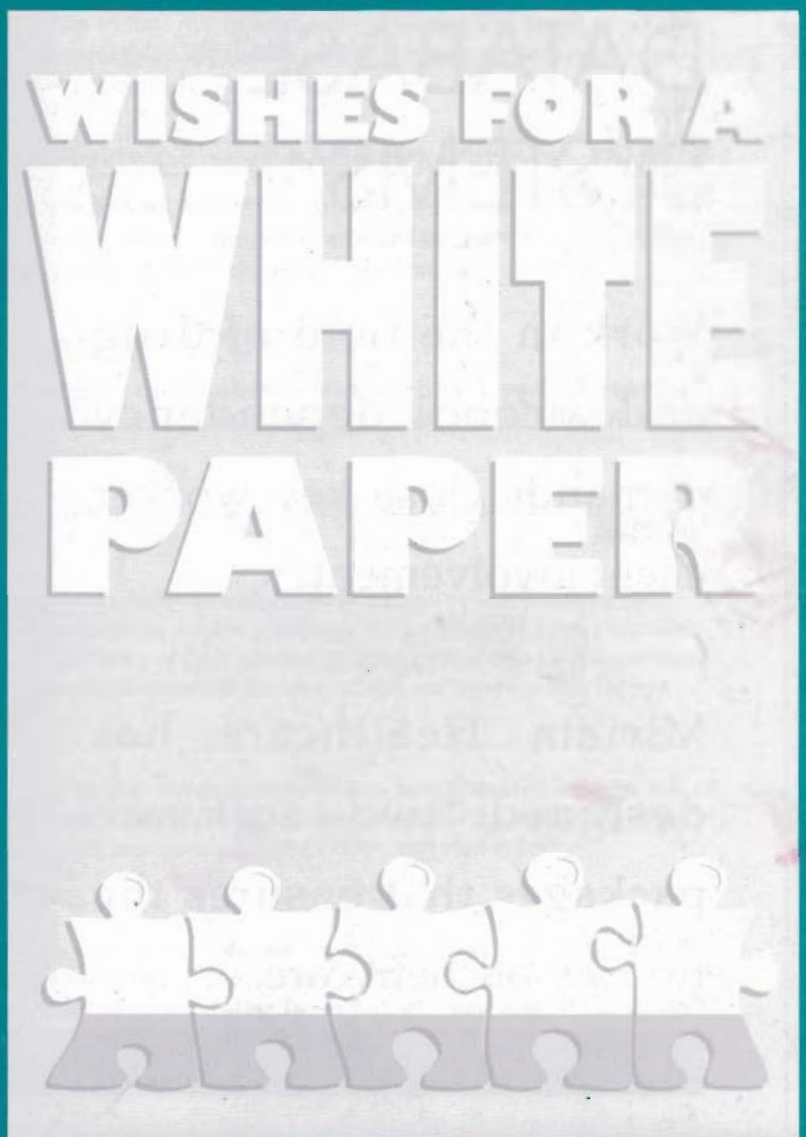
Volume 10 issue 2 March/April 1995

DRUG link

8 wishes for how the *Tackling Drugs Together* green paper should change before it becomes government policy

See page 9



isdd Institute for the Study of Drug Dependence

DRUG link

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

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Part of the solution

IN THIS ISSUE

In our last issue Simon Polley explored how drug users can contribute to the services set up to help them. Now research funded by the Department of Health and conducted by one of Britain's leading research centres shows how drug users not in touch with services can play their part (page 14). Social networks of drug users – previously attacked as spreading drug use – are being acknowledged as central to the harm reduction effort against HIV, confirming a radical shift in how we view drug users – as part of the solution, not just part of the problem.

ARTICLES

REGULARS

Cover: Mike Ashton

LSD's military history exposed and patients allege 'ruined' lives

MPs have been expressing concerns about the experimental use of LSD for medical and military purposes in Britain. These two separate developments have spotlighted the extent and potential consequences of the legitimate use of LSD in the 1950s and 1960s.

The CIA's LSD experiments during the height of the Cold War are well documented. LSD figured in the CIA's search for an effective truth drug and for a drug to disable enemy armies. Less well known was the involvement of our own Ministry of Defence through the Chemical and Biological Defence Establishment at Porton Down during the '60s.

Last October the *New Statesman & Society* published an article which for the first time exposed the extent of LSD testing on animals and volunteer servicemen in the UK and the degree of collaboration between the UK and other NATO allies, particularly the USA, in exchanging information on test results. On the back of this piece, MP Dr David Clark asked the Secretary of State for Defence for further details of "the Moneybags experiments". A reply from Graham Pearson, Chief Executive of Porton Down, confirmed much in the original article about the use of human volunteers, but stated categorically (perhaps with a view to the current strength of animal rights groups) that "no animals were involved".

4500 treated with LSD

Also last year, an ex-patient of Powick mental hospital in Worcester wrote to the Wolverhampton *Express and Star* to complain that the LSD psychotherapy she had undergone had later ruined her life.

In the years following Albert Hoffman's first LSD trip in 1943, doctors in several countries investigated the therapeutic potential of LSD. They hoped it could produce a model psychosis through which to study mental illnesses and unlock the childhood memories of psychiatric patients, suppression of which was believed to be blocking treatment. A team at Powick hospital headed by Dr Spencer led Britain's LSD therapy programme, publishing a paper on results with 36 patients as early as 1954.

Therapeutic use of LSD expanded in the '60s. A survey conducted in 1968 by Dr Nicholas Malleson of London University in association with ISDD reported on 4500 LSD-treated psychiatric patients who between them had undergone nearly 50,000 LSD sessions. Given proper medical supervision, Dr Malleson concluded that the incidence of adverse reactions "is not great".

In 1973, the *Lancet* published two case reports of delayed psychosis from LSD which concluded that its therapeutic use should be discouraged. This brought a riposte from clinicians involved with LSD therapy on the basis that the victims were recreational users, but also a letter from an ex-psychiatric patient complaining about the long-term effects of her LSD therapy. However, this was also the year the Misuse of Drugs Act came into force. LSD became a designated drug that only those holding a Home Office licence could use for medical or research purposes. The subsequent dearth of UK papers on the subject suggests therapeutic use of LSD fizzled out.

LSD 'ruined patients' lives'

Little more was heard about the subject until the letter in the Wolverhampton press. Labour MP for Wolverhampton East, Ken Purchase, took up the case and tabled two questions in the House of Commons after which he received several letters from other ex-Powick hospital patients. Mr Purchase asked how many patients had been tested, how many had been NHS patients and whether there had been any long term monitoring, but Health Minister John Bowis simply said LSD was not now in medical use and there was no evidence to suggest that it had been in recent years.

Ken Purchase then wrote to Worcester District Health Authority which was able to state that 46 patients had been given LSD at Powick. But the DHA said it would cost £45,000 for a clinician to go through the 10,000 hospital records to ascertain the full extent of LSD testing. Believing that the scale of testing has not been fully reported, the MP intends to table more questions and there is the possibility of legal action by patients – though, with the risk of reliving past mental traumas, there are no signs that those allegedly affected are willing to go down that route.

In February, the tale of two Powick patients, plus the wife of one since deceased, was taken up by BBC Radio 4's *You and Yours* programme. Chris Green, the reporter who researched the story, provides an interesting footnote to a saga that will probably end here, one which may link these medical applications to the military's interest in LSD. According to Green, the three people he spoke to said American observers were present during LSD therapy.

Harry Shapiro *ISDD*

From information collector to information provider

ISDD is known by *Druglink*'s readers and many others, as the national information collection on drugs. But from our research over the last year, we know we could do much to provide more information in more useful ways to all of you, and to the many others now in need of information about drugs. ISDD is making a new commitment to information provision – we are planning lots of improvements to our current services and some new developments. Here, we describe the changes we think will be of most interest to *Druglink* readers.

ISDD has to change for three key reasons:

• The number and types of people involved in drug policy and practice are increasing. *Tackling Drugs Together* reinforces these changes. New groups of people will inevitably have different information needs – their level of expertise will be different and they may want information presented in different ways. ISDD has to provide the best available information in the most usable ways for all these people.

• Funding is a problem for all voluntary agencies and ISDD is no exception. If ISDD is to be here in two years time to provide information about drugs, we have to find new and larger sources of income. That means finding new ways to raise money to subsidise services and charges for some things now free.

• Europe wants information from the UK, and information about policy and practice in other EU member states is potentially very valuable to us all. ISDD is uniquely placed to make this exchange of information possible because of the European and national recognition we already have as a UK information centre.

We have encapsulated our new direction in the following statement: **ISDD is here to advance knowledge, understanding and policy making about drugs.**

In the next three years we want to establish ISDD as the leading drug information agency in Europe. Clearly the key to success is serving UK users – the more information we have for and about the UK the more we will be able to offer our European counterparts. This will make it possible for us to exchange information with other EU member states, giving you the benefit of European information.

We will continue to provide the services you know – *Druglink*, *Drug Misuse in Britain*, *Drug Abuse Briefing*, *Drug Notes* and the library enquiry service among others. But we hope to make these better. For example, we will be producing factsheets to answer the most standard enquiries so that we can concentrate on answering your more detailed enquiries. We will produce a range of new publications to meet new information needs and keep in touch with what information users want so the list is always being added to. This could mean more magazine-style materials as well as books, leaflets, videos, posters and multi-media products.

Among the new services we plan are:

• **Better access to the library database** by making it available on-line or on CD-ROM or both, and increasing the speed with which you can get full text copy of material in the database.

• **Information to suit your needs** with customised briefings and reviews on the topics you are interested in.

• **Rapid information and electronic networking** with a bulletin board to give you new information as quickly as possible and provide an opportunity for users to exchange ideas and data.

• **A statistical database** will be created to pull together existing UK data about drugs in electronic form.

Before we do any or all of these things, we have to be sure we can fund them. So the first step will be to find out more about what people would like, whether they are prepared to pay, and whether we can get funding. But we expect to launch one new service like those above in each of the next three years. If there are particular things you would like us to consider, please let us know.

Research amongst our users shows that you value ISDD's independence from government and other powerful interests in an increasingly political field. This will not change. Our explicit commitment to advancing policy making does not mean we will be taking 'policy positions' for their own sake. Our prime role is to provide information, and this includes information to aid policy making. Often we are asked what we conclude from that information. When we do draw conclusions we will always identify them as the interpretation of ISDD or a member of our staff.

Anna Bradley *Director, ISDD*

❑ **The US Department of State's *International Narcotics Control Strategy Report* for April 1994 says "UK authorities believe heroin abuse is their biggest drug problem. They acknowledge that while the anticipated crack cocaine epidemic has not occurred, cocaine use is increasing". The report notes the US Drug Enforcement Administration's assessment that "of all European nations, the UK has the highest demand for LSD".**

❑ The US RAND Institute has conducted a study of the benefits of the US military's pilot community outreach programmes.[1] A programme which cost $100 per youth would need to stop just 0.6 per cent of them starting cocaine use to pay its way compared to 3 per cent for cannabis. Comparing costs with the impact of similar schemes, the authors conclude that several programmes were cost effective. The most successful relied on volunteers, were locally designed but had central guidance, and targeted high-risk youth.

1. Caulkins J. P. *et al. Preventing drug use among youth through community outreach.* RAND, 1994.

❑ **A report from the Social Services Inspectorate into five social service departments illustrative of those in England has strongly criticised their failure to implement official guidance applicable to drug and alcohol users.[1] None had a policy, strategy or service agreements specific to these groups. Little progress had been made in achieving standards. Assessments were resource-led and services inaccessible to users who had to "jump through a number of hoops and express high levels of motivation before gaining access to a service at all". Fuller report in the next *Druglink*.**

1. Social Services Inspectorate. *Inspection of social services for people who misuse alcohol and drugs.* Department of Health, 1995.

