Election special: toughing it out at the ballot box

Before you vote, read Druglink! Everything you ever wanted to know about the parties’ line on drugs is here, from the Tory wish for Britain to become ‘the Singapore of Europe’ to Labour’s pledge that the national strategy might have ‘some slightly more distinctive things’ under a new government (page 8). We’ve also got the background behind some of the ‘big ideas’ doing the rounds in political circles, and a warning that the ‘treatment lobby’ should be on its guard (page 12). Prescribers should also get their philosophical act into gear (page 16) but the Drugs Prevention Initiative already has, according to its boss (page 15). Finally (page 4), the grandaddy of the drug field, the Addict Index, fades away – but will anyone notice?

The party line

With the election only a few weeks away, we ask the main political parties where they stand on drugs. Aside from falling over themselves in the scramble for the moral high ground, plenty was said about sentencing, the media, legalisation, education . . . and Oasis.

New ideas in the field

While the politicians argue about strategy, some new and innovative ideas are creeping into the debate. Philip Bean introduces a couple of them and warns drug agencies that their day in the sun could be nearing its close.

Preventing confusion

In the last Druglink, Tony Newton suggested the Home Office could ‘review’ the Drugs Prevention Initiative. Some people took this to mean that the DPI was in trouble. Not so, says its head, and here Lorraine Rogerson explains why.

Substitute prescribing: social policy or individual treatment? (and why we must make the decision)

Politicians aren’t the only ones with ideologies. Prescribers can find many ways to justify their actions, but it’s about time they tightened up their thinking. Or else, says Duncan Raistrick, ‘the scrib’ could become a thing of the past.

NEWS

Noel Gallagher’s ‘cuppa’ has come in for a lot of attention in recent weeks (you can read what he said here) but the whole brouhaha exposed how weak politicians’ grasp is on ‘public opinion’. A weak grasp on the law has been shown by others, as poppers sink into a legal quagmire (we won’t say we told you so), but Druglink’s very own Mystic Meg sheds a tear or two as the Addict Index finally winds up. Meanwhile, they’ve been thinking the unthinkable in south London – DATs are useless shock horror.

CONNECTIONS and LETTERS

Responses to Newton and funding alarm bells, while support is, as ever, sought.

REVIEWS

A new handbook gets a hammering, but advice on family support is warmly received.

LISTINGS

Publications, Meetings, Conferences.

Cover photo: The three main party leaders share a joke [courtesy of PA News]
End of Index barely registers in drug field

Some doctors are already being told not to bother re-nurturing clients to the Addict Index, and unless there’s an eleventh hour change of heart, a parliamentary announcement will shortly close the book on half a century of British drug history.

Ministers are about to sign off on the Home Office Addict Index which until recently was the only official indicator of the size of Britain’s drug problem. Established in 1935, the intention of the Index was to reduce the opportunities for ‘dual scripting’, when drug users build up their supplies by going from doctor to doctor.

It also became symbolic of the liberal nature of the ‘British System’. Being on the Index was increasingly seen as conferring the right to a regular supply of opiates. Even the words used (the ‘Index’, ‘registered addict’) seemed to indicate some form of licensing system, the result being that many addicts even today still feel that being ‘registered’ legitimises and medicalises their opiate use.

A whimper, not a bang
Perhaps indicating its largely symbolic status, very few doctors Druglink spoke to would mourn the passing of the Index. As an indicator of the current status of the British drug scene, epidemiologists and statisticians also agree that the Index is well past its sell-by date. Even so, they will be hoping that the Home Office can house the thousands of confidential records so that researchers can still access a valuable historical resource.

As in life, the death of the Index may ultimately be seen as symbolic. With its epidemiological function being transferred to the Department of Health’s Regional Drug Misuse Databases, the Home Office is left to concentrate on policing the Misuse of Drugs Act. Furthermore, there could be a message for the ‘British System’ itself in the end of the Index – after all, GPs lose their central role as the sole notifier.

