure with a remand in custody or action for breach of a court order. Drug misusers are often portrayed as drug-crazed junkies who cannot control their habit nor associated crimes and, therefore, need to be remanded in custody rather than given bail in order to prevent reoffending.

The risk of a harsher sentence was also a major concern. Scottish legal history was recently made when the Court of Criminal Appeal in Edinburgh quashed a probation order on a 19-year-old for supplying LSD to two school girls and substituted a three-year custodial sentence.[9] Courts still believe in the theory of deterrence and drug misusing offenders are easy targets.

2 LOSING YOUR DEALER

Offenders were concerned that disclosing drug use might mean they'd be seen as informants and that police would target their suppliers, who might use or threaten violence in revenge.

For offenders unafraid of their suppliers there was still the anxiety that dealers may be busted, robbing them of a valuable source of drugs.

3 LOSING YOUR HOME

Having your accommodation searched was an anxiety. What is there to prevent the probation officer notifying the police, who in turn would pay the offender a home visit with a search warrant?

Coupled with this was the fear that landlords who learn of drug misuse on their premises would swiftly evict the tenants. Probation hostels automatically exclude residents when drug misuse is discovered.

4 LOSING YOUR JOB

We are seeing the advent of drug testing as part of the application process for some jobs and part of the in-job health and disciplinary process in others. Losing employment because of having committed an offence is always a fear, but if the defendant is known as a drug misusing offender, it increases the chances of being given the sack.

5 LOSING YOUR SCHOOL

Young drug misusing offenders were especially wary of disclosing because they felt their parents would immediately be notified. Adolescence is difficult enough without aggravating parents any further.

Exclusion or expulsion from school was an equal concern. "The fear of school exclusion, a visit to the police station and catharsis at home almost guarantee denial."[10]

6 LOSING YOUR BENEFITS

Benefit agencies may deny that they suspend or reduce income support payments to drug misusing offenders, but that doesn't stop this being a major concern for many if this is their only source of income.

7 LOSING YOUR CHILDREN

Fear of having children taken into care was especially pertinent to female drug misusing offenders, who believed revealing drug misuse would mean they would be seen as 'bad mothers'. Recent research in Glasgow would support this view.[11]

8 LOSING YOUR PARTNER

The shock felt by wives, husbands and lovers when they found out that their partner was taking drugs was often described as similar to that of disclosing or discovering adultery. Some offenders said they would be happier to disclose infidelity than drug misuse.

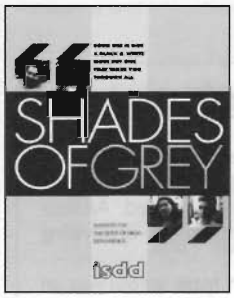
about drug misuse, but there needs to be some incentive for them to do this, or at least less discrimination shown towards them.

When drug misusing offenders are stereotyped and labelled and perhaps sent to prison more quickly for using drugs, then they will continue to remain reticent. When magistrates and judges continue to perceive drug misusers as chaotic and a threat, then offenders will continue to remain reticent.

But policy seems to be moving in the opposite direction. The 1994 Criminal Justice and Public Order Act provides for compulsory drug testing of prisoners. Home Secretary Michael Howard has said there will be "targeted testing of all known drug users" and that "any prisoners testing positive – or who refuse the test – will be liable to disciplinary action". This could include another month in jail, confinement to cells and loss of privileges.[6] The policy framework into which this fits emphasises stamping out drug use in prisons, not the care of problem drug using prisoners.[7] For prisoners, or defendants who know they may end up as prisoners, these provisions are bound to add a major new disincentive to disclosure.