❑ A survey which has been sampling 14–15-year-olds in three Wolverhampton schools since 1969 reports that by 1994 the proportion who knew someone taking drugs had risen from 15 to 65 per cent and those offered drugs from 5 to 45 per cent.[1] TV continued to be cited as the youngsters' main source of drug information, also a finding of the 1992 British Crime Survey. Responses from over a 1000 12–15-year-olds revealed that most remembered having drug education lessons but less than fifth thought they had received enough information about drugs from their schools.[2]

1. Wright J. D. *et al.* "Knowledge and experience of young people regarding drug misuse, 1969–94." *British Medical Journal*: 1995, *310*, p. 20–24.
2. Dowds L. *et al. Drug education amongst teenagers.* Home Office, 1994.

Meeting of minds over green paper plans

Responses to the Central Drugs Coordination Unit's (CDCU) green paper for England were due in by 20 January. Perhaps at the top of the pile will be those from relevant national bodies and the politicians who will debate the strategy. ***Druglink*** obtained copies of responses from some major players to look for common themes and differences of opinion. All welcomed the report but there was remarkable agreement over what needed to change, giving the CDCU a clear agenda to respond to. Here we can only present highlights from documents which testify to the success of *Tackling Drugs Together* in stimulating debate.

Top police back treatment

Given the strong role for enforcement in the draft strategy and the resources devoted to it, the response of the top police officers in ACPO is arguably one of the most important. Where it stood out was in its support for an enhanced place for treatment. In this ACPO was at least as emphatic as service providers themselves.

ACPO called for a "comprehensive network" of "adequately ... resourced" drug treatment services across the country. There was, they said, an "urgent" need for accessible services able to respond promptly – "crucial" to arrest referral schemes.

Underlying police enthusiasm is the growing view that enforcement cannot curb drug misuse and related crime without services to break the cycle of re-offending. Frustration that under-resourcing leaves today's services unable to fulfil this role is evident in the police's paper. Treatment's capacity to curb the criminal activities of drug dependent offenders seems well established, but research from ISDD and elsewhere suggests that treatment linked to diversion from criminal justice has yet to justify the police's enthusiasm.

Police concern at the green paper's 'inadequate' commitment to treatment was strongly echoed by the All Party Drugs Misuse Group, LGDF and ADSS, as well as SCODA. The politicians called for the statement of purpose at the heart of the strategy to include support for treatment, as did SCODA and ADSS. Only ACPO went further to suggest treatment be added to education and prevention among sectors to be given "a new emphasis" in the statement, leaving enforcement to be continued vigorously but not newly emphasised.

See page 9 for eight personal responses to the green paper

We obtained the submissions of:
ACPO Association of Chief Police Officers;
ACOP Association of Chief Officers of Probation
ADSS Association of Directors of Social Services;
LGDF Local Government Drugs Forum
All Party Drugs Misuse Group bringing together MPs and members of the House of Lords with an interest in the issue;
NLGCHDE National Liaison Group, Coordinators of Health and Drugs Education;
TACADE national voluntary sector drug education specialist;
SCODA; **Release**; **Phoenix House**; **ISDD**.

The National Association of Health Authorities, the Prison Governers' Association and the Society of Education Officers did not make a formal response.

Cutting the cake

Nearly all respondents said more resources were essential to make the strategy work. As LGDF put it, "People, from all sectors, feel they are being given additional responsibilities without additional funds".

But there is a snag. Privy Council President Tony Newton has insisted the strategy is mainly about spending current resources better. With spending controls tight, a "new emphasis" for some sectors could mean others losing out – a possibility implied by pooling the sectors into a single strategy. Enforcement, absorbing nearly two-thirds of anti-drugs expenditure, is an obvious target. This prospect threatens rifts in the 'partnership' approach.

The Department of Health effectiveness review tempered demands for a short-term hike in funding for treatment. SCODA and Phoenix called as a minimum for the maintenance of current levels, though ACPO's response implied a large and urgent increase.

Within three years SCODA too was looking for expenditure to have "shifted significantly in favour of treatment, prevention and education". "Significantly more" was needed for these sectors, agreed the All Party Group. The omission of enforcement was almost certainly not accidental. Release spelled it out: "Some of this funding could be found from diverting some of the money presently spent on enforcement".

But police, facing "additional demands" arising from the strategy, warned that without more resources they would have to short-change "other critical areas of policing". They were open to a review of the sharing out of resources between treatment, education and enforcement – but only with respect to "additional funds".

The innocent-looking paragraph 7.18 of the green paper is set to become a battleground between treatment and criminal justice interests. SCODA welcomed it as promising funding for help services working in criminal justice settings, funding which presumably would come from criminal justice sources. Top probation officers, who would stand to lose chunks of their budgets to fund treatment for offenders, said the proposal could "prove divisive and ... jeopardise the spirit of partnership". They argued that community services should be available to offenders on the same basis as to everyone else, ie, without being singled out for special funding. Hinting at a counter-offensive, they warned health purchasers that they might lose more than they gained if the principle were applied in reverse.

The issue of reallocation is related to the call from SCODA, the All Party Group, LGDF and ISDD for effectiveness reviews of other sectors to parallel that of treatment. The All Party Group and SCODA also call for more money for treatment, prevention and education, appearing to express confidence that such reviews will show enforcement the least cost-effective. Evidence supporting such confidence is strong for treatment but distinctly weaker for prevention and for the preventive capabilities of education.

Whither harm reduction?

The green paper's opening assertion in the chapter on reducing health risks is that "abstinence ... must be the goal of drug services". Local government, with no tradition of seeing drug use as something to be addressed in its own right, delivered the most forthright rejection of this apparent sidelining of harm reduction. "Emphasis on abstinence as the ultimate goal of drug services is unrealistic and unhelpful," said LGDF. Although accepting abstinence as the "ultimate goal", ADSS warned that "single and unequivocal" commitment to this goal risked deterring drug users from services.

Drug services and probation were less critical, variously divining under the rhetoric a continuing commitment to harm reduction and a retreat from an absolutist anti-drug 'war'. Release did not address the abstinence issue while SCODA commented on the "confusion" this part of the green paper had caused in drug services, in a passage which perhaps reflected

continued on page 7 ▶

SCODA members agree constitutional review process

SCODA representatives expressed delight after an AGM which focused on the future rather than the past year's upheavals. "We've finally got to a more constructive point", said Robin Burgess, the Executive Committee member who presented the chair's report to the AGM on 2 February. "Everyone was very optimistic about the future", said Pat Littlewood, the EC member who fronted the main debate on setting up a constitutional review group. Chief executive Roger Howard said "SCODA is now in an excellent position to move forward". Chair Jane Goodsir saw a "general concern to take things forward".

There was also keen awareness of concerns about SCODA's actions over the past year, which led to the dismissal of all core professional staff and the appointment as chief executive of the man who headed a consultancy imposed on SCODA by the Department of Health.[1] Papers for the meeting and the address of the chair had extended defences of SCODA's actions. Robin Burgess stressed that "at no time did the Executive Committee lose any sight or control over the consultancy". Roger Howard said there had been an "enormous amount of consultation" and the now "very respectable" drugs field had a "chance of a seat at the table with policy makers".

Though they surfaced at the meeting in comments from the floor, criticisms of the Executive Committee never came to a head. There were also strong expressions of support for the change process and its outcome. A model resolution circulated at the meeting condemned the Executive Committee for a series of alleged failures but no one was prepared to propose it. After the meeting Roger Howard said SCODA does not plan any special review in the light of such concerns as were voiced.

Constitutional review

Some of the more potentially controversial issues were left to a constitutional review group. The meeting agreed to an amended version of the Executive Committee's proposal for a group to report within a year on "membership, governance and consultative matters".

The background was the issue of admitting statutory services as members. This is allowed for by constitutional changes made after the 1994 AGM but, wrote SCODA's chair, not implemented due to its "complexity and sensitivity". A paper supporting the proposal stressed that the Executive Committee was aware of "concerns" and said the group is intended to find ways of making change "equitably", reflecting concern "not to distort the purpose of the organisation and its traditional supporters". Another key task was ensuring SCODA's "traditional values" are maintained and built on.

A complicated debate with amendments to amendments left both sides reasonably happy.[2] In an impressive coming together of minds, speaking for the Executive Committee Pat Littlewood accepted parts of an amendment from Alison Chesney of Cranstoun and Jerry Sutton of Inward House, two of the most outspoken critics of SCODA's handling of change, amid vigorous signs of approval from the chief executive. These fine-tuned the group's membership and ensured their report would be put to the membership at the next general meeting without having first to be agreed by the Executive Committee.

> Finally we've got to a more constructive point

Sticking point

For both sides a key issue was whether SCODA's role had been decided already or was to be considered by the review group. The original proposal had SCODA's "new role" as a given for the review while the amendment sought to include SCODA's "future role" in the group's work. It was the sole sticking point. The outcome was a compromise which set the review "in the light of SCODA's role in a changing environment", allowing both sides to support the motion while holding different views of what it meant. An amendment from the floor added the interests of drug users to those of services in the description of SCODA's commitments and the final motion was carried unanimously.

After the event we contacted some of the main players to ask how they felt about the outcome of the debate. Jerry Sutton pronounced himself "reasonably satisfied". Ensuring the review's report could go direct to the next general meeting was, for him, the most important achievement of the amendment he'd seconded – "it made sure the process was accountable to the membership".

At the meeting Pat Littlewood had strongly resisted the attempt to include SCODA's role in the review group's work. She explained that this was out of tune with the forward looking tenor of the meeting. Last year's consultations had led to a *Statement of Purpose* which encapsulated SCODA's role "and now we need to get on with the job. Continued contemplation of what SCODA is here for is not now the key task."

Robin Burgess saw it the same way. He thought the Executive Committee "could never accept" that bit of the amendment. "As trustees the buck for SCODA's accountability stops with [us]. We have the liability under law, not the membership. The Executive Committee owns the *Statement of Purpose* as its work – it's not the Department of Health's and not exclusively Roger Howard's. The review group's role is not to go over that but to look at how SCODA attracts, reports to and consults the membership."

For Alison Chesney, who proposed the amendment, the implication in the original that SCODA's "new role" had been agreed was a prime concern. "The *Statement of Purpose* has not been agreed by the members. The main significance of our amendment was to make sure the future role of SCODA was debated and agreed by the members". She looks to the review group to at least clarify the statement so it can be brought back to the members as part of their report, debated and approved.

But even the critics were prepared to vote for the final resolution. A series of actions by the Executive Committee before and at the meeting would have helped head off any confrontation.

The tricky and potentially controversial issue of how membership can be extended while safeguarding both current members and SCODA's advocacy role was left to the review group, promising all concerned another bite at the cherry and a means to gain the consensus that might have been lacking at the meeting. Changes accepted by the Executive Committee to the review group proposal helped make it broadly acceptable.

Any differences of opinion over the *Statement of Purpose* – probably the single most important document to emerge over the past year – were left unvoiced because the document was not presented for debate.

Perhaps as important in defusing dissent was the fact that Jane Goodsir's written report for the first time gave a detailed account of the events of the past year including the Department of Health consultancy, the process leading up to the issuing of redundancy notices to five staff, and the recruitment of the chief executive – the areas of greatest concern. Her willingness to lay so many cards on the table will have been refreshing to those members who in the past felt they have been kept too much in the dark.

