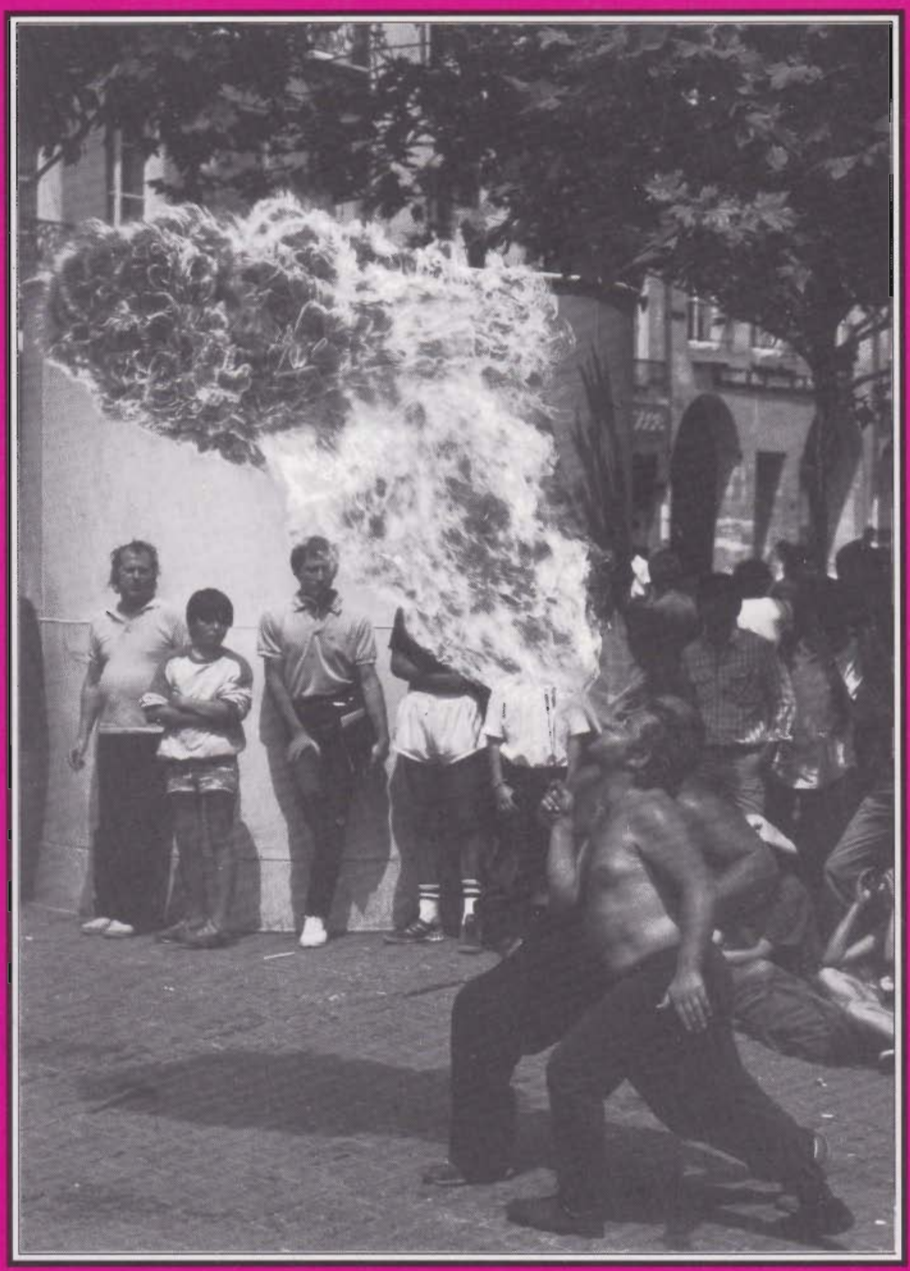
DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN March/April 1991



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Vol 6 issue 2
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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Look after yourself

It isn't always easy to think about yourself when your clients may be at risk of their lives or their liberty, or facing the prospect of AIDS. But drug workers too need protection – from legal risks (see page 11) and from the harmful effects of stress (see pages 12-14).

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Central Drugs Squad quits Met

Crack squad officers to be dispersed

In a major reorganisation of drug enforcement in London, the Metropolitan Police will lose its Central Drugs Squad to a new authority, Regional Crime Squad 9, covering the London area.

The Central Drugs Squad is by far Britain's biggest and does the most 'business' in terms of traffickers caught or seizures made. In 1989 over half the heroin seized by police and nearly two-thirds of the cocaine was seized in London. The squad's metamorphosis into a regional drugs wing has major repercussions for drug enforcement in the South East.

All the regional crime squads come under the command of their Executive Coordinator, Neil Dickens, overseen by a committee drawn mostly from the Association of Chief Police Officers (ACPO). This latest move can be seen as a further step in the development of the autonomy of the police, as it involves a transfer of accountability from the Home Secretary to ACPO.

The Met's Crack Intelligence Coordinating Unit – wrongly reported to have been disbanded in 1990 but in fact still highly active – will be broken up in the re-organisation. One favoured option is for experienced officers to be absorbed into other Met units. This would retain their expertise and relations with informants without the odium attaching to an identifiable squad said to specialise in targeting Jamaican crack dealers.

Formation of Regional Crime Squad 9, to take effect this year, brings London into line with the organisation of top-level policing in other parts of Britain, where regional squads and their drugs wings are responsible for targeting most serious crime.

The unpublished 1985 Broome Report[1] described a structure with regional drugs wings at the top (working with Customs), drugs squads in the middle, and local CID tackling the retail market – dividing responsibilities in a manner comprehensible to police officers and politicians alike.

The national role allocated to the now complete network of regional crime squads is also an essential part of the police's need to be seen as having a drug enforcement role as important as Customs'.

Senior Metropolitan Police officers are now working out the implications for middle-level drug enforcement in the capital, amid concern that the departure 'up market' of the Central Drugs Squad will leave a gap in anti-trafficking measures. London's eight area drugs squads are to undergo a 'thematic review', meaning their *raison d'etre* will be reviewed and possibly modified.

The likeliest scenario is that the status of area squads will increase as they become recognised as equivalent to force drugs squads outside London. Officers will officially be encouraged to go after more serious targets.

There may well be resource implications as the areas seek to expand their operations. Complaints about inadequate resources, with dealers outclassing the area squads in technical equipment, are legion throughout the capital.

Police sources pointedly remark that if (as is often assumed) one tenth of all drugs imported are seized by Customs then nine-tenths get in and present potential targets for the police, who should be given the resources to do the job.

The main demands are for secure communications equipment, cars changed often enough not to become known to traffickers, and sufficient overtime for officers to be able to apprehend their targets.

Nicholas Dorn

ISDD

1. This September, Routledge will publish ISDD research in the book *Traffickers: drug markets and law enforcement*, which will include the most important sections of the Broome Report.

Hospital pharmacies may no longer be a safe haven for confidential prescribing

Drug agencies which have sought to prevent police gaining access to clients' names by arranging for their drugs to be prescribed from a hospital pharmacy may find this ploy no longer works after April 1.

From that date NHS hospitals lose Crown Immunity against legal action, a move primarily designed to bring their catering and other systems within health and safety legislation. But one side effect could be to render their pharmacies' controlled drugs registers open to inspection by police, as is currently the case for community pharmacies.

Authorised under the Misuse of Drugs Act, these inspections are intended to ensure pharmacists adhere to the regulations and to trace doctors who fail to notify addicts. But they could also serve to identify addicts by their repeated receipt of methadone prescriptions.

To sidestep this, Jane Goodsir of Release says many agencies have arranged for their clients' drugs to be dispensed from hospitals, but already in one area police have visited a hospital to arrange to inspect their records after April 1.

Release are writing to the Government and to the Home Office officials to seek guidance on the new legal situation, but Alan Macfarlane, Chief Inspector at the Home Office Drugs Branch, is well aware of the problem and is himself seeking clarification.

He believes it could all depend on whether the hospital pharmacy "adopts a retail position" charging for its services. If it did then it would probably become subject to the regulations.

Even so his feeling was that the sensitivity of police inspecting hospitals would make it preferable for Home Office inspectors to take on the task. Some Home Office civil servants are already privy to addict names through the notification index and have a good but not unchallenged record of maintaining confidentiality.

A former Home Office Chief Inspector recently cautioned against assuming that police are less likely to preserve medical confidentiality than other groups, but this is unlikely to reassure clients, many of whom regularly break drug laws.

isdd NOTICEBOARD

Fame at last!

How to get your name in ISDD's library catalogue? Comb your files for drug-related written materials not formerly published which may be of interest to others in the drugs field – theses, research reports, local educational materials, manuals, etc, could all be valuable additions to our collection. Contact Phil Defriez (071-430 1961) with your offerings.

Prevention research

ISDD's first research in the 1970s was concerned with drug education and prevention it is only recently that we have returned to these themes.

● This spring sees the publication of *High Policy*, a pack for youth work managers, developed out of work funded by the Department of Education and Science. The pack includes a manual of the same name, a sample copy of the previously published and highly successful newspaper, and a copy of ISDD's *Drug Abuse Briefing*.

Designed for those concerned with curriculum development, staff support and training at local authority or area levels, *High Profile* offers step-by-step advice on how to generate youth service policy on legal and illegal drugs. It also contains a new sample policy statement, covering integration of drug-related issues into broader curriculum concerns, legal issues, health and safety issues, and the use of performance indicators to demonstrate commitment and legitimise funding.

POLICY

● Expected soon is a Home Office-funded report reviewing the literature on drug prevention at local level. Commissioned for the Central Drug Prevention Unit, the report is expected to examine models or theories of prevention plus some examples of practice and what is know about outcomes. The work covers recent interest in 'demand reduction' where this forms a bridge between multi-agency working and the policing of retail drug markets and their customers.

Community care grant oversubscribed

By the time you read this local authorities should have been notified whether their bids have succeeded for a slice of the £2 million community care money for drug and alcohol dependents in England in 1991/92.

This "Specific Grant" was a last-minute concession by government in response to concern that local authorities would be reluctant to fund services for these clients out of their general community care budget. It was to be spent only on voluntary organisations.

To gain access to the 70 per cent of the grant provided by government, local authorities had to provide 30 per cent of their bid from "other sources". Fears that they would be unwilling to do even this were eased when the Department of Health made it clear that those sources need not be the local authority's funds but could include money secured for the project from charities, business or the voluntary agency itself.

It could be acceptable for a voluntary agency to raise 30 per cent of a project's costs and persuade the local authority to bid for the remainder from the Department of Health. But the authority would have to include the project in its 1992/93 community care plan.

Bids for the first year's funding closed on 31 January with the grant oversubscribed. The financial value of bids received was evenly split between drug only and alcohol only projects (35 per cent and 38 per cent respectively) with the remaining 27 per cent requested for combined projects.

The procedure for dispersing the 1992/93 Specific Grant will be much the same as for the first £2 million, but what happens after 1993 is as yet undecided. From April of that year it's planned that local authorities will take responsibility for funding community care for all sections of the community.

It's likely that a sum to be devoted to alcohol and drug dependents will still be 'ring-fenced' by government to protect those relatively unpopular groups. What worries many drug and alcohol projects is whether local authorities will narrow their area's residents' choice down to local projects or to the one or two with which they've negotiated block contracts.

The alternative scenario of each residential project having to negotiate contracts with tens of local authorities is an administrative nightmare of which the Department of Health is fully aware. Preliminary impressions from Turning Point's survey of drug and alcohol rehabs in England and Wales suggest it is not unusual for each to receive referrals from 30 or more local authorities.

The survey has also documented the well-known fact that some local authorities regularly pay rehabs top-up funding for residents from their areas while others are hardly worth asking.

Karen Varney, who is undertaking the initial analysis, also hopes the data will be used to explore apparent anomalies, such as the fact that in 1989/90 Liverpool City referred 328 drug users to residential rehabs in the survey and had a further 142 residents, while the corresponding figures for alcohol users were 9 and 4.

Other Mersey boroughs present a similar picture while not far away in Manchester the figures for drug and alcohol referrals are practically equal at 220 and 219 respectively.