THE DILEMMA for probation officers has been nicely summmed up in a Home Office research paper: "On the one hand [they] were expected to act as part of the criminal justice system, reporting illegal behaviour, and on the other hand were supposed to find out what was contributing to offending behaviour and work on it".[8] Only when probation service areas develop clear policies and strategies to resolve this dilemma will the offenders I interview refrain from telling me to 'Mind your own business'. ❍

1. Advisory Council on the Misuse of Drugs. *Drug misusers and the criminal justice system.* HMSO, 1991, p. 10.
2. Bean P. *The social control of drugs.* Robertson, 1974, p. 124.
3. Laurie P. *Drugs.* Penguin, 1967.
4. Advisory Council on the Misuse of Drugs op cit, p. 11.
5. H.M. Inspectorate of Probation. *Offenders who misuse drugs. The Probation Service response.* Home Office, 1993.
6. Home Office and Prison Service News Release 198/94, 19 October 1994.
7. UK Government. *Tackling drugs together.* HMSO, 1994.
8. Nee C + Sibbitt R. *The probation response to drug misuse.* Home Office Research and Planning Unit paper 78 (1993)
9. *Independent*: 24 September 1994.
10. Parker M. and Measham F. "Pick 'n' mix." *Drugs: Education, Prevention and Policy*: 1994, *1*(1).
11. Green S.T. *et al.* "Female streetworker – prostitutes in Glasgow: a descriptive study of their lifestyle." *AIDS Care*: 1993, *5*(3).



ISDD's "high quality" drug awareness training video

SHADES OF GREY. ISDD, 1994. Video. £47 inc. p&p.

This training resource consists of a 35-minute video, trainers' guidance notes and the ubiquitous ISDD *Drug Abuse Briefing*. It aims to lay the foundations for more advanced learning and practice by introducing course participants to a variety of central themes and issues. Throughout, emphasis is placed on the importance of *enquiry* and *action learning*. Participants are encouraged to "chew thoroughly before they decide to swallow".

The video comprises 11 sections which link similar headings in the trainers' guidance notes. Useful reference notes, suggested reading and training cues appear in each section of the trainers' booklet.

Without doubt this is a high quality, well researched resource. Its sophisticated approach in linking a variety of complex concepts is rarely found in a video-led package. Indeed, no other carves (on the whole) such an incisive line of enquiry.

We had to run through the video several times together with the guidance notes before appreciating its worth. At times we forgot which section we were viewing – a numbering system might have been helpful. The guidance notes may have benefited from colour coding and graphics to aid familiarity.

As always, there are one or two 'niggles' regarding content. The distinction between "drug use" and "problem drug use" was perhaps addressed much later in the video than it should have been. A reference to the fact that both cannabis and heroin can be taken for 20 to 30 years without any "physical or mental problems" is accurate, but extremely provocative. Much depends on the quality of the trainer. Like drugtaking, it's the way training packages are used that causes problems, not the package itself.

The subject specialists who took part in the narration were Dr Michael Gossop, Dr Virginia Berridge and Edward Neequaye who, together with David Hicks and Harry Shapiro (the authors), lent authority to the text.

This package could be very useful both to generic and specialist agencies. But it needs to be located within a well-thought out training programme by a competent trainer who is familiar with the issues and themes addressed.

Andy Malinowski
Director
Druglink, Drug Advisory Centre, Swindon

Donna Lee
Project Worker, Probation

Shades of Grey *is available from ISDD, £47 inc. p&p., £10 non-returnable inspection fee.*

Drug users have their say about drug services

COMMENT. Scottish Drug Forum, 1994. Video. £11 inc. p&p.

A lot of things have been done in the name of user involvement, but not enough and not all of them pretty. However, as the cover of this video notes, "Involving drug users in service planning and provision is increasingly accepted as an essential part of drugs work" – and not before time.

This video is by ex-users from PARC (Place Aftercare and Recovery Centre) in Glasgow who asked users and ex-users their views of the services offered to them. The comments are notable in how universal they are. Among them were: the lack of appropriate detoxification and aftercare facilities; the need for residential services for single parents with their children; the dearth of crisis intervention services; and waiting lists. All are well described.

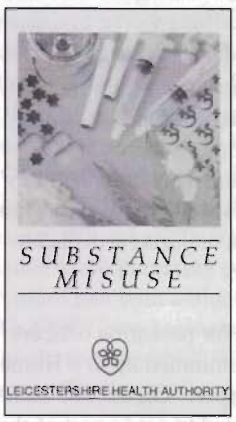
The impact comes from hearing these views expressed, by people from a range of backgrounds, including women, in approximately 18 minutes.