❑ By mid-March the void in SCODA's staff will be partly filled by the appointment of Alison Dewar from Business Links to the communications post and Stephen Taylor from Hillingdon's drug education team to head member services.

Mike Ashton

Ex-deputy director Hugh Dufficy, made redundant last year along with four of his colleagues, broke his silence to ***Druglink*** to express "anger" at what he saw as the "denial" of the role of the Department of Health in the chair's written report to the AGM and its "unfair attacks" on staff. In the report staff repeatedly feature as holding back or refusing to engage in the process of change. Hugh Dufficy backed the views of former staff, expressed in the last issue of ***Druglink***, that offers of consultation and negotiation were "not valid" and that SCODA was now an "agency of government". Lending his words extra weight is the fact that he was asked by the Executive Committee to stay on and hold the organisation together after the director resigned last spring.

Underlying differences of opinion over whether SCODA's role still needs to be agreed by members are different views of the adequacy and status of last years's extensive consultations with and beyond the membership, including approval from SCODA's Members' Advisory Committee for a version of the *Statement of Purpose*. These are cited by SCODA as one of the main legitimations for the document. Jerry Sutton asks why if the Executive Committee had such confidence in the consultations they "did not put the statement before the membership for agreement or amendment".

Alison Chesney believes the proof of the inadequacy of the consultations is that the *Statement of Purpose* which emerged from them "makes no mention of serving the needs of drug users, protecting their interests or upholding their civil rights – an amazing omission". Supporting her case was the successful call at the AGM for just such a clause to be added to the review group proposal. Roger Howard's response is that SCODA is "*not* about directly serving the needs of drug users. The field has emphatically said that is the business of drug services."

1. See pages 5 and 8 of the last issue of *Druglink*.
2. At the time of writing an official version of the resolution was not available so statements here about its content should be considered provisional.

▶ *continued from page 5*

the difficulty of squaring the varying views of its membership.

SCODA supported "the principle that an [sic] ultimate aim of drug services should be to support efforts which enable drug misusers to cease use" and "therefore" welcomed the green paper's commitment to "risk minimisation" services. Then government was asked to acknowledge that the goal of drug services should be to "meet the needs and goals of those seeking help" – sometimes abstinence, often not.

Neither Release's nor SCODA's submissions included the terms 'harm reduction' or 'harm minimisation'. These were also absent from the green paper, it's said because they were politically unacceptable. All three documents framed their discussion in less banner-like phrases which substituted 'risk' or 'damage' for harm. Others in education and information kept to the established terms.

Don't talk about deprivation

The green paper didn't, but most of our sample did, some indirectly by complaining of the failure to draw links to policy areas that most directly affect social welfare. The All Party Group's reference to the "essential contribution of ... housing, employment, training, recreation and leisure" is in this category. Some were more direct, as in LGDF's assertion that "unemployment, housing and other areas of social exclusion play a major role in the escalation of drug problems". "Clearly politics plays a part" in the green paper's blind spot, said ACOP.

Flexible action teams

Flexible boundaries for drug action teams to suit local circumstances is the favoured alternative to the green paper's health authority districts. ACPO, ACOP, ADSS, LGDF, SCODA and Phoenix House all go for this option. Among their reasons are problems of co-terminosity and the fact that senior officers, especially in probation and police, would need to attend several DHA-based teams. Local government submissions preferred local authority boundaries, as did SCODA and ISDD.

Directors of social services were dismayed at the "mistake" of their omission from drug action teams; nearly everyone else made a similar point. A related point made by the politicians, police, social service directors and SCODA was the lack of reference to the role of education authorities in drug education. For LGDF it adds up to role of local authorities being "underplayed throughout". The All Party Group agreed.

> Let local areas decide drug team boundaries

Signs from the CDCU are that it will reverse the exclusion of social services from drug action teams, but much movement beyond this seems unlikely. The thrust of government policy has been to curtail the powers of local authorities, especially in education.

Educational manoeuvres

Another point made in several submission, including ACPO's, was that prison urine testing should not be implemented before a full range of help services is available in prisons. Not to do so would be "catastrophic", said the All Party Group. A greater role for GPs, the need for a clear definition of drug-related crime, and a feeling that much more work was needed on the performance indicators, were also mentioned in several papers.

Inevitably, the responses of the education sector were more specialist than the others. TACADE and the education coordinators called for legal drugs and solvents to be in the strategy, reflecting the reality of classroom practice. Both claimed a place for harm reduction/minimisation and skills development in education.

Drug education is now clearly a growth area for official support, and TACADE expressed concern over the crowding of the market. In their firing line were the potential "surplus" of new education materials and "the growth of organisations ... claiming to represent education and prevention without a proven track record". SCODA's ambition to represent education and prevention sectors was a special target. TACADE makes it clear that, "at least in the short term", it believes it has a greater claim to coordinate education and prevention. SCODA is just one of a range of new and old forums and organisations taking a renewed interest in drug education. Currently there appears to be some jockeying for the lead positions.

Mike Ashton

Twelve new drugs prevention teams for England

From 1 April 1995 there will be 12 drugs prevention teams in England. The teams will consist of five or six people – a team leader, two or three senior development officers, an administrator, and a secretary. At the time of writing the level of funding for the teams was undecided. The 66 staff in the new teams compares with an estimated 51 (three per team) in the previous 17 English teams, but the aim is to extend the benefits of their work from six to 16 million people.

The teams will be:

Northumberland and Tyne and Wear Five people will cover the two counties replacing the Newcastle team. The team office is expected to be in Newcastle.

West Yorkshire Five people will cover the county replacing the Bradford team. The team office is expected to be in Bradford.

Manchester, Salford, Bolton, Rochdale and Stockport Six people will cover these areas in Greater Manchester replacing the Manchester and Salford teams. Salford is expected to host the office.

Merseyside Six people will cover the county replacing the Liverpool and Wirral teams. The team office is expected to be in Liverpool.

Nottingham, Leicester and Derby Five people to cover these three cities and adjacent areas in Nottinghamshire, Derbyshire and Leicestershire, replacing the Nottingham team. The office is expected to be in Nottingham.

Birmingham, Wolverhampton, Dudley, Sandwell and Walsall Six people will cover these areas of the West Midlands replacing the Birmingham and Wolverhampton teams. Office location may be W. Bromwich, Oldbury or Sandwell.

Essex A new team of five will cover the county. The team office is expected to be in Chelmsford.

Avon and Somerset Five people will cover these counties replacing the Bristol team. The team office is expected to be in Bristol.

East and West Sussex Five people will cover these two counties replacing the Brighton and Hove team. The office is expected to be in Brighton.

North-East London Six people will cover the boroughs of Newham, Tower Hamlets, Camden, Islington, Hackney and Haringey, replacing the Newham and Hackney teams. No decision has yet been taken as to the location of the team office.

North-West London Six people will cover Westminster, Kensington and Chelsea, Hammersmith and Fulham, Brent and Ealing, replacing the Brent team. The office is expected to be in Brent.

South London Six people will cover Wandsworth, Lambeth, Southwark, Lewisham and Greenwich, replacing the Lambeth, Southwark and Lewisham teams. The team office is expected to be in Southwark.

❑ **Of 287 respondents at the gay and lesbian community's Winter Pride event in 1994, nearly three-quarters of the men and nearly 60 per cent of women used a recreational drug at least every few months, reports the new Project LSD drugs outreach project (see Connections page for more on Project LSD).[1] Poppers and cannabis were towards the top of the list (at around 70 per cent except for women's popper use, 48 per cent), nearly half of both sexes had tried LSD or ecstasy and a third cocaine. Project LSD warns that the findings are preliminary only and may be biased by self selection of drug users.**

1. Smith R. *A report on the findings of Project LSD's preliminary survey into lesbians, gay men and bisexuals drug use*. 1995.

❑ In interviews 2330 drug injectors in 12 European countries in 1989–90 were asked who they can talk to about their fear of AIDS. None of the UK sample of 189 injectors mentioned health professionals (Euro average 30 per cent) and 85 per cent mentioned injecting friends (average 43 per cent). In the UK less than a quarter mentioned health professionals as a trusted source of information about HIV/AIDS.[1] The latest results from the government's anonymous HIV testing programme in England and Wales show that in 1993 just 4 per cent of male injectors in London and 0.6 per cent outside the capital were infected.[2] In London, 1 in 570 pregnant women tested positive – 40 times higher than elsewhere.

1. Richardson S. C. *et al.* "Knowledge, attitudes and beliefs of European injecting drug users concerning preventive measures for HIV." *European Journal of Epidemiology*: 1994, *10*, p. 135–142.
2. "HIV infection concentrated in London." *British Medical Journal*: 1995, *310*, p. 213.

❑ **As the drug 'overdose' death toll for Strathclyde in 1994 reached 95, the pathologist who conducted post-mortems on over 100 of the deceased suggested that the deaths may be linked to hepatitis C. In recent post-mortems, 80 per cent of Glasgow's addicts were found infected.[1] Dr Marie Cassidy says the infection impedes the processing of drugs meaning they accumulate in the body. This, she believes, may explain why many recent victims had not taken large amounts of drugs. Perhaps another factor is the fact that temazepam, a favourite among addicts in Scotland, has a greater sedative effect in overdose than other benzodiazepines.[2]**

1. *Independent*: 29 December 1994.
2. Buckley N. A. *et al.* "Relative toxicity of benzodiazepines in overdose." *British Medical Journal*: 1995, *310*, p. 219–221.

'SCODA – setting the record straight'

Dear Editor,
We suppose it will perhaps be too much to ask that in reporting the change process under way at SCODA, Mike Ashton would not drop the usual standards of factual reporting which **Druglink** has a reputation for. Unfortunately the article in the last edition smacks more of speculative tabloid journalism at its worst. So, we have asked for a right of reply to set the record straight.

At the AGM in early February, there was overwhelming endorsement for management efforts to take the organisation forward. Moving away from the debilitating debate about whether SCODA should represent statutory and other drug services was the essence of the enormously productive discussion. Speakers endorsed previous decisions to broaden membership and for steps to make the organisation more effective; so Mike Ashton's speculative arrow missed the mark by a wide margin. The membership does support change. Which leads us to supposed disquiet over the process of change.

Our reports to the AGM extensively catalogued the change process SCODA has been working through during the past year. Many of your readers will be unaware of events and will look to the journal for information. Again we have to set the story straight. The process started over two years ago following a report to the Department of Health. As a national agency with DoH core funding, by 1993 SCODA had still not been exposed to the new contract culture funding arrangements as its membership had. The gap between members' expectations and SCODA's capacity to deliver gradually widened. There were major internal organisational and management changes to be addressed. These facts have been the driving force for change.

Our reports also detailed one of the most extensive consultation exercises ever into the management and direction of a national representative body. This was conveniently overlooked in Mike Ashton's article. This involved regional focus groups; meetings with a variety of drug forums; stakeholder discussions; open invitations and feedback meetings again on a regional basis in response to draft statements of purpose and priorities. There will of course be those who chose not to attend meetings or to make their views known. There will be those who feel their point of view has not been listened to or heard. But they would be wrong. The Members' Advisory Committee, constitutionally charged with advising SCODA's trustees, has also endorsed the process and content of change, conveniently overlooked in the article. Let us also look at the facts about the recruitment of new staff.

It is perhaps disappointing but perhaps not unexpected that criticism about organisational and personal probity were raised in the article. However, a number of those at the AGM expressed confidence in the integrity of the process followed by trustees in making appointments. We in turn recognise communications could have been better.

