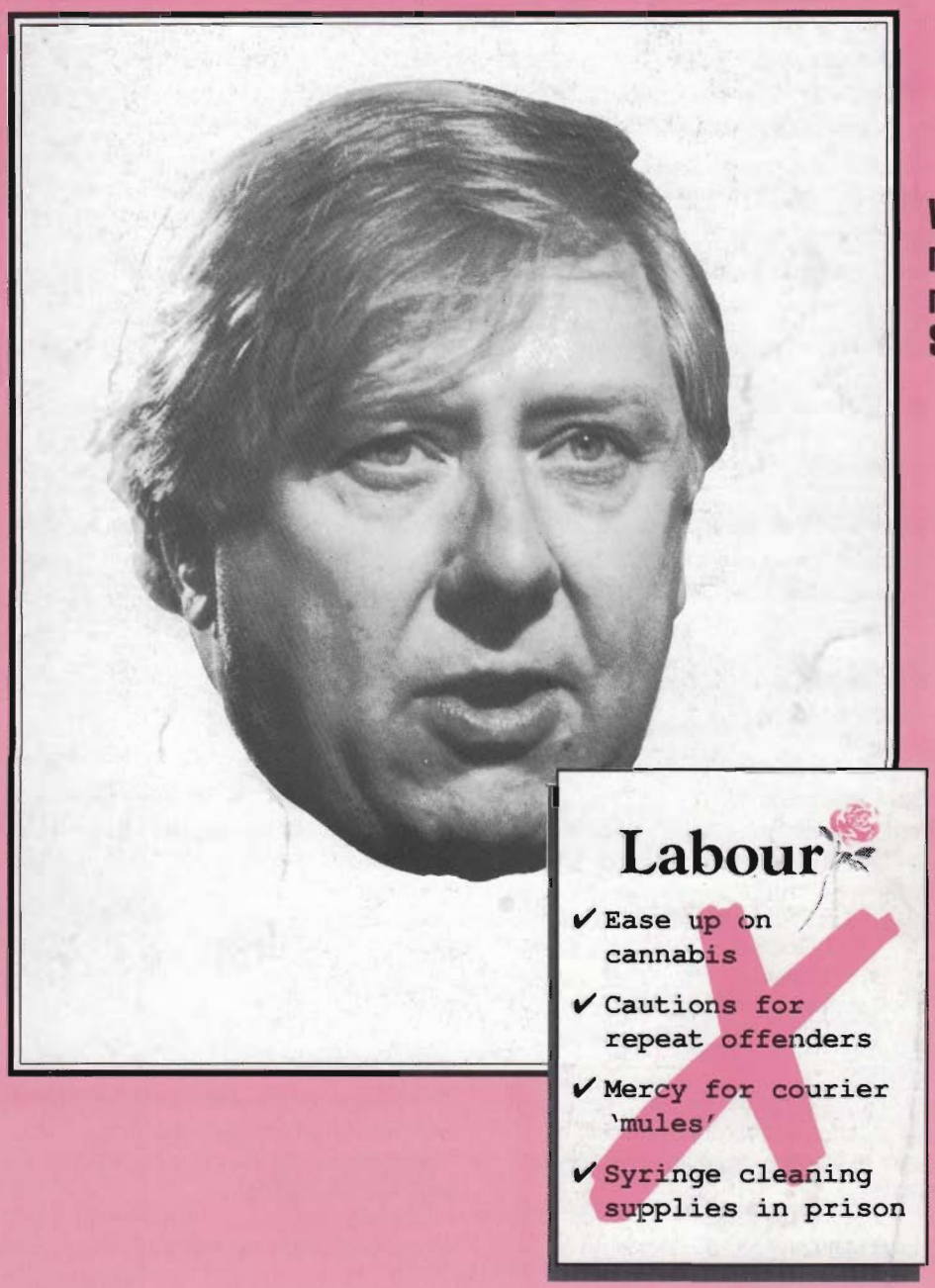
DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN July/August 1991



What Hattersley means by harm-minimisation. See page 6

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DRUGLINK

July/August 1991
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THE JOURNAL ON DRUG MISUSE IN BRITAIN

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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DRUGLINK is a forum for the recording and interpretation of facts and opinions on drug misuse in Britain. **Druglink** does not represent the views or policies of **ISDD**.

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At the sharp end

HIV positive and addicted. On page 8 the story of a mother dying from AIDS, unable to legally obtain the drug of her choice in the last months of her life. On page 11, why she and others like her need specialised services to plug the gap left between HIV services and drug services. It's a problem that's bound to grow.

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Research backs fear of rehab closures

£60 million needed to meet anticipated demand

Widespread closures of residential drug and alcohol projects can only be averted if these are exempt from the normal community care funding arrangements due to come into force on 1 April 1993. From that date social security payments to residents will be replaced by local authority community care budgets as the main funding source for rehabs.

Researchers at Turning Point have established that just one in five referrals to residential projects originate from the project's home local authority. The remainder are often widely dispersed across the country.

Forced to secure funding from each resident's home authority, the fear is that agencies would run into the bureaucratic nightmare many currently face in securing 'top-up' funding.

Many local authorities are unwilling to fund their residents and those that do sometimes require extensive paperwork. As a result, top-up funding is sparse and intermittent and seeking it makes major administrative demands on projects. Projects survive because top-up from local authorities is only a minor part of their income. If these problems extend to what after 1993 will become their main funding source, then Turning Point believe many will close.

The alternative promoted in *All Change after the DSS*, a joint Turning Point/SCODA/Alcohol Concern report launched at the House of Lords on 16 May, is for the local authority hosting the rehab to fund all the project's residents, regardless of where they came from. To do this the authority would be given a slice of the government allocation for drug/alcohol community care based on the number of beds in the project.

Turning Point's research has for the first time given a basis for estimating how big that allocation will need to be. A survey of all 97 registered drug or alcohol residential services known to be operating in England and Wales in 1989/90 estimated that by 1993 these would need a minimum £15 million to replace current social security payments.

However, this would merely maintain existing provision and occupancy levels. In 1989/90 nearly 20,000 people identified by referring agencies as in need of residential care were referred to drug or alcohol rehabs, but just 5000 became residents. Meeting this excess demand for places might require as much as £60 million to be made available to local authorities by central government.

FOR MORE INFORMATION

■ **ALL CHANGE AFTER THE DSS. Executive summary £1.50.** *Available from Linda Hunt, Turning Point, 401 Backchurch Lane, London EC1A, phone 071-702 2300.*

Prevention measures fail to stop HIV in injectors spreading 'more rapidly than was thought'

Disturbing new findings suggest there is already a significant pool of HIV-infected injectors and that high-risk behaviours continue at a level that threatens further spread.

The Centre for Research on Drugs and Health Behaviour found that nearly 13 per cent of injectors interviewed last year in London were carrying the virus. Most of the 534 injectors were injecting heroin but not in treatment. Nearly half had shared needles in the past six months although 80 per cent had a source for clean syringes.[1]

Presenting the findings to the 7th International Conference on AIDS in June, researcher Adam Crosier said the implication was that "despite... free needles and condoms, spread of HIV must be continuing regardless and more rapidly than was thought".

Another group from the Centre for Research has for the first time confirmed the suspected high levels of HIV infection among drug users in prison. Rebuffed by the Home Office, Paul Turnbull and colleagues were funded by the AIDS charity AVERT to interview ex-prisoners within three months of their release.[2]

The sample of 452 ex-prisoners from across England included 168 drug injectors. Over 10 per cent of injectors who provided a saliva sample were infected with HIV. Among the 45 women the infection rate reached 15 per cent.

Fifteen of the 19 HIV-positive ex-prisoners in the whole sample were drug injectors. One had injected five times while in prison, each time re-using uncleaned syringes and each time passing them on for further re-use.

Once out of prison, sharing syringes was rare among those HIV-infected, but most had unprotected sex.

Over a quarter of injectors injected in prison and of these nearly three-quarters had shared syringes. Effective cleaning methods – bleach or boiling – were rarely used. Both in and out of prison, hot water – an ineffective technique – was most common.

With the results of an Institute of Psychiatry study,[3] these findings suggest that English and Welsh prisons house 250-300 HIV-positive drug injectors, compared to the known total of 52 among all prisoners in 1990/91. The Institute estimated there may be around 4000 drug dependent prisoners of whom two-thirds had previously injected. An earlier study found that nearly a quarter of female prisoners were drug dependent at the time of their offence.

Anonymous screening of women attending English antenatal clinics in 1990 found that in inner London 1 in 500 were HIV-infected, but infection rates were practically zero in the handful of provincial clinics in the study.[4]

Patients at six genito-urinary clinics were also tested showing an overall 2 per cent HIV infection rate, rising over 4 per cent among those identified as drug injectors. In London, 1 in 90 of heterosexual male GUM patients were infected.

Evidence of HIV spread among heterosexuals in London spurred Minister of Health Virginia Bottomley to announce she will lead an AIDS Action Group targeting high prevalence areas.

1. Stephens S. *et al.* Paper presented at 2nd International Conference on the Reduction of Drug-Related Harm, March 1991. *Guardian*, 18 June 1991. Personal communication from the authors.
2. Turnbull P.J. *et al. Prisons, HIV and AIDS.* AVERT, 1991.
3. Maden A. "Drug dependence in prisoners." *B.M.J.*: 1991, *302*, p.880.
4. Department of Health. Press Release H91/226, 17 May 1991.

isdd NOTICEBOARD

■ Who's in charge at ISDD? Like most charities ISDD's work is overseen by a voluntary management committee (we call it the 'Council') which in our case is independent of government or any other external agency. So who are they?

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■ Who's asking what questions about drug misuse in Britain? *Drug Questions* gives the answers – this research directory is one of those unpretentious products worth more than a pile of glitzy 'packs' to people interested in talking to other people in the same line of business. Order issue five now from ISDD – £10 inc. p&p – and help us compile issue 6 – see the flyer in this issue of ***Druglink***.

Cabinet upgrade for drugs issue

At the Parliamentary All Party Drug Misuse Group in March, Home Office Minister John Patten revealed that a Cabinet drugs subcommittee had been established reporting directly to the Cabinet.

This meant "drug abuse was now being seen as a much more important issue," he explained. The subcommittee supersedes the Ministerial Group on the Misuse of Drugs, which since 1984 has handled interdepartmental coordination of drug policy. It is chaired by the Home Secretary as opposed to the junior ministers who previously chaired the Ministerial Group.

Broadly the same personnel and departments are involved, but the secrecy surrounding Cabinet subcommittees means its operations are unlikely to be as public as those of its predecessor.