In other circumstances this same format could act as a conduit for the views of users to agencies, management committees and the often more inaccessible echelons of service planners and purchasers. It is a creative approach rather than having one person trying to represent a range of drug users' views to a committee or conference.

The most important immediate use for this video is for it to be given to other service users to show what has been done. Hopefully, it can act as a catalyst for many more initiatives like this and beyond. Buy it. Watch it. Show it. Imitate.

Exeter Drugs Project

Comment *is available from SDF, 5 Oswald Street, Glasgow G1 4QR, phone 0141 221 1175.*



Like a *Drug Abuse Briefing* on video

SUBSTANCE MISUSE. Leicester Health Authority, 1992. Video. £88.13 inc. p&p.

"All substances that influence the mind are potentially dangerous and knowledge of the serious consequences that can result from their misuse is therefore essential." So states this video in its introductory section which commendably establishes the context within which all societies have used mind altering drugs of some sort. The bulk of the video is a description of each group of drugs giving details of their history, formulations, routes of administration, effects and dangers.

So far so good – or is it? The video is in many ways a well-presented guide to drugs, not unlike a video *Drug Abuse Briefing*. But, perhaps inevitably, there are problems: problems of omission, problems of balance and problems of application. Among the omissions, there is no mention of heat exhaustion and dehydration in relation to MDMA or of the plethora of substances masquerading as 'E'. In the section on benzodiazepines there is no mention of the particular problems of temazepam gelfix capsules. The video does not cover poppers or anabolic steroids, substances not easily classified within the framework it uses but widely used by young people. Barbiturates are covered in detail – these are certainly very risky but are not now widely prescribed or used much on the streets.

Which leads on to problems of balance. By providing roughly equal amounts of information about the physical effects of different stimulant drugs the video is certainly comprehensive, but may well leave the viewer believing that the physical risks of cocaine and caffeine are much on a par. Whilst most viewers will know enough about caffeine to not overestimate its risks, I would certainly not want people to underestimate the risks of cocaine.

Ultimately, the important question is whether this video is useful. I believe it is *providing* there is a knowledgeable presenter who can ensure that balance and omissions are redressed and make learning from it an active experience. On its own, little of the information in a video like this is likely to be retained, particularly as there is so much but no back-up materials are provided. If its makers were to reduce the price and provide basic photocopiable sheets to back up and update information in the video, this production could be a real educational asset.

Lynne Milburn
Independent trainer and consultant

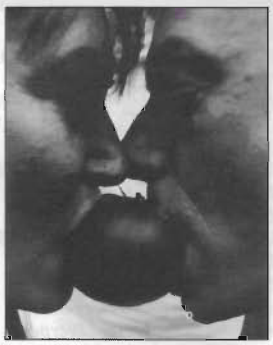
Substance Misuse *is available from Health Education Video Unit, Clinical Sciences Building, Leicester Royal Infirmary, PO Box 65, Leicester LE2 7LX, phone 01162 550461.*

Drug misuse databases record only part of 'sharing'

Dear Editor,

In their feature article "You say 'sharing', I say ..." in ***Druglink***'s July/August 1994 edition, Neil Hunt and colleagues point out the difficulties in estimating the threat posed to drug injectors by 'sharing' as the term means different things to different people.

Since May 1994 Cornwall Community Drugs Team has been providing a confidential testing and advisory service for HIV, hepatitis B and hepatitis C. We compared the incidence of 'sharing' in the narrow sense and 'sharing' in the broader sense.



Sharing can mean so much

During pre-test and post-test HIV counselling sessions, clients were asked if they had ever shared "anything" with "anyone". It was explained that "anything" means spoons, filters, injection water, a hit, etc, and "anyone" includes spouse, sexual partner, trusted friend, etc. We compared this data with answers given for the regional database forms, which were filled out at the time of interview. These only ask about sharing a needle and/or syringe.

Eighty-one injectors aged 19-47 were tested. Twenty-three were female and 58 were male. In 41 per cent of cases their main drug was an opiate, mixed opiates and amphetamines for 38 per cent, and amphetamines for 21 per cent.