The Executive Committee made it clear at the very beginning of the recruitment process that anyone who might have the slightest interest in the post would be excluded from subsequent decision making. It is the trustees of SCODA who make appointments – not the DoH. SCODA would refuse any imposed restrictions or constraints on who it should or should not employ. This would have been a flagrant breach of our equal opportunities principles and commitment, something widely acknowledged at the AGM. Which takes us to the other charge levelled at SCODA – independence from the Department of Health.

SCODA has many stakeholders – its members; its legal trustees; charitable funders; and of course its principal funder, government. It has to work within the constraints on political campaigning under charity law. It also is aware of those who benefit from its efforts – problem drug users and those concerned about the effects of drug use in their communities. The simple fact is, SCODA is an independent body accountable and responsible to stakeholders for what it does.

The changes we are introducing are aimed at ensuring SCODA is more responsive and accountable. Government have nailed their colours to the mast in *Tackling Drugs Together*, where they support the trustees' efforts for it to be a "robust and representative body" and say SCODA "is not an arm of Government". Our own position is very clear. We will comment on drug policy and practice when we feel something should be said. We will do so where it is agreed policy of SCODA and where the weight of evidence clearly supports and represents our members' concerns. That is not only within the terms of reference for charities about political campaigning. It is core business, good management and sound common sense. Our responsibility to the DoH as core funder is to represent the professional interests and expertise of drug services, what the organisation was set up to do. Our accountability to the department is to make sure we do it well, efficiently, and effectively. Like drug services on the ground, we have to provide value for money.

We believe the change process SCODA's Executive Committee is working through has been vindicated by the overwhelming majority of its members. Change is never easy. It is now clear the membership as a whole and others are moving into a constructive stage – helping to shape a vibrant and energised representative body. There are many more important challenges on the horizon than the internal machinations at SCODA. Our task is to shape an organisation fit for addressing outcomes, rationing, ring fencing, standards and other major policy debates. It is that we are now engaged upon – not the rewriting of history.

Jane Goodsir *SCODA Chair*
Roger Howard
SCODA Chief Executive

ISDD was happy to give SCODA and its ex-staff an opportunity to respond to the news report on SCODA in the last issue as we do routinely with anything in **Druglink** *readers wish to respond to. Given the length and prominence of the original report we thought it fair to allow responses in greater length than normal. In so far as they question the accuracy or balance of our reporting, we will be replying in the next issue of* **Druglink**. **Editor**

Ex-staff challenge SCODA's defence

Dear Editor,
Although your report on SCODA in the January/February edition of **Druglink** gives a factual account of what happened over the last year, some of the points made need to be challenged. In your article the defence for what has happened at SCODA comes from Jane Goodsir and Roger Howard. I do not share their perception of what has happened.

It is claimed that the drugs field was consulted on the proposed changes at SCODA. This process was cosmetic. Consultative meetings were arranged at short notice and some were cancelled. Through my work it was evident that most people in the drugs field did not know what was happening at SCODA.

Jane Goodsir is reported as saying that "structures to safeguard existing members" will be set up. Why should members believe this when the current structures have not been used, eg, the Members' Advisory Committee was excluded from most of the decision-making process. It is difficult to believe SCODA is "robustly independent" when it has had to respond to the Department of Health's timetable throughout the year. The same contradiction exists with it having a "client advocacy" role.

I am surprised that Roger Howard thinks the fact that his contract was with the DoH and not SCODA helps justify his being allowed to apply for and eventually be appointed to the chief executive position. This suggests that if it had been with SCODA then that process would have been unacceptable, yet the fact that his contract was with the DoH was in this respect a technicality. Effectively he was running SCODA from the beginning of his consultancy. There was a conflict of interest between his role as a consultant and his intention to apply for the chief executive post.

As regards equal opportunities, the union representing SCODA's staff never received satisfactory evidence that equal opportunity practices were followed in the appointment of the chief executive, and its request for an independent observer at the interviews was not carried out. Readers might have been left with the impression that SCODA has an equal opportunities policy – it does not, it merely has a statement subject to wide interpretation.

While at SCODA, I was one of the staff's union representatives. I know that the comments in this letter are shared by the staff; I am not only putting forward my own view. My comments are not those of an aggrieved ex-staff member. I have thought about these matters a great deal, so have other staff, and we all believe that these things should not go unchallenged.

Sara Wilson
To December 1994 SCODA's training officer and joint union representative for SCODA's staff.

We are grateful to Inspector David Scott of the Nottinghamshire Constabulary and to Tim Millar of the Drug Misuse Research Unit, University of Manchester for agreeing to our holding over their letters on the DARE drug education programme and the sharing of injecting equipment respectively. **Editor**

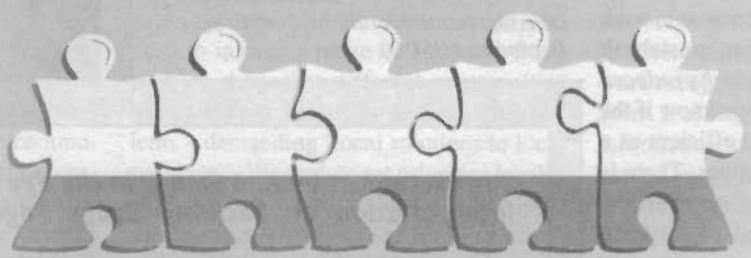
Letter was an 'extreme distortion'

Dear Editor,
I read with a mixture of amazement and amusement the letter sent to you by Ms Hewitt (***Druglink***: January/February 1995). When you have been a lecturer for nearly 20 years, you become used to being misunderstood. But there are, however, some extreme examples of distortion, and Ms Hewitt's letter is certainly one of these. I have the impression that she did not retain one single point of my lecture – which undoubtedly speaks badly of my skills as a lecturer – because she is even attributing to me concepts that I have been openly fighting for many years.

Several pages would be necessary to explain the differences between what I said and what Ms Hewitt understood. I would certainly have been very pleased to send her a written copy of the lecture, saving her the effort and time spent attempting to recall what I never said, but she never asked for one.

Augusto Perez-Gomez
Visiting Professor, The Centre for Research on Drugs & Health Behaviour; Professor, University of los Andes, Bogota

WISHES FOR A WHITE PAPER



From Mike Linnell's tongue-in-cheek send-up to Robin Burgess's passionate endorsement, we present eight reactions to the Tackling Drugs Together *green paper, the consultation document soon to be transformed into the Government's drug strategy for England. With the final document just weeks away, these are our correspondents' wish lists for the White Paper to come.*

The leader of Britain's leading drug information agency homes in on how information provision is handled in the green paper

The green paper is a very cleverly crafted document with some subtle policy shifts, constructed with a high degree of political pragmatism. Our comments are similarly pragmatic, concentrating on points that might be changed in the White Paper.

ISDD shares many of the concerns expressed by others: the likely impact of urine testing in prisons and the lack of supporting services; the absence of proposals to review the effectiveness of education, prevention, and enforcement; the fact that so much is left out – foreign policy, employment and the links with housing, benefits, etc.

On the assumption that others will have made these points, I will concentrate on two things: performance indicators, and information and coordination.

Performance indicators

We are very pleased to see performance indicators in the green paper; this is the first time drugs policy will be measured in this way. Potentially it will be the most valuable aspect of the strategy. But we are concerned that the indicators will not tell us which activities are achieving which results.

Some of the proposed indicators will tell policymakers whether an activity has been done, and some will record whether the intended effect has been achieved. But the most important thing to establish is that it was *this activity which produced that effect*; only then can we know if the activity was effective and efficient as a means of achieving objectives. There is no indication in the green paper of the work that will be needed to establish such correlations.

A further concern is that, like the overall strategy, the measures relate to the work of individual government departments. This may limit the degree to which the indicators as a whole can monitor the success of the overall strategy. For example, will they help policymakers adjust the balance of resources between enforcement, health and education?

Information and coordination

The section on information and coordination is the most underdeveloped part of the strategy. Much of the green paper is a weaving together of existing work, and responsibility for achieving objectives remains largely in the hands of the three most relevant government departments. Given this, there is a desperate need to retain a national coordinating function, but the green paper has no concrete plans for such a body.

We are also very concerned at the absence of any information strategy. Laudably, the green paper acknowledges that access to good information "requires coordinated efforts to identify, evaluate and disseminate key research findings as well as ready access to brief overviews or 'meta analyses' of valid research studies within the overall strategic framework and in line with the Statement of Purpose."

But the measures proposed to provide such information are thoroughly inadequate, amounting to a restatement of existing roles and responsibilities. They simply underline the absence of a thoroughgoing information strategy.

Such a strategy would clearly state how decisions will be taken about the information that needs to be generated, how this work will be commissioned or developed, the way the output will be disseminated, and how the quality of the information is to be assured. In each case one would expect to see responsibility clearly allocated. We hope the White Paper will include such a statement.

Anna Bradley

Director, Institute for the Study of Drug Dependence (ISDD)

Edited extracts from the Lords debate on the green paper on 1 December 1994.

Many working in the drugs field are pleased that the document recognises the value of a coordinated strategy and acknowledges the growing pressure on local communities by establishing drug action teams in every district health authority [but] there is grave concern about the potential gap between a paper policy and practical reality. In other words, where are the resources to make it all work?

It is unfortunate that the green paper pays scant attention to the role of the voluntary sector and volunteer action. They have the credibility and often the kind of information and support that is more acceptable to drug misusers than the statutory sector. It is vital that they are equal partners in any drugs strategy and any AIDS strategy and that they are properly resourced to do their own work.

I am pleased that the Department for Education will offer new resources to

Here and on the next two pages – thought-provoking reactions to arguably the most significant drug policy document since the '60s

The cartoonist behind *Smack in the Eye* and Peanut Pete offers his interpretation of *Tackling Drugs Together*'s jigsaw trademark

Mike Linnell

Publications Manager, Lifeline Project

The Labour Party's response to the green paper reflected two of the major concerns of the drugs field – where is the money coming from – and where does this leave England's harm reduction policy?

schools but those programmes will have to be very sensitively introduced, particularly to those teachers who feel somewhat scarred and burned by all the furore in the past few years about sex education and the removal of HIV and AIDS from the national science curriculum.

Many teachers are now extremely wary of the whole area of personal and social education. The climate, which a few years ago produced helpful, open discussion in schools and clear direct information for pupils, has changed. It has changed because the policy messages from ministers have frankly been inhibiting and regressive. Perhaps the climate has now changed again and perhaps the green paper signals another change. But any new initiatives which try to introduce new programmes on drugs and health will need very careful nurturing.

The green paper's dominant theme is much more concerned about law and order than about public health. That is perhaps not surprising when the Government spend twice as much on control and enforcement as they do on prevention and treatment. The overall law and order tone of parts of the green paper seems to distort some of the health objectives and may even work against some of the successful work on drugs that the Department of Health itself previously supported and promoted.

Harm reduction 'ignored'

Time and again the green paper underlines the ambition of total abstinence for drug misusers. Nowhere is harm reduction explored as a suitable goal. Yet, all the evidence suggests that it has been the effective programme of harm reduction, through needle exchanges, substitute prescribing and education on safer drug use and safer sex, that has produced the stable HIV infection rate of which we are now rightly proud.