Court criticises drug valuations

The Court of Appeal has ruled that prosecutors must take greater care in ensuring that a correct assessment of the value of seized drugs is put before the courts, after accepting that in a recent case the value had been inflated by over 100 times. Valuations of drugs have been a bone of contention since the introduction in the 1983 'Aramah' case of sentencing guidelines based partly on the 'street value' of seized drugs.

Drugs services often have excellent information on local drug prices, purity levels and general patterns of drug use. If this were routinely available to sentencers, a more accurate and accountable picture of drug prices might emerge in court.

In June the Appeal Court[1] heard that two defendants had been sentenced to eight and twelve years on the basis that they had imported heroin with an estimated street value of £500,000.

They were arrested with 1,236 grams of powder containing only 1 per cent of heroin. The value estimate put forward by the prosecutor was arrived at by applying an 'average' street value per gram at 'average' purity levels.

A standard multiplier was then applied, on the basis that drugs are always further 'cut' or adulterated, increasing profits.

But after hearing evidence from Release and other drug services the Court of Appeal accepted that the actual value was between £2,400 and £4,000, over 100 times less than the original estimate. As a result the sentences were cut to five and eight years.

This case illustrates the problems facing courts in assessing street drug values when relying only on evidence from prosecutors or police.

Current prosecution valuations, if unchallenged, often fail to reflect the fact that supply, demand and purity levels in the illegal drugs market change from day to day and from area to area.

Jane Goodsir, *Release*

1. R. v. Afzal and Arshad, 1991.

Pickles fillip for legalise lobby

Judge Pickles delivered his anticipated 'verdict' in favour of legalising drugs in BBC2's *Byline* programme broadcast on June 11.

For Britain's would-be legalisers the judge's public recruitment to their cause could be a significant PR coup. His presentation as an open-minded observer simply convinced by the 'evidence' may have helped legitimise public debate on the issue.

A major article in the *Times* (6 June 1991) argued that "until recently" public discussion on the issue has been "resistant to reason... With Judge Pickles on side, how much longer will politicians be able to claim that public opinion would not stand any loosening of the drug laws?"

Reacting to Pickles' appearance on the *Wogan* programme on 5 June, Home Secretary Kenneth Baker took a full page in the *Mail on Sunday* (9 June) to explain why he would not countenance cannabis legalisation. He took the trouble to address the medical and social arguments in unusual detail.

Labour's independent weekly *Tribune* (7 June 1991) sided with Pickles, arguing for complete cannabis legalisation as a more coherent option than merely decriminalising possession.

Three days after Pickles' broadcast, Professor Griffith Edwards of the Addiction Research Unit in London delivered an uncharacteristically vehement public denunciation. Billed as the "strongest counter attack on the 'legalise drugs' lobby yet heard in this country", the eminent psychiatrist and researcher argued easier availability would mean more addicts using higher doses.

Despite their renegades, government and opposition are officially united in their determination not to weaken the drug laws. Neither the voters nor recent expert opinion give the politicians much incentive to change their minds.

While there is some evidence of public support for Judge Pickles' starting point – that enforcing anti-drug laws can't reduce the drug problem – this has not generated significant public support for scrapping those laws.[1]

The latest expert advice to government also gives no credence to legalisation calls. As predicted in ***Druglink*** (January/February 1991), the prestigious Justice committee, British section of the International Commission of Jurists, contented itself with recommending that cannabis be demoted to class C of the Misuse of Drugs Act.[2]

Their recommendations stop short of those made over 12 years ago by the Advisory Council on the Misuse of Drugs.[3] The council also called for cannabis to be demoted to class C, but coupled this with a call for magistrates' courts to be unable to imprison for cannabis possession.

Like Justice, the ACMD were aware that reducing penalties would mean cannabis possession was no longer an arrestable offence. Unlike Justice, they were not convinced that this would present the police with practical difficulties justifying the retention of arrestability.

The two voluntary sector drugs field organisations represented on the Justice committee both dissociated themselves from its findings. SCODA and Release condemned the proposals as a "fudge" that would in practice do little to reduce the severity of sentences for cannabis offenders.

1. Gallup. *Gallup political index*. September 1989. *Survey for Miller Lite*. Spring 1989.
2. Justice. *Drugs and the law*. London: Justice, 1991.
3. ACMD. *Report on a review of the classification of controlled drugs and of penalties under schedules 2 and 4 of the Misuse of Drugs Act 1971*. ACMD, 1979.

■ **Justice's proposal to distinguish 'social' supply of drugs from supply for gain could have practical benefits for Britain's drug users.[1] The fact that a drug user passing a small quantity of a class A drug (such as LSD or heroin) to a friend faces a theoretical maxi-mum sentence of life imprisonment and stigmatisation as a 'pusher' has long been considered a major anomaly in the Misuse of Drugs Act.**

1. Justice. ***Drugs and the Law*****. 1991.**

■ In April Home Secretary Kenneth Baker announced that the UK's share of assets confiscated under international agreements will be fed into a fund to support drugs work here and abroad.[1] Also to be channelled through the fund are rewards from other countries for help received from UK enforcement agencies, such as the recent $3 million from the USA. Previously the fund only supported international police investigations. The new fund becomes operational in April 1992.

1. Kenneth Baker's speech to ACPO Conference, 18 April 1991.

■ **The latest report from the group monitoring solvent misuse deaths estimates 113 died after sniffing solvents in 1989, meaning deaths have exceeded 100 each year since 1985.[1] Gas fuels (mainly butane-containing lighter refills) accounted for 50 per cent of deaths in 1989 compared to on average 33 per cent in the previous six years. Emphasising the dangers of experimentation as well as long-term use, the researchers say nearly a fifth of deaths since 1971 were in people thought to be first-time users.**

1. Wright S.P. ***et al. Trends in deaths associated with abuse of volatile substances 1971-1989.*** **St George's Hospital Medical School, 1991.**

■ After 6 weeks Britain's first drug-agency based information and advice service on the use of drugs in sport has received 75 enquiries and seen 15 people all of whom injected steroids. Mersey Drug Training and Information Centre's (MDTIC) new service is staffed one evening a week by nurse volunteers including a member of the British Olympic rowing team. Callers so far have been concerned about the health side-effects of steroids, including HIV, rather than dependence. More information from the MDTIC on 051-709 3511.

Labour minimises electoral harm

Offering a presentable face to the electorate, while attracting sympathetic professional advisers with hints of a more "progressive" post-electoral approach, appeared to be the main preoccupations of the Labour Party at their Drugs Policy conference on the 18 June.

Excised from the consultation paper presented to the meeting were references in earlier drafts to directing enforcement agencies to prioritise "dangerous class A drugs". Enforcing anti-cannabis laws is "not the most sensible use of scarce resources", the drafts explained.

Gone too were specific references to cautioning being appropriate for offenders found in possession of small quantities of drugs, even on their second offence.

Of considerable concern at the meeting was the dropping of any commitment to direct HIV prevention measures in prison, such as making cleaning equipment available. Earlier hints of a softer approach to "naive couriers" used by traffickers as 'mules' to carry drugs into Britain were also missing.

A drug worker recruited to help Labour develop their policy was told Shadow Home Secretary Roy Hattersley agreed to all these points in principle, but had them deleted as potential electoral liabilities.

At the conference Hattersley explained Labour "does not support decriminalisation of so-called soft drugs because this would soften the climate of opinion against other drugs". On HIV prevention in prisons, he would "not be prepared to do anything which condones or might be seen as condoning the use of drugs in prison".

What remained in the consultation paper will to most eyes be barely distinguishable from current Conservative government policy. Summing up, SCODA Coordinator David Turner called it an "extraordinarily conservative document for the Labour Party".

Barry Sheerman – Labour's front-bench Home Affairs spokesperson – explained that cannabis law reform and syringes in prisons "are not the issues to raise in the run up to an election". Hinting of a rethink once securely in office, he said "there is more than one way to arrive at a progressive policy".

In the meantime both Labour and Conservative parties are gravitating towards an apolitical consensus on the need for a multi-agency approach geared to HIV prevention as well as to reducing drug use. Both have firmly closed the door on the potentially vote-losing law-reform debate.

The only distinctively Labour elements in the consultation paper were references to what Hattersley called the "undeniable" link between drugtaking and urban deprivation, and an argument against legalising drugs because this "would be a disaster for third world economies" as big business displaced peasant farmers.

One clear threat for the drugs field, which has flourished under the Conservatives, is that once in office Labour will treat drug problems as merely a symptom of urban decay, and redirect resources to dealing with what they see as its root causes.

The major plus point must be that the party that may form the next government is taking drugs seriously enough to treat it as a distinct element in their home affairs policy-making.

The consultation document talks of "treatment on demand" with central guidelines on the range of services to be provided locally, including maintenance prescribing and syringes for those unable to stop using drugs.

On criminal justice, cautioning is supported plus heavy reliance on voluntary or probation-supervised treatment options for convicted offenders. There is a commitment to end the segregation of known HIV-infected prisoners and to provide addiction treatment services in prison similar to those outside, including methadone.

FOR MORE INFORMATION

■ **DRUGS: A CONSULTATION DOCUMENT.** *Contact the Labour Party on 071-701 1234.*

Injuries blamed on 'abuse-resistant' drug

Workers at the busy Cleveland Street needle exchange in central London believe the new 'abuse-resistant' gel-filled temazepam capsules manufactured by Wyeth and Farmitalia may have caused a rash of serious physical damage among their clients.

Suzi Bernard, coordinator of Bloomsbury and Islington's Harm-Minimisation Service, says that since March eleven of the exchange's clients have had to be sent to hospital after injecting the contents of the capsules.

Gel-filled capsules replaced the liquid-filled capsules, which especially in Scotland were commonly broke open and the contents injected. The idea was to make it harder for the drug to be prepared for injection, but soon drug users discovered that merely heating the gel liquifies it sufficiently for injection.

Clients and workers in some London projects believe that after injection the temazepam mixture can 're-gel', obstructing blood flow. In five weeks at Cleveland Street three clients had to have parts of their limbs removed and two suffered gangrenous fingers, which in one case will result in loss of the fingertips.

The problems developed within hours of injecting gel temazepam. With the earlier liquid formulation abscesses were not uncommon but serious damage of this kind was rare.

Evidence for the re-gelling theory comes from a letter published a year ago in the *Pharmaceutical Journal* (9 June 1990) which said liquified gel temazepam re-gelled as it cooled to either 35°C or 37°C, depending on the make – 37°C is body temperature.

Manufacturers Farmitalia, told *Druglink* that once dissolved into the bloodstream it was not possible for the gel to 'regroup' and form a clot. But a spokesperson did admit it was "just possible" that the high molecular weight solvent used to create the gel might trigger clot formation more readily than the low molecular weight solvent used in the liquid-fill capsule.