Nobody tested positive for HIV, one tested positive for hepatitis B and 33 were positive for hepatitis C. According to the results collected for the regional database forms, 55 per cent said they shared at some time, but 91 per cent described some form of sharing in the wider sense of the word. This figure rose to 100 per cent in those testing positive for hepatitis C.

From the low incidence of HIV infection it is clear that injectors have changed injecting habits, but the hepatitis C virus appears to have slipped through the net of HIV precautions. All education on harm reduction must take into account 'sharing' in the broader sense to reduce the risk of hepatitis C infection in injectors.

A.B. Charnaud
Consultant Psychiatrist
Barry O'Muirithe
Clinical Assistant
Cornwall Community Drugs Team

Mockery of drugs ban on 70-year-old bowlers

Dear Editor,

The article by Ross Coomber (***Druglink***: November/December 1994) on sport and the use of performance-enhancing drugs illustrated the limitations of current policies. However, even within these intolerant philosophies, one would hope that sporting authorities would exercise a degree of discretion.

In the wake of serious drug offences at the soccer World Cup and summer athletics' tournaments, inflexible policy enforcement was illustrated by the decision of the Scottish Women's Bowling Association to ban two women in their '70s from a national tournament due to their therapeutic diuretic requirements.[1] Such a rigid application of rules makes a mockery of current policies.

At the other extreme, condoning the use of drugs in sport poses major problems, although as Coomber states, this issue is separate from controlling the use of steroids for aesthetic purposes.

> 43% said they had shared needles but 91% had shared in some sense

Consider the possible future situation of a sports champion who has used drugs as a training/performance enhancer. Would this perpetuate a negative image of sporting ethics while glorifying drugtaking? Would the next sporting generation abandon 'It's not the winning, it's the taking part' for 'Win at all costs'? Would traditional training values such as 'No pain, no gain' be replaced by performance enhancers? Would spectators be tempted into drugtaking in order to emulate their heroes? Would international success become dependent on a country's ability to develop performance-enhancing drugs?

Sport, with its extensive media coverage, is an opiate for a large proportion of the public and its influence should not be underestimated.

Incidentally, we would be interested to hear from any readers who know what performance-enhancing properties diuretics have in women bowlers.

Gareth Morgan
Substance Misuse R&D Officer
Alan Willson
Chief Administrative Pharmaceutical Officer
West Glamorgan Health Authority

1. "Drug rules reach into recreation for the elderly." *Pharmaceutical Journal*: 6 August 1994.

Detox in pregnancy – let the woman take the lead

Dear Editor,

I was recently rung by a pregnant drug user whose friend (a patient of mine) had recently come off drugs during pregnancy; the baby was born without withdrawals.

The patient's friend lived in south London and was having joint care from a well-known project and her GP. She was keen to have the baby.

She had been using large amounts of drugs including prescribed methadone and diazepam and was anxious to use the time of pregnancy to rationalise her drug use and if possible to stop altogether.

Her complaint was that the project was being incredibly rigid in how and where she could detoxify, and between which weeks of the pregnancy she could alter her drug use. They were also quite frightening about the risks when she suggested she would like to detoxify quicker.

Our experience, and the much greater experience in Glasgow,[1] is that detoxification in pregnancy is much better led by the woman and that it is basically safe to do as much as the woman feels able to do. This can be done at any stage, at any speed and as often as required. The only exception is rapid benzodiazepine reduction; this may need to be done on an inpatient basis and doses divided during the day to reduce the risk of maternal convulsions.

Chris Ford
General Practitioner, North London

1. Hepburn M. "Drug misuse in pregnancy." *Current Obstetrics and Gynaecology*: 1993, *3*, p.54-58.

No courage needed to oppose legalisation

Dear Editor,

Although working in the drugs field in a street agency, I write in a personal capacity.

A large specialist audience attended the Dorothy Black Lecture at the Centre for Research on Drugs and Health Behaviour, given by Professor Perez-Gomez, a visiting academic from Colombia who runs an outreach centre there for mar-ginalised people. The Professor's topic was legalisation and he made some significant points, but I had concerns about his approach.