Two-thirds of the 102 drug and alcohol rehabs polled by Turning Point responded, giving the organisers a solid base from which to lobby for an appropriate system for funding drug and alcohol residents up to and after 1993.

New lobby aims to keep drugs on the education agenda

Concern that drugs are slipping down the educational agenda has led to the formation of a new organisation to protect and build on the advances fuelled by government funding in the late '80s.

A group of health/drug education coordinators and allied workers met on 29 January to form the Drug Education Forum, whose central mission will be to "maintain the high profile of drug education".

Behind the meeting was Colin Chapman, drug education coordinator for Redbridge in Essex. Motivating his initiative was what he and like-minded colleagues see as a pincer movement at both local and national levels which threatens the work funded by the £2 million p.a. DES drugs initiative launched in 1986.

From 1986 to 1989 each local authority was funded to employ a drug education coordinator, but when the grant was renewed in 1990/91 their brief was widened to take in legal drugs and HIV as well as drug misuse. Along with HIV inevitably came sex education.

Renamed 'health education coordinators', some local contracts further widened their remit. In Berkshire, for instance, Adrian King's responsibilities now include child protection training for teachers – an issue that on its own could easily swamp drugs work.

The new organisation's other main aim is to maintain the broad community and multidisciplinary approach to drugs education developed in many areas.

The first drug education coordinators were often motivated by a general concern about drug use by young people, and allied themselves with other agencies to develop educational initiatives outside as well as inside the school. Adrian King, secretary of the coordinators' National Liaison Group, is convinced that education in settings such as youth clubs – where "trust is greatest and pressure least" – can be the most effective.

As their short-term contracts expired, coordinators tended to be replaced by staff attracted by the new broad health education remit. Colin Chapman says typically these were advisory teachers unused to a broad community education approach.

Increasingly hard-pressed local education authorities may also be tempted to concentrate funds on essential schools-based work.

The net result could be to narrow drug education down to classroom lessons, while a feeling that drugs have 'been done' may justify the topic's downgrading in the health education spectrum.

What happens in March 1992 when the current government grant expires is worrying some health education coordinators, who say it will be easier for the government to cut funding under the label 'health' rather than the more emotive 'drugs' label.

Colin Chapman insists the Drug Education Forum is no rival to the coordinators' existing National Liaison Group. That group's secretary Adrian King sees the forum as an "exciting" development which has a good chance of maintaining the commitment and expertise "which might otherwise be diluted" by the coordinators' broader job descriptions.

For more information contact Colin Chapman, c/o Redbridge Community Drug and Alcohol Service, Chadwell Heath Hospital, Grove Road, Chadwell Heath, Essex RM6 4XH, phone 081-599 3007 ext. 5282.

Paraphernalia case fails

A Notting Hill shopkeeper's appeal against his conviction for offering to sell items believing they would be used to take cannabis succeeded at Knightsbridge crown court on 27 December.

The case was being seen as a test of the section of the Drug Trafficking Offences Act 1986 which made it an offence to supply or offer to supply items believing they are to be used for illegal drugtaking.

A previous case succeeded on the basis of an incriminating statement from the defendant, but in this case there was no admission from Lee Harris that he believed the pipes and rolling papers he sold were for drugtaking. Police were also unable to show that they had actually been used for these purposes.

The prosecution claimed that working in a 'high drug use' area and stocking drug-related artifacts, Mr Harris must have known some of his customers would use the goods for illegal purposes. Though the failure of this case makes it less likely, theoretically any tobacconist aware that some of his customers might use rolling papers or even tobacco for illegal drugtaking could face prosecution.

Methadone maintenance'cost effective and saves lives'

A major US study of the effectiveness of drug dependency treatment has concluded that the benefits far outweigh the costs and that for heroin addicts methadone maintenance "has yielded the most positive results for those who seek it."[1]

The full report of this study (mentioned briefly in the last issue of ***Druglink***) has now been received by ISDD and adds substantially to the growing body of international opinion favouring a treatment which many still see as merely perpetuating addiction.

At the behest of the US government, the Institute of Medicine of the US National Academy of Sciences called together a committee of experts to study the spectrum of drug treatment in the US.

Their 320-page report says there is "strong evidence... that opiate-dependent individuals have better outcomes on average in terms of illicit drug consumption and other criminal behaviour when maintained on methadone than when not treated at all, when simply detoxified and released, or when methadone is tapered down and terminated as a result of client request, program expulsion, or program closure."

What little cost-benefit evidence was available suggested, said the committee, that methadone maintenance "provides individual and social benefits... substantially higher than the cost of delivering this treatment".

The report says methadone maintenance is the most rigorously studied treatment in the United States. There was less evidence of the success of therapeutic communities, detoxification or non-drug treatments, with twelve-step programmes particularly poorly researched yet with the highest financial revenue.

Also adding to the international respectability of methadone treatment is a report from the World Health Organisation, particularly concerned with the drug's role in HIV prevention.[2]

A group of experts from four continents acknowledged that "protracted methadone maintenance may be an unappealing notion for some health professionals and policy planners. Nevertheless, this option may be preferable to cessation of treatment in light of the range of health consequences of relapse, including those associated with the risk of HIV infection."

Methadone has been seen primarily as an HIV prevention strategy, but a Swiss study published recently in the *British Medical Journal* found evidence that compliance with the treatment can also retard progression to AIDS among injectors already infected with the virus.[3]

1. Gerstein D.R. *et al eds. Treating drug problems.* National Academy Press, 1990.
2. *Options for the use of methadone in the treatment of drug dependence.* WHO, 1989.
3. Weber R. *et al. British Medical Journal:* 1990, *301*, p.1362-5.

Heroin haul supports EC border controls

Two lorries laden with 204kg of heroin provided the British Customs service and Government with a propaganda coup in their campaigns to retain border controls after the start of the single European market in 1992.

Releasing the 1990 seizure tally on 15 January, the minister responsible for Customs pointed out that the lorries had passed unhindered across seven European borders before their cargo was exposed by the "vigilance" of Dover's Customs officers.

Among the borders so easily traversed was the European Community's own external border: Britain can't rely on its community partners to seal drugs out of the EC as a whole, was the diplomatically unspoken message.

Reinforcing the point was the now customary addendum to the statistics revealing what proportion of seized drugs reached the UK via Europe – about two-thirds for both heroin and cocaine.

1990 was by far the Custom's record year for cocaine and heroin seizures. Last year 589 kilos of heroin were seized – 77 per cent up on the previous year. At 561kg, cocaine seizures were 32 per cent up on 1989, itself a record year.

For the minister, these figures were "especially gratifying" because there was no evidence of similar rises in the numbers of addicts, suggesting enforcement was making a real dent in the availability of drugs.

However, it was revealed that on average street prices for heroin and cocaine were unchanged (meaning in real terms they have gone down), which suggests the alternative explanation that the figures merely reflect a greater influx of drugs into the country. Supporting this interpretation is the strong rumour that when released Metropolitan Police heroin seizures for last year will show a large increase.

Reading too much of anything into customs seizure statistics would be a mistake, as so much depends on whether in any particular year 'hunch' or random searches pay off with large seizures.

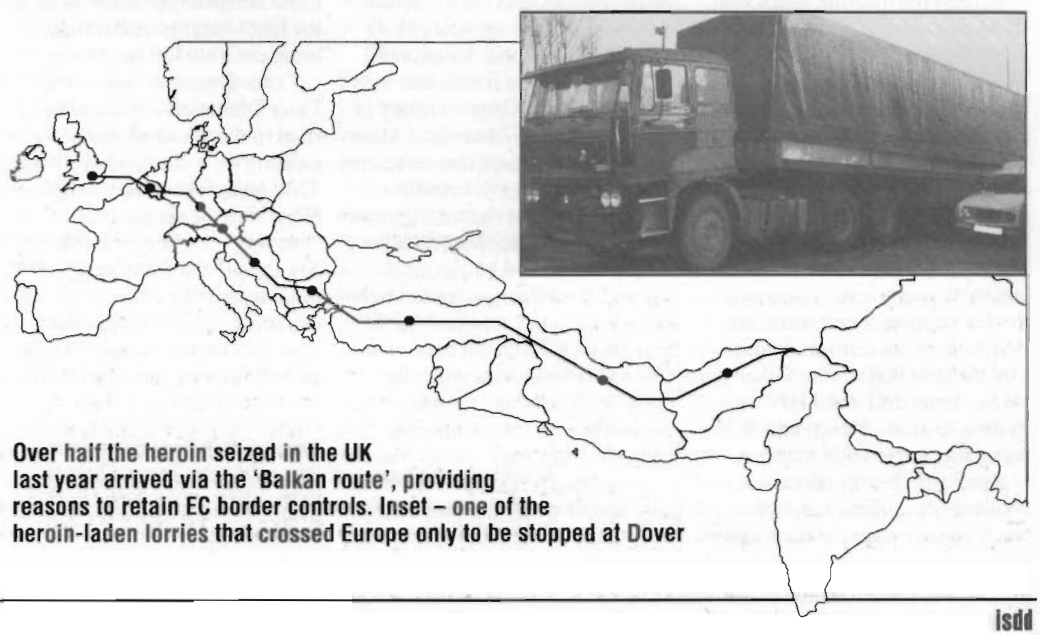
In 1990 the largest single heroin seizure was 204kg – the year before it was 45kg. Without the two Turkish lorries, heroin seizures would have risen by just 16 per cent.

With the overland lorry route re-established, there may now be greater opportunity for Customs to make single large seizures. This in itself could account for increased seizures.

In 1990, over half Britain's seized heroin travelled overland from the Indian subcontinent via the 'Balkan route', whose revived importance reflects international military and political developments. The route begins by taking advantage of the end of the Soviet presence in Afghanistan, then crosses Iran, now free of the war with Iraq. Lorries are loaded in Turkey and enter Europe in Bulgaria. Germany and Belgium are the main EC countries traversed en route to the UK.

Cocaine seizures continued the upward trend of recent years with Colombia the largest single source. However, there was a growing secondary route from Jamaica and the Eastern seaboard of America – primarily female couriers bringing in kilo amounts. The National Drugs Intelligence Unit believes it is this cocaine rather than the bulk supplies from South America via Europe that feeds the as yet limited 'crack' market in the UK.

Amphetamine seizures were also up, attributed by Customs to the pressure being put on home producers by the enforcement agencies, while cannabis seizures declined nearly a half to 24 tonnes. Last year's figure did include a single seizure of 17 tonnes and cannabis seizures have in general declined worldwide.



Over half the heroin seized in the UK last year arrived via the 'Balkan route', providing reasons to retain EC border controls. Inset – one of the heroin-laden lorries that crossed Europe only to be stopped at Dover

Drug education under scrutiny

A damaging evaluation of drug education in Scotland was tabled at a recent meeting of the Ministerial Group on the Misuse of Drugs, the UK's highest tier of drug policy-making. It showed that despite national coordination, education had not affected use levels nor hardened attitudes against drugs (see below).

The Scottish Office-funded report has yet to be published, but its findings could dampen government enthusiasm for further drug education expenditure. Already one proposed drug education research project in England – at first encouraged by the DES – later met with a cool reception from a key national official. Researchers were cautioned to "keep quiet" lest the government got to hear of the Scottish findings and blocked future funding.

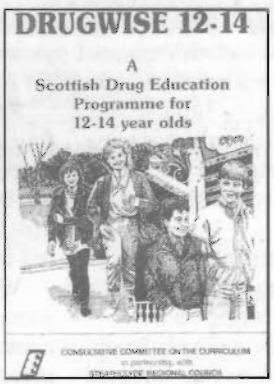
The Scottish Education Department is attempting to see the positive side of the research. An official emphasised that it showed their initiative had placed drug education in most schools and improved pupils' knowledge, even if there was no evidence it had turned them off drugs.

But one major drug education agency believes turning children off drugs is exactly what the Treasury now wants from drug education: "They want quantifiable benefits ... their criteria is, 'How many addicts have we saved from being put on the streets?'"

The Scottish Office is taking comfort from the fact that learning about drugs did not lead to *increased* use, but this "neutral" impact is unlikely to appeal to the current English administration.