However he had no evidence that the new temazepam formulation was causing more problems on injection than the old – which itself was unsuitable for injection.

■ **A new information exchange and debating network for people working in the addictions field in the British Isles was launched on 7 June. The Addictions Forum has recruited major figures in British drugs research and training to its steering group. The new organisation has been seen as a direct rival to the London-based Society for the Study of Addiction which is seen as being heavily biased to psychiatric research and practice. More information from Dr Martin Plant, 031-447 2011.**

■ Financial crisis has forced the drug agency behind the *International Journal on Drug Policy* to seek a commercial publishing home for the journal. The Mersey Drug Training and Information Centre hope to maintain the journal's radical stance, though whether they will retain editorial control is unclear. Apart from ***Druglink***, the journal is Britain's only national non-academic drug misuse magazine.

■ **Evidence of past or present hepatitis B infection was found in a third of the 1275 saliva samples taken from drug injectors attending a range of drug services across England and Wales in 1990.[1] But the Public Health Laboratory Service comment that infection was found less often in people who had started injection after 1985 (22 per cent) compared to those whose injection career began in the early '80s when hepatitis B infection was high (42 per cent). Around 1 per cent of the 1421 samples tested for HIV showed evidence of infection.**

1. PHLS. *Communicable Disease Report*, 21 June 1991.

■ Scottish Minister for Health Michael Forsyth has reversed his opposition to pharmacists supplying free syringes and needles, which until now has prevented the development of pharmacy-based syringe exchanges in Scotland. In March he announced that in 1991/2 £130,000 would be available to fund pharmacy-based exchanges.[1] His announcement followed a similar one by Health Secretary William Waldegrave covering England, where £1.3 million will be available to fund pharmacy schemes.[2]

1. *Pharmaceutical Journal*, 23 March 1991, p.354.
2. *Pharmaceutical Journal*, 23 February 1991, p.224.

Self-referral drug clinics exempt from internal market

Drug dependency clinics which allow self-referrals must accept patients from other districts in the region regardless of whether the patient is self-referred or referred by their GP. Clinics may ration slots on the basis of staffing or funding but should not refuse to accept patients merely because they reside in another district.

This appears to be the effect of little-known regulations implementing the NHS and Community Care Act which came into force on 1 April. Known as the "Functions Regulations",[1] these exclude self-referral clinics from the change over to districts securing the provision of health services to their residents. For self-referral clinics, districts must continue to accept all-comers. The same applies to AIDS and HIV services, whether self-referral or not.

In at least one region these regulations have been interpreted as meaning that self-referral drug misuse services must treat "all those who wish to avail themselves of the service irrespective of district of residence". In this region the RHA has promised to adjust each district's financial allocation accordingly.

1. NHS Management Executive. *National Health Service Act 1977. Directions to authorities in relation to the exercise of functions.* EL (91)45, 18 March 1991.

'How to do it' anti-HIV posters

FOR MORE INFORMATION

■ **Phone Mainliners on 071-274 4000 ext 315.**

Mainliners, the national service for HIV positive drug users and ex-users, believes its four new HIV/AIDS and drugs information posters break with previous campaigns by directly providing information. The emphasis is on the practical steps injectors and sexually active youngsters can take to protect themselves from HIV.

Two of the posters advise on how to clean and dispose of used injecting equipment instead of simply trying to persuade injectors not to share. The intention is that the posters should be displayed not just in drug agencies but in colleges, GPs' surgeries and other public places. One aim is to get information to injectors not in contact with drug services.

'No retreat' claim Mersey drug workers

Mersey's future as an influential test-bed of new approaches to drugs and HIV seems in the balance. Suggestions in the last issue of ***Druglink*** that Mersey RHA was now reining in its harm-reduction work have been denied by workers in the region. Well known figures in the field said there was "no evidence" of a retreat, citing developments in the Wirral as evidence of continuing innovation (see below).

In the last half of the '80s enthusiastic middle managers were given their head with the backing of Mersey RHA's chair Sir Donald Wilson, a Thatcher supporter for whom being at the cutting edge of health service privatisation went hand in hand with an equally innovative approach to HIV prevention.

In this issue of ***Druglink*** Allan Parry, the region's former Drugs/HIV Coordinator, argues that political pressure on Sir Donald became overwhelming when on television in 1990 a DoH official supported the prescribing of smokable cocaine in Mersey clinics. At the same time Margaret Thatcher's government was hosting a high-profile international anti-crack 'summit'.

From that point on, what had been a vicious war between the Militants on Liverpool City Council and the RHA 'progressives' appears to have become a battle within the health authority, with the previously unchecked safer drug use advocates being brought to heel by their until then only nominal bosses.

Claiming that "nothing has changed but the rhetoric", a Mersey RHA spokesperson explained that "we've had people involved in minority projects who've spoken as if these were the whole of Mersey's policies". RHA officials had been "actively promoting drugs – that was never our policy and should never have been presented as our policy".

But the most recent statistics not made public by the RHA show most outreach workers in the region contact less than one new injector a month, while just 5 per cent of new clinic patients are prescribed injectables – signs to some that the policies which kept Mersey at the bottom end of the HIV infection league are withering from neglect.

Jeremy Clitherow, the pharmacist behind the Reefer Project, intended to use an RHA grant to develop techniques for the production-line manufacture of smokable heroin cigarettes as an alternative to injectables.

Despite being told there was a "91 per cent" chance of its being returned, it now seems that the £40,000 recouped from the project by the RHA will not be re-allocated. RHA officials say it was only for a clinical trial which ended with inconclusive results.

Whether such developments herald a retreat from the 'extreme pragmatism' of Mersey's drug policies in the growth years of the mid-'80s is hotly contested.

So highly charged are the politics of drugs work in the region that none of ***Druglink***'s correspondents were prepared to be identified. Accusations of lying, misappropriation of funds, drug use and dealing by officials, threats of physical violence and intimidating late-night phone calls are the order of the day.

Those still reliant on health authority patronage are unwilling to threaten their patients' or their own futures by speaking out, while others are forbidden to do so. Even official spokespersons prefer to speak off the record.

Britain's first GP drug clinic opens in Wirral

In April Britain's first GP-staffed drug dependency clinic opened in the Wirral in Merseyside. Instead of a consultant psychiatrist, the service's medical director is a GP who had previously treated drug misusers in his surgery. Other GPs are employed on a sessional basis. Health authority staff and workers seconded from other agencies complete the complement.

Heading the service is ex-nurse Steve Dalton. He explains that the local family health service authority – which funds general practice – agreed to pay the new centre's drugs bill and medical staff's salaries on the basis that it offered a primary health care service effectively centralising the drug-related work of the district's 186 GPs. The GPs benefit from now having a referral option for drug users turning up at their surgeries.

Elsewhere in England attempts have been made to persuade FHSAs to fund addiction treatment prescribing bills to sidestep the financial constraints on health authorities, but in Wirral the FHSA was a willing partner. Their annual drugs/dispensing bill from the new service could reach £700,000.

Faced with the escalating costs of not having a local drugs service, Wirral District Health Authority agreed to fund non-medical costs. In a single year the district housing John Marks' clinic sent the authority a bill for £250,000 for the treatment of 84 Wirral residents. These patients are now being referred back to Wirral with the promise that they will receive the same prescription.

In a highly unusual move, the Home Office is to license the GP heading the service to prescribe heroin, enabling him to continue the treatment of patients being prescribed injectable or smokable heroin.

One advantage of the primary health care approach is the integration of general medical care with dependency treatment. In August a women-only service will offer obstetric treatment from the same site. Wirral's drug service also offers mobile and office-based syringe exchange and conducts effective outreach work in the area.

" Protecting her from a lifetime of addiction was hardly the issue "

NO TIME BEFORE I DIE

Andria Efthimiou

Dying from AIDS, a prescription for smokable heroin could have allowed an addict mother devote her last months to her daughter.

NEARLY TWO YEARS ago I was asked to meet an old friend in London who had been diagnosed as having developed AIDS. It was a painful meeting at which she asked me to be her counsellor/worker. As I'd had a close personal relationship with her in the past, I felt this inappropriate, but offered to help sort out any practical issues. Being the respectful and insightful woman that she was, she accepted this was reasonable.

She was a committed heroin smoker, but her treatment consisted of oral methadone prescriptions – not enough to prevent her using the illicit market to get the drugs she felt she needed. Soon after we met she asked me to investigate the chances of her being prescribed opiate reefers before she died. When we met in the hospital she was fighting a bout of tuberculosis; I thought she might die within two years – she died two months ago.

We discussed obtaining a reefer script at great length and on many occasions. Her argument was that she wanted to spend some "quality time" with her 8-year-old daughter before the virus finally debilitated her completely. Her daughter also was "angry that mummy and me can never spend any time together".

Assessing with the individual their needs and then trying to meet them is for me the only way to work. But in this case there was more. As far as my client (and I) were concerned, in her present health and family circumstances, she had a positive right to her drug of choice before her death. What she wanted was the chance to get away from the illegal street scene; it was too distracting, and there were so many practical things to do, not least of which was to organise custody of her daughter in the event of her death.

Not long before we met the Advisory Council on the Misuse of Drugs had produced its *AIDS and Drug Misuse Part 1* report calling for innovative strategies to tackle HIV among drug users. Despite this it seemed that only a few clinics in Merseyside included heroin reefers among their prescribing options. For several months I liaised with workers from London and Mersey, trying to establish whether it would be possible for my client to be referred to a doctor in London who could prescribe her reefers. Eventually I was referred to a doctor in a London clinic who, like many in the capital, was simply about 'getting people off drugs'.

In this case it was a singularly inappropriate attitude. Everyone involved with my friend and client must have known she was dying from AIDS – it was, after all, in her interests to tell them and it was no secret from her family and friends. Protecting her from a prescription-maintained lifetime of addiction was hardly the issue. Oral medication would not have ended her need to use the illegal drugs market. Prescribing injectables would have been a retrograde step, both in terms of her drug use and in terms of her HIV disease. Moving from smoking to repeated injecting might have hastened her death. Reefers seemed the obvious choice for the prescription to see her through to her death.

But in the event she died having spent 14 months of her last 22 fighting for her right to use her drug of choice. Continued heavy involvement in the illicit market robbed her of the chance to concentrate on her relationship with her daughter. The consequences will live beyond her – though showing great dignity and self-possession way beyond her years, her daughter will have to live with being doubly deprived – of her mother's life and of the part of it that should have been hers alone.

The impact on my client and on her daughter was enormous. It meant there wasn't even the possibility of them spending an hour a day together. Her daughter explained: "Most of mummy's day was stolen from us because she had to keep going to get her drugs. I was so sick of it and I was so scared of losing her without knowing her...".