However, the loss of the Index appears to be the main reason for its demise, and the cut follows the recent announcement that the General Household Survey – the only national source of alcohol and drug use statistics – is likewise to be shelved. As yet, there is no indication as to whether the Department of Health will inherit the Index’s finances as well as its epidemiological mantle. Clearly though, without that money, it is unlikely that the regional databases would ever be able (or even willing) to fulfill the Index’s control function.

From national to regional
Although the data which the regional databases produce can, like the Index, only be an indicator of treatment demand, they do cover both a wider range of drugs and a wider range of service. They also provide a more rounded picture of the treatment population including data on injecting, employment status, housing and such like.

But for regional database statistics to be at least as valid a reflection of the annual treatment population as the Index, certain anomalies will have to be rectified. Firstly, the databases report to the Department of Health on a six-monthly rather than a yearly basis and because of overlap, the two six-month figures cannot be added to produce an annual total. If the regional databases are to become the only national indicator of ‘drug addiction’, this six-monthly timeframe could in fact mask the true extent of the problem.

Secondly, unlike the Addict Index, there is at present no scope for ‘renotifications’. Currently, someone attending a drug agency will not be re-recorded on a database unless there is a six month break in contact. This means that a user with an unbroken two year agency contact will only appear in the statistics once, unsatisfactory both from an Anthony point of view and also for the agency whose workload is severely underestimated by this method of counting. Plans are in train for an end of year renotification form to be completed by agencies.

Following the script
But what about the Index’s role as a check on dual scripting? It is clear that the Index was far from perfect. There may very well be doctors who didn’t know about the statutory requirement to notify, couldn’t be bothered with the paperwork or simply didn’t want to notify their patients. Yet for many others, it was an invaluable tool for checking ‘cold-calling’ clients. Even now, the Home Office admits to getting 300 calls a month from practitioners who want to know whether a client has been recently seen by another doctor.

But for its part, the Home Office does not consider that the Index is its main weapon in the fight against ‘script-happy’ doctors. For this, it tends to rely either on informants (often drug agencies) or its pharmacy inspection programme carried out by the Home Office-funded (but police-run) Chemist Sergeants. Yet this doesn’t deal with the issue of doctors who get ‘shopping’ for prescriptions, and because of their anonymity, the regional databases cannot be used by doctors to check whether a patient has seen other doctors.

Whether this is important or not depends largely on how well the local network of drug agencies and doctors communicates, and also on the stability of the local addict population. One doctor working in the Greener Manchester area told Druglink, "We have very good links with other drug teams and with local GPs. Most of the clients who come in we know anyway. If we have reason to be suspicious of anyone, it’s easier to check up without having to use the index which in any case is quite often out of date because doctors can take some time to notify clients they see”.

The Index is dead...

But in an area like London, with a huge transitory population of drug users, the situation is not so cut and dried. Many of the 300 calls a month received by the Home Office come from London agencies raising checks on their whole caseload against the Index. A

How will I know if someone’s getting private prescriptions and seeing another drugs agency?

Senior London consultant psychiatrist believes that having no rapid checking procedure will damage his relationship with clients:

"It will make us cautious in a number of respects. For example, we use the index when we take on new clients, in less rigorous ways like rapid access or homelessness - sometimes you want to act quickly where people are vulnerable or in need. But drug users are so mobile. How am I going to know if somebody has moved into my area temporarily three months ago, and is getting private prescriptions from Harley Street and seeing a drug agency in another district?"

... long live the index?
Ironically, private prescribers - so often blamed for being the main culprits of over-prescribing - may actually be at the cutting edge of developing a new form of index. Their mainly London-based group is currently developing an on-line computer system which could house details of a client’s signature, NHS number and photograph. The system will be linked to surgeries and pharmacies, and ultimately could prove to be a more foolproof bulwark against double scripting than the Addict Index ever was.
London DAT toys with shut-down

A south London Drug Action Team (DAT) has recently reconsidered its structure on the grounds that the new structure "simply adds another layer" and that consultation and joint commissioning arrangements already exist. Although the particular DAT has pulled back from the brink, the question of Drug Action Teams' efficacy is now firmly on the policy and practice agenda.