Former DES minister responsible for drug education Alan Howarth presided over the blossoming of drug education in the late '80s and developed a close relationship with drug education specialists. His successors Michael Fallon and now Robert Atkins appear to be taking a much more hard-nosed approach. In this context, the Scottish evaluation is being seen as reinforcing official scepticism about drug education as a preventive strategy.

The principal Scottish researcher Niall Coggans believes that while "simplistic" strategies may not prevent drug use, strategies "raising awareness of how to avoid harm" may be more appropriate in areas of high drug use.



The flagship of the Scottish Office's drug education drive

Despite their upbeat interpretation, the Scottish Office has not disseminated the research findings nor published the report that has been with them for over a year. The researchers are being allowed to publish academic papers but these are unlikely to reach many teachers or parents.

Much hinges on exactly what the researchers were evaluating in the years 1987 to 1989. TACADE is Britain's most influential drug education centre known for its skills-based educational packages. TACADE's director Jeff Lee says at the time of the evaluation Scottish drug education was primarily cognitive with skills-based approaches only just on their way in. "The field has moved a long way since then," explained one of his colleagues.

Niall Coggans insists that skills approaches "had taken hold" at the time of the research. His report explains that in the sample it was impossible to find second-year pupils who had received drug education but *not* been exposed to *Drugwise 12-14*, a social skills education pack. Next most popular were two packs which TACADE itself had helped produce – *Drugwise 14-18* and the now discontinued *Free to Choose*.

Despite its defence of drug education to date, the Scottish Office is learning some of the lessons of its evaluation. The new *Promoting Good Health* booklet now being issued to schools encourages a 'whole school' approach to health education.

For Niall Coggans this is an important step in the right direction. Case studies in his report point out the need to establish a healthy "school system" as the context for effective health education. Everything from educational policy downward should, he believes, conspire to produce an environment conducive to healthy behaviour.

"Attempts to enhance decision-making skills will be undermined in schools where all the decisions have already been made for the pupils" says Niall Coggans. His research gives examples of poor teacher morale leading to cuts in extra-curricular activities. The result is to impede the development of a trusting relationship within which issues like drug-taking can openly be addressed.

'Neutral' impact says government evaluation

The *National Evaluation of Drug Education in Scotland*[1] aimed to assess the impact of the Scottish Education Department's drug education initiative.

The research was carried out between October 1987 and September 1989 and included an evaluation of the impact of drug education using a representative sample of 1197 pupils in years two to four of secondary schooling. Pupils who had been given no formal drug education were compared with those who had been educated using drug education packages in their entirety, only partially, or not using packages.

There was no evidence that drug education of any kind reduced drug use either legal or illegal, nor that it made pupils more anti-drug. Education had the least impact of the variables assessed. However, the more drug education pupils had had, the greater was their knowledge, and there was no evidence that education led to *more* use.

The report had some sharp words to say about the mainly skills-based drug education packages in use in Scottish schools at the time. While purporting merely to improve the pupil's decision making, it's said these in fact aimed to influence pupils to a decision to reject drugs. The assumption that young people take drugs or accept an offer of drugs because they are socially inadequate is challenged as is the credibility of the information in some of the packages.

1. Niall Coggans *et al. National evaluation of drug education in Scotland: final report.* University of Strathclyde, September 1989. Available from the author – phone Niall Coggans on 041-552 4400 for price.

■ Five years after being withdrawn from long-term benzodiazepine use, two-thirds of a group of 41 psychiatric outpatients were free of the drugs, though half of these had returned to benzodiazepine use at some time during the five years.[1] The researchers say it was "disturbing" that most of the group had been re-prescribed benzodiazepines despite the publicity about dependence. Prescribing tranquillisers to previously withdrawn patients is one of the grounds on which doctors are being sued for negligence.[2]
1. Hilton A. and Tyrer P. *British Medical Journal*: 1990, *300*, p.1241-2.
2. *Pharmaceutical Journal*: 18 August 1990, p.202.

■ Increases in the perceived risks and social disapproval of using cannabis or cocaine have been associated with recent falls in use of these substances among US high school pupils.[1] University of Michigan researchers say lifestyle factors such as religion and truancy rate strongly predict who will use drugs, but cannot account for the national trend to reduced use. Over the same period availability of these drugs has been maintained, suggesting demand-reduction techniques alone can cut use.
1. Bachman J.G. *et al. J. of Health and Social Behaviour*: 1990, *3*(1), p.173-184.

■ A study of imprisoned drug users in Stockholm, where amphetamine is the main drug injected, found that over 45 per cent of 194 heroin injectors were HIV positive compared to just under 6 per cent of 958 amphetamine injectors.[1] The researchers say this difference may partly be due to the greater "desperation" of heroin addicts faced with the choice of sharing a syringe or enduring further withdrawal symptoms.
1. Kall K.I. *et al. AIDS*: 1990, *4*(2), p.153-7.

■ After examining treatment services in the USA and the Netherlands, AIDS expert Dr Ray Brettle of Edinburgh's Infectious Diseases Unit has concluded that prescribing and HIV services for injecting drug users should be delivered from the same site by the same doctors, to ensure continuity and quality of service on both fronts.[1] The implication is that drug dependence treatment and HIV specialists "need to exchange and acquire each other's skills".
1. Brettle R.P. *AIDS Care*: 1990, 2(2), p.171-181.

From addiction to control

Motivational interviewing as a technique for leading the sceptical heroin addict towards self-control

Although behavioural self-control training has proven to be one of the most effective methods for creating change in addictive behaviours, it is not as widely used as it could be. Motivational interviewing could perhaps act as a go-between – a link between clients engaging in high-risk behaviour and a method that could help them become responsible heroin users. Two case examples are presented.

Henk Van Bilsen & Brian Whitehead

Brian Whitehead is Parkside Health Authority's District Drug Training Coordinator and a drug counsellor in London. Henk Van Bilsen is a psychologist/psychotherapist and behaviour therapist at the Institute of Child and Adolescent Psychology in Rotterdam.

MANY PEOPLE FIRMLY believe that heroin and some other controlled drugs can only be used in an uncontrolled and addictive way. 'Chipping' – limited and controlled use – is looked upon as merely a phase leading from abstinence to addiction, and an impossibility for the former addict.

This prejudice hampers motivation for change in people suffering from addictive behaviours, as one of the beliefs that promotes change is that *the desired change is actually possible*.[1,2] In our present decade it is even more important than in the past to exclude all change-hampering aspects of treatment: the AIDS problem forces society and treatment services to reconsider options and common practices. The fact is that *all behaviours* that can become excessive can also be untrained and enjoyed again in moderation. Let us take a closer look at the case of heroin.

"All behaviours that can become excessive can be untrained and enjoyed again in moderation"

The first research on occasional heroin use was published in 1973.[3] Twelve people questioned about their heroin use revealed a varied pattern of use including once a week or once every two or three months, averaging once a month. Sometimes heroin was used two to three times a week followed by a period of two or three months' abstinence.

In an extensive series of studies, Zinberg and Harding have tried to answer the question of whether controlled, limited heroin use is possible and how long people can maintain it (see references 4-9). Controlled heroin use was defined as regular heroin use but without physical dependence or interference with personal or social functioning. In some of the research, information given by users was cross-checked.[10] The average length of controlled use was found to be three to six years, but some had been using in this way for more than ten years.

Research in the early '70s in Detroit found that 37 per cent of a group of 60 young male heroin users used every day, 40 per cent used in a limited way, and 23 per cent had used regularly in the past year but not in the previous month.[11]

What this research proves is that a small group of people manage to use heroin in a controlled way: the population of heroin users consists only in part of addicts. Estimates of the size of the addict group vary from 50 per cent[12] to 20 per cent of all heroin users.[13]

Harding moved one step further when he concluded that addicted heroin users can return to non-addictive, controlled use.[14] A study of a small group of ex-addicts showed that six were now controlled users – five following therapy. They were using heroin no more than twice a week and had been for at least two years – in fact, on average for longer than they had been addicted.

How did these users control heroin? The researchers found that controlled, moderate use of heroin, integrated into rather than dominating the user's life, was possible whenever a small subculture developed social sanctions and rituals that limited use. Examples of such social sanctions and rituals are:

- rules limiting the frequency of use, eg, not more than twice a week or not more than a certain amount;
- rules allowing use only on certain occasions with certain groups of friends but never alone;
- rules that take into account the variable quality of street heroin by first 'tasting' a

main text continues p.10

Case One: HARRY HEROIN

Facts

- Age: 29 years
- Length of drug use: 12 years
- Amount of heroin use: one gram a day
- Personal circumstances: single, a loner, no job, has no contact with his parents, leads a 'good' life as a successful dealer of drugs

Treatment process

Harry came to see me because he had received some warning signals that the police were on his tracks because of his dealing. The only way he would be able to stop dealing was to regain some control over his heroin use. He had tried several other treatment centres but these refused to help him because he wanted to become a recreational heroin user rather than abstinent.

At first Harry set an ultimate goal of a maximum ½gm a week, five heroin-free days, and a maximum ½gm on any one day. Treatment sessions were every other day but after the fifteenth session they were held weekly.

Harry decided to decrease his heroin use gradually. At about the fifteenth session, he became unsure whether it would be wise for him to maintain the goal of recreational use (being on the dole it would be very expensive). Re-negotiation resulted in the ambitious goal of complete abstinence. His reward at the very end of treatment was to buy a second-hand bike with a very good lock – "These junkies will steal anything, you know".

Outcome

- Number of sessions: 30
- Length of sessions: in total, 24 hours client-therapist contact
- Goals at the end of treatment: abstinence
- Situation 12 months after end of treatment: abstinent, two lapses of ½gm each after being refused entry to some training

Case Two: MONA MULTIPLE

Facts

- Age: 29 years
- Length of drug use: 5 years
- Amount of heroin use: two grams a day plus various other substances in large quantities
- Personal circumstances: married, rich and suffering from depression since childhood – drug use was a medicine for her depression

Treatment process

Mona was forced to come and see the therapist by her family (husband and parents). Their instructions to the therapist and Mona were that she should stop using any drugs.

The motivational process for Mona consisted mainly of boosting her self-esteem and self-efficacy. One way of doing this was to create a negotiation process between Mona and her husband concerning her use of heroin. Mona decided that she would like to become a recreational user of heroin and remain abstinent from all other drugs. She succeeded in convincing her husband and the self-control training could begin.

Training was aimed at controlling two behaviours: drug use and depressed moods. Mona's ultimate goal was to use one gram of heroin every other weekend; out of 14 days, she intended to remain abstinent for 12. She decided to work gradually towards this goal, stopping use of the other drugs (amphetamines, cocaine, crack, etc) immediately. After the functional analysis a mood-improvement programme was introduced.

Outcome

- Number of sessions: 60
- Length of sessions: about 60 hours' client contact
- Situation 12 months after end of treatment: ½gm of heroin used during one month, only at the weekends

"Harry' became abstinent from heroin, 'Mona' became a weekend user. Both achieved their own form of self-control through motivational interviewing techniques

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Five phases to self-control

PHASE ONE: Introduction. In this phase objective information about heroin and heroin addiction is given, the possibility of personal choice is stressed, and examples of successful clients are discussed. Instructions for self-observation are given and from the first session clients are trained in recording their heroin use.

The clients then evaluate their heroin use and set standards for future use – the treatment goals. Goals are set for the maximum amount of heroin use in a week, maximum use during one day, and number of heroin-free days in a week. The therapist takes on an advisory role in the client's decision-making process – for instance, informing them that using heroin two days in a row is more difficult to control than using on alternate days. A reward is discussed for the client to give themselves if they achieve or comply with their goal.

After clients have set themselves their ultimate goal, therapist and client negotiate how this is going to be achieved: will the client gradually reduce use, or change in one big step? The client is then asked to set goals for their use in the period until the next session. For every intermediate goal, small rewards are negotiated for the client to give to themselves. Setting realistic intermediate goals is very important – goals which both client and therapist are confident of achieving. A typical client with sessions every two days might set the following goals: maximum use two days a week, using no more than half a gram a day, and no use between 1pm and 6pm.