As we know, harm reduction methods are complicated and expensive, but they have been successful. The *AIDS and Drugs Misuse Update* [report from the ACMD] and *The Health of the Nation* handbook seem to reaffirm the basic tenets of the drugs and AIDS programme in this country far more strongly than the new green paper does. I hope that by presenting the green paper the noble Baroness, Lady Cumberlege – who was very much in the forefront of these programmes – is not lending the Department of Health's authority to an approach which seems to be based far more on control and punishment than on public health.

Baroness Jay of Paddington
Labour Party Health spokesperson in the House of Lords

A view from the senior police officer renowned for being prepared to 'think the unthinkable' in the search for a more realistic drug policy

Four key features of London's draft police drug strategy dovetail with *Tackling Drugs Together*:

Community consultation, what the Home Secretary called "a more responsive police service". Our police-community consultative groups and other community activities to reduce the supply of drugs will be at the heart of our strategy with local police drugs advisers. We will also work through local youth forums to build structures for local demand reduction.

Demand reduction The green paper emphasised our role in schools, not just with children but with parents, teachers and governors.

Community harm limitation, with an emphasis on prevention and education (particularly in respect of young people) to increase the safety of communities.

Active leadership and management Four of eight case studies in the green paper involve good police practice. Two were actually led by the police.

Tackling Drugs Together emphasised the *local* nature of effective action against drug misuse. London's draft police strategy envisages drug problem profiles of localities produced with other groups and used to inform a range of agencies. Such profiles show that different communities have different priorities and different problems – demanding 'local solutions to local problems'. We seek to set priorities locally so that everyone has shared ownership in the possible solutions. The aim is realistically modest – to jointly reduce harm and help reduce demand in order to relieve the social pressure exerted by untrammelled drug misuse. Only education and prevention initiatives can actually tackle the social problem.

In partnership

Partnership in lid-sitting is hard but often rewarding police work. We welcome this aspect of the green paper and are ahead of the game. Here are some examples of how we are already engaged in the partnership work called for in the green paper.

Prevention, providing total health education packages and current information to schools, and teaching teachers, parents and governors.

Cautioning policies are one way we work with other services to address the personal causes of drug misuse. Others are arrest referral schemes and getting involved with street agencies. In one Metropolitan Police division, 11 agencies were collaborating together in this way. We were pleased to see our role in this work recognised in the green paper.

Joint training with police contributing information on drug use and trading networks, recognising drugs and drug use, patterns of drug use, citizenship and personal safety – another function identified in the green paper.

Intelligence Potentially police have the best intelligence sources because of the sheer scale of our activity – 130,000 officers nationwide and a million contacts a year in London alone, touching all levels of the community. Within obvious limits, it's information we are happy to share. The green paper suggests regular liaison with HM Customs; already we have a permanent liaison officer in my Intelligence Unit. We particularly welcome the inclusion of intelligence at the heart of the police performance measures in the green paper covering enforcement against dealers and traffickers.

Commander John Grieve
Director of Intelligence, Metropolitan Police

Edited extracts from the Lords debate on the green paper, 1 December 1994.

Lord Mancroft's contribution to the green paper debate was described by Liberal spokesperson Viscount Falkland as "probably the best back-bench speech that I have heard in this House on any subject"

I see this document as a statement by [the Government] that they have finally realised the extent and the serious nature of Britain's drug problems and that they are going now to do their level best firmly to grip this problem. [It] contains a really thorough and deep review of the present state of affairs and what steps the Government at all levels have taken until now.

There are really only two ways one can deal with the drug problem. One can seek either to control the supply of drugs using the criminal justice system – or one can seek to control the demand. There are two ways of doing the latter. The first is through education and prevention, and the other is through treatment of the existing addict population.

In Britain the emphasis has been on trying to control supply via the criminal justice system, but over the past few years it has become increasingly clear that does not work, so the emphasis has switched to reducing demand, which means education and prevention on the one hand, and treatment on the other.

No evidence for prevention

Looking at the green paper, it seems that the Government have opted for education as the means of prevention. Clearly, prevention is better than cure – but only if it works.

The existing strategy for education and the proposed strategy are very much the same thing. We have had [these] policies to a much lesser extent for four, five or 10 years and during that time drug use among young people has increased.

I have not found a single study to demonstrate that if you put a [drug education] programme into schools, you will lower drug use. The assumption is that by educating children about the dangers of drugs, they will be able to make informed and responsible decisions about drug use. That is based on the idea that part of the problem is ignorance. However, the green paper openly states that on the whole, the kids know more about this than the teachers. So, if ignorance is not the problem, why would education be the answer?

We are already doing more work in the areas of education and prevention than ever before. Since 1990 the Home Office drug prevention initiative has started 1000 projects, yet drug use has doubled. We must ask whether the object of the initiative is to start projects or to lower drug use. It appears to be very good at starting projects, but it does not seem to lower drug use.

Is it sensible to set as the cornerstone of the new policy a strategy that cannot demonstrate any tangible evidence of success? I would have liked the Government to say that, based on what the [Task Force to Review Services for Drug Misusers] says, they will make a commitment to bolster treatment and fulfil the recommendations by more resources and more effort. The right sort of treatment applied in the right way at the right time works. The patient who is undergoing the treatment, the families and everyone involved derive sub-stantial benefits. If something works, let us concentrate on that.

Adrian King offers a bird's eye view of drug education in his capacity as a contact person for coordinators of health and drugs education. This is his personal reaction to the green paper

Tackling Drugs Together, if it works, will be a considerable improvement on 'tackling drugs by ourselves, any way we can', which perhaps too often describes the current picture. A multi-faceted approach is surely needed to address the disparate issues raised by drug use and abuse. Still, this attempt to find common objectives and, in these respects at least, get everyone to pull in the same direction, is to be welcomed.

Drug education received a setback when its grant funding was axed in 1993. Now it is back on the map as teachers' and youth workers' responsibilities get a boost in the green paper. Education has a vital role as young people tussle to grow in a world where experience comes cheaper than understanding. Teachers attempt to foster understanding, but their work is complicated by the persistant glut of well-meaning adults from all walks of life who feel they know best how this subject should be taught. Nothing in the document dispels this view. Let us hope that the entreaty to police and HM Customs and Excise to engage with young people will strengthen a partnership approach with schools, not undermine teachers' professional skills and judgment.

The chapter on "Helping Young People to Resist Drugs" makes no mention of the Department for Education in its Year Three tasks. Is the teacher not *central* to this chapter's targets? Surely the DfE's role is a long-term one which requires explicit financial provision and commitment to steady support beyond the three years covered by the strategy. Seven years' experience with health and drugs education coordinators shows how slow educational change can be when it involves developing specialist skills in non-specialist teachers.

So perhaps the White Paper will contain a commitment to developing initial teacher training and the creation of a corps of specialist drugs and personal and social education teachers – making the English teacher unwillingly tackling drugs education with year nine next Friday a thing of the past.

Adrian King
Health Education Coordinator, Berkshire

This vocal and effective critic of how th handled fears some key lessons fron

The government has launched a 'new' strategy on drugs which needs looking at with care. If it exists, it is important to recognise a change of heart, but not to be fooled by rhetoric. So we need both to receive the politicians' words with cautious hope and submit them to the most rigorous scrutiny.

All those concerned with drug prevention should be grateful for the new money to support local drug action teams. I hope the Government will use this to risk funding existing innovative work by people with more experience of this field than they have, not to establish new bureaucratic teams on currently fashionable lines, in which an obsession with 'cost effectiveness' and 'performance indicators' will lead to yet more paper work and neglect of people and serious thought.

In the East End of London the Maze Project has been working on prevention and education for over five years. After some years without any statutory support, we have now been saved through a combination of the local health authority and the voluntary sector. But we have lost several years through insecure funding; during this time many young lives have been damaged. Our position is typical of many voluntary projects.

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INFORMATION FOR DRUG WORKERS FROM ISDD

12 PROZAC

Recently in the news as a new kind of 'feel good' drug, Prozac is now turning up among the drugs used by drug agency clients. Prozac (fluoxetine hydrochloride) is an antidepressant introduced by Eli Lilly in 1987. It is a Prescription Only Medicine available as a 20mg green and white capsule but is not controlled under the Misuse of Drugs Act. The two main groups of antidepressants are tricyclics and monoamine oxidase inhibitors (MAOIs). Prozac is related to tricyclics in that it blocks the re-uptake of a neurotransmitter (NT) in the brain.

How does it work?

Electrical messages move around the brain from cell to cell. When a message reaches a gap (or 'synapse') between cells, it needs to be 'ferried across' by a neurotransmitter chemical released by the cell. Once the job is done, the NT is reabsorbed by the nerve cell to await the next message.

Once released, NTs also appear to affect physical and psychological functions such as temperature control, appetite, sexual functioning and mood states. Serotonin is one such neurotransmitter, low brain levels of which are thought to be linked to depression. Prozac selectively prevents serotonin being reabsorbed, making IT more 'available' in the brain and (it's thought) inducing the drug's 'feel good factor'.

Most antidepressants ameliorate symptoms of depression and make patients feel drowsy. In contrast, Prozac's action on serotonin gives it a stimulant rather than a sedative quality. Even people not diagnosed as suffering from depression claim to feel 'better' having taken it, hence its reputation as a mass market 'happy pill'.

However, many more people experience mild, chronic depression than are diagnosed as such. These people may simply be responding to the effects of an antidepressant in the same way as a diagnosed patient would. (All this supposes that depression and 'feeling good' are related to levels of serotonin, far from proven.)

What is it prescribed for?

At its recommended daily dose of 20mg, Prozac has been prescribed for a range of depressive states, plus conditions such as bulimia and obsessive compulsive disorders.

Case reports and at least one controlled study suggest that drugs such as Prozac which stop serotonin being reabsorbed might have a role in addiction treatment, for example, by lessening the reinforcing properties of the drug of addiction.

Prozac has been prescribed to relieve the 'comedown' from using cocaine or crack; to help methadone maintenance patients who use cocaine to reduce this use by reducing their craving for cocaine and the 'quality of the high'; and in the treatment of heroin addiction, again to curb craving and to relieve withdrawal symptoms such as sleep disturbance and depression.

What are the risks?

Physical The most likely side-effects of Prozac include insomnia, headaches, nausea, dryness of the mouth and jitteriness – not unlike those associated with amphetamine. Other possible effects include skin rashes, loss of coordination and tremor. The drug is not recommended for those with liver or kidney problems or epilepsy and should not be given to pregnant women or breastfeeding women. So far there does not appear to be a withdrawal syndrome associated with Prozac nor is it easy to overdose on. One case report records that a psychiatric patient with a history of drug misuse injected Prozac daily.

It is very dangerous to take Prozac while taking MAOIs such as Nardil, Marplan or Manerix. This can cause very high blood pressure, vomiting and shock and should be treated as a hospital emergency. Prozac has an exceptionally long half-life of two to three days and one of its metabolites is still detectable up to five weeks after last use. Official advice is that someone on Prozac should not switch to MAOIs without a break of at least five weeks.

Psychological Here the picture becomes confused. There is a best-selling book in praise of the drug and a Prozac Survivors' Support Group – an indication of how far 'out' the jury is on Prozac.

It takes around two weeks for the drug to start working. Some people give up before that because of the side-effects. Some continue but feel no improvement in their condition. There have been a number of press reports about patients committing suicide or acts of violence due to the effects of Prozac and some case reports on Prozac-induced mania. In this state, patients might become very agitated and over-excited with grandiose delusions. From the limited literature, those who have reacted most dramatically to the drug are on higher than recommended doses and/or have a long history of psychological disturbance. However, medical advice is to carefully monitor anybody on Prozac who might have suicidal tendencies.