With everybody running round 'tackling drugs together', the decision of Lambeth, Southwark and Lewisham DAT to openly discuss ceased operations seems not only to be going against the grain but also financially suicidal. In deciding to maintain the status quo, the DAT may have taken this last point into account - although only one argument against disbanding was put in the papers presented at the decision-making meeting, it may have carried a lot of weight: "that the DAT 'might be unacceptable to central government'.

According to Don Lavolle, the DAT coordinator, the decision to review the DAT's function was made at the very beginning, in September 1995, and was prompted by the fact that the DAT was set up along health authority boundaries, encompassing three London boroughs.

"We already had existing groupings in which a lot of drug activity came together. We have a three-borough planning group, which is basically a three-borough Drug Reference Group which brings together all the providers; we have a commissioners group and we jointly commission a number of projects across the three boroughs. So even though we don't necessarily put all the money into one big pool, what health buys is influenced by social services and vice versa. And the DAT came along, imposed another layer and did not necessarily add any value."

Three into one won't go

The 'three-borough' structure of the DAT has ensured health authority participation at the highest level. But (as with a number of other DATs across the country), it has also placed a strain on the majority of its members who are based at the borough level - council chief executives and directors of education and social services among them. "The DAT is meant to provide for a significantly wider planning base than that required by the Health Commission," according to Judy Barker of the South London Drugs Prevention Team. "This in mind, to see the DAT as an imposition on existing Health Commission arrangements is somewhat missing the point, and belies perhaps our current DAT arrangements as too closely aligned to Health Commission priorities."

On the other hand, the option of splitting the DAT into three borough-based versions could cut the health authority (and its money) out of the equation. Such quandaries will be familiar to DAT coordinators throughout England ("a lot of other DAT coordinators were cheering me on when I was bringing up the issue that we may disband the DAT", says Don Lavolle), although it seems that in Lambeth, Southwark and Lewisham at least, things are moving in this direction.

The Drug Reference Groups (DRGs) may provide the let out. The solution may ultimately be to devolve the decision-making process to the borough-based DRGs and to use the three-borough DAT as a mouthpiece to communicate with central government.

Until that day, according to Don Lavolle, the DRGs will continue to come up with a wish list which they throw up to the DAT and say, "Oh, give us money to do this or that. And of course the DAT looks at them and says, "What? And, in some ways the DRG is looking to the DAT to say, Tell us what to do, give us direction and the DAT is looking at the DRG and saying, "Look we're a bunch of chief execs - we know nothing about drugs, we're not in a position to tell you what to do. The whole thing is grinding to a halt."

The murky waters of defining poppers

On January 13, the Medicines Control Agency (MCA) finally reclassified amyl nitrite as a prescription only medicine. In doing so, the Health Minister, Gerry Malone, said, "I am determined to protect the public by stopping this illegal trade", but it is still as yet unclear how the change under the Medicines Act will impact on the sale of 'poppers'.

The Act does not in fact specify any particular substances as medicines, the move has not required any change in the law - amyl nitrite has not been made illegal. In effect, the Act was a law waiting to be enforced and previous attempts to do so in the 1980s only really failed because of a lack of will.

However, as regular Druglink readers will know, the 'poppers' sold in sex shops and elsewhere are rarely amyl nitrite-based. Most poppers tend to be either butyl or isobutyl nitrite, and despite a worrying degree of confusion within the Department of Health, neither of these has ever been used medically and so neither has ever come under the Medicines Act. As Druglink has pointed out in the past, any change to the Act does not - in theory at least - impact on these nitrites.

Animal nitrite

The move against amyl nitrite, therefore, at first seems misdirected and largely redundant, as any change from 'pharmacy only sale' to 'prescription only medicine' should have no affect on whether sex shops sell the drug. However, the fact remains that amyl nitrite is the only 'genuine' medicinal product (with a history as a treatment for angina) and so only amyl nitrite could be advanced against without undertaking a lengthy consultation process and introducing new legislation.