PHASE TWO. Say no to heroin. This consists of training in saying no to drugs that are offered. Client and therapist engage in role play tailored to the client's needs, during which the client learns various ways to say no.

PHASE THREE. Rules and regulations. A list of rules on heroin use is given to the client, who at each session is expected to choose a new rule to apply to their heroin using behaviour. Examples could be: never use heroin in the living room/kitchen/bedroom/ etc; before use, have a short brisk walk around the block; phone parents/friends before every use; leave at least x hours between every use; etc.

PHASE FOUR. Functional analysis. Based on the client's self-monitoring, a 'functional analysis' is presented, analysing which situations, emotions and thoughts elicit uncontrolled heroin use, and what situational, emotional and cognitive goals the client is seeking to achieve by this use.

PHASE FIVE. Planning new behaviour. Based on the functional analysis, plans are made and evaluated to engage in new non-drug-seeking behaviours. The functional analysis helps client and therapist become aware of the high-risk situations for this client and which skills they lack to engage in self-control.

small part to assess its strength and prevent overdose (comparable with wine tasting);
◆ other rules reinforcing the view that heroin use takes only a minor place in life and supporting obligations and relationships that have nothing to do with heroin.

Self-control – the ability to "refuse that offer one couldn't possibly refuse" – involves doing something which will result in immediate punishment or diminish short-term rewards, but which will instead gain longer term rewards. The short-term loss of positive feelings may be quite extreme, as in the heroin addict who decides not to take their next hit: they must be able to withstand withdrawal symptoms in exchange for vague promises of a better life in the future.

Self-control in addictive behaviours has two options. Either the person can abstain from the behaviour, or they can decrease its frequency in order to eliminate problems while maintaining the joys of successful moderation. Behavioural self-control training with addictive behaviours has been successful, especially with problem drinking.[15,16]

Training people for self-control consists of three steps:[17]
◆ **self-observation:** being aware of what you are doing;
◆ **self-evaluation**: evaluating your behaviour against certain standards or norms and based on this setting yourself behavioural goals;
◆ **self-reinforcement**: reinforcing and maintaining the behaviour needed to achieve these goals.

Based on various sources,[18,19,20] we have developed a behavioural self-control programme for heroin which is individually tailored to each client. The programme is structured into five phases consisting in total of 24 sessions each lasting between 15 minutes and one hour. Depending on the client, the frequency of sessions could vary from once a day to once a week. Common practice is to start with a high frequency and to fade out towards the end, perhaps down to a session a month.

Motivating self-control

The problem with self-control therapies is that, while highly successful, they are difficult to 'sell' to clients and professionals because of the widely held belief (prejudice) that heroin is a 'demon drug' which can only be controlled by 'curing the disease'. Motivational interviewing is a therapeutic approach that might act as a link between sceptical clients and an effective treatment approach.

Basically this approach aims to help the client to make wise decisions about their situation.[21,22] Making use of techniques derived from various therapeutic schools, motivational interviewing tries to help clients make a firm commitment to change. Behavioural psychotherapy, Rogerian psychotherapy and strategic psychotherapy are combined in an approach which:
– raises the client's awareness of their problems;
– increases their concern about these problems;
– raises self-esteem ('a good person like me should not have these problems'); and
– increases their feelings of competence to change.

THESE TECHNIQUES are based on the firm belief that people can regain control over addictive behaviours. In an atmosphere of empathy, the client's responsibility is stressed. Instead of diagnosing a client and giving them instructions to enter a certain treatment, a treatment goal and method is negotiated with the client based on their preferences and the objective facts of their personal situation. ■

Harm reduction and the under-16s

Judicial decisions on under-age contraception can help negotiate the legal minefield of harm-reduction work with juveniles

A NUMBER OF drug agencies are trying to formulate policies in relation to young people still legally the responsibility of their parents.[1]

There is particular concern about offering needle exchange services without parental consent. Staff need to assess the level of professional risk-taking, while not discriminating on grounds of age.

Much can be learned from the celebrated case of Gillick v West Norfolk and Wisbech AHA and the DHSS, involving the provision of contraceptive advice and treatment to under-16s without parental consent, which was eventually dealt with by the House of Lords.[2] In the House of Lords judgment, some useful points were made about responsible practice which could as easily be applied to young drug injectors as to sexually active young women.

In the Gillick case conflict arose over Department of Health guidance on family planning services to young people, which recommended that in exceptional circumstances, under-16s could be treated without parental consent.

The guidance recognised that abandoning the principle of doctor/patient confidentiality for under-16s *"might cause some not to seek professional advice at all. They could then be exposed to the immediate risks of pregnancy and of sexually transmitted diseases, as well as long-term physical, psychological and emotional consequences."*

Strong parallels can be drawn between the harm-reduction objectives in *AIDS and Drug Misuse Part 1* from the Advisory Council on the Misuse of Drugs and the guidance at issue in the Gillick case. In their judgment, the Lords held that *in general* the rights of parents applied to duties over the child's welfare. However, circumstances might arise when a doctor (and other professionals) could use their discretion to act in the child's best interests without parental consent. Such circumstances would, the Lords said, be *exceptional* and might be regarded as action taken in an *emergency*.

Lord Fraser of Tulleybelton was one of the three who delivered the majority verdict in Gillick. I have adapted his judgment simply by substituting 'drugs' for 'contraceptive', and 'young person' for 'girl' or 'she'. Lord Fraser said treatment without parental consent might be justified where a doctor is satisfied:

❶ that the young person, although under 16 years of age, will understand his advice;

❷ that he cannot persuade the young person to inform parents or to allow him to inform the parents that the young person is seeking drugs advice;

❸ that the young person is very likely to begin or to continue using drugs with or without drugs treatment;

❹ that unless the young person receives drugs advice or treatment the young person's physical or mental health or both are likely to suffer;

❺ that the young person's best interests require him to give the young person drugs advice or treatment or both without parental consent.

Throughout the judgment reference was made to "clinical judgment". It was recognised that professionals other than doctors work with young women seeking contraceptive advice, but clearly the Law Lords were relying on the doctor's capacity to make medical judgments and supervise non-medical staff.

Effectively, the judges delegated responsibility for decisions about under-16s to professionals (doctors) better qualified than they to deal with such cases on an individual basis. This implies that professionals must themselves resolve the tension between parental rights and confidentiality, judging each case on its merits.

Many drug services employ a variety of professionals, often advised by medical staff. Involving a doctor in the delivery of services to young people will minimise legal risks and the possibility of drug services being ostracised by professionals in other agencies.

Careful thought should also be given to the *intention* of the person delivering the treatment. In Gillick, the judges held that those honestly acting in the best interests of the girl would not be guilty of aiding and abetting a criminal offence – in this case, unlawful intercourse. But a doctor who instead intended to facilitate unlawful sex could be guilty of a criminal offence.

Drug agency staff successfully handled this kind of difficulty some time ago when setting up needle exchanges. However, given the sensitivity of dealing with young people, it is worth thinking carefully about the way services are delivered. This may involve internal staff communication, supervision and support, as well as policy issues. A degree of professional consensus among drug services about treatment responses and standards of care for young people would afford some legal protection to staff working in this area. ■

Jane Goodsir

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1. The concern has been over the under-16s, though in relation to drugs work, 17 years of age is the more relevant cut-off point as until then the youngster is in several ways still their parents' responsibility. Treatment without parental consent could be extended to treatment without the consent of those standing in loco parentis – for example, local authority staff – if appropriate conditions are satisfied.
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Managing stress
A challenge
not a threat

Surviving drugs/HIV work means managing stress – your own as well as the client's

Working with people who are or may be ill with HIV infection will increasingly raise the potential for stress among drug workers. Skills for mitigating stress range from breathing techniques to a strong philosophy of life. How stress events are interpreted determines their impact on the individual. Seeing events as a *challenge* over which you have some *control* in an area of work you are *committed* to, protects against the harmful effects of stress.

Dave Macdonald

The author is a training organiser with the Drugs Training Project at the University of Stirling.

NON-MANAGEABLE STRESS is becoming increasingly recognised as a problem for paid workers and volunteers in the helping and caring professions. It can lead to many harmful and destructive consequences for individuals and organisations alike. For example, a report on *Stress in the Public Sector* suggests that the effects of stress in education, health and welfare organisations are "low worker morale; high sickness level; high absenteeism; high staff turnover and wastage; inefficient and ineffective delivery of services; client damage".[1]

Taken together, these effects are symptomatic of what has been labelled 'staff burnout', a condition that may be more likely to affect drug workers than many other types of worker in the helping and caring professions.

Luckily, however, people do not literally 'burn out'! They may be physically/mentally/emotionally exhausted and unable to function, but with adequate rest they will recuperate.

This syndrome can manifest itself in many different symptomatic forms, particularly physical signs and psychological-emotional problems.[2]

Physical signs
Feeling of exhaustion and fatigue
Unable to shake off lingering colds, bronchial complaints
Headaches
Gastrointestinal disturbances
Sleeplessness
Shortness of breath
Skin complaints
General aches and pains

Psychological/emotional signs
Touchy and irritable
Easily moved to tears
Apparently unprovoked outbursts of anger
Marked sadness
Screaming and shouting
Unwarranted suspicion and paranoia
Avoiding commitments to caring
Lethargic

In Holland drug work is seen as having such a high burnout potential that workers can be employed on a four-day working week, in recognition of the fact that they will need a day to 'come down' and unwind before enjoying their two-day break. Many drug projects in Holland employ a full-time staff guide/psychologist with specific responsibility for the welfare of the staff team as a group and also of its individual members, including volunteers.[3]

Sources of stress

What is it that seems to make drug work such a high-risk occupation as far as stress and burnout are concerned? On one stress management course we held for a group of 16 drug workers, the following factors were cited as some of the sources of stress in the workplace:
- dealing with other workers;
- dealing with management committees and administrators;
- uncertainties about funding;
- being a particular type of worker, eg, project leader, outreach worker;
- unclear project goals;
- volume of work;
- time management problems.

In addition to these sources of stress – which mirror the concerns of many other types of worker – drug workers in the main work with drug users who consistently take risks that other clients do not: risks with their health, their freedom and their lives. Clients who at times appear to be chaotic and 'out-of-control' can leave workers feeling deskilled and frustrated, causing anxiety about whether the drug user will overdose, will receive a long prison sentence or, more recently, might be or become infected with HIV.

Having to work with people who may have HIV and at some uncertain time in the future may go on to develop AIDS and die

has enormous potential for elevating the stress level of many drug workers. Otherwise competent workers may feel anxious and uncertain about the level of skill they have to meet the new needs of users. They may require 'top up' training in areas like coping with the chronically sick, sexuality, pregnancy, bereavement, health care, and hygiene practices including giving advice on safer injecting.

They will also have to cope increasingly with the anxiety and stress experienced by drug users who learn they are HIV positive. As one worker expressed it, "It's ironic that you are on the point of helping a user to renew his life when he is discovering that he may only have a few years left to live. You're helping him to discover new reasons to live, then he dies...".

There are many such increased day-to-day stressors for workers – and there will be more and more as HIV infection develops into AIDS-related illnesses: "Users with HIV constantly talk to me about their 'symptoms' and I try to reassure them while being uncertain whether their nightsweats are caused by the drugs they are taking, by two blankets and a duvet – or are the real symptoms of impending AIDS."

Other workers voice their concerns about other types of pressure. "I'm having hassles with GPs who do not want to examine a drug user with HIV"; "The stigma of AIDS affects workers as well as clients. There are greater demands and expectations made on us from outside agencies, committees and organisations that we will 'solve' the problems... yet there are just not enough resources".

Resistance resources

There is, of course, no universal panacea for dealing with the stress-related problems that drug workers are likely to face, but there are several identifiable 'resistance resources' that will mitigate the negative effects of any stress.

A framework which tries to make sense out of the plethora of information on various stress management techniques is suggested by Aino Nucho. This author sees successful stress management as resting on the acquisition of skills at three levels (see opposite).[4] One of the most important lifestyle skills in this group is how to acquire supportive personal relationships, both at home and at work.