Professor Perez-Gomez noted that the debate is carried out between urbanised countries, who neither acknowledge that they themselves are drug producers, nor the distorting effects that the demand for drugs in their countries has on developing economies, whose peoples also have a valid perspective. He added that the discussion is conducted emotionally rather than scientifically, that "nothing is proven", and that he would present varying perspectives neutrally.

He then went on passionately to oppose liberalisation, citing as "facts" matters which could be seen as philosophical. The main references were to cocaine and heroin, but the speaker used the generic term 'drugs' to illustrate his thesis. This was that: all drugs are harmful, medically, socially and to the foetus; all drugs pharmacologically trigger violence; drug users are natural criminals whose dependence cloaks their antisocial behaviours. He drew a parallel between relaxing the drug laws and "legalising murder, rape and armed robbery".

> The UK liberalisation debate has been timid

Professor Perez-Gomez caricatured the decriminalisation case, defining the British system of licensed prescribing of heroin by responsible doctors in treatment of addicts as "legalisation". His discourse was set fast within existing orthodoxies, implying that these were under siege from heartless economists and libertines and that the West was poised to legalise, with appalling effects for developing countries.

I wonder if the Professor realises how timid the liberalisation debate has been here. Overt repression of this debate is unnecessary because the manufacture of a semblance of consent is so effective. The debate only exists at all because of a *handful* of brave individuals in a field which includes many with private sympathies but who fear to court disapproval by speaking publicly.

I am concerned that this lecture, annually one of the most prestigious in the field, coincidentally took place during the month the *Taking Drugs Together* green paper ruled out any progress in decriminalisation (even of personal use of cannabis). Sadly, this debate is effectively over and a further generation of British drug users will be doomed to suffer the medical and social effects of criminalisation and the pains of imprisonment.

How much courage do your readers think it really takes in this country openly to vilify drugtaking, condemn drug users and oppose legalisation?

Lorraine Hewitt
Whitstable, Kent

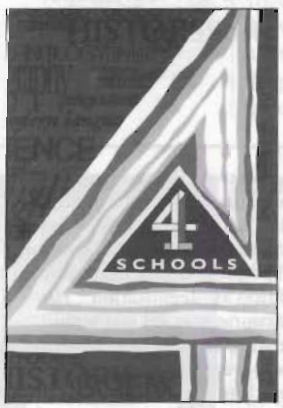
Letters should normally be less than 500 words in length and may be abridged at the editor's discretion.

PUBLICATIONS

Education/prevention

❑ **JIMMY SNIFFS: A PREVENTIVE APPROACH TO SOLVENTS AND SAFETY. Chris Ward. Birmingham: Birmingham Health Authority, 1994. Pack. £42.50.**
Available from Birmingham Heath Education Unit, Martineau Education Centre, 74 Balden Road, Birmingham B32 2EH, phone 0121 428 2262.

❑ **DIRECTIONS: DRUG AND ALCOHOL EDUCATION THROUGH MODERN FOREIGN LANGUAGES. TACADE. Pack.**
Teacher's guide.
Available fron TACADE, 1 Hulme Place, The Crescent, Salford M5 4QA, phone 0161 745 8925.



❑ **THE GOOD HEALTH GUIDE TO DRUGS. Video. £4.99**
❑ **OFF LIMITS: TALKING ABOUT DRUGS. Video. £4.99**
❑ **GOOD HEALTH. Booklet. £3.95.**
❑ **OFF LIMITS. Booklet. £4.95.**
❑ **GOOD HEALTH GUIDE TO DRUGS. Terry Brown and John Bennett. Resource book. £8.99.**
❑ **TALKING ABOUT DRUGS RESOURCE BOOK. Julian Cohen. Resource book. £5.99.**
❑ **DRUGS INFORMATION POSTER. Alan Aboud. £3.95.**
Coordinated package of resources for schools.
Available from Channel 4 Schools Initiative, Educational Television Company, PO Box 100, Warwick, CV34 6TZ, phone 01926 433333.