In practice, the change to amyl nitrite's status does impact on the other nitrites, through association. It has been argued that - as they are chemically similar to amyl nitrite - butyl and isobutyl nitrites should be treated in law as if they were amyl nitrite. The counter-argument would be that there is no medical history of these nitrites' use, people who sell them cannot be proceeded against under the existing medical legislation. But as yet, there has been no defence of their sale in court.

Last year's case taken by the Royal Pharmaceutical Society (RPS) against a shopkeeper went uncontested, and it is highly unlikely that any shop accused of selling nitrites would be prepared to go through a costly court case when they could get away with a fine of £100.1 Putting it bluntly, neither the government, the MCA nor the RPS can afford to lose such a case and a shopkeeper cannot afford to win one.

Public consensus on drugs – definitely maybe...

At the end of January, a wave of indignation against the pronouncements of East 17’s Brian Harvey and Oasis’s Noel Gallagher threatened to swamp the launch of Britain’s most expensive “drug careers” campaign and raised in question the future of celebrity endorsements.

Amidst rumours that members of East 17 and Oasis were to attend the launch of the London Drugs Safety campaign on 30th January, Noel Gallagher’s “as normal as a cup of tea” statement may have finally put an end to pop star involvement in drug education initiatives. Pop stars may now be “too risky” a proposition, especially for campaigns which are partly-funded (as the London one was) by central government.

There are unconfirmed reports that Liam Gallagher’s appearance at the launch was vetoed by the Central Drugs Coordination Unit, and it seems that the bands may now be feeling the same way too – Noel Gallagher has just pulled out of a head-to-head with Tom Sackville, the Home Office minister, for the NME music paper. “It’s a mixed blessing”, Slade Lloyd-Hayward, the campaign organiser, told Druglink, as the pop star’s statement hit the headlines. Some public exposure may indeed have been lost, but the £500,000 campaign’s high public relations work has already been done. Using last year’s Dance Till Dawn Safely guidelines as a blueprint, the capital’s clubs have been blitzed with information about the campaign’s health and safety training courses for club managers, bouncers and bar staff. Ultimately, when all the fuss about Gallagher’s comments has died down, this greater awareness among club.

Promoters may be the lasting legacy of January 1997.

**Change the story, morning glory**

That said, national coverage of the campaign was swept from the front page by Noel Gallagher’s outburst. The day before the launch, the Oasis songwriter had appeared on BBC radio, and on other things likened drug-taking to “having a cup of tea in the morning.” Next morning, unrepentant, he issued a press statement which further expanded on his remarks (see box). His comments were greeted by a barrage of criticism, with Leah Betts’ parents leading the field. “To say that he is helping to start an open debate is a load of crap”, said Paul Betts.

The change of tune could redefine public opinion

Government ministers followed suit – Michael Howard deplored such statements, while Tom Sackville, the minister responsible for drugs, condemned “spoil brats like him [who] can take drugs and get away with it. If you are Gallagher you have got lawyers, you have got doctors.” Tim Rathbone, chair of the All-Party Parliamentary Drugs Misuse Group, even called for the prosecution of the star under the Misuse of Drugs Act for inciting drug-taking.

**Press gang**

Elements of the media also joined in, with the Sun saying: “If he reckons taking drugs is no different to having a cuppa, he must be a couple of tea bags short of a pot. And he deserves to be locked up.” However, not all the nationals were so predictable in their response to the call for “an open and honest debate”. Under the headline, “Noel was right to be wrong”, the Daily Express carried a piece which declared that it was “the height of absurdity and never mind the hypocrisy, to break into hand-wringing rane”.

But perhaps the most significant voice was that of the Daily Mirror, which only a fortnight earlier ran a special ‘shock’ issue on ecstasy. This time round, the paper which had castigated the band Pulp for its Sturte for Es and Wizz single, ran a front-page story on “Why Noel’s right on drugs” and set up a readers’ phone poll which resulted in 87 per cent of callers backing the singer’s comments.