This need for good support systems is acknowledged in the *AIDS and Drug Misuse. Part 2* report from the Advisory Council on the Misuse of Drugs. This states that "Staff of all grades in all likely settings must be adequately trained for working with sero-positive drug misusers; staffing levels must be adequate; and staff must have access to emotional support, be it through mutual support groups or external agencies, including line management where appropriate".[5]

"Support", however, is a very broad concept – a very personal thing with different meanings for different people. What one person may perceive and experience as supportive may by another be seen as threatening or even destructive.

A discussion paper initiated by two experienced drug workers in Edinburgh (where there is a very high correlation between intravenous drug use and HIV) addresses this issue. Concerned about the inadequacies of existing support structures, they suggest a menu of individual supports "so that workers can choose options which suit their own particular needs".[6]

Their list of options includes: individual counselling/therapy; facilitated support groups; mutual support groups; peer or co-counselling; time off/out of work to deal with grief/bereavement; external consultants; adequate staff supervision, training, evaluation and development.

Controlling the job

Many of these work-based support systems are resourced, staffed, and indeed 'allowed' by the employing organisation. Consequently, it may be the organisation's – rather than the individual's – needs that are being met.

One example is 'supervision', often seen as synonymous with support. As the Edinburgh workers point out, "Effective supervision, based on a reasonably open, trusting relationship should have strong supportive elements within it which could mitigate against the stress generated by work in the drugs/HIV field. However, many workers experience supervision solely as a monitoring exercise, and some supervisors would see monitoring as their primary task... The supervisor carries not only authority, but also power over the supervisee, for example, to write references, report to senior managers, evaluate their work and influence promotion".[7]

External consultancy is a recognised alternative to the support function of supervision, providing individuals and work-teams with support – but an alternative not always encouraged by employers. Statutory organisations in particular may perceive recourse to external consultants as highlighting organisational weaknesses and as a threat to their own internal systems and procedures, rather than as an acceptable part of good work practice which should be encouraged.

Stress management itself is often seen in terms of individual behaviour change and coping strategies (relaxation techniques, physical exercise, time management) rather than learning how to take positive action to prevent the stress engen-

Aspects of stress

"When I took this job I chose to work with drug users, I didn't choose to work with people with AIDS. We still aren't properly prepared and resourced to deal with it."

"Is this the year we are going to have all the deaths? How will we get through it? I'm scared of how it's going to feel inside my head."

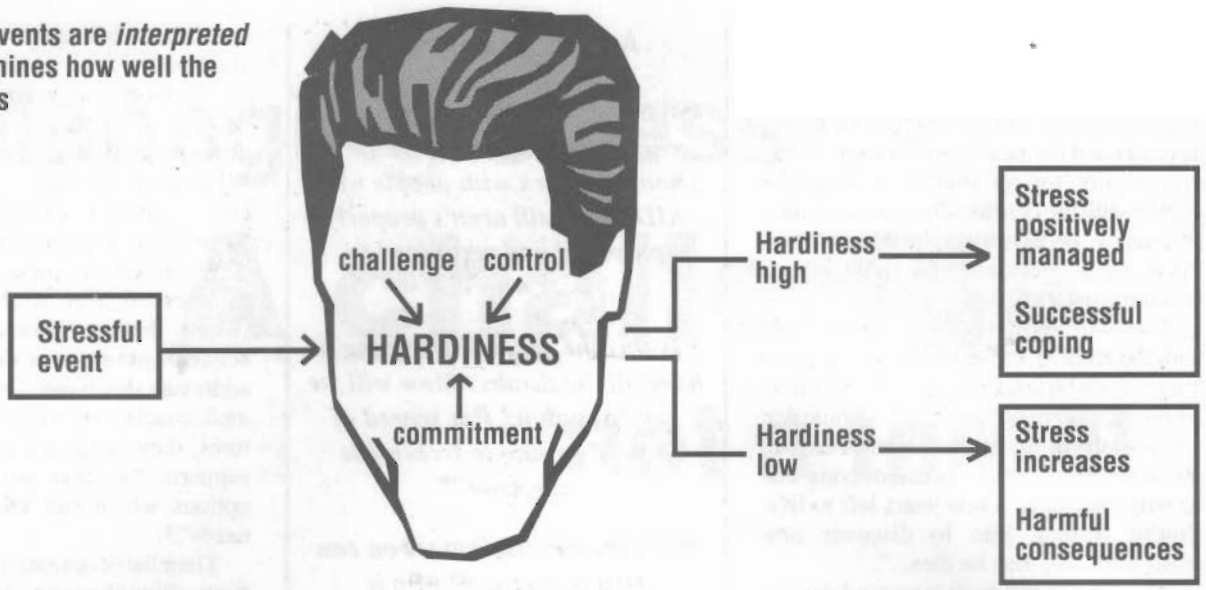
"It's the uncertainty... You can visit a drug user who is chronically sick in hospital and a week later you see them in the shopping centre."

"It's stressful explaining to management that this work is stressful and we need the space and resources to deal with it."

"I try to reassure them while being uncertain whether their nightsweats are caused by two blankets and a duvet – or are the symptoms of AIDS."

"You are on the point of helping a user renew his life... you're helping him discover new reasons to live – then he dies..."

How stressful events are *interpreted* crucially determines how well the individual copes



dered by organisations that provide unsupportive, oppressive or under-resourced working conditions. It is no coincidence that participants on our stress management and support systems workshops frequently ask for further training in assertiveness and confrontation skills.

Perhaps the most significant research that substantiates the importance of this dual perspective (the individual and the organisation) on stress management was carried out by Suzanne Kobasa and her colleagues at the Chicago Stress Project.[8,9] They found that the way a person *defines and interprets stress* is as important as the stressful event itself in determining harmful consequences.

They looked at a number of 'resistance resources' capable of neutralising the otherwise debilitating effects of stressful life events, such as social supports, constitutional strengths, meditation or health practices like yoga or running. But they found the crucial resource was a personality trait they labelled 'hardiness', consisting of three components – *challenge, control* and *commitment* (see diagram above).

What this means is that if a stressful event is met as a *challenge* – an interesting incentive to growth rather than a threat to security – then people are better able to cope with it. Kobasa talks about the founder-volunteers of *Gay Mens' Health Crisis* in New York who "knew the horror of the epidemic, yet felt that there was something they could do to determine the course of events... they were certainly willing to confront uncertainty – viewing the epidemic as a challenge and not a mere threat".[10]

Similarly with *control*: stress is handled better if a person believes and acts as if they can influence circumstances by what they imagine, say or do, instead of feeling helpless and lapsing into a 'victim' role. *Commitment*, too – actively engaging with whatever you are doing or encounter rather than passively avoiding it or feeling alienated – helps cope with stress.

"As a constellation of three crucial personality characteristics – commitment, control and challenge – hardiness is presented as facilitating the kind of perception, evaluation and coping that leads to successful resolution of the situation created by stressful events".[11]

This research suggests some questions drug workers need to ask themselves (see below).

In an era of public service cutbacks and lack of resources, in addition to Kobasa's three personality factors there is perhaps a fourth factor which will help us take a more realistic look at where we stand within this framework – that of compromise.

Gaining more personal control within a work situation is not always easy, especially if you work in a large statutory bureaucracy. Time spent negotiating with and confronting colleagues and management about 'control' issues may mean less time spent with clients. Given limited job opportunities plus mortgages and other personal and family commitments, it may be difficult to move to another job where there is greater control over the work.

It may also be difficult consistently to perceive a potentially stressful 'front-line' job in the drugs/AIDS field as a 'challenge', and it may only be possible to feel committed to this type of work for a limited period. It is being *aware* of our own levels of control, challenge and commitment – and how far we are willing to compromise them – that will be most effective in helping us cope better with stress. ■

Ask yourself

- ? How much control do I have over my work situation?
- ? Do I see AIDS work as a challenge rather than a threat?
- ? What am I doing to help myself?
- ? What am I doing to change my organisation?
- ? If I have done everything I can to change myself and my work situation and still can't cope, will leaving my job be a positive step in stress management?

For more information

This article has been adapted from the chapter on Stress Management and Support Systems in the forthcoming publication *A Handbook of Drug Training* by Dave Macdonald and Vicky Patterson (Routledge, scheduled for June 1991).

The handbook has practical information on how to organise and structure a five-day two-part residential workshop on stress management and support systems for drug workers.

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Audio-visual material available in Britain

FOCUS ON DRUGS

The '80s spawned a range of generally video-based education and training materials of variable quality. Traditional scare tactics approaches have been supplemented by more materials reflecting the harm-reduction trend in drug services. Nearly all the materials listed here are available for viewing at ISDD's library – phone 071-430 1993 for an appointment. Inclusion in this list does not constitute a recommendation – you are strongly recommended to view materials in advance.

For young people

V BETTER DEAD... THEN AND NOW • 1972/1985
First produced in 1972 and features young heroin users talking about their use of drugs. Graphic sequences of users injecting. Followed up by *Better Dead '85*, a reflection by one of the original group on his drug using career. With teacher/presenter notes.
Available from: Project Icarus, 214a Havant Road, Drayton, Portsmouth, Hants. PO6 2EH, phone 0705 324248.
To buy: £75 inc VAT. To hire: £10 for 2 weeks. Reduction on purchase price by negotiation (normally 50 per cent) for groups engaged in drug education.

V CHASING THE BANDWAGON • 1985
Produced by the YMCA and starring Lenny Henry. With teaching materials and posters. Aims to stimulate discussion on decision-making over whether to take drugs.
Available from: CFL Vision, PO Box 35, Wetherby, Yorkshire LS23 7EX, phone 0937 541010.
To buy: £59.80. To hire: £16.

V "CHICKEN": A STORY ABOUT SOLVENT MISUSE • 1989
Suitable for use by those who work with young people aged 11-14 in education, health or youth work.
Available from: Re-Solv, St. Mary's Chambers, 19 Station Road, Stone, Staffs. ST15 8JP, phone 0785 460971 817885.
To buy: £25.00.

V THE CHOICE • 1987
Education package for secondary schools illustrating the influences which can affect the attitude and behaviour of young people towards drugs. Twelve-minute video with teacher's booklet, notes and script.
Available from: Plymouth Medical Films, Palace Vaults, 33 New Street, Barbican, Plymouth PL1 2NA, phone 0752 267711.
To buy: £25. To hire: £11.50, refundable on purchase.

V DOUBLE TAKE • 1986
Drug education package for 13–15-year-olds. Comprises:
A Little Bit of Give and Take (three-part trigger video featuring Dennis Waterman and George Cole with teacher materials by TACADE);
Thinking Twice (on decision making for young people with accompanying documentation, by ISDD).
Available from: ISDD.
To buy: £34. Extra sets of teaching materials for each film, £5 each. Free to secondary schools on application to CFL Vision (see above).

V THE DRUG KNOT • 1988
For young students to learn about the destructive effects of drugs.
Available from: Viewtech Audio Visual Media, 161 Winchester Road, Bristol BS4 3NJ, phone 0272 773422.
To buy: £154. To hire: £16.

V DRUG USE: THE FACTS YOU NEED TO KNOW/IT'LL NEVER HAPPEN TAE ME • 1988
Education package for the 16+ age group including video and booklets.
Available from: Youth Enquiry Service, Strathclyde Resource Unit, 12 Commercial Road, Glasgow G5 0PQ, phone 041-429 2114.
To buy: £20.

V DRUGWISE 12-14: A SCOTTISH DRUG EDUCATION PROGRAMME FOR 12–14 YEAR OLDS • 1988
Education package including video and teachers guide.
Available from: Scottish Curriculum Development Service, Lymehurst House, 74 Southbrae Drive, Glasgow G13 1SU, phone 041-954 8287.

V DRUGS AND THE NERVOUS SYSTEM 3rd rev. • 1988
Explanation of how legal and illegal drugs affect the nervous system. For 13–16-year-olds.
Available from: Boulton-Hawker Films Ltd., Hadleigh, Ipswich, Suffolk IP7.
To buy: £85 + VAT.

S DRUGS AND THE PRIMARY SCHOOL CHILD • 1986
Health education pack divided into modules using slides and printed materials. Originally produced by the Wirral Health Education Unit and now revised by TACADE for national distribution.
Available from: TACADE, 1 Hulme Place, The Crescent, Salford, M5 4QA, phone 061-745 8925.
To buy: £33.95.