❑ **YOUNG PEOPLE AND DRUGS: GUIDELINES FOR PARENTS. TACADE. Booklet. £4.95.**
Available from TACADE, 1 Hulme Place, The Crescent, Salford M5 4QA, phone 0161 745 8925.

Users' guides

❑ **A GUIDE TO SAFER INJECTING. HIT. Liverpool: HIT, 1995. Leaflet. £35 per 100.**
Pocket-size guide.
Available from HIT, Liverpool Palace, 9 Slater St., Liverpool L1 4BW, phone 0151 709 3511, fax 0151 709 4916.

❑ **THE DETOX HANDBOOK: A USER'S GUIDE TO GETTING OFF OPIATES. Andrew Preston and Andy Malinowski. Redhill: Brittania Pharmaceuticals, 1994. 32 pages. £0.70 each, bulk discounts available.**
Available from ISDD, Waterbridge House, 32-36 Loman Street, London SE1 0EE, phone 0171 928 1211.

❑ **HELPING YOU COPE: A GUIDE TO STARTING AND STOPPING TRANQUILLISERS AND SLEEPING TABLETS. Mental Health Foundation. London: MHF, 1994. 13 pages. Free.**
Available from Mental Health Foundation, 37 Mortimer St., London W1N 5RJ, phone 0171 580 0145.

Drug services

❑ **GREAT EXPECTATIONS. DRUG SERVICES AND PROBATION: A GUIDE TO PARTNERSHIP. Dawn Hart and Russell Webster. London: SCODA, 1994. 37 pages. Report. £6.**
Available from SCODA, Waterbridge House, 32-36 Loman Street, London SE1 0EE, phone 0171 928 9500.

❑ **GUIDANCE TO LOCAL AUTHORITIES: CONTRACTING FOR RESIDENTIAL AND NURSING HOME CARE FOR ALCOHOL AND DRUG USERS. Local Government Drugs Forum. London: LGDF, 1994. 40 pages. £10.**
Available from LGMB, Arndale House, Arndale Centre, Luton LU1 2TS.

Young people

❑ **THE PLACE AND MEANING OF DRUGS IN THE LIVES OF YOUNG PEOPLE. Julia Hirst and Alison McCamley-Finney. Sheffield: Health Research Institute, 1994. Report. £5.**
Findings from a twelve-month research project.
Available from Health Research Institute, Sheffield Hallam University, Collegiate Crescent Campus, Sheffield S10 2BP.

❑ **YOUNG PEOPLE AND ILLEGAL DRUGS, 1989-1995: FACTS AND PREDICTIONS. John Balding. Exeter: Schools Health Education Unit, 1994. 35 pages. Report. £7.**
Summary of data from annual questionnaires.
Available from School of Education, University of Exeter, Heavitree Road, Exeter, Devon EX1 2LU, phone 01392 264722.

Other

❑ **GUIDELINES ON THE TESTING FOR DRUGS OF ABUSE IN THE WORKPLACE. Faculty of Occupational Medicine of the Royal College of Physicians, 1994. 28 pages. Report. £10.**
Available from Faculty of Occupational Medicine of the Royal College of Physicians, 6 St Andrew's Place, Regent's Park, London NW1 4LB.

❑ **CRACK OF DOOM. Jon Silverman. London: Headline, 1994. 246 pages. Book. £16.99.**
Available through bookshops.

❑ **ADDICTION: PROCESSES OF CHANGE. Griffith Edwards and Malcolm Lader. Oxford; OUP, 1994. x, 273 pages. Book. £45.**
Available through bookshops.

❑ **PURSUIT OF ECSTASY: THE MDMA EXPERIENCE. Jerome Beck and Marsha Rosenbaum. New York: State University of New York, 1994. xi, 239 pages. Book. £12.**
Study of users.
Available through bookshops.

❑ **FALSE FIXES: THE CULTURAL POLITICS OF DRUGS, ALCOHOL, AND ADDICTIVE RELATIONS. David Forbes. New York: State University of New York, 1994. 278 pages. Book. £24.**
Available through bookshops.

❑ **DRUGS AND OFFENDING. Council on Addiction. Northampton: CAN, 1994. Pack with video. £69.**
Available from CAN, Spring House, 51 Spring Gardens, Northampton NN1 1LX, phone 01604 22121, fax 01604 29557.