My friend was not alone in having unmet needs. From the murderous and insane policies of New York – where even clean syringes are denied injectors – to those for whom harm reduction is the only approach, the individual's needs get lost in the general debate. As an HIV worker I am acutely aware of the damage incurred to drug users who continue to inject. Not everybody needs a prescription of injectable heroin or of heroin reefers – but why are drug users still having to fight for these options?

WHY DID MY client not have the time to organise for the custody of her child? Why did she get given the run-a-round by the medics when she was in the last year of her life? ■

The author is Drugs Counselling Officer at the Terrence Higgins Trust.

Out on your own: making solo outreach work

It was sink or swim when the ex-clinic worker had to outreach alone

An account is given of the tactics used to increase the effectiveness of drugs outreach work in an area with only a single employed outreach worker. Although reassuring for the worker, too close an association with office-based services was counter-productive and instead a community base was established. Use of employment trainees and volunteers from the drug using community helped extend the work and proved therapeutic for some of the current 'street' users.

Keith Bolton & Sue Selleck

Keith Bolton is Outreach Development Worker and Sue Selleck is an Outreach Worker at the North East Essex Drug and Alcohol Service. *They thank Peter Sternberg, District HIV Worker, for his assistance.*

FEW DISTRICTS outside major cities employ more than one drugs outreach worker. Many knowledgeable people believe such a set up is unworkable or at least difficult, and perhaps dangerous. Having been in just such a situation, I would like to share some of the problems I experienced, together with some of the ways I attempted to overcome them.

When I first took up post with the North East Essex Health Authority, my desk was in the main office in the drug centre. Initially this helped me to feel at home in an environment I knew and felt comfortable in. Clinic attenders all seemed to speak well of the centre so I felt I could ride on the back of its success.

This proved to be my first big mistake: the more I got involved in outreach, the more clients I came across who held very strong negative views on drug services. As soon as I was seen as part of the drugs team, I found myself facing questions such as "Why don't 'you' give injectables/maintenance/amphetamines/heroin?", and I spent a lot of frustrating time trying to answer them.

I also felt 'caught between a rock and a hard place' when clients attending the drug centre for oral methadone (so are not supposed to be using other drugs) also turned up at the needle exchange.

Although it was very tempting for me to get involved in clinic work because of my professional past and the need to do something 'useful', I began to recognise the need to distance myself from the drugs team.

But once I had distanced myself it was not obvious where I should go and what to do when I got there. I went to work every day with my diary almost empty; my few appointments were with other agencies, not with drug users. It was obvious that I needed some new direction to move in. These are some that I tried to make single outreach work.

Employment Training trainee. With no money left for new posts there seemed no chance of a second outreach worker, but during a meeting at our local Employment Training organisation the possibility of an employment trainee was discussed. It seemed unlikely that the organisation would offer a suitable person, so I set about looking for my own candidate.

The wife of a drug user in rehabilitation had said she would like to return to work. She had many attributes important in an outreach worker: knowledge of the local drugs scene and of drugs, a drive to help people involved with drugs and an accepting, non-judgmental nature. She could be around drug use without being shocked and her resistance to the temptation to use drugs had already been tested.

ET training offered her £10 on top of her income support plus a childminding allowance of up to £50 for each of her two children. After seven months' training she is now a full-time paid drugs outreach worker, an appointment made possible by the progress made while she was an ET trainee.

Moving base. In our main town most drug use and drug dealing occurs inside houses or flats, making initial contact with users more difficult. Many of the area's drug users lived on a large housing estate accounting for half the drug centre's new referrals, so we looked for an easily accessible, user-friendly base on the estate. A new community resource centre was being set up by a church-based organisation in a caravan close to the estate's main shopping precinct, offering drop-in facilities using specialist input from a variety of agencies.

Much to our surprise they showed great enthusiasm about our involvement. The caravan provided us with a fixed-site needle and syringe exchange in the centre of the estate close to a main methadone-dispensing pharmacy, as well as an accessible base to work from. All the staff including visiting

specialist agencies helped in the exchange when we were not there. This added respectability to the scheme without putting clients off.

However, our needle exchange became busier and higher profile than we'd anticipated. This was thought to be to the detriment of the other services. Also some clients exhibited disruptive behaviour which may have been accepted in an exchange staffed by experienced workers but not in a multi-functional centre. Eventually we had to leave.

Syringe exchange packs. Despite ten pharmacies and a fixed site open two afternoons a week, we were still not attracting enough syringe exchange clients. Those who did attend mostly went to the pharmacies, where all they took were needles and syringes, declining condoms and educational literature.

To attract more people and offer a more comprehensive service, we devised a pack system. Initially we developed 'starter packs' consisting of a mixture of needles and syringes, condoms, guidelines on safer sex and injecting techniques, a mini sharpspack, addresses for disposal of used needles and syringes, and an order form for the next issue.

Starter packs are held at mental health units, social work departments, GU clinics and accident and emergency departments. These organisations are asked to ascertain whether injectors they see use the syringe scheme, and if not to offer them an introductory pack. Similar packs are now supplied by pharmacies instead of supplying injecting equipment alone.

Nevertheless, about half of the clients exchanging syringes still only attend the pharmacies. One of the benefits of outreach workers making up packs for the pharmacies is that we can use them to distribute information to people we do not meet, with a fair chance it will get into their homes and be read by other drug users.

To attempt to avoid used equipment being discarded when we are not around to collect, the health promotion HIV worker arranged with the council to install a 'needle dump' in the public toilets on the estate. This sealed disposal bin is fed by a chute large enough to take a mini sharpspack but small enough to prevent anyone retrieving disposed equipment.

> ***"With few maintained users to draw on, we decided to recruit 'street' users as volunteers"***

Outreach volunteers. Like many outreach workers, I use drug users as informal volunteers by asking them to take information or deliver some needles and syringes to a mate. With this in mind we decided to embark on a more formal outreach worker volunteer scheme.

The lack of maintenance treatment in our district meant we had no pool of methadone maintained users to draw on. To fill the gap we decided to include current 'street' users among our volunteers – a potentially controversial step.

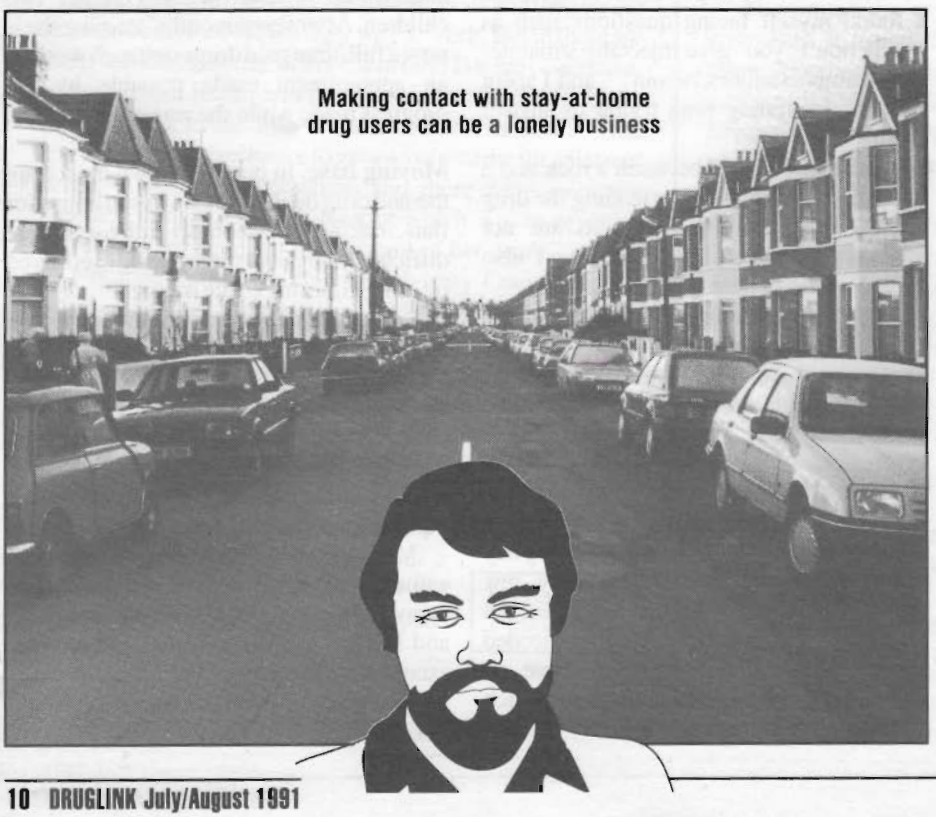
A detailed description of the scheme was circulated to all relevant people including drug service managers, police, the Director of Public Health and the area health authority. No objections were raised.

Our recruitment campaign included letters in our needle exchange packs, adverts in the university magazine, and registering at the volunteer bureau. We then held open evenings presenting the scheme to all interested parties. Interviews were held and a member of the volunteer bureau helped in the selection.

At the time of writing we are over half way through training the second group of volunteers. These groups are made of one third current street drug users, one third ex-drug users, and one third non-drug users. The aim is:[2]

– to provide a balanced team approach;
– to aid credibility of the scheme among service users;
– to offer a consistent service (could be difficult if only current drug users were involved);
– to involve drug users in service planning and provision;
– to have an in-built monitoring mechanism within the team.

We seem rightly to have anticipated a high drop out rate from the scheme: from the first group of nine workers only four are left. Being a valued member of an organisation makes some users consider their situation more seriously and gives them confidence to tackle their own problems. This may result in them leaving both the drug scene and the volunteer scheme, perhaps meaning we have to constantly train replacements. But even those who have dropped out (particularly current users) apparently continue to act as outreach workers, offering advice and information to their peer group. ■



Making contact with stay-at-home drug users can be a lonely business

1. Gilman M. "Reaching out or copping out." *SCODA Newsletter*: July 1989.
2. "Stop the spread: addicts as outreach workers" *Mainliners Newsletter*: 1990, 5, p.5.
3. Yates R. *et al eds. Seeing more drug users: outreach work and beyond*. Lifeline Project, 1990.

FOR MORE INFORMATION

■ **THE AUTHORS can be contacted on 0206 48481 or by writing to NEEDAS, 1 Hospital Road, Colchester, Essex CO3 3HJ.**

■ **SEEING MORE DRUG USERS: OUTREACH WORK AND BEYOND. Rowdy Yates *et al eds.* Lifeline Project, 1990. £2.95+p&p.** *Available from NWRDTU, Kenyon Ward, Prestwich Hospital, Bury New Road, Manchester M25 7BL, phone 061-798 0919.*

■ **HIV OUTREACH IN BRITAIN. Tim Rhodes *et al. Druglink*: 1991, *6*(3), p.12-14.** *Copies from ISDD's library on 071-430 1993, £0.70.*

■ **REACHING THE HARD TO REACH. Tim Rhodes *et al. Druglink*: 1990, *5*(6), p.12-15.** *Copies from ISDD's library on 071-430 1993, £0.92.*

■ **ISDD's INFORMATION SERVICE is available on 071-430 1993.**

"An AIDS trainer described drug users as 'mad, bad and dangerous'"

FALLING through the MUDDLE

Mainliners Ltd

Can HIV or drug agencies meet the needs of those at the sharp end of both problems – HIV positive drug users?