Arguing against Prozac being seen as 'addictive' is the fact that its use does not seem to result in drug-seeking behaviour. Those who take it regularly may wish to carry on doing so because it alleviates their depression.

Non-medical use

Prozac increases levels of serotonin; serotonin, LSD and ecstasy all act similarly on the brain. This may be related to evidence that Prozac has a presence on the drug scene. It would seem prudent to suggest people do not mix Prozac with other drugs or alcohol, though the literature on possible outcomes is sparse. Two case studies suggest a possible link between mania and the use of Prozac with LSD and cannabis respectively. Because fluoxetine has been shown to block MDMA neurotoxicity, some users in America take Prozac before ecstasy as a 'harm-reduction' measure which does not lessen the ecstasy experience.

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© Institute for the Study of Drug Dependence (ISDD) 1995. Written by Harry Shapiro. With thanks to Professor Malcolm Lader of the Institute of Psychiatry, Dr John Ramsey of St George's Hospital Medical School and Dr Andrew Herxheimer.

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Legalisation 'fudged'

In what is generally a very serious and good paper, one element appears to me to be rather facetious and light. [Legalisation] is probably the most important issue in the drug world today. If you destroy a black market, take it over and lower the price, people are not going to steal to raise the money.

Would the benefit, in terms of reduced crime, be heavily outweighed by the human cost of widely increased drug dependence? If we can control and destroy the black market we would inevitably make drugs more available. If they are more available, how many more people will take them? We can make some reasonable assumptions.

The danger area is those aged 10 to 30. They are the ones identified in the green paper as currently taking drugs in ever-increasing numbers. We need to direct our services towards them but we cannot direct the services that we would like because so much money is tied up in the criminalising and policing of drugs.

Lord Mancroft

Conservative backbench peer

e last great shake-up in drug policy was the late '60s have yet to be learnt

It is good that the Government has now recognised the importance of prevention, but they have done so very late in the day; a lot of ground has already been lost. After so much damage, in many areas true prevention is no longer possible – one cannot prevent what has already occurred. The scale of drug use today means much drugs work now is bound to be containment and harm reduction.

The most disappointing aspect of the strategy is its failure to see how drug policy has *itself* helped produce the present appalling situation. We never had illicit powder heroin, or criminal syndicates in the drug scene, until after 1968. The correlation between heroin/cocaine use and chronic unemployment is a post-80s phenomenon. Britain has followed US urban policies (including drug policies) in all those respects where they have most conspicuously failed. Now not only doctors and youth workers but senior police officers are saying this loudly and clearly. Home Secretary Michael Howard seems unable to hear. But until the damage due to policy is recognised, there will be no substantial improvement.

Reverend Kenneth Leech

Anglican priest and community-based theologian, St Botolph's Church, Aldgate, London

Its very title suggests partnership is the key to *Tackling Drugs Together*. Northamptonshire provides one of the clearest examples of local partnership work in Britain, and the voluntary Council on Addiction headed by Robin Burgess is at its heart

Tackling Drugs Together is a visionary document. It is a source of amazement that a sustained intellectual line flows through the document, resulting in the most consistent and comprehensive directive on social policy for drug misuse ever to have emerged in the UK. As such, it questions some of the key principles that underlie funding and organisation of services.

The green paper escapes the narrow consensus of previous drug policy. This located responses principally in terms of individual pathology, HIV and AIDS, and the medical model. *Tackling Drugs Together* says that drug misuse is bigger than AIDS – maybe as big as any problem facing society – and that its implications are primarily social, not medical. It may not explicitly mention poverty, unemployment or social disintegration, but they are there on every page, unseen presences at the feast of ideas. Drug misuse is recognised as a socially destructive force ... and for the first time, here is a policy that says: this must not happen because the cost *to society* is too great. In this sense it is a *political* document.

The next stage of the development of the strategy must be free of suggestions that the current draft denies the individualistic nature of addiction, fails to address HIV, or is the product of right-wing, anti-free choice, drugs-are-evil values. The writers must ensure they do not water down their message by listening too hard to these voices.

However, if its vision is going to develop with its basic values intact then it has to alter one key point: the location and funding of the coordination of the drug action teams. The programme these will need to coordinate will frequently lie outside the intellectual environment of health purchasers (and many NHS drug teams); locating coordination with health authorities runs contrary to the sustained drive of the document. Throughout, it points to one locus of coordination: the local authority. Central government animus aside, only local authorities have the breadth of vision to carry the thing through unscathed.

The voluntary sector should be cheering. Some may whinge about being left out of the action teams; others will raise issues of human rights. Most should see the draft strategy as a lifeline, the reordering of drug policy to the tune that voluntary drug agencies have been playing, often single-handedly, in the face of blank health authority stares.

However, redirection of funding is needed to make it work. *Tackling Drugs Together* will only become a reality if we get a level playing field with equal access to NHS finance for both NHS and voluntary providers. If funding continues to be shovelled into projects which only operate on about one third of one of the strategy's key objectives, whilst the voluntary sector has to compete for every last pound, the document will become another sad, wasted footnote in UK drug policy.

Robin Burgess

Chief Executive of the Council on Addiction for Northamptonshire

Visionary ... escapes the previous consensus

Robin Burgess

Where are the resources to make it work?

Labour Party

No evidence prevention works

Lord Mancroft

It's better than 'tackling drugs by ourselves'

Adrian King

Drug policy has helped produce this appalling situation

Kenneth Leech

Cleverly crafted... highly pragmatic

Anna Bradley

We're already doing it.

John Grieve

Drug user lifestyles and peer education

This research shows how social networks of drug users – previously attacked as spreading drug use – can be central to the harm reduction effort. The findings contribute to a radical shift in how we view drug users – as part of the solution, not just part of the problem

by
Robert Power
Steve Jones
Gerry Kearns
Jenni Ward

Centre for Research on Drugs and Health Behaviour, London

SUMMARY

Research among heroin, cocaine and amphetamine users in three areas showed how peer education and outreach can build on informal risk-reduction strategies. Only by understanding these can services dovetail with drug scenes and with the lifestyles of those they target. Locally targeted interventions based on action research are essential, but regional consortia of agencies should develop strategies and guidelines to help ensure that these reflect best practice and research evidence.

The ACMD's latest AIDS report[1] stated that outreach aimed at drug users should now emphasise peer education and maximising new contacts. This involves targeting social networks of drug users, identifying the social factors that underpin high-risk behaviour, and encouraging behaviour changes that fit into drug users' lifestyles. For all this we need detailed 'ethnographic' research describing drug users' daily routines – we need to know what they are doing before we can decide what needs to be changed and how best to change it.[2,3]

This article summarises one such study (our own) and shows how qualitative research can be of practical help in devising peer education outreach initiatives.[4] It involved samples and networks of regular users of heroin, cocaine and amphetamine, in three areas: inner London, a Midlands town ('Midtown') and Hertfordshire.

Using the networks

For practical and functional reasons – often connected to obtaining drugs – drug users tend to form social networks. Most respondents in our study were in contact with other drug users. These networks overlapped, highlighting the potential for using key individuals as indigenous advocates and peer educators. Almost unwittingly, the ACMD's suggestion that networks of drug users should be the targets for detached work is a radical rethink that reflects the reality of drug users' lifestyles. Like train spotters, hill walkers and wine connoisseurs, illicit drug users operate in networks with focal points, meeting places and methods of communication. These are our main findings about the networks we researched.

The shapes of drug users' social networks affect the potential for health advocacy The structure of these networks and the activities they mediate depend partly on the drug market they operate in. In our research the more diverse, hence more anonymous, London drug scene contrasted with the tighter networks in the other two sites; respondents from London had many more drug using contacts but fewer friends among these contacts.

Primary drug of choice and how it was taken also influenced the user's social network. Networks based on heroin use were more cohesive than those based on amphetamine and cocaine. Users of these drugs (who were more likely to be non-injectors) had more non-injecting friends than did heroin users; heroin users had more injecting friends.

Drug user relationships were commonly founded on the need to maintain drug supplies. This mutual aid may be threatened when supplies are short and users are forced to act more individualistically. Then the drug user 'grapevine' becomes even more important as a medium for communicating drug availability, quality and prices, if not for actual drug supply. Offshoots of the grapevine often linked different networks through common contacts.

For public health purposes, this grapevine – informal and nebulous as it is – offers a way of disseminating information. One of the key tasks is to identify and enlist well-connected individuals within drug user networks who can be used to convey updated and relevant health messages. This happens when agency clients tell peers about the activities and offerings of local services. Among those not in contact with services, we need to be proactive in identifying nodal points for disseminating information.

Identifying roles and rules within social networks helps target interventions We found that the cohesiveness of drug users' networks was influenced by factors such as the drug used, local drug economies, population density, and wider drug trends. London had fully functioning, open street drug scenes; there were no such venues in Midtown or Hertfordshire. Amphetamine tended to be distributed in semi-public venues such as public houses while cocaine and heroin might be traded on the street.

Information on drug use and dealing arenas is clearly essential to outreach interventions. It is also important to catalogue the social landscape – the rules that bind social networks and the individuals who enforce them. This helps us interpret the social interactions that encourage

IMPLICATIONS FOR COMMUNITY-BASED SERVICES

To influence any interest group you need to understand its functions and contact key players and influential opinion leaders. High-status individuals, from specific populations of drug users have an important role as indigenous advocates in promoting health and peer education. By way of illustration, let us explore the increasingly recognised phenomenon of sharing of injecting paraphernalia.[9,10]

First, simple things can be done. The degree of risk involved in filter and spoon sharing is unknown,[11] but let's be safe rather than sorry. The message, preferably delivered by ex- or current drug users, should be, *Don't share or borrow or pass on or muddle injecting equipment. (P.S. This includes your lover, your friend, your running mate, Uncle Tom Cobbly and all).*

We need also provide the means to achieve this. So injecting packs should include all that is needed; syringe, needle, swabs, sterilised water, filter. Some projects have provided needles that incorporate a filter.[12]

Build on existing behaviour

Spoons may be a problem. These are used to heat the drug solution to prepare it for injecting, and form part of the routine of apportioning drugs. One way to sidestep this (tried in Holland) is for each kit to include a small plastic calibrated container for measuring out the 'hit'. A steady hand may be needed to pour the solution from the spoon into the container, but if the risks are made clear then we are in with a shout of changing this aspect of drug injectors' routines. Such innovative technologies need to be market tested among the target group and rigorously evaluated.

Peer education needs to build on drug injectors' existing informal strategies. Drug agencies need to know what goes on out there, not just yesterday, but today and tomorrow. Only by understanding the nuances of behaviour amongst networks of drug users, and plotting these on a continuous basis, can we provide services that dovetail with prevailing drug scenes and reflect, rather then conflict with, the lifestyles of those we target. Such research should be seen as integral to the development of services, not a threat. The type of work done by Hunt and his colleagues in Maidstone should be applauded.[13]

Again, simple things can be put in place under the rubric of what may broadly be termed action research. Outreach workers can routinely report shifts in drug scenes and behaviours. Focus or discussion groups can be held with agency clients to examine lifestyles and daily routines. Such simple but important information will keep service providers abreast of local drug scenes. Yesterday's heroin injector is not today's crackhead; just as the MDMA raver from the Summer of Love differs markedly from the clubgoer of today.

Locally relevant interventions are important, but one of the main criticisms of outreach work has been its lack of strategic direction. This not only relates to carving up the territory and agency strategies, but also to overall aims. A little autonomy is important (especially to encourage imaginative responses); too much can at best lead to wasteful duplication, at worst to an inefficient and inappropriate service. Sometimes 'autonomy' is used as an excuse for ignoring good practice and research evidence.