When coupled to other recent television and radio polls (and the government’s own survey on public attitudes to drug crime), the Mirror’s change of tune seems to be pointing towards a possible redefinition of what actually constitutes ‘public opinion’ and whether it is as monolithic as politicians and parts of the media assume.

Last year’s Lewisham Citizens’ Jury on drugs further demonstrated that information and education can help members of the public reach a better understanding of a complex issue, and – whatever they may say – politicians are at least beginning to recognise this.

George Howarth, Labour’s drugs spokesperson, told Druglink, “There are often very confused and confusing messages as to what public opinion really is. It’s difficult to know whether in that sense we’ve got it right or wrong.” But whether an evolving public opinion will finesse political and media opinion is another matter entirely.
NATIONAL INITIATIVE ON COUNSELLING FOR ASIAN COMMUNITIES

EACH (Ethnic Alcohol Counselling in Hounslow) is a counselling service based in West London catering to the needs of Asian people.

We are now in the process of updating and expanding a second edition of the National Directory of Counselling Services for Asian People. The publication covers alcohol services, drug abuse and mental health, and goes beyond the usual type of directory which simply lists services, and provides information on why culturally targeted services are needed and what they should comprise.

If your organisation provides counselling services to Asian people and you would like it to be included in the next edition, please contact Meena Ray for an application form at the address below.

Contact: Meena Ray, EACH, clo CVS, 27-29 Vauxhall Grove, London SW8 1SY, phone 0171 793 9213, fax 0171 793 9209

TRAVELLER EDUCATION

It has recently come to my attention that possibly due to high levels of illiteracy, much drug and health education is not reaching some of the more vulnerable sections of the travelling community.

I would therefore appreciate any information, ideas and suggestions on work carried out within the travelling community in relation to drug education and work using audio tapes for educational purposes.

Contact: Andrew Broughton, Community Development Worker, Thurrock Community Hospital, Gifford House, Long Lane, Grays, Essex RM16 2PX, phone 01375 364430 x 5672

METHADONE SUPPORT GROUPS

Does anyone who is currently providing a methadone maintenance programme also offer a support group within the service? If so, Doncaster Community Drug Team ("The Garage") would like to hear from you. We are considering providing this service, but would like help on the best way to proceed and any problems encountered. Please write, telephone or fax.

Contact: Doncaster Drug Team, The Garage, 37 Thorne Road, Doncaster DN1 2EZ, phone 01302 730956, fax 01302 361453

LETTERS

Newton’s views welcomed but strategy threatened by funds attack

Policy coherence

Dear Editor,

I cannot speak for other Drug Action Teams (DATs), but Druglink’s interview with Tony Newton (Newton’s law. Druglink: 1997, 12(1), p.8-10) certainly provoked a great deal of thinking within the Bealey and Greenwich DAT. I canvassed our DAT members for their opinions, and I hope the feedback’s of interest to Druglink readers.

Unsurprisingly, our members strongly endorse Mr Newton’s confidence in DATs. Members believe that the DAT has been a beneficial development and point to local partnerships and initiatives which would not have otherwise come about.

They also support his concerns about the top-slicing of budgets. One DAT member feels that while “there would be clear benefits if DATs had budgets that were not at risk of weakening support services, the feeling of competitiveness that could be engendered by this approach would not be beneficial”.

Another sees the Drugs Prevention Initiative as a potential source of money. “The DPI does not fit into the strategic framework of Tackling Drugs Together and should be wound up. The Home Office funds freed by this move could then be made available to DATs, who on assuming joint commissioning responsibilities could make progress towards seamless service provision”.

The importance of the role played by Tony Newton and the CDCU has also been emphasised. Many DAT members urge Mr Newton to use his position to encourage the pooling and sharing of information for strategic planning purposes, and central government departments to keep up the pressure on public sector services to prioritise substance misuse. “The CDCU’s role should be strengthened to provide a continuing, strong, coherent strategic guidance”.