IN RECENT YEARS drugs service organisations have been under financial, social and political pressure to tackle the problems associated with HIV; likewise AIDS organisations have been pressured to tackle drugs and drug users. Already struggling to meet their original aims, many have been put under further strain. Despite their efforts there remains a lack of care, support, understanding and good quality information for people affected both by HIV and by drugs – including those working in the field. People doubly affected by a serious disease and by drug use often need individualised intensive support with an emphasis on good health, good living conditions and minimising the health risks of continued drug use. Achieving this kind of transformation is no easy task, particularly for those with few financial or social resources.

But there is little clear recognition of the needs of drug users with HIV and in many agencies the service offered them is largely tokenistic. Some drug agencies have focused exclusively on harm minimisation – a needle exchange and primary health care – which does not constitute a comprehensive service.

Drug rehabs have also not adapted sufficiently to the needs of HIV positive residents; the few changes have been cosmetic, such as 'reducing the level of stress'. Some are so fixated on 'total abstinence' for their clients that they fail to provide even basic information about safer drug use.

Much of the information available from AIDS organisations is simply no use to drug users, especially if their lives have become very chaotic: tips on healthier living, alternative treatments, nutritious diets and so on are useless to somebody who hasn't got enough money to buy food to stem the nausea from AZT.

The fact is that at the moment, drug users with HIV aren't getting a good deal. In theory they 'plug in' to either drugs or HIV services; in practice many (perhaps by choice) do not. This leads to isolation, inadequate medical care, lack of financial resources, poor diet, and increases the problems associated with their drug dependency or their HIV-related illnesses – an unknown number are "fixing themselves to death", in the words of one inner-city outreach worker.

It may be idealistic and naive to assume that it's possible, or even desirable, for one service to suit all comers – as some AIDS organisations are now attempting to do. People affected by drugs, by HIV, or by both, have different needs which must be tackled independently.

Some services, notably the Healthy Options Team in Tower Hamlets, the Health Improvement Team in Bloomsbury, and Mainliners, were set up specifically to deal with the needs of drug users with HIV, who feel removed from the traditional role of both drugs and AIDS services.

Drug users with HIV have to face disproportionate prejudice and discrimination, even from within so-called 'caring agencies' – a trainer on a counselling course run by a prestigious AIDS agency recently described drug users collectively as the "mad, the bad and the dangerous".

To challenge this prejudice, services need to enable those with drug-related HIV to become active participants in the planning and provision of services. This goes beyond having a selected user 'on the committee', to developing an entirely new structure for the transformation of the client role from passive to active and its integration into all aspects of service planning.

The stigma attached to illegal drug use has to be exposed as judgmental, moralising, and damaging to those at the receiving end. There is an urgent need for training for GPs, hospital staff, workers in HIV/AIDS agencies, social workers, home care teams, and other services in contact with drug users.

One of the major flaws in services generally is the tendency to focus on HIV or on drugs to the exclusion of all else: the individual is seen only as HIV positive, or as a drug user: their needs as an individual, which may be completely unrelated, get lost. Users and ex-users need places to go where they feel welcome and accepted, and where they can get involved in creative, productive activities which can provide a sense of purpose and self-worth.

Mainliners hopes to play a key part in developing and improving services for drug users at risk of HIV. Mainliners is fundamentally committed to the principle of self-help. Through a process of consultation we aim to provide a range of services to enable people to empower themselves – setting up the structures for HIV positive drug users and ex-users to start taking control of their lives, making demands about the kinds of services they want, and realising that they are entitled to a certain quality of life just like everybody else. ■

Mainliners is a national charity for people affected by HIV and drugs/alcohol. Contact on 071-274 4000 ext. 443 or 315.

Supply and demand: lessons from Poland

Poland's recent history can help disentangle the forces that lead to increased drug use

The recent history of opiate use in Poland provides a 'natural experiment' which can help disentangle the relative contributions made by supply and demand forces to levels of drug use. In Poland demand first developed in the absence of supply and then led to a non profit-oriented supply system that did not cause escalating demand and use. As Poland opens up to international market forces the situation may change.

Peggy Watson

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POLAND'S EXPERIENCE of drug problems has differed in a number of fundamental ways from that of Britain. At first sight its unusual 'home-grown' opiate scene seems unlikely to be relevant to the sorts of issues which policy-makers and others are concerned with in Britain today.

But recent work on the operation of the Polish drugs market[1] has led me to believe that, far from simply providing an exotic case study, drug use in Poland has developed under conditions which amount to a 'natural experiment'. Poland's isolation has provided an opportunity to gain comparative evidence which is otherwise hard to come by.

For example, under normal circumstances it is very hard to independently change demand versus supply-related factors in order to understand the relative effects of each. Poland can contribute here, because it offers a case where levels of use seem to have been almost exclusively demand-driven.

Home-grown opiates

Recreational drug use took hold in Poland as a result of the spread of specific Western cultural values – but also under economic conditions which sealed the country off from the international drugs market more effectively than any supply control policy could possibly do. This says something about the power of the demand for illicit drugs to generate supply against all the odds.

In contrast to some areas of the Soviet Union, traditional forms of drug use have not been part of Polish culture. First signs of an interest in – the beginnings of a demand for – recreational drugs became visible in the late 1960s. But matching supply with demand was not easy. The non-convertibility of Polish currency acted as a barrier to imports of all kinds, including illegal drugs, so for would-be drug users a long search began for what essentially were regarded as substitutes for 'proper drugs'.

A breakthrough was eventually achieved in 1976 when a pharmacology student in Gdansk developed a technique for easily deriving an injectable opiate preparation from poppy straw, a waste product of the opium poppy when grown for seed.

In the spirit in which it was conceived, the substance was dubbed 'Polish heroin', though in fact in the early stages it probably contained no heroin at all, but rather a mixture of codeine and morphine. Despite the technical hitches, demand had at long last generated a peculiarly Polish form of supply.

The technique was subsequently exported to other countries in the Eastern Bloc, but in Poland its discovery did not give rise to an immediate increase in levels of opiate use. Unchanged conditions of supply prevailed for another four years without levels of use markedly increasing. Demand had created supply, but the new supply possibilities did not lead to an immediate escalation of demand.

Not until 1980-81, traumatic years when people were joining Solidarity in their millions, did demand significantly increase and

Cooking up poppy straw in a Warsaw flat

opiate use really gain popularity. The whole Solidarity movement was brought about by the actions of manual workers 'taking on' the government: it was also primarily among this class that drug use increased.[2]

Non-profit market

If the nature of the drug product in Poland differs from that in the West, so too does the economics of its supply. The peculiarities of the opiate supply mechanism in Poland go a long way towards explaining why supply has failed to create escalating demand.

This mechanism has meant that the amount of ready-made opiates available for the market at any given time is closely tied to the current number of users – a result of the fact that almost all drug users are also drug producers, and the proportion they sell on the market is subject to a number of constraints.

Although most users produce drugs, they do so on an intermittent basis. In Warsaw, where the commercialisation of drug use is at its most advanced, all users buy on the market from time to time. To produce drugs, typically three users form a temporary alliance. One will have access to poppy straw, another will provide a suitably safe flat for converting it to drugs, and the third will sell the proportion designated for the market. After the costs of production have been covered, the profits are split.

New users usually begin by buying on the market, located in a shifting but easily identifiable area of town where sellers and potential customers congregate. However, the economics of drug use – the cheapness of producing one's own relative to buying on the market – dictates that soon they will try to establish their own production alliance.

Perhaps the most important aspect of this supply process is the fact that *at no point does the accumulation of profit have any role to play*. The farmers sell poppy straw on an opportunistic basis, either in exchange for goods unavailable in the villages, such as lightbulbs or tractor batteries, or to cover extra costs such as a daughter's wedding; drug users produce and sell to support their own drug use and as a means of subsistence.

There are similarities here with the lowest user-dealer levels of drug distribution in Britain. The crucial difference is that there is no commercial superstructure of producers or traffickers in it purely for the money. The result is that there is no tendency to expand the market, so the extent to which levels of consumption are supply-driven is reduced.

This explains the delay between the development of supply (1976) and increased drug use (1980-81). Lack of commercialisation may also have contributed to the marked stabilisation in levels of use since the early 1980s. Official statistics and interviews with drug users in Warsaw last year[3] show negligible numbers of new users over recent years – a fact which is all the more striking in view of the continuing and dramatic rises in levels of poverty, unemployment, homelessness and crime.

What the Polish evidence does is to illustrate very clearly both the potential and the limitations of measures which aim to control the extent to which supply will generate demand. The point at which this kind of policy ceases to be effective is the point at which increasing demand begins to generate supply – in whatever way it can.

Future uncertain

There is an analogy here with prescribing as a way of regulating drug supply. As traditionally conceived, the 'British system' provided an indigenous non-commercial supply of opiates geared to the number of (heavy) users seen by doctors. With demand met, there was, the theory ran, none left for the commercial suppliers to exploit and expand.