Coordinated autonomy

Most drug workers will know that the flavour of the month is peer education with ex- (and dare we say it again, current) drug users acting as indigenous fieldworkers. Research suggests this can make a valuable contribution to harm minimisation.[14,15] But we must develop coherent and workable models of peer education that are relevant to the local population.

To this end, we should consider consortia of agencies (certainly at regional level) to develop these strategies, plus guidelines of good (as in 'effective') practice. This will help ensure that locally relevant interventions evolve and are effective, as well as underpinning resource allocation at regional level. Action research needs to be an ongoing facet of such initiatives and groups such as the national detached workers' forum and drug user advocacy groups should be involved at the outset.

protective strategies or sustain high risk activities and identify ex- or current drug user who might act as peer educators.

In the networks we observed, some behaviours (like being too chaotic) were grounds for exclusion from the group and its support mechanisms, a process exemplified by one well-established London network. Founded on the sale and use of heroin and cocaine, its core established members passed advice and information to new or casual recruits to the network on issues such as the dangers of needle use and sharing, inappropriate drug combinations, and how to seek help. Advice was delivered spasmodically, arbitrarily, and informally, in the context of getting on with the main business of buying, selling and taking drugs.

For reasons of group security and cohesion, persistently chaotic members were eventually excluded from the network, but still gained in health terms from their temporary membership. A positive by-product was that excluded drug users could carry the informal health education gained while part of the network across to other groups of drug users, often more chaotic and younger both in years and in their drug careers. Such informal peer education should be built on and incorporated into innovative outreach interventions.

Stigmatisation of injecting was common Drug users who did not inject commonly stigmatised those who did. By using indigenous advocates as peer educators, this stigmatisation could help health educators discourage injecting.

But there is a risk of this tactic backfiring. Afro-Caribbean heroin injectors reported being doubly stigmatised: within their own communities, heroin was not seen as an acceptable drug, and injecting it was often labelled 'white junkie' behaviour. The result is that black drug injectors tend to be alienated from both drug using networks and from wider Afro-Caribbean society. In turn this is likely to lead to unsafe injecting practices.[5] Interventions using the indigenous advocate model need to be tailored for for these special situtations and groups.

Risk-reduction strategies

Everyday strategies to control drug use and injecting risks were common.

Controlling drug use Nearly three-quarters of the sample of 100 drug users reported some measures to control their drug use. The most common were to buy small amounts and divide drugs into smaller portions. Most (especially heroin users) took periodic breaks from drug use by leaving the area. This often involved

HOW THE RESEARCH WAS DONE

The research was funded by the Department of Health and took place from October 1991 to September 1993. A primary aim was to provide qualitative data to help existing and new interventions be more relevant and accessible to drug users.

The study involved samples and networks of regular users of heroin, cocaine and amphetamine sulphate in: an inner city area of London; a Midlands town ('Midtown'); and the semi-rural county of Hertfordshire. Respondents were recruited by 'snowballing' through existing contacts and 'cold' contacts at venues where drug users congregated.[16] Ethnographic fieldwork and participant observation facilitated by local drug users in each of the sites, employed for their knowledge of, and access to, local networks of drug users. Employing those with a drug using background as 'indigenous fieldworkers' has been discussed elsewhere.[17]

The principal methodologies were: a semi-structured survey of 100 drug users; focus groups; in-depth interviews that recorded details of their daily lives; and participant observation. Except for focus groups, each method was used in all the sites.

Of the 100 respondents to the survey, 58 were from London, 25 from Hertfordshire and 17 from 'Midtown'. There were two males to every female. Sixty-six per cent were 'white British'. Heroin was the drug of choice for 69 per cent, amphetamine sulphate 18 per cent, and cocaine 13 per cent. Polydrug use was common. Seventy per cent were current injectors.

staying with non-using friends or family, suggesting a role for these in encouraging harm minimisation and healthy lifestyles.

Other main control strategies included: testing the quality of drugs before purchase; substituting one drug for another (such as methadone for heroin or Dexedrine for amphetamine sulphate); and using drugs in a measured and controlled way.

The most common strategy for assessing quality was relying on a (trusted) dealer. Whether quality could be directly tested was related to how much was bought and where. Purchases under a certain amount rarely allowed for personal testing and the risk of being observed in open street dealing venues demanded a swift transaction which precluded testing. Prescribed drugs were commonly obtained to be shared, bartered or sold in times of shortage or as an alternative to the primary drug.

Any peer education activity needs to build on these informal coping strategies. Strategies used to control drug use should be encouraged and disseminated to other drug users by indigenous advocates.

Coping strategies related to injecting We know that drug injectors adopt personal protective strategies.[6,7] Our findings show how these form part of injectors' daily routines. This has implications for fitting interventions into the everyday lives of networks of drug injectors.

Ensuring a supply of new equipment and re-using their own syringes (often personalising them to prevent accidental sharing) were the most popular strategies to reduce the chances of sharing. None of our respondents were regular syringe exchange clients. Their main sources of new injecting equipment were a pharmacy, followed by a dealer, who may well be a friend. Four-fifths of the injectors had at least one other source of syringes. Other strategies to prevent syringe sharing were keeping spare needles and syringes around the house, leaving injecting equipment with non-using friends, going to dealers known to provide fresh equipment, and replenishing supplies when down to the last needle and syringe in a pack.

These strategies mean pharmacists and, in particular, user/dealer friends can play an important role in ensuring syringe availability. Outreach workers and peer educators should encourage drug users who obtain syringes from pharmacies and syringe exchanges to act as secondary distribution points, supplying especially those who are not regular syringe exchange clients. However, we must be cautious in how we engage active drug users in peer education. Any outreach initiative must be aware of the potential risks to their safety and well-being.

Protective strategies were in evidence even when syringes were re-used. Cleaning injecting equipment was common, though rarely efficient. Most popular was flushing/rinsing with water. Some were more rigorous when using another's syringe, as opposed to re-using their own. The few who used bleach or disinfectant were mainly those who used drugs in the privacy of their homes. Most injectors placed greater emphasis on the provision of sterile equipment, but indigenous advocates clearly have a role in educating on the best cleaning methods – especially given recent evidence that only at full strength is bleach effective against HIV.

Situations in which syringe sharing took place Several factors were commonly linked to the non-availability of new equipment, leading to the sharing of injecting equipment. These echo observations since the mid-80s and included: being in a sexual relationship with another injector; the immediate need to use drugs (especially at night); withdrawal; intoxification; and being in situations or places where injecting equipment was scarce. Isolation or exclusion from social networks was liable to lead to high-risk activity as the user resorted to unfamiliar sources of drugs, such as street dealing scenes. High-status indigenous advocates could have a role here, providing sterile injecting equipment in street drug arenas and other high-risk 'hotspots'.

Drug injecting paraphernalia as an HIV risk factor Most injectors in our study reported sharing injecting paraphernalia, such as filters and spoons, commonly seen as a low-risk activity. Contributing to this was the fact that drug users were wary of carrying injecting paraphernalia, believing this might be used as evidence against them if arrested. Filters were used as an emergency drug supply in times of shortage and sometimes exchanged for other drugs, particularly pharmaceutical ones.

Social etiquette played an important part in the sharing of filters. Drug users would often find themselves injecting in another drug user's house; in some networks, used filters were commonly left behind for the host – both a courtesy and payment in kind, as after injection a residue of drug is left in the filter.[8]

Education about the risks of paraphernalia sharing and practical alternatives to sharing this equipment can be promoted by indigenous advocates, with the aim of changing the social attitudes and etiquettes that sustain this behaviour. We need to make clear to injectors that sharing any and all injecting paraphernalia can risk infection.

THESE FINDINGS have substantial implications for community-based services, explored further in the panel on page 15; in a nutshell, we have a fair idea of what works:

- peer education using respected 'indigenous fieldworkers';
- flexible (and imaginative) outreach interventions that incorporate an action research dimension;
- strategically planned and coordinated initiatives that involve agencies collaborating in inter-agency consortia.

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A book with illustrative material from this study and which draws out its practical implications for service providers is now available from: The Tufnell Press, 47 Dalmeny Road, London, N7 ODY. *Coping with illicit drug use* by Robert Power *et al* (ISBN 1 872767 17 6) costs £4.99 inc. p&p.

What is 'sharing'?

Are we double-counting the number of people at risk from sharing injecting equipment?

DRUG SERVICES were given one clear target in the Department of Health's *Health of the Nation* (1992) strategy and in the associated *HIV/AIDS and Sexual Health* (1993) key area handbook. The aim was "to reduce the number of injecting drug misusers who report sharing injecting equipment in the previous four weeks" – more precisely, to halve the sharing rate from a baseline of 20 per cent of injectors in 1990. This baseline is a good estimate derived from research at the Centre for Research on Drugs and Health Behaviour and the Public Health Laboratory Services' collaborative survey (the 'spit tests').[1]

Questionnaires used in both studies asked about lending and receiving equipment. The Centre for Research asked:

1. "... did you inject with a needle or syringe that had already been used by someone else?"

2. "... did you lend, pass on or let someone else use one of your used needles or syringes?"

If the answer to *either* question was positive the respondent was deemed to have shared.

Similarly the PHLS study asked:

1. "... to how many people have you passed on used needles or syringes ...?"

2. "... from how many people have you received used needles or syringes ...?"

These questions, or something like them, have continued to be used in other surveys.

Either a lender or a borrower?

There is a logical fallacy here. Imagine 20 drug users, 10 called Smith and 10 called Jones. Each Smith is friendly with a different member of the Jones clan. All the Smiths go to their needle exchange and always inject with clean equipment, which they then pass on to their friend among the Jones's. Then a researcher asks each whether they have passed on *or* received injecting equipment.

All the Smiths would say 'Yes', they have passed on equipment; all the Jones's would say 'Yes', they have received equipment. The sharing rate would be reported as 100 per cent. *But only 50 per cent, the Jones's, are at risk of infection from contaminated equipment.* We would have overestimated the risk behaviour of this sample by a factor of two. If we want to know how many people are at risk from blood-borne infections, we should define sharing as using *injecting equipment that has been used by somebody else* (including needles, syringes, spoons, water and filters).

Though this is logical, does it make any sense in the real world? One could argue that there are likely to be very few drug injectors who pass on used injecting equipment but never receive it from others. Even if this were true, it would not eliminate the error. There would be less of an overestimate of the *number of people* who have shared, but we would still double-count the *rate* at which they shared, as each would be counted once as a receiver and once as a passer on.

Counting *either* receiving or passing on used equipment as sharing may not make sense if we want to know how many people are at risk of infection, but it does make sense if we want to know how many we could target for risk-reduction messages. In the example above, all the Smiths and the Jones's should be encouraged not to pass on or receive used equipment.

There is a logical fallacy in how we count 'sharing'

Consistency is the key

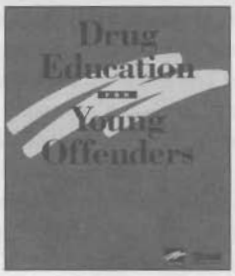
In East Anglia in 1993 we tried a questionnaire which did not attempt to define sharing but just asked, "When did you last share any works? (This includes needles, syringes, spoons, filters and water)". Learning from the advertising industry, we used a single sheet that could be folded and stuck with the FREEPOST address showing, and then just popped in a post box. This seemed to work well, and we have repeated the survey in 1994. In 1993, 22 per cent of respondents admitted 'sharing' in the past four weeks, falling to 12 per cent in 1994.[2]

Workers at the Drug Research Unit of the University of Manchester adapted this questionnaire for their own survey in 1994. They are trying very detailed sharing questions and have still managed to limit it to one side of paper.