V FOOLS PARADISE: AMPHETAMINE AWARENESS VIDEO • 1987
A combination of dramatic sequences and factual information mainly for use with young people.
Available from: Jacelton Video, 12 Station Road, Thetford, Norfolk IP24, phone 0842 2203.
To buy: £18.

V HAPPY HOURS...SURVIVING IN A DRUG TAKING CULTURE • 1989
Drama looking at drug use from a young persons viewpoint.
Available from: Swingbridge Video, 41 Stowell Street, Newcastle-Upon-Tyne NE1 4YB.
To buy: £35. To hire: £10 per day.

V HEALTHWISE – SMOKING, DRINKING AND DRUGS • 1989
Uses puppets to educate about the effects of drugs.
Available from: Viewtech Audio Visual Media, 161 Winchester Road, Bristol BS4 3NJ, phone 0272 773422/717030.
To buy: £49 + VAT + postage. To hire: £16.50 for 2 days.

V JUNKIE
Three self-contained films on heroin addiction. With notes for the teacher-presenter.
Available from: Project Icarus (see above).
To buy: £86.25. To hire: £10 for 2 weeks.Contact Project Icarus for special discounts.

V KIDS' STUFF
The circumstances surrounding the death of a glue sniffer.
Available from: Project Icarus (see above).
To buy: £57.50. To hire: £10 for 2

weeks. Contact Project Icarus for special discounts.

V NOT TO BE SNIFFED AT • 1985
Originally shown as a BBC schools programme. Why young people sniff solvents, the effects and the dangers.
Available from: BBC Enterprises Ltd, Education and Training Sales, Woodlands, 80 Wood Lane, London W12 0TT, phone 081-743 5588.
To buy: £85 + VAT. To hire: not available

S POT OR NOT • 1989
Facts about alcohol, tobacco and drugs, particularly cannabis.
Available from: Focal Point Audio Visual Ltd., 251 Copnor Road, Portsmouth, Hants. PO3 5EE.
To buy: £12.75 (slides/filmstrip).

V A PREVENTION OF SOLVENT ABUSE • 1984
Video and audiotape aimed at the younger groups in secondary schools. Includes teachers' notes, work cards and other background information.
Available from: The Robertson Centre, 16 Glasgow Road, Paisley PA1 3QG, phone 041-887 3726.
To buy: £32.

V SELF DESTRUCTION • 1985
Prevention video depicting the early drug career of a young heroin user.
Available from: Phil Cooper, 'Drug Aid', 23 Chadwick Street, Bolton BL2 1JN.
To buy: £23 plus a contribution to postage.

V STAND UP FOR YOURSELF! PEER PRESSURE AND DRUGS • 1988
Skills, motivation and encouragement to handle peer pressure in relation to alcohol, street drugs, tobacco, etc.
Available from: Boulton-Hawker Films Ltd., Hadleigh, Ipswich, Suffolk IP7 5BG.
To buy: £65.

V TALKING ABOUT DRUGS • 1988
One-to-one and street interviews, 'problem page'- style letters and role play situations, with the emphasis on what young people think about drugs.
Available from: Oxford Independent Video, c/o Pegasus Theatre, Magdalen Road, Oxford OX4 1RE, phone 0865 280150.
To buy: £30.

One of the many faces of Lenny Henry in the YMCA's polished video production, *Chasing the Bandwagon* (see page 15)

In-service training

V BRIEF GROUP PSYCHOTHERAPY WITH THE FAMILIES OF DRUG ABUSERS • 1988
The therapist leads a group of parents and partners in discussing the drinking, drug use and related behaviour of their family members. Suitable for counsellors, teachers, parents and drug or alcohol workers.
Available from: Concord Video, 201 Felixstowe Road, Ipswich, Suffolk IP3 9BJ, phone 0473 715754.
To buy: £60. To hire: £12.

V D MEN • 1985
Video, training exercises and tutor briefing notes. To be used either as part of a longer training course or as a 'stand alone' seminar on the issue of problem drug use and the mythologies surrounding it.
Available from: North West Regional Drug Training Unit, Kenyon Ward, Prestwich Hospital, Bury New Road, Manchester M25 7BL, phone 061-798 0919.
To buy: £31. To hire: £6 on 10 day approval.

V DRUG ABUSE: THE PRESSURE'S ON YOU?
Drug abuse is one of seven topics on this tape of a monthly television programme for GPs, issue 27.
Available from: British Medical Television Ltd, 3-4 Woking Business Park, Woking, Surrey GU21 5JY, phone 04862 27676.
To buy: £45 annual subscription (12 programmes), £6 per extra copy and back numbers.

V DRUG ABUSE: THE PROBLEMS AND POLITICS
Drug abuse is one of six topics on this tape of a monthy television programme for GPs, issue 26.
Available from: British Medical Television Ltd, 3-4 Woking Business Park, Woking, Surrey GU21 5JY, phone 04862 27676.
To buy: £45 annual subscription (12 programmes), £6 per extra copy.

V DRUG MISUSE AND THE PRESCRIBER: A HOME OFFICE GUIDE FOR THE GENERAL PRACTITIONER • 1989
Available from: Home Office, Queen Anne's Gate, London SW1H 9AT, phone 071-273 3000.

V ILLUSIONS
Training film focusing on intervention options with young solvent misusers.
Available from: CFL Vision (see above).
To buy: £45 + VAT. To hire: free.

V JUST SAY NO • 1986
Video and information pack by the BBC Drugwatch team. Why young people start using drugs, effects, how to give up and material for parents' groups.
Available from: BBC Enterprises Ltd. (see above).
To buy: £28.75.

V MOTIVATIONAL INTERVIEWING • 1988
Introduction to motivational interviewing; interviews with a gambler, a problem drinker and an amphetamine user; discussion between the authors and UK drug/alcohol workers.
Available from: Training Video, East Dorset Community Drugs Team, Royal Victoria Hospital, Gloucester Road, Bournemouth BH7 6JF.
To buy: £35.

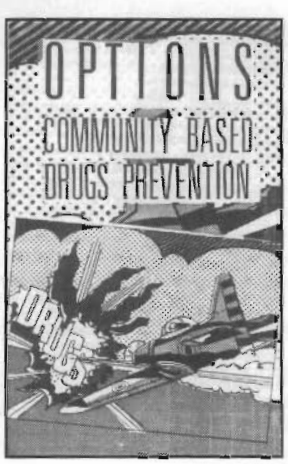
V OPTIONS: COMMUNITY BASED DRUGS PREVENTION • 1988
For specialist and non-specialist workers. Highlights the variety of community-based secondary prevention options available in the drugs field.
Available from: North West Regional Drug Training Unit (see above).
To buy: £46. To hire: £7.

V RATIONAL-EMOTIVE THERAPY WITH THE PARENT OF A DRUG ABUSER. Parts 1+2. • 1988
Two videos filmed 6 weeks apart. Interviews with the mother of a drug abuser covering parental responsibility, enabling, rescuing, shame, guilt, anxiety and hostility. The goals are to counsel the mother and assist the daughter to recovery.
Available from: Concord Video, 201 Felixstowe Road, Ipswich, Suffolk IP3 9BJ, phone 0473 715754.
To buy: £50 per video or both parts on one video £80. To hire: £12 per video.

V SOLVENT ABUSE: THE ADOLESCENT EPIDEMIC? • 1986
15-minute video for professionals only. Aims to improve understanding of solvent abuse.
Available from: Re-Solv, 19 Station Road, Stone, Staffs. ST15 8JP, phone 0785 817885/46097.
To buy: £10 inc. p&p.

A S SOLVENT MISUSE: A TRAINING MANUAL FOR PROFESSIONALS
Produced by the Health Education Council: manual, audio cassette, slides and overhead transparencies.
Available from: Michael Benn Associates, P.O. Box 5, Wetherby, Yorkshire, phone 0937 844524.
To buy: £25.

V SYRINGE EXCHANGE SCHEME: THE LIVERPOOL EXPERIENCE • 1987
An insight into the establishment and operation of the innovative Liverpool service.
Available from: The Maryland Centre, 10 Maryland Street, Liverpool L1 9BX, phone 051-709 3511.
To buy: £50. To hire: £12.



V UNDERSTANDING PROBLEM DRUG USE • 1986
How drugs can be used, the problems and the range of responses available. Supported by literature pack and tutor briefing notes.
Available from: ISDD and NWRDTU (see above).
To buy: £31. To hire: (from NWRDTU only) £7 inc. p&p.

V USER FRIENDLY • 1988
The work of the Portsmouth Drugs Treatment and Advice Clinic; explores attitudes towards drug abuse.
Available from: Project Icarus (see above).
To buy: £25.

V (VIDEO FOR GPs) • 1986
What GPs can do and gives a brief history of treatment of drug users in Britain.
Available from: Abbott Laboratories, Queensborough, Kent ME11 5EL, phone 0795 663371.
Free of charge – on loan for viewing purposes.

Worth listening to – *Talking About Drugs* (see page 15)

V WHO DARES LOSES • 1985
For GPs.
Available from: Lederle Laboratories, Fareham Road, Gosport, Hants. PO13 0AS, phone 0329 224000 ext. 4582.
To buy: £150 + VAT. To hire: free of charge.

V WORKING WITH DRUG USERS • 1986
Training pack to use with those who come into contact with drug users in their day-to-day work. Twelve modules on one video lasting 2 hours 45 minutes and full back-up printed materials for tutors and course participants.
Available from: CFL Vision (see above)
To buy: £47. To hire: free on purchase of course notes, £15.

General viewing

V ACID • 198
Interviews with ex-users about their experiences with LSD and the consequences.
Available from: Project Icarus (see above).
To buy: £46.

V AN EASY PILL TO SWALLOW • 1979
Women describe how it feels to be dependent on Valium and how they would like to be free of it. Doctor explains how prescribing it can often be a substitute for real help. By National Film Board of Canada.
Available from: Concord Films, 201 Felixstowe Road, Ipswich, Suffolk IP3 9BJ, phone 0473 76012/715754.
To buy: £50 + VAT + p&p. To hire: £10 (1 day).

V "A BOMBSHELL?" WHAT EVERY PARENT SHOULD KNOW ABOUT SOLVENT ABUSE • 1988
Available from: Royal Society of Medicine Services Ltd., 1 Wimpole Street, London W1M 8AE, phone 071-499 7422.
To buy: £20.

V COCAINE ABUSE: THE END OF THE LINE • 1989
Interviews with cocaine users revealing the effects of the drug on the body. Distinguishes between effects associated with different rates of administration.
Available from: EM Video, 235 Imperial Drive, Harrow, Middx. HA2 7HE, phone 081-868 1908/1915.
To buy: £95 + VAT + postage. To hire: phone 081-868 1908 for details.

V COCAINE AND HUMAN PHYSIOLOGY • 1989
The addictive nature of the drug and the damage it can cause to the body.
Available from: EM Video (see above).
To Buy: £95. To hire: phone 081-868 1908 for details.

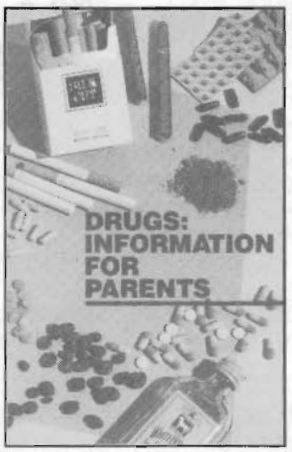
V DON'T LET THEM HAVE IT • 1979
Retail staff training video concerning the laws on supplying solvents.
Available from: Re-Solv (see above).
To buy: £10.

V DRUG EDUCATION IN THE PRIMARY SCHOOL? • 1989
For teachers, governors and parents.
Available from: Health Eduction Coordinator, Furness Teachers' Centre, Dowdales School, Dalton-in-Furness, Cumbria LA15 8AH, phone 0229 62988.
To buy: £13.

Saying it with slides – *Drugs and the Primary School Child* (see page 15)

V DRUGS AND THEIR EFFECTS
Commentary on the effects of a range of legal and illegal drugs.
Available from: South West Regional Drugs Training Unit, 29a Southgate, Bath, Avon BA1 1TP.