> ***"At no point does the accumulation of profit have any role to play"***

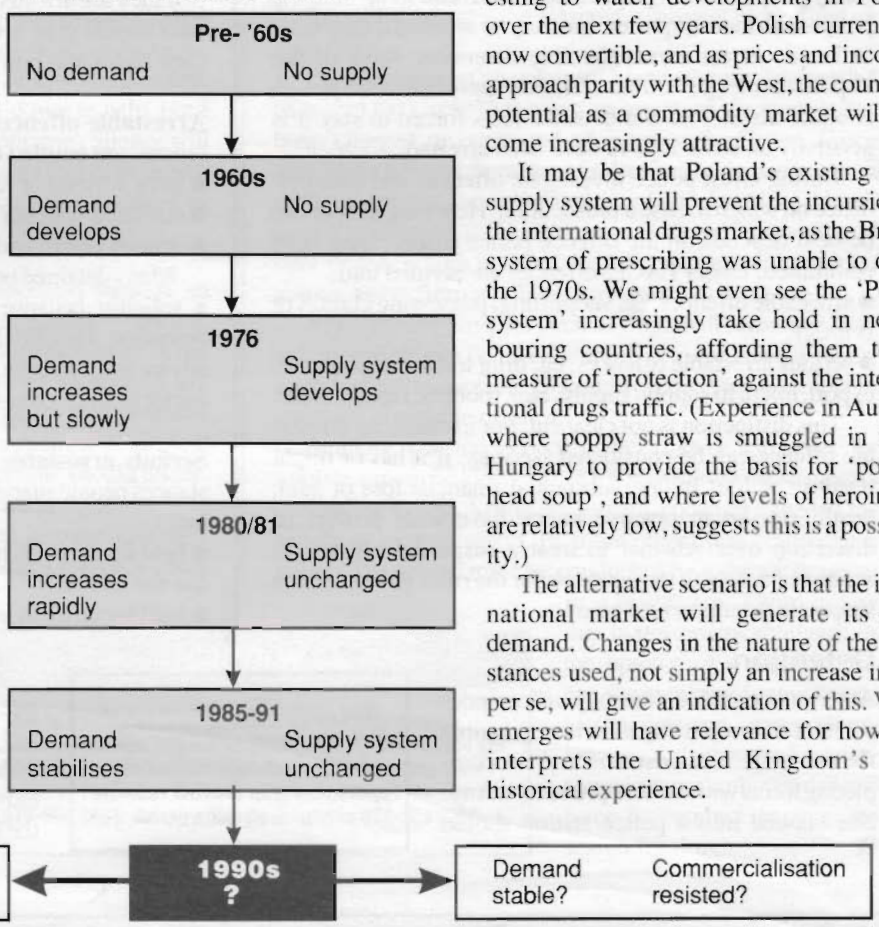
The difference is that the supply system which has developed in Poland is one capable of responding to a dynamic situation where the demand for drugs is increasing. As a means of regulating supply, prescribing can only cope with a relatively static situation – new non-addicted users must seek their drugs elsewhere.

For this reason it will be extremely interesting to watch developments in Poland over the next few years. Polish currency is now convertible, and as prices and incomes approach parity with the West, the country's potential as a commodity market will become increasingly attractive.

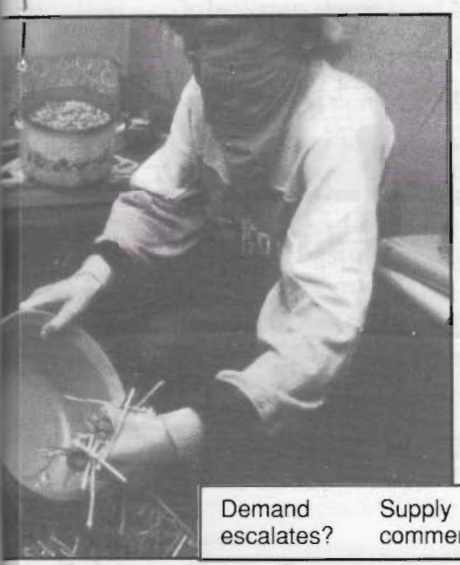
It may be that Poland's existing drug supply system will prevent the incursion of the international drugs market, as the British system of prescribing was unable to do in the 1970s. We might even see the 'Polish system' increasingly take hold in neighbouring countries, affording them too a measure of 'protection' against the international drugs traffic. (Experience in Austria, where poppy straw is smuggled in from Hungary to provide the basis for 'poppy-head soup', and where levels of heroin use are relatively low, suggests this is a possibility.)

The alternative scenario is that the international market will generate its own demand. Changes in the nature of the substances used, not simply an increase in use per se, will give an indication of this. What emerges will have relevance for how one interprets the United Kingdom's own historical experience. ■

Demand forces have dominated the development of opiate use in Poland – but can that survive the internationalisation of drugs markets?



1. Watson P. "Levels of drug use and the Polish drug market." Paper presented to WHO Consultation on Sociocultural Factors in Drug Abuse, Reims, December 10-12 1990.
2. Watson M. "Drug use and policy in Poland in the 1980s." *International Journal of Health Services*: 1989, *19*(3).
3. Watson P., op cit.



3

LAW IN PRACTICE

Guidelines for drug users and drug workers

DETENTION and QUESTIONING

Jane Goodsir

THE MOST IMPORTANT law on detention and questioning is the Police and Criminal Evidence Act (1984) – PACE. This sets out police powers to stop, search, arrest and detain and governs almost every aspect of detention procedure.

Arrest

Many people held in police stations are said to be 'helping police with their enquiries' but may be arrested if they want to leave. Arrest means forcible detention. Most of the important rules governing detention apply only if the person is under arrest – so if a detainee feels forced to stay it is generally an advantage to have been arrested.

During arrest police investigate offences and gain evidence on which to base a prosecution. How long people can be held depends on the offence police suspect they have committed. Under PACE, offences are divided into:

- arrestable offences, eg, shoplifting, possessing class A or B drugs;
- serious arrestable offences, eg, drug trafficking (import, export, intent to supply, supply, etc), robbery, rape, murder.

This distinction is not clear cut. For instance, an arrestable offence can be considered 'serious' if it has or might result in serious injury, substantial financial loss or gain, death, etc. So in practice police have wide powers of discretion over whether to treat a suspected offence as serious or not, with implications for the rules governing the suspect's detention (see below).

Detention

At the police station a custody officer independent of the investigation is responsible for the welfare of prisoners and for completing forms which check procedure. Anyone booked into a police station should ensure their arrival time is correctly logged and that they don't sign for property which doesn't belong to them. Detainees with a medical problem needing attention should tell the custody officer immediately. If unsure whether they're under arrest, detainees should check with the custody officer. If prevented from leaving, they should insist that they are arrested and booked in by the custody officer, who should give arrested suspects written information on their rights and how to get legal help.

Arrestable offences. People suspected of 'arrestable offences' are entitled to:

- have a friend or relative informed;
- consult a solicitor;
- consult police codes of practice.

Many detained people sign to say they do not want to see a solicitor because they're told this will prolong their detention. Despite this it is imperative to have good legal advice while in custody. After 24 hours people suspected of minor offences must either be charged or released.

Serious arrestable offences. In certain defined circumstances people suspected of serious arrestable offences may be:

- held for up to 36 hours without having anyone informed (on the authority of an inspector or above);
- held for up to 36 hours without access to legal advice (on the authority of a superintendent or above).

After 36 hours, access to a solicitor is guaranteed. Continued detention can be authorised by a magistrate in stages up to 96 hours (4 days). After that suspects must either be charged or released (except under the Prevention of Terrorism Act). Foreign

The author is the Director of Release Legal and Emergency Services, a national service specialising in the law relating to drug misuse.

nationals have the right to contact their embassy or consulate in the UK.

How to help the suspect. Contact a solicitor immediately – Release is in touch with a panel of solicitors nationwide. You should not normally be asked to pay the solicitor's fees as most help is covered by legal aid. Don't be tempted to go down to the police station – you won't be able to help much and are very unlikely to get access. After someone has been charged (and sometimes before) it is possible to send them cigarettes, food and clothing.

Questioning

The best strategy while in custody is always likely to be silence. Interviews at the police station should be taped but detainees should remember that any verbal exchange may be noted and given in evidence. If the detainee is innocent they should say so, and if there is a simple explanation likely to satisfy the police, give it. Beyond this it should be remembered that it's easier to say nothing from the start rather than to stop answering questions when they get difficult. Answers that seem innocuous can be twisted in court.

Many people get convicted through signing confessions in the absence of a solicitor. Often no other evidence is needed. What is said during questioning will be critical during the trial, even if there has been no formal caution. Police are trained in interrogation and know that people in custody are disorientated. Many people are prepared to do almost anything to get out – even to sign false confessions.

If questioned detainees should insist a solicitor is called. If police persist the best response is 'I'd like to help, but I won't say anything until I have seen a solicitor'. Silence will probably prolong detention, but there are strict time limits; eventually the suspect will either have to be released or charged.

People under 17 should not be questioned without an appropriate 'responsible adult' being present – parent, social worker or some other responsible person over 18 not working with the police. Without this the interviews are never admissible in court. Responsible adults should realise that police are usually very anxious for them to be present so they can record interviews. Young people should understand that they too have the right to remain silent.

Juveniles should, like other detainees, also exercise their legal right to advice from a solicitor. For this reason it's best for 'responsible adults' to go to the police station with a solicitor; otherwise they may be brought in to witness an interview when the young person could instead have had the benefit of legal advice. Release can advise parents and 'responsible adults' on how to help.

Key points

- **Suspects should identify and contact a good solicitor at the earliest opportunity**
- **Detainees have the right to remain silent**
- **If prevented from leaving detainees should ensure they are formally arrested**
- **Once under arrest there are strict limits to the length of detention**

Getting a lawyer

Once allowed access to a solicitor, suspects can call their own, phone Release for advice and a solicitor, or rely on the duty solicitor scheme. The duty solicitor scheme is merely a panel of solicitors independent of the police and working locally dealing with criminal cases. Some are good, some are not so good.

Detainees seeing solicitors should insist on being fully advised on their rights, not be afraid to ask questions, and ask to talk in private. During interviews with the police the solicitor can comment and make notes but won't be able to answer questions on the suspect's behalf.

Legal aid is available to cover solicitors attending police stations and advising before court appearances. Lawyers can arrange sureties, negotiate bail, and contact relatives and friends on the suspect's behalf. Solicitors are often reluctant to deal with trivial offences and prepared only to give telephone advice. Even in relatively significant cases the duty solicitor scheme can break down leaving detainees without access to legal advice, especially overnight and at weekends. In these cases it is even more important that detainees understand their rights, including the right to silence.

Obtaining evidence

Police are entitled to take *fingerprints*, if necessary by force, if a superintendent has reasonable grounds to believe this would prove or disprove involvement in a criminal offence. Fingerprints can also be taken if a suspect is charged or convicted.

Photographs can't be taken without consent unless needed to record the circumstances of an arrest, or if a suspect has been charged or convicted of a criminal offence. Force should not be used. Samples of saliva and urine can be taken without consent, but other *intimate body samples* – blood, semen and tissue and swabs from body orifices – should only be taken with consent, by a doctor, and with written authorisation from a police superintendent or above.

Non-intimate samples such as fingernail scrapings, hair and footprints can be taken without consent when a superintendent has reasonable grounds to suspect involvement in a serious arrestable offence.