❑ **LEXICON OF ALCOHOL AND DRUG TERMS. World Health Organisation. Geneva: WHO, 1994. 65 pages. Swfr11.90. Book.**
Available from HMSO.

❑ **DRUG MISUSERS AND THE CRIMINAL JUSTICE SYSTEM: PART 2: POLICE, DRUG MISUSERS AND THE COMMUNITY. Advisory Council on the Misuse of Drugs. London: HMSO, 1994. 95 pages. Report. £8.20.**
Available from ISDD.

❑ **DRUGS IN SCOTLAND:MEETING THE CHALLENGE. REPORT OF THE MINISTERIAL TASK FORCE. Scottish Office. Home and Health Department. London: HMSO, 1994. Report. £5.00.**
Available from HMSO.

MEETINGS

❑ **ACTING FOR HEALTH: A SHOWCASE FOR THEATRE IN HEALTH EDUCATION. 25 January 1995. London.**
Details from Noel Dunne, Theatre in Health Education Trust, MFC, Balden Road, Harbone, Birmingham B32 2EH, phone 0121 428 2106, fax 0121 428 2353.

❑ **COMMISIONING ALCOHOL SERVICES. 22 February 1995, London.**
Details from Karen Ames, Alcohol Concern, Waterbridge House, 32-36 Loman Street, London SE1 0EE, phone 0171 928 7377.

❑ **NATIONAL CONFERENCE ON WOMEN AND DRUGS. 15 March 1995, Birmingham. £35.**
Details from the Women's Interagency Group, 6 Unity Pl., Oldbury, W. Midlands B69 4DB, phone 0121 544 3737.

❑ **6TH ANNUAL CONFERENCE ON THE REDUCTION OF DRUG-RELATED HARM. 26-30 March 1995. Florence.**
Details from Conference Administrator, Associazione PARSEC, Piazza Orazio Marucchi, 00162, Rome, Italy.

❑ **PRESCRIBING METHADONE – A NATIONAL CONFERENCE. 28 April 1995, Leeds.**
Details from Christine Wetherill, Training Administrator, Leeds Addiction Unit, 19 Springfield Mount, Leeds LS2 9NG, phone 01132 926930.

❑ **7TH INTERNATIONAL CONFERENCE ON TREATMENT OF ADDICTIVE BEHAVIORS. 28 May-1 June 1995. Leeuwenhorst Centre, The Netherlands. DF500.**
Details from Dee Ann Quintana, Department of Psychology, Logan Hall B50c, The University of New Mexico, Albuquerque, NM87131-1161, USA, fax 010 1 505 277 1394.

COURSES

❑ **CHAOTIC AND LONG-TERM CLIENTS. 12 January 1995. £23.50.**
❑ **PROZAC, KHAT, GHB AND IBOGAINE. 17 January 1995. £23.50.**
❑ **CHILDREN, DRUGS AND THE LAW. 18 January 1995. £23.50.**
❑ **THE SOCIAL CONTEXT OF SEXUAL RISK AND DRUG USE. 3 February 1995. £23.50.**
❑ **SAFER SEX: GETTING IT ACROSS TO DRUG USERS. 9-10 February 1995. £47.**
Details of these and other courses from Emma Webb, HIT, Liverpool Palace, 9 Slater Street, Liverpool L1 4BW, phone 0151 709 5311, fax 0151 709 4916.

❑ **ALCOHOL AND DRUGS STUDY COURSE: THE PREVENTION OF PROBLEMS. 21 February-28 March 1995. 1 day a week.**
❑ **PROBLEM TO SOLUTION. 3 March 1995.**
❑ **MOTIVATIONAL INTERVENTIONS WORKSHOP. 9-10 March 1995.**
❑ **DIPLOMA IN ADDICTION STUDIES BY DISTANCE LEARNING. April 1995.**
Details of these and other courses from Christine Weatherill, Training Administrator, Leeds Addiction Unit, 19 Springfield Mount, Leeds LS2 9NG, phone 01132 926930.