V DRUGS AND YOUR AMAZING MIND • 1989
The dangers of hallucinogens, stimulants and depressants, including health risks from contaminants. Also the benefits of the drugs when used properly.
Available from: EM Video (see above).
To buy: £95 +VAT + postage. To hire: phone 081-868 1908 for details.



V DRUGS: INFORMATION FOR PARENTS • 1987
Training pack intended for use with parents' groups or those who want basic information on the effects of drugs; includes tutor notes and flashcards.
Available from: NWRDTU (see above).
To buy: £46. To hire: contact NWRDTU.

V HEROIN • 1985
One video featuring a three-part series from Yorkshire TV:
Part 1: The story of Paul Ackland, son of actor Joss Ackland
Part 2: Studio discussion involving sociologist Jock Young and parents
Part 3: Studio discussion involving drugs workers and ex-users.
Available from: N.T. Sales, Yorkshire TV, Television Centre, Leeds LS3 1JS, phone 0532 438283.
To buy: £44.95 or £19.95 per film.

V THE HEROIN BARONS • 1983
Granada *World In Action* programme examining the illicit trade in Britain.
Available from: Concord Films (see above).
To buy: £190 + VAT + p&p. To hire: £9.80 (1 day).

V HEROIN EYES • 1986
Story of a 15-year-old drug user.
Available from: Guild Sound & Vision Ltd, 6 Royce Road, Peterborough PE1 5YB, phone 0733 315315.
To buy: £22.

V MARIJUANA AND HUMAN PHYSIOLOGY • 1989
The toxicity and psychological effects of marijuana and hazards of driving under the influence of marijuana and alcohol.
Available from: EM Video (see above).
To buy: £95 + VAT + p&p. To hire: phone 081-868 1908 for hire details.

V MY LIFE: ELAINE PATTERSON • 1984
A glue sniffer interviewed on Yorkshire Television followed by an interview with a therapist about her treatment.
Available from: Yorkshire TV (see above).
To buy: £24.95.

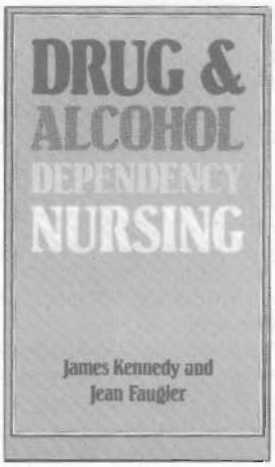
V THE SUBSTANCE IN QUESTION • 1989
The origin, pharmacology and effects of stimulants, hallucinogens, hypnosedatives and opiates. Suitable for various audiences, eg, parents, teachers, social workers, nurses etc.
Available from: Project Icarus (see above).
To buy: £34.50. To hire: £14.95.

V SUFFERING FROM LIFE • 1987
Social, health and legal issues in relation to women's use of illegal and prescribed drugs. Pregnancy and child care are dealt with in terms of medical treatment and social workers' responsibilities.
Available from: NWRDTU (see above).
To buy: £21. To hire: £7.

A TRANQUILLISER INDEPENDENCE • 1989
A self-help cassette based on advice given to patients who wish to stop taking tranquillisers including alternative relaxation techniques.
Available from: Dr Hallstrom, Charing Cross Hospital, Fulham Palace Road, London W6 8RF.
To buy: £5.95.

See also: *Better dead ... then and now*, *Junkie* and *Kids' stuff*.

KEY:
V Video
A Audiotape
S Slide



A timely guide from leaders in the drug dependency nursing field

DRUG AND ALCOHOL DEPENDENCY NURSING.

James Kennedy and Jean Faugier. Heinemann Nursing, 1989. 188 pages. £9.95.

Although written primarily for specialist and non-specialist nurses concerned with substance misuse, this book will be of equal use to those in other disciplines who are looking for a general guide to drugs and drug work which is well researched and yet accessible in its language and approach.

The authors have had wide experience as teachers on the special drug/alcohol dependency course accredited by the English National Board for Nursing, Midwifery and Health Visiting, as well as having been practitioners in this field. Their concern for and commitment to nurses working in the field of substance misuse is well known. Both were founder members of ANSA (the Association of Nurses in Substance Abuse); Jean Faugier is currently its National Coordinator, James Kennedy having been the first.

The first three chapters of their book are neatly compressed, giving brief background information on the history, nature and effects of drugs and alcohol. The lists of references at the end of each chapter are more than adequate for those who wish to delve further. But nurses looking for nursing models in the chapter on principles of intervention may be somewhat disappointed, as this chapter is more concerned with describing a range of treatment approaches and the key roles which nurses play in their implementation.

Nonetheless, the authors are right to express concern at the lack of training made available, especially since the shapes and pattern of both old and new drug and alcohol services are changing so rapidly with nurses continuing to play a key role as specialist workers.

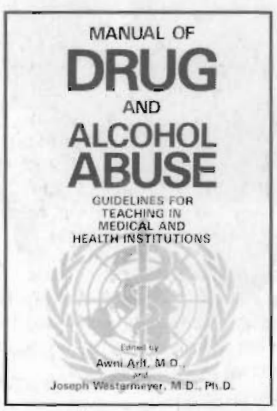
It is in the chapter on the role of nurses not specialising in drug dependence that the book targets its audience most effectively. This theme is accorded a high priority in the book and its message could have a positive effect if it can be brought home to these groups and to other non-specialist workers, including medical staff.

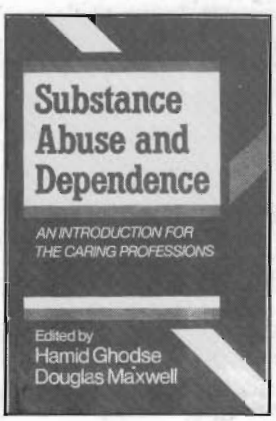
The chapters titled Models of Service Provision and The Need for Research, Evaluation and Education may give the reader – in this case assumed to be a manager, project officer or planner – a glance at the types of services that have been successfully developed as well as a range of options which could be considered when planning their own.

Drug and Alcohol Dependency Nursing is a well-written and well-documented firsthand guide on drug and alcohol for nurses and workers in related disciplines. Given the rapidity of change in this field, the book is a useful and timely analysis of the problems faced by these workers, providing thoughtful suggestions on how to adjust to these changes. With even more changes coming as a result of the NHS and Community Care Act and new information on HIV/AIDS, the authors may well be advised to start thinking now about their second edition.

Raj Boyjoonauth
Operational manager for Riverside Health Authority Substance Misuse Service

Drug and Alcohol Dependency Nursing *is available from ISDD, £10.50 inc. p&p.*





Both books aim to give practical guidance to doctors – how do they compare?

MANUAL OF DRUG AND ALCOHOL ABUSE: GUIDELINES FOR TEACHING IN MEDICAL AND HEALTH INSTITUTIONS.

A. Arif and J. Westermeyer *eds*. Plenum, 1988. 327 pages. $51.00.

SUBSTANCE ABUSE AND DEPENDENCE: AN INTRODUCTION FOR THE CARING PROFESSIONS.

Hamid Ghodse and Douglas Maxwell *eds*. Macmillan, 1990. 263 pages. £14.95.

The new Ghodse and Maxwell book aimed primarily at a medical readership provides an opportunity to compare texts that also aim to give a broad practical briefing to the doctor. One of the most important is the WHO manual by Arif and Westermeyer.

This 'manual' is really a co-authored work supported by a group of collaborators and an editorial panel which reviewed the final manuscript prior to publication. Thus it has a consistent editorial policy and a coherent, logical layout. The authors distinguish, in conventional medical practice, the precursors of drug problems, the natural course of the disorder and the influence of the pharmacological properties of the drugs consumed. They then proceed through diagnoses and assessment of the individual to discuss separately the management of detoxification, medical complications, psychosocial issues and the pharmacotherapies of addictions.

They conclude with sections on public health prevention and here make a nice distinction between the conventional disease model which, with acute illnesses, can be applied to all members of a given population, and the particular characteristics of chronic disorders. These they point out are not universally distributed within a population, but involve special high risk sub-groups and multiple causative factors itemised in a well thought out list.

Arif deals fairly with drugs subject to very different legal controls in different nations so that cannabis, alcohol, opiates and nicotine are evenly considered with a refreshing lack of moral opprobrium. Also the roles played in different societies by therapies practised within religious-based institutions broadens the horizon of the English reader.

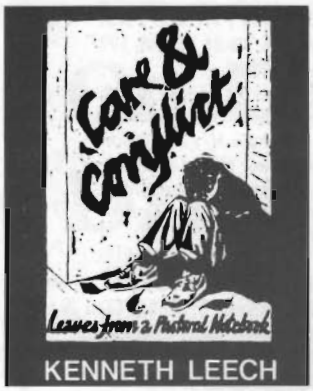
The concise summary of the range of 'alternative' treatments such as aversion therapy and electrotherapy, are crisply summarised with appropriate warnings such as "efficacy of... has not yet been demonstrated in controlled studies...", but in all cases with full references and useful suggestions for further reading that will be of value to non-medical as well as medical workers seeking guidance in this field.

Finally, and in my view most importantly, anyone concerned in training and curriculum development should regard the 21 pages devoted to guidelines for teaching and training as mandatory reading.

By contrast, the English multi-author textbook edited by Ghodse and Maxwell is very much a series of separate contributions and lacks the didactic clarity of Arif's manual. The style tends to be more discursive and descriptive, and there is inevitable overlap and repetition between some of the contributors. However, for those looking for a description of the various British responses to the treatment of drug problems it provides an excellent source of material.

Which one to recommend for those with a modest budget? Personally I would opt for Arif's manual for international comprehensiveness and well referenced factual information. For a practical guide to current NHS treatment services, I would recommend another Hamid Ghodse book, *Drugs and Addictive Behaviour*, which provides a very clear practical guide to British NHS treatment programmes (see review in ***Druglink***, March/April 1990, p.18).

Martin Mitcheson
Consultant psychiatrist, Avon Drug Problem Team, South West Regional Drug Advisory Service



CARE AND CONFLICT: LEAVES FROM A PASTORAL NOTEBOOK. Kenneth Leech. London: Darton, Longman and Todd. 179 pages. £7.95.

Ken Leech was curate of St.Anne's, Soho, during the late 1960s when Soho was the centre of the drug culture. He spent much of his time "loitering" (his word) in pubs, clubs, dives, and coffee bars deliberately wearing a dog collar as "the best way not to be mistaken for a policeman". His description of life on the streets at that time is illuminated by the particular approach he tried to bring to his work. He had no time for the "crusaders" who were "drawn to Soho as wasps to a jampot". He was equally sceptical of a "liberal professional kind of caring which is detached, skilful, and keeps its distance". At the heart of both he perceives a "desire for tidyness and a kind of purity, and a revulsion against mess", the opposite of the closeness to and solidarity with outcasts that Christ pursued. Both in his view did incalculable damage. His aim was transformation through sharing the pain, "the crucified mind".

Ken Leech was responsible for many innovations in the drugs field. He organised weekly seminars at St.Anne's with an array of international experts as speakers and an audience ranging from hippies to psychiatrists and bureaucrats. He produced the first directory of helping agencies (later taken over by SCODA). He founded Centrepoint to provide accommodation for homeless youngsters drawn to Soho from the provinces. His accounts of these, descriptions of Soho subcultures, and in later chapters of racism in the East End, provide illuminating footnotes to the history of the period.

But what makes this book a refreshing experience is not the history, but the subjecting of responses to drug misuse, racism and the other social problems described to a theological critique. Reading Leech makes one realise how much most discussions of drug misuse lack any kind of grounding in any philosophical reality. Leech's radical Christian theology, developed out of an intellectual tradition endemic in European thought for two millennia, places drug misuse in the context of the human condition that we all share. Though the labels that Leech uses may be unfamiliar, the underlying concepts will have recognisable analogues for many of us. Thus at one point, discussing the search for some spiritual meaning that characterised many of the '60s movements, he writes about the gulf between academic Christian theology and spirituality on the one hand, and between spirituality and justice on the other. Leech illustrates his argument with wonderfully apposite quotations from radical thinkers of all kinds, from folksingers like Bert Jansch to liberation theologians and labour leaders like Saul Alinsky, who said "Reconciliation means I am in power and you get reconciled to it".