Intimate searches of body orifices can be authorised by a police superintendent or above who believes the suspect is concealing a class A drug (eg, heroin, cocaine) intended for supply or export/import, or some object that could cause injury. The search must be conducted by a doctor or nurse in a hospital or clinic unless this is not practicable and, in the opinion of a superintendent, the item could cause injury to the detainee or to others. Doctors and other medical personnel are not authorised to use force to conduct an intimate search for drugs. ■

CAUTION

■ **This is a complex area on which we can only provide general guidelines. Anyone involved with the law should get legal advice at the earliest opportunity by contacting their solicitor or Release – Release's 24-hour emergency number is 071-603 8654; during office hours phone 071-729 5255.**

PART TWO

Drug Politics in Liverpool

a personal account

Allan Parry

Part one of this two-part account described how in the early '80s the Militant-dominated Liverpool City Council adopted a populist 'war on drugs' stance to gain support for its confrontation with the Conservative government. Until then seen by his Militant colleagues as a valuable ally, opposition to this tactic led the author to be seen as an enemy.

OPPOSING MILITANT's plans to exploit the drugs issue was enough to brand me as an enemy. My joining Mersey Regional Health Authority in 1985 incensed Liverpool's Militants even further, particularly as they were about to launch a 'community' campaign against the newly opened Liverpool drug clinic with its policy of maintaining clients – on heroin if necessary. The RHA had also outlined plans to open their own Regional Drug Training and Information Centre, which was perceived as a threat to the Militant-sponsored Merseyside Drug Education and Training Unit.

Militant knew they could not gain political control either of the drug clinic or of the new RHA drugs centre. It spelt failure for their attempt to seize the political and media spotlight by presenting themselves as the main local agency in the war against drugs. Portraying themselves as the protectors of Liverpool's youth by campaigning against the prescribing of the clinic, and against its 'propaganda wing' the regional drugs centre, was seen as their only chance of regaining the lead.

Aware of how they could present themselves as protecting 'the kids' from 'social control' by bourgeois psychiatrists, Militant wanted our unit to 'expose this attempt at sedating working class youth'. Being as anti-drug as it was possible to be became Militant's new image; 'drug-free' was the only acceptable goal. To bolster this image they supported the establishment of an electro-acupuncture clinic run by the type of 'entrepreneurs' that a year ago they would have picketed.

By now the city council's Drug Liaison Office (DLO) had – as planned – been set up beyond direct democratic control in the City Solicitor's Office. Not accountable to anyone, DLO staff could make the most outrageous claims of success of 'their' acupuncture clinic and the failure of the health authority's.

Militant war against RHA

The announcement that I had taken post as the RHA's Regional Drugs Training and Information Officer saw Militant's campaign against myself and the 'new evil' of harm reduction start in earnest. Letters arrived at RHA headquarters alleging I was a drug dealer, user, etc. My position was made clear when I was personally confronted and warned about 'exposing' any information gained when I had been regarded as 'one of them'.

The bigger the RHA's drugs initiatives became and the more they established Liverpool in the forefront of a rational policy, the more resources Liverpool City Council's Militant leaders had to allocate to their DLO. Almost everyone in the local drug field knew the Drug Liaison Office was there primarily to undermine the rising acceptance of many of our strategies.

In no uncertain terms, council employees were instructed to have no dealings either with myself or with any of the RHA's harm reduction agencies. The drug clinic was elevated to public enemy status for prescribing the methadone that was 'preventing a youth revolution'. Basically the local authority was trying to force a boycott of all health authority drug services. Meanwhile the DLO became staffed by more Militant activists inexperienced in drugs work.

The 'pushers issue' appeared to offer the Drug Liaison Office an attractive target in their attempt to gain popular support for their position. But no matter how much the Militants promised to clear them away, the pushers were always one step ahead. Seeing no real success in the Militants' drive to clean up the streets, the populace turned on the council: 'You promised to get rid of them, they are still there, you are failures'.

Another ploy went wrong when Militant tried to push through a plan to evict any convicted dealer from council housing. Unfortunately people asked awkward questions like, 'What if the pusher has a wife/husband and kids?' The plan was eventually dropped by increasingly frustrated Drug Liaison Office staff.

By 1987 the DLO had realised that they could not defeat the RHA on their own. Finally Militant resorted to 'democratic' procedures by creating a drugs sub-committee of the education committee. Community representatives were invited on to the com-

The author is a freelance consultantt. Until last year he was Mersey Regional Health Authority's HIV/Drugs Coordinator. From 1983-5 he headed the local authority-sponsored Merseyside Drug Education Training and Research Unit.

WAR has broken out between the health authority and the city council . . . and Liverpool's drug addicts are the losers.

Social workers and teachers who come up against the drugs scourge have been ordered to boycott Allan Parry's training centre.

Instead they have been instructed to take a training course run by Sheila Sweeney at the city council.

Out in the open – the civil war between Liverpool's City Council and its health authorities exposed by the *Liverpool Echo*, 16 May

He said: "We try to cure people from their addiction. The Labour Party here takes the view that that is just tinkering with people's lives.

Dossier

"We are anaesthetising the revolutionary ardour of Liverpool's youth. We should be sending them to the Labour Party to give them a sense of purpose in life."

An exhibition on the health authority's drugs work planned for Picton Library was blocked by Liverpool City Council.

Cllr Crowley says it was she who blocked the exhibition at Picton Library.

"There are a lot of nut cases involved in the drugs field. I wanted to make sure that the exhibition was in line with our policy."

mittee – but as non-voting advisers, they were there only to involve them in and gain local credibility for the DLO's work. This too backfired when Militant lost control of the city council. Once under Labour moderate leadership, the advisers on the drugs committee (reconstituted as a social services sub-committee) were given a vote – the 'enemy' in the form of RHA representatives now had direct influence on city council drugs policy.

Aware that this could become politically difficult, a deal was struck between Militant and the new moderate council leader. Keva Coombes needed all-faction support for his budget plans; Militant wanted sole ownership of the drugs issue. Coombes agreed; he knew drugs was a political minefield and was only too happy to 'give' Militant the issue, as he was by now engrossed with the city's overwhelming financial problems.

Credibility went completely when Militant totally misjudged the AIDS issue. They believed the community would never accept syringe exchange schemes and painted a picture of a Liverpool overrun with drug-crazed, needle-waving criminals. Attempts were made to convince local parents' support groups that their kids would start infecting each other with HIV, courtesy of the RHA – but from bitter experience the parents knew that the rhetoric of the Militant anti-drug warriors was nothing more than false promises.

Community hijack frustrated

Many parents attended sessions we organised to explain why we were giving needles out, and most groups finally came out in support of exchange schemes. In 1987 one family support group even decided to start their own, but their building was leased to them by the city. The group's chairperson received a visit from the DLO who warned that if they proceeded with their plans the council would withdraw the lease. Similar threats were received by any council-supported projects that expressed an interest in exchange schemes.

Such blatant intimidation eventually led to an almost total ostracism of the DLO within the community and an appreciation of the difficult political circumstances we had been working in for years.

Militant could not prevent RHA drugs initiatives because decision makers in local health service management do not have to answer either to the voters or to their political representatives.

Frustrated at having no local democratic NHS procedure to influence, Militant attempted to build an alternative power base by organising 'community forums' all over the city – especially on estates where the drug problem was 'out of control'. DLO staff would organise open meetings, ostensibly to hear the community's views.

However, almost as soon as a 'forum' was established, DLO staff would announce, usually during heated arguments about what should happen to the pushers, etc, that the RHA was going to be dishing out needles to drug users. Frightened parents would hear their local authority officer explain how syringe exchange staff encouraged heroin smokers to inject – creating junkies who would then soon be threatening them with HIV-soaked syringes. Whenever we could get our voice heard at these meetings, common sense soon prevailed and many who had listened to the DLO soon realised that they were in the middle of a political issue. The forums ran out of steam when it proved impossible to get them to organise against the syringe exchanges.

> ***"The drug clinic was elevated to public enemy status for prescribing methadone"***

By 1988 Militant were on the run in Liverpool after a series of incredible errors of judgment. Non-Militant councillors started to take an interest in the RHA's drug strategy. No longer satisfied with Militant-prepared dossiers on myself and others, they started to appreciate our work and many were enraged to discover the degree to which a number of us had suffered at the hands of *their* DLO.

The Militant cookie finally crumbled in 1989 when DLO staff attempted to introduce their own drug education pack into primary schools. The pack was so absurd that it became a laughing stock at meetings of drug education coordinators. As the *Liverpool Echo* later revealed (18 August 1990), neither education committee councillors nor the education department's drugs and health advisers were consulted before the DLO's letters went out to the schools. "Furious" councillors forced the pack's withdrawal. 'Who are these people we are paying to produce this rubbish?' councillors at last began to ask.

Ironically, the demise of the DLO comes at the same time as the demise of the RHA strategies they had opposed for so long. Central government – apparently nervous of the influence Mersey was starting to have nationally and internationally – used one of the regular anonymous allegations against myself and others as the opportunity to demand that this 'offshore island' be brought back into the mainstream of British drug policy thinking.

Central government and senior Mersey RHA managers were never really comfortable with such initiatives as syringe exchanges, teaching safer drug practices, and prescribing smokable heroin or cocaine. The final straw for government was a TV *World in Action* programme about Mersey's strategy broadcast in 1990 as Thatcher was holding her 'World Summit' on drugs. As she ranted against the intrinsic 'evils' of crack, a Department of Health spokesperson voiced official support for the experimental prescribing of smokable cocaine – effectively, crack – by two of Mersey's drug clinics.

Doctors gain control

Until then Mersey RHA's chair had supported its radical drug policies. But eventually the continued anonymous allegations and increasing pressure from his friends in Thatcher's government paid off. By 1991 there had been a 'coup' in the RHA's management, which heralded the return of the abstentionist doctors as the ideologues of regional drugs strategy. The word had come from ministers – 'get a grip' on the 'social entrepreneurs' who for years had been given the lead role.

The result is that reports from the RHA's own Drugs/HIV Monitoring Unit revealing the poor performance of many of the newly spawned outreach, syringe exchange and treatment services are being 'filed' into obscurity. Morale in these services is declining as their support is eroded.

Carefully planned initiatives are being shelved as health service managers opt to keep a low profile until the pressure subsides. Now under district control, ambitious plans for the former RHA Maryland Centre to act as a base for mobile exchanges, outreach schemes, and as a health centre for drug users have been abandoned. RHA funding for the development of a production line to enable smokable heroin to be more widely prescribed and dispensed has been withdrawn. Of the latest 600 plus addicts notified from Mersey, just 34 were receiving injectable methadone.

A year ago staff in agencies were paranoid about the city council. The simple truth is that the council's Drug Liaison Office is no longer needed to 'moderate' the RHA's radical activities – the RHA is doing it itself. But Militant's campaign against myself and others continues. At a recent local Labour Party meeting a DLO officer had it recorded in the minutes that I had been sacked from the RHA for drug dealing.