❑ **WORKING WITH PROBLEM DRUG USERS. £135.**
❑ **SPECIALIST THERAPEUTIC SKILLS FOR DRUG WORKERS. £150.**
❑ **ORGANISATIONAL DEVELOPMENT FOR DRUG SERVICES. £150. Various dates and venues.**
Details of these and other courses from Maudsley/Regional Drug Training Unit, National Addiction Centre, 4 Windsor Walk, Camberwell, London SE5 8AF, phone 0171 703 0269.

ORGANISATIONS

❑ **DRUGS IN SCHOOLS HELPLINE. Release. Phone 0171 729 5255.**
❑ **THE EARLY BREAK DRUGS PROJECT. Phone 0176 229537.**
A drug service for young people under 18 and their parents.

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☎ ON MORE NEW PUBLICATIONS AND ARTICLES: order *Drug Abstracts Monthly* – £20 p.a. from ISDD, phone 0171 928 1211.
☎ ON TRAINING: phone Dave Hicks, chair Drug Trainers' Forum, on 0191 230 1300.

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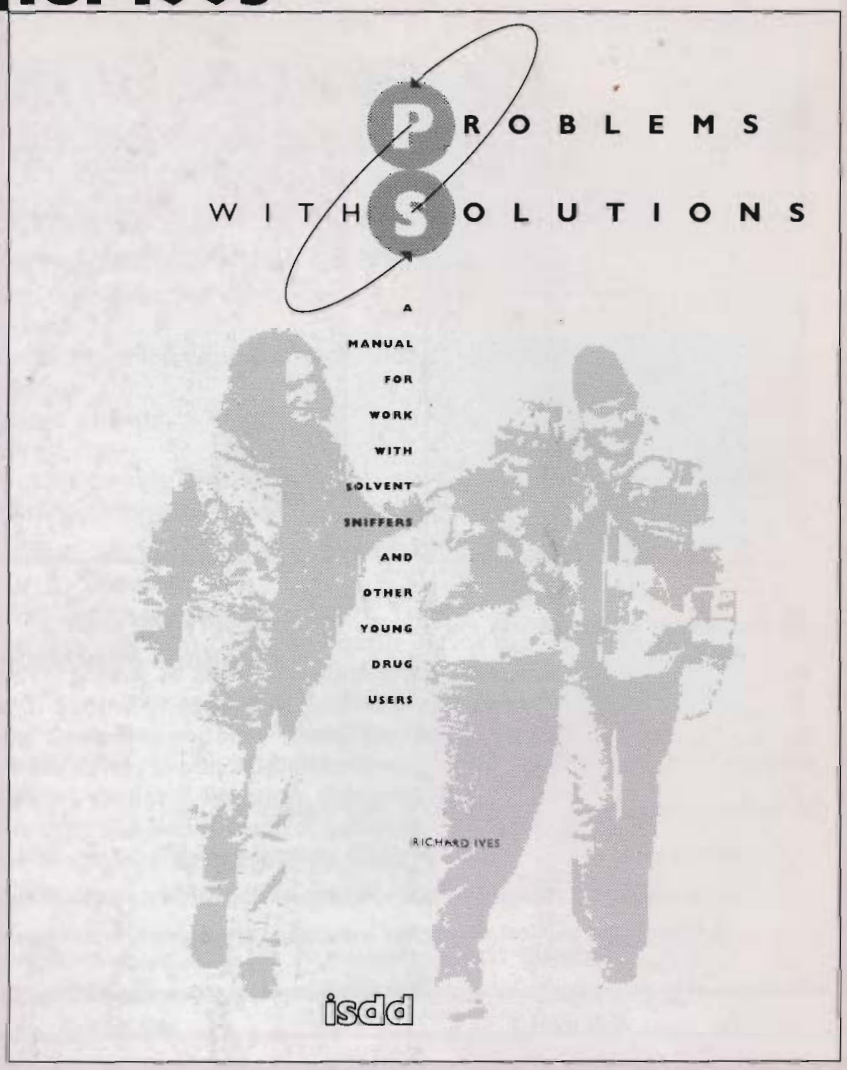

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