If you feel it is time you took stock of what you are doing in the drugs field, this book may well give you much to think about.

Jasper Woodcock

Director, ISDD.

Help fill an educational gap

Dear Editor,
Local drug advice centres have been receiving an increased number of requests from 13-year-olds doing drug education projects at school. We are likely to receive more requests in the future, due to the requirements of the new National Curriculum.

We couldn't identify anything produced by ourselves or any other agency that suited this age group. As a result approaches were made to the local drug education adviser who called together a working group.

Before meeting we contacted similar drug advice centres throughout the country (28 in all) and found that not one has specific material for this age group that would satisfy the needs of the type of projects they were doing. Most of these agencies felt there was a gap in the market and were interested in any initiative to provide materials.

Having identified the need for this type of low-cost drug material, we started to look at the ISDD leaflet *So You've Chosen Drugs for your Project* with a view to targeting it at 13-year-olds.

We concluded that the provision of such material could be of national concern. We understand the limitation of this type of school project and accept that later in their school careers children will embrace the various debates that surround drug use, but feel we need to support children and teachers in this area of learning.

We are writing to *Druglink* in the hope of engaging the interest of other agencies to fill this 'gap'. If you wish to affirm our views, or support the development of materials, or have produced useful resources, please contact us.

Cheryl Arnold, Judy Foster, Rod Grant, Dave Hill, Ruth Joyce, Vale Moore, Lesley Plant

Contact Ruth Joyce, Staff Development Unit, Godmanchester School, Park Lane, Godmanchester, Huntingdon, Cambs. PE18 8AG.

New rehab emphasises education

Dear Editor,
We should like to draw your attention to Milton House, a new community-based drug-free rehabilitation project open for referrals from February 1991.

Milton House will offer a different approach to working with newly detoxified drug users with the emphasis on education. The project comprises a hostel and day centre. The hostel will take up to 12 people with six places reserved for women, and has in addition three places for children under 5 accompanying parents. Single people and couples from the Greater London Area will be accepted.

The day centre will offer a structured programme enabling the acquisition of life, job, leisure and creative skills. It has its own creche and a family worker will be available to teach parenting skills.

At present the day centre will cater only for the residential group, though we hope later to cater for those living in the community.

Milton House is a response to a perceived gap in services. Many drug users return to unsuitable accommodation after detoxifying. Others apply to drug-free programmes which have long waiting lists.

The project will allow clients to continue their rehabilitation in a supportive environment, and will aim to help them make an informed decision about their next step. We hope to allow the limited residential resources available to be used more efficiently, and thus to reduce the 'revolving door' phenomenon.

Milton House will pay particular attention to attracting referrals from those currently under-represented in the drugs field, including people from different ethnic and cultural backgrounds, gays and lesbians, women, parents and people with disabilities.

Contact Milton House, 395-497 Liverpool Road, London N7, phone 071-700 6255.

Letters should normally be less than 500 words in length and may be abridged at the editor's discretion. Contributors must supply name, address and occupation/affiliation, but if necessary can require their letter to be published anonymously.

PUBLICATIONS

Drug facts

■ **DRUG ABUSE BRIEFING. Fourth edition. ISDD, 1991. 48 pages. Booklet. £2.50.**
Revised and redesigned basic facts booklet including alcohol and tobacco.
Available from ISDD.

■ **OVER-THE-COUNTER (OTC) MEDICINES. ISDD, 1990. 6 pages. Leaflet. £0.95.**
In ISDD's Drug Notes series. Basic facts for professionals on abusable medicines available without prescription.
Available from ISDD.

HIV and AIDS

■ **WOMEN, HIV, DRUGS: PRACTICAL ISSUES. Sheila Henderson *ed.* ISDD, 1990. 72 pages. Book. £4.95.**
Reports by practitioners on their experiences of providing HIV services for women in the UK.
Available from ISDD.

■ **AIDS, THE WORKS: WOMEN AND HIV. Mainliners and Immunity, 1990. Leaflet.**
Available from Immunity Publications, 260a Kilburn Lane, London W10 4BA.

■ **AFRICAN WOMEN'S HEALTH ISSUES. Positively Women, 1990. Leaflet.**
Latest in a series of useful leaflets on women and HIV.
Available from Positively Women, 5 Sebastian Street, London EC1V 0HE, phone 071-490 5501.

■ **HIV & AIDS: INFORMATION ABOUT MOTHERS AND CHILDREN WITH HIV INFECTION. Briefing sheet. 4 pages. £0.20.**
■ **HIV & AIDS: INFORMATION FOR LESBIANS. Leaflet, 6 pages. £0.30.**
■ **HIV & AIDS: INFORMATION FOR WOMEN. Leaflet, 19 pages. £0.45. Terrence Higgins Trust, 1990.**
Available from THT, 52-54 Grays Inn Road, London WC1X 8LT, phone 071-831 0330.

■ **PREVENTING THE SPREAD OF HIV INFECTION: A STUDY OF DRUG PATIENTS' SYRINGE AND CONDOM USE. Cindy Fazey *et al.* Liverpool: University, 1990. v, 84 pages. Report. £5.**
Study at four clinics in Mersey.
Available from the Centre for Urban Studies, 4 Cambridge Street, University of Liverpool L69 3BX.

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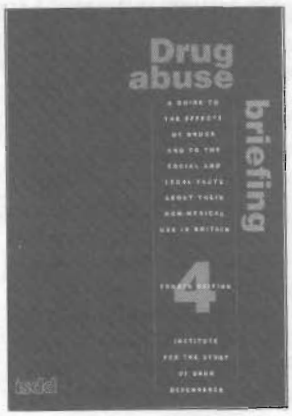

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■ **OPTIONS FOR THE USE OF METHADONE IN THE TREATMENT OF DRUG DEPENDENCE. World Health Organisation, 1989. 11 pages. Report.**
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Available for reference at ISDD. Copies from WHO, Geneva, Switzerland.

■ **RELAPSE PREVENTION FOR ADDICTIVE BEHAVIOURS. Shamile Wanigaratne *et al.* Blackwell Scientific, 1990. 200 pages. Book. £12.95.**
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■ **TOGETHER IN PRACTICE: THE NON-STATUTORY SECTOR DRUGS STRATEGY FOR LOTHIAN. Scottish Drugs Forum and Edinburgh and Lothian Drug Action Group, 1990. iii, 23 pages. Report.**
Illustrates what comprehensive planning can achieve.
Contact Scottish Drugs Forum, 9 Forrest Road, Edinburgh EH1 2QH.

■ **APPROACHING DRUGS: HARM MINIMISATION AS A TECHNIQUE FOR MINIMISING THE ABUSE OF DRUGS. Laurie Dunn *ed.* Commonwealth Youth Programme, 1990. Policy report. £5.**
Available from the Commonwealth Secretariat, Marlborough House, Pall Mall, London SW1Y 5HX, phone 071-839 3411.

■ **HELPING DRINKERS AND DRUG USERS: A PACK FOR SOCIAL WORK EDUCATORS AND TRAINERS. Scottish Council on Alcohol and Alcohol Studies Centre, 1990. v, 79 pages. Pack with handouts £36.50.**
Available from Scottish Council on Alcohol, 137/145 Sauchiehall Street, Glasgow G2 3EW.

MEETINGS

■ **DRUG ADVISORY COMMITTEES – DO THEY WORK? National Local Authority Forum on Drug Misuse. 20 March, 1991, London.**
Conference on the findings of a research study.
Details from Jacquie Brown, NLAFDM, 35 Great Smith Street, London SW1P 3BJ, phone 071-222 8100 ext. 293.

■ **NATIONAL CONFERENCE ON WOMEN AND SUBSTANCE ABUSE. Institute of Psychiatry and Maudsley Hospital. 20-21 March 1991, London. £80.**
Presentations on HIV, black women, pregnancy, women as carers, etc.
Details from Mrs Lee Wilding, Conference Office, Institute of Psychiatry, De Crespigny Park, London SE5 8AF, phone 071-703 5411, ext. 3170.

■ **TRAINING EXCELLENCE. Alcohol Interventions Training Unit (Kent University), Kent Council on Addiction and SCODA, 8-11 April 1991, Canterbury.**
International conference aiming to raise standards of training practice in drugs/alcohol field.
Details from CONCILIA, PO Box 18, Ilkley, W. Yorkshire, LS29 6RA, phone 0943 72763.

■ **AIDS AND DRUGS. Alcohol Research Group, Edinburgh University. 15 May 1991, Edinburgh. £34.50.**
National conference.
Details from Hamish Macandrew, UnivEd Technologies Ltd, Freepost, 16 Buccleuch Place, Edinburgh EH8 0LL.

COURSES

■ **MOTIVATIONAL INTERVIEWING. 1-3 May and 26-28 June 1991. £150.**
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Details from Brian Whitehead, Drug Training Unit, Central Middlesex Hospital, Acton Lane, London NW10 7NS, phone 081-453 2287.

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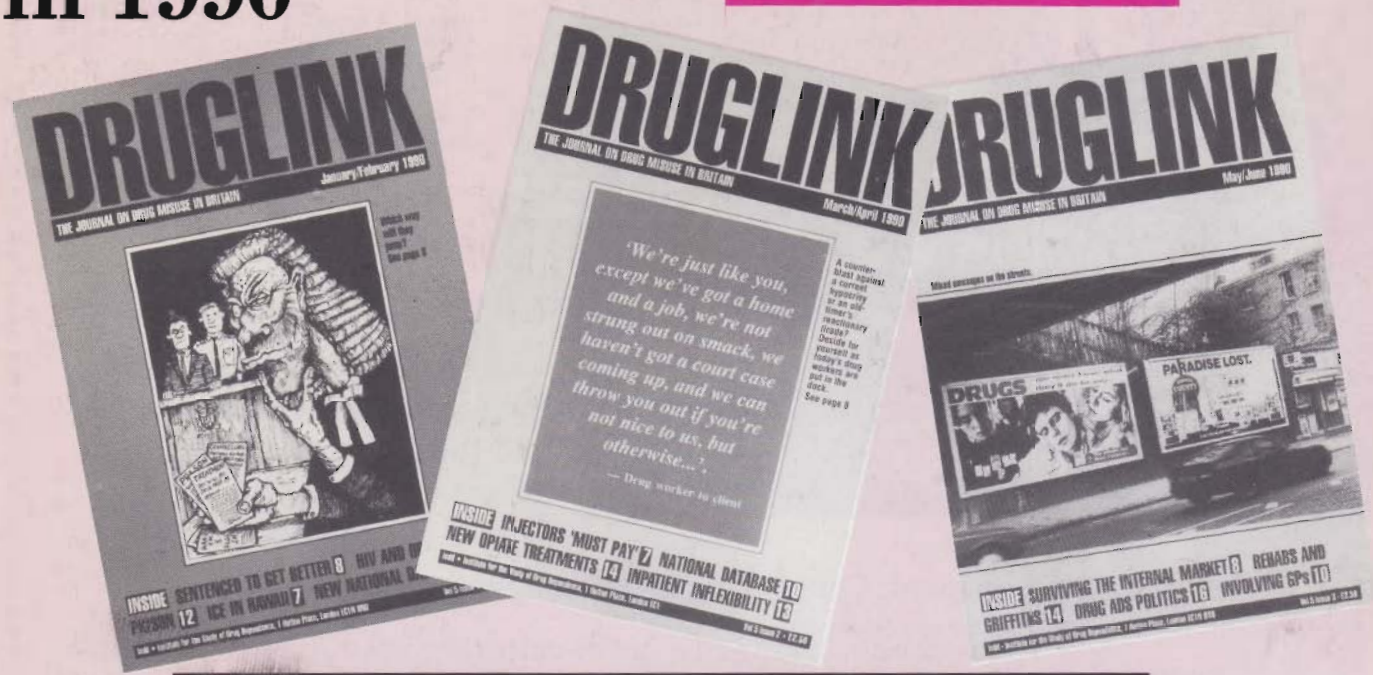

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