SHORTLY AFTER THE announcement of the impending closure of the DLO, two jubilant but naive Liverpool drug workers wrote in the local paper that now everyone could get on with developing sensible, pragmatic services for drug users, free from interference by these rabid abstentionists. Too late, friends, the Drug Liaison Office has finally had its way, the RHA is now well on the way to recovery. ■

PUBLICATIONS

HIV and AIDS

■ **SEX DRUGS AND HIV: HEALTHY OPTIONS FOR DRUG USERS. Terrence Higgins Trust, 1991. 11 pages. Booklet. £0.45.**
Available from THT, 52-54 Grays Inn Road, London WC1X 8JU, phone 071-831 0330.

■ **CARING FOR SOMEONE WITH AIDS. David Yelding *ed.* Consumers' Association and Hodder and Stoughton, 1990. 312 pages. Book.**
Available through bookshops.

Tranquillisers

■ **COPING WITH TRANQUILLISER (& SLEEPING PILL) ADDICTION. Council for Involuntary Tranquilliser Addiction. Wendy Lloyd Audio Productions Ltd, 1991. Audiotape. £6.25 inc. p&p.**
Tape from self-help group aiming to support users withdrawing.
Available from Tranquilliser Tape, PO Box 1, Wirral, L47 7DD.

■ **BENZODIAZEPINE DEPENDENCE, TOXICITY, AND ABUSE. American Psychiatric Association. Washington: APA, 1990. 116 pages. Book. £19.95.**
Comprehensive review.
Available through bookshops.

Other

■ **THE PROTECTORS. HARRY J. ANSLINGER AND THE FEDERAL BUREAU OF NARCOTICS, 1930-1962. John C. McWilliams. London, etc.: Associated University Presses, 1990. 251 pages. Book. £29.50.**
The life and influence of the notorious US anti-drugs bureaucrat and campaigner.
Available through bookshops.

■ **ADDICTION CONTROVERSIES. David Warburton *ed.* Harwood Academic, 1990. 386 pages. Book.**
Thought-provoking papers including many from well-known British and European researchers and practitioners.
Available through bookshops.

■ **EXECUTIVE SUMMARIES. Centre for Research on Drugs and Health Behaviour. Series of briefing papers. £20 p.a.**
Aimed at health directors and drug advisory committee members. First four cover aspects of treatment and HIV prevention.
Available from Centre for Research on Drugs and Health Behaviour, 200 Seagrave Road, London SW6 1RQ, phone 081-846 6565.

■ **DRUG USERS IN THE RESIDENTIAL HOSTEL. NACRO South West Regional Drug Training Unit, 1991. Training pack. £35.**
For training hostel workers not specialising in drugs work.
Available from South West Regional Drug Training Unit, 29A Southgate, Bath BA1 1TP, phone 0225 336766.

■ **POSITIVE HEALTH HANDIGUIDE 1991. Intercomm Data Base Services, 1991. Directory. £15.95.**
Lists organisations in London offering help with sex or drug problems.
Available from Intercomm Data Base Services, 45B Blythe Street, London E2 6LN.

■ **THE FACTS ABOUT ADOLESCENT DRUG ABUSE. John Davies and Niall Coggans. Cassell, 1991. 88 pages. Book. £6.95.**
Practical guidance for teachers and workers involved in helping young people, from the researchers involved in the Scottish national evaluation of drug education.
Available through bookshops.

MEETINGS

■ **PRACTICAL APPROACHES IN THE CONTRACTS ERA. Network Association of HIV and AIDS Workers. 15-18 July 1991, Leicester.**
Implications of NHS and Community Care Act.
Details from Professional Briefings, 120 Wilton Road, London SW1V 1JZ, phone 071-233 8322.

■ **DRUGS, ALCOHOL AND TOBACCO: MAKING THE SCIENCE AND POLICY CONNECTIONS. Institute of Psychiatry. 16-19 July 1991, London. International Conference. £250.**
Details from Action on Addiction, 199 Westminster Bridge Road, London SE1 7UT, phone 071-261 1333.

■ **AIDS AND DRUGS – UNDERSTANDING THE CONTEXT OF RISK BEHAVIOUR. British Sociological Association, Medical Sociology Group. 27-29 September, York.**
Main speaker is Dr Gerry Stimson.
Details from Steve Platt, Medical Sociology Unit, 6 Lilybank Gardens, Glasgow G12 8QQ.

■ **RURAL DRUGS AND ALCOHOL SERVICES. Mid Glamorgan Health Authority. 2-3 October 1991, Powys.**
Details on 0443 224455.

■ **BENZODIAZEPINES INTO THE 1990s. Hamlin and Hammersley. 10 October 1991, London. £65.**
Including discussion of whether 'street' drug users and tranquilliser users need the same service.
Details from Hamlin & Hammersley, Southbank, Grants Lane, Somerset BS28 4EA.

■ **EDUCATIONAL OBJECTIVES AND TRAINING METHODS IN ADDICTION. Society for the Study of Addiction (SSA). 21-22 November 1991, Manchester.**
SSA annual symposium.
Details from Professor Ghodse, Division of Addictive Behaviour, St. George's Hospital Medical School, Cranmer Terrace, London SW17 0RE, phone 081-672 9944, ext. 55718.

■ **THIRD INTERNATIONAL CONFERENCE ON THE REDUCTION OF DRUG RELATED HARM. Alcohol and Drug Foundation (Melbourne) and Mersey Drug Training and Information Centre. 23-26 March 1992, Australia.**
Details from Conference Administrator, PO Box 529, South Melbourne, Victoria 3205, Australia, phone 61 (03) 690 6000.

■ **ALCOHOL AND DRUGS – FACING UP TO THE EVER-CHANGING SCENE. 36th International Congress on Alcohol and Drug Dependence. 16-21 August 1992, Glasgow.**
Details from Congress Secretariat, c/o SGA, 135/145 Sauchiehall Street, Glasgow G2 3EW.

COURSES

■ **BLACK HIV/AIDS NETWORK TRAINING COURSES. July/August, London.**
Range of courses for managers, practitioners and black voluntary organisations.
Details from BHAN, BCM BHAN, London WC1N 3XX, phone 081-741 9565.

■ **WORKING WITH HIV SYMPTOMATIC DRUG USERS. 18-19 July 1991.**
■ **TRAINING METHODS. 19-20 September 1991.**
N.W. Regional Drug Training Unit. Manchester.
Details of these and other courses from NWRDTU, Kenyon Ward, Prestwich Hospital, Bury New Road, Manchester M25 7BL, phone 061-798 0919.

■ **DEVELOPING MOTIVATIONAL INTERVIEWING SKILLS. National AIDS Counselling Training Unit. 19-22 August 1991. London.**
Details of this and other courses from Brian Whitehead, NACTU, St Charles' Hospital, Exmoor St., London W10, phone 081-968 8514.

■ **FAMILY SUPPORT COURSES. ADFAM National. September 1991-February 1992. London, Birmingham and York.**
Range of courses on different aspects of family work.
Details from ADFAM NATIONAL, 82 Old Brompton Road, London SW7 3LQ, phone 071-823 9313.

■ **HEALTH AND LEGAL EMERGENCIES. 30 Sept., Winchester; 3 Oct., Bristol; 4 Oct., Mid Glamorgan. £40/£80.**
■ **COURT REPORT WRITING. 14-15 Oct., Oxford. £90/£180.**
■ **HARM REDUCTION: PROFESSIONAL RESPONSIBILITIES. October, Oxford. £40/£80.**
■ **DRUGS AND THE LAW FOR OUTREACH WORKERS. 7 Nov., London. £40/£80.**
Release. 1991. Prices non statutory/statutory.
Details from Alasdair Cant, Release, 388 Old Street, London EC1V 9LT, phone 071-729 5255.

■ **DIPLOMA IN ADDICTIVE BEHAVIOUR. St George's Hospital Medical School and SW Thames RDPT. October 1991-June 1992, London.**
Course for GPs: approved for Postgraduate Education Allowance.
Details from Mari Ottridge, Division of Addictive Behaviour, Jenner Wing, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE.

■ **PRACTICE SUPERVISORS' COURSE. 2-4 December 1991, Ripon. Residential £112.**
■ **ADVANCED COURSE IN THE MANAGEMENT OF SUBSTANCE MISUSE. 2 days per week 6 January 1992 to 11 September 1992, Leeds.**
Leeds Addiction Unit.
Details from Gillian Tober, Leeds Addiction Unit, 19 Springfield Mount, Leeds LS2 9NG, phone 0532 316930.

ORGANISATIONS

■ **ADDICTIONS FORUM**
New organisation aiming to encourage debate, share information and network drug misuse practitioners and researchers.
Details from Martin Plant, Alcohol Research Group, University of Edinburgh, Morningside Park, Edinburgh EH10 5HF, phone 031-447 2011 ext. 4509.

FOR MORE INFORMATION ...

☎ ON THE PUBLICATIONS LISTED HERE: phone ISDD on 071-430 1993.

☎ ON MORE NEW PUBLICATIONS AND ARTICLES: order *Drug Abstracts Monthly* – £16 p.a. from ISDD, phone 071-430 1961.

☎ ON A PARTICULAR TOPIC: phone ISDD's library on 071-430 1993.

☎ ON TRAINING: phone the Training Officer at the Standing Conference on Drug Abuse (SCODA) on 071-831 3595.

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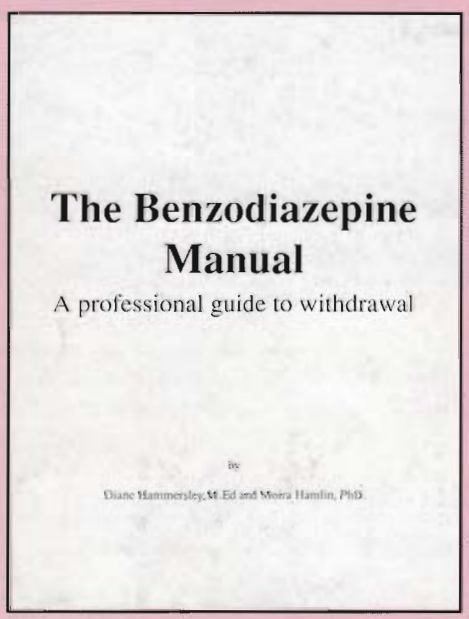

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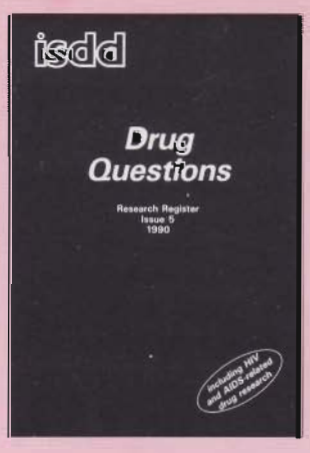

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