Of course, the 'true' rate of sharing will never be known, but progress towards targets can be estimated by examining trends over time. To have confidence in trends means that surveys have to be repeated, consistently asking the same questions in the same way, either of the same people, or of people selected in the same way. One problem with not doing this in the same way nationwide is that cross regional comparisons are complicated, perhaps impossible. I hope this article stimulates some more debate on what we are trying to find out and why we want to know, so that we can agree on the essential questions and the methods used to answer them. ❍

from
Stephen Green
Health of the Nation, Anglia and Oxford Regional Health Authority, Union Lane, Chesterton, Cambridge, CB4 1RF, phone 01223 375331.

1. The Centre found a sharing rate of 21 per cent among 869 attendees of 20 syringe exchanges in England. The PHLS reported rates of 18 per cent in 1990 and 19 per cent in 1991.
2. Copies of the report of the 1994 survey can be obtained from the author.



Probation services 'won't find better'

DRUG EDUCATION FOR YOUNG OFFENDERS. TACADE, 1994. Ring-bound folder. £29.95.

Anyone in probation knows the worrying extent of substance use-related offending, and the widely ranging capacities of staff to respond in a helpful manner. This manual addresses the needs of probation officers and of our clients in a very comprehensive and constructive manner; little is left to chance, everything has been anticipated and programmed, like those manuals that enable your average weekend mechanic to aspire to a full engine transplant.

It offers a compendium of activities and strategies to support probation staff working with young adult offenders who use drugs. It is not the first to do so, but it is by far the best I have seen, a fine example of careful research and planning based on sound educational principles and an appreciation of current theories on substance use and the nature of change. When many drug education materials pander to the latest design imperatives, resulting in groovy but vacuous publications, these are refreshingly clear and simple.

The manual and curriculum result from over two years' research with two probation areas. "Key principles" are the minimisation of drug-related harm, a reduction in drug-related offending, and the promotion of responsibility in drug use. The teaching strategies, which may be applied in groups or individually, promote active, participatory learning.

The syllabus is organised into Guidance Notes and five Activity Units, each with up to 19 sessions lasting 15 minutes to half a day. Some activities will be familiar but many are newly devised; all have been carefully prepared to be appropriate and sensitive to the widest range of client needs.

My only criticism is that it does not sufficiently recognise how being regarded as (and regarding yourself as) 'dependent' can be a driving force in long-term substance use. But, insofar as it is possible to devise an all-inclusive curriculum applicable across the country, this is 'state of the art'. All probation divisions should buy a copy – not for the bookshelf, but for constant use; they won't find better.

Jeff Allison

Divisional Substance Misuse Officer, West Yorkshire Probation Service

Drug Education for Young Offenders *is available from TACADE, 1 Hulme Place, The Crescent, Salford, Greater Manchester M5 4QA.*

Help with a crucial task – educating prisoners about the risks of drug use

DRUGS AND OFFENDING. Council on Addiction for Northamptonshire, 1993. Video pack. £69.

At the Prisoners' Resource Scheme (PRS) we do a lot of group work with offenders in prisons and struggle to find suitable health education materials. *Drugs and Offending* takes a harm reduction approach, using the Prochaska/DiClemente model of behaviour change (who doesn't these days?). It contains a video, board game, information leaflets, and game cards for a six-week course, plus guidance on using the materials and on assessing prospective participants.

We tried some of the exercises in a group we run in a category B long-term prison. The simplest one – cards on the dangers, methods of use, legal status, etc, of different drugs – went down a storm; the session was filled with debate on the merits and drawbacks of the various drugs. It was "interesting", "educational", "challenging" and "made me think".

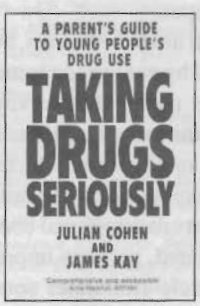
The video of a drug user's unhappy progression from financial difficulties to becoming a victim of crime was seen as "too tame". Clean-cut actors and the avoidance of the seedier aspects of life conspired to "glorify drug use". Although it didn't suit the Barry Norman in them, if the objective was to stimulate discussion, again it worked. Our worker thought it would go down better with a younger, less experienced group. The case studies exercise also easily and profitably filled the two-hour session.

This resource pack offers little that is new (see publications from Healthwise, TACADE, and ILPS), but has a structured, easy-to-use format, and adopts the sort of pragmatic approach we can work with. The need it doesn't meet is for materials with a particular resonance for prisoners, whose choices around drug use are inextricably linked to prison life. Now that would be interesting.

Kenroy Cole

PRS, London

Drugs and Offending *is available from Council on Addiction, Spring House, 51 Spring Gardens, Northampton NN1 1LX, phone 01604 233227.*



A revealing comparison of two attempts to advise and inform parents

TEENAGERS AND DRUGS. John Davies and Niall Coggans. Booklet and audio tape. £10.95 inc. p&p.
TAKING DRUGS SERIOUSLY. Julian Cohen and James Kay. Thorsons, 1994. Book. £4.99.

Both these attempts to advise and inform parents start by reassuring them that most young people's use of drugs is experimental and non-problematic. But the audio tape understates the potential harm from illegal drugs. It also fails to explore the dangers of alcohol and tobacco. The life-threatening aspects of volatile substance abuse are mentioned just once, by a parent. Also ignored are the dangers of HIV/AIDS arising from injecting or unprotected sex while intoxicated.

The tape has very good sound bites from young people and parents, but sometimes these give inaccurate information. One ex-user says drug use is an experience "most young people are going to go through". This is not directly contradicted, though later the presenter points out that only about one in five young people try illegal drugs. On side two of the tape a parent tells of a drugs squad raid on her house in the middle of the night and a daughter who injects: suddenly teenage drug use doesn't seem so harmless and transitory. How is this helpful to the concerned parent, who has perhaps been over-reassured by side one? The booklet with the tape has a brief guide to drugs and their effects and draws usefully on Niall Coggans' research on drug education. Again, negative effects of drug use are downplayed.

Taking Drugs Seriously is more comprehensive and more measured. It reassures, but is more careful to identify dangers. It is also more fun; there are quizzes and an exercise to draw a graph of your drug career. Many of the short quotes from parents and young people stress the importance of parents listening to teenagers. An excellent exercise asks parents to rate their abilities as a listener, and then ask their children to rate them as well. A helpful short chapter covers setting rules. Detailed information is provided about different drugs, their effects and legal status. This is a useful, detailed and accurate book for parents worried about drugs. Workers with parents could also draw on the exercises. It's also cheap. Recommended.

Richard Ives

Teenagers and Drugs *is available from TSA, 23 New Road, Brighton BN1 1WZ, phone 01273 693311.*
Taking Drugs Seriously *is available through bookshops.*

LESBIAN, GAY OR BISEXUAL? YOU CAN HELP NEW PROJECT

Calling all queers! Project LSD (Literature and Services on Drugs) is a new lesbian, gay and bisexual drugs outreach and education project. We are an independent group of queers who were fed up with the lack of accurate, non-judgmental drugs information and services targeted at the diverse lesbian, gay and bisexual community. We started in late '94 with a grant from Hackney Drugs Prevention Team.

We are producing our own leaflets on safer drug use to use with our outreach service in clubs and pubs (also available for bulk sale).

In November '94 we conducted a drug use survey at Winter Pride (contact us for a copy) and would like to conduct needs assessment surveys of drug users in the lesbian, gay and bisexual communities.

We need your help and experience as lesbians, gay men and bisexuals working in the drugs field. Please let us know you exist!!

Contact: *Project LSD, Box 9, 136-138 Kingsland High Street, Dalston, London E8 2NS, phone 0181 806 7353.*

ON OFFER – GUIDELINES ON DRUGS ON HOSPITAL WARDS

I recently coordinated the drawing up of guidelines for the appropriate course of action that staff in hospital should take if they suspect or discover that a patient in their care is using an illegal drug in hospital. The guidelines have been adopted by our local NHS Trust.

If anyone would like a copy of these guidelines, please let me know.

Contact: *David Keech, Clinical Nurse Specialist/Manager, Alcohol and Drug Advisory Service, Salisbury Health Care NHS Trust, 139 Fisherton Street, Salisbury, phone 01722 412632*

DRUG SERVICES FOR AGE 16s AND UNDER

Thanks to those individuals who responded to the recent request for information/advice on working with under 16s. Although the response was limited it was appreciated. Any more information welcomed.

Contact: *Pam Fields, Wigan C.D.T., Meeks Building, Bretherton Row, Wigan WN1 1LL, phone 01942 826880*

HELP STUDY DRUG COUNSELLOR SUPERVISION

I am currently undertaking a Diploma in Multidisciplinary Studies of Drug Misuse at Ruskin College, Oxford. For my dissertation I am researching "Supervision of counsellors in the substance misuse field". So far I have uncovered very little specific material and would therefore be grateful if any information on articles, books or dissertations could be passed to me.

Contact: *Madeleine Comben, The Community Alcohol Service, 342 Oxford Road, Reading RG3 1AF*

EXPERIENCE OF PROMOTING RURAL NEEDLE EXCHANGE?

Ayrshire and Arran Addiction Services Team are currently managing the expansion of their needle exchange facilities. This is an area of small towns and villages where confidentiality of those approaching and using services requires careful consideration.

We are currently looking at options for advertising these services in a form which is appropriate for the area. To complement the usual posters and flyers we are considering other advertising formats, including message bearing cigarette lighters, toothbrushes, etc.

Any feedback on experience of similar attempts would be most welcome.

Contact: *Stevie Lydon, Senior Health Promotion Officer (Addictions), Addiction Services Team, The Bentinck Centre, East Netherton Street, Kilmarnock, Ayrshire KA1 4AX, phone 01292 610556*

A&E RESEARCH CONTACTS SOUGHT

I am interested in liaising with an accident and emergency department with a view to setting up a monitoring service of the number of drug-related incidents. I would be grateful to hear from anyone who is doing anything similar, or who has any information.

Contact: *Jo-anne Hardman, Trafford Community Drug Team, Chapel Road, Sale, Cheshire M33 1FD, phone 0161 962 8810*

OPIATE USE FOR SERIOUS ILLNESSES

One of our clients uses heroin to relieve the effects of muscular dystrophy and diabetes but doctors will only prescribe methadone, which adversely affects his diabetes. Can you help him with information relating to:

1. people using opiates to relieve the combined effects of muscular dystrophy and diabetes; and
2. being prescribed opiates for one or both of the above conditions.

Contact: *Bill McIntyre, SHADO, 120 Stonebridge Lane, Croxteth, Liverpool L11 9AZ, phone 0151 546 1141*

DRUG link highlights from 1994

January

- The legalisation debate
- New concepts in HIV/drugs outreach

March

- The market for drug services – a reassessment
- AIDS and drug policy – revolution or revision?

May

- The argument for peer education
- Prescribing amphetamines

July

- Steroids misuse – the first national assessment
- The dangerously different meanings of 'sharing'

September

- Race and drugs in Tower Hamlets
- How fear campaigns can backfire

November

- New English and Scottish national drug strategies
- Peer pressure debunked

DRUG link isdd Institute for the Study of Drug Dependence • Waterbridge House • 32-36 Loman Street • London SE1 0EE
To order: use the new publications order form opposite page 13 or phone ISDD on 0171 928 1211

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