As for the issue of whether the structures have been “got right”, DAT members stress that “while clear structures are the subject of much national attention and are clearly of some help, outcomes – particularly practical ones – are the key to developing work in this area. DATs must be seen to be tackling issues and mustn’t sit on their laurels”.

Anni Ryan
Coordinator, Bealey and Greenwich DAT

Funding coherence

Dear Editor,

We warmly applaud Tony Newton’s support of the drug field and his commitment to new thinking, a number of worrying developments on the ground may be threatening further progress. Despite a very welcome increase in overall funding during 1996-7, the recently announced 1997-8 health authority allocations for drug misuse services come at a time when other funding issues are far from resolved.

The essential points arising from this process are:

• Of the 100 Health Authorities in England, 57 will, over a four year period, be net losers; 43 will on balance, gain in resource distribution. A number of areas stand to lose 60 per cent or so of their allocated drug misuse resources. Some of these are where demand for services is very high.

• New growth resources for drug misuse services of nine per cent have been identified for 1997/8.

• Regions which stand to lose quite significantly (should future real growth for drug services not materialise to soften the impact of transition) include the South and South West; the Midlands and particularly the North West.

The new resource allocation formula cannot, therefore, be seen in isolation from other resourcing matters which significantly impact on all drug services:

• HIV/AIDS monies are being redistributed.

• Housing Corporation support for housing associations is going through fundamental change.

• Social services support under community care arrangements is buckling in a number of areas;

• and the probation accommodation grants scheme has been decentralised and is causing consternation to many drug services.

The cumulative effect of these seemingly disconnected issues is potentially going to lead to some seismic changes. We believe that the time is right to press government to consider the coordinated resourcing of drug treatment and rehabilitation services.

The reality is that no-one knows what is being spent and who by, and such unrelated financial decisions may actually hinder and frustrate a national strategy’s objectives. With Tackling Drugs Together we finally have ‘policy coherence’; what we perhaps need now is funding coherence.

Roger Howard
Chief Executive, SCODA
The Party Line

As you read this, the election campaign may have already started – officially. But we all know that the campaign has been underway for a good many months. They may all be promising different versions of the future, but is there really any difference when it comes to the parties’ stand on drugs? Exclusively for Druglink readers, we tried to find out by asking about their policies and views.

Judge for yourself who (if any) is most convincing.

by

Oswin Baker

Editor, Druglink

speaking to

Tom Sackville MP
Currently a Home Office Under Secretary of State responsible for drugs. Tom Sackville has been MP for Bolton West since 1983, winning with a 1000 majority at the last election. He has been secretary of the All-Party Parliamentary Drugs Misuse Group

George Howarth MP
Shadow spokesperson on drugs and representing the safe Liverpool seat of Knowsley North since a 1989 by-election. George Howarth has previously held the environment brief. He was deputy leader of Knowsley Council in 1982 and was active in the Welsh TUC

Alex Carlile MP
The only Liberal Democrat MP with a seat in Wales, Alex Carlile doubled his majority in 1992. A QC, he is currently party spokesperson on justice and home affairs and as such, is responsible for the Liberal stand on drugs. He is standing down at the next election

What will happen to Tackling Drugs Together after the election?

The strategy would continue, but it’s my personal view – looking at it from the Home Office side – that we’re going to have to be much more draconian in some of the things we do if we are serious about the supply side. Clearly, it is very easy to bring drugs into this country, and so if you’ve got a big enough demand and you’ve decided that you’re not going anywhere near the legalisation route, then you have got to redouble your efforts to stop importation and supply.

As far as the European loosening of border controls go, we are not opening our borders, we are not lowering our guard, because it’s clear to us that the Channel is an advantage in terms of countering drugs. Broadly speaking we welcome Tackling Drugs Together, because for the first time it means that there is a national strategy and it provides strong local structures. So to that extent we welcome what has already taken place and would want to continue with it, although obviously there might be some slightly more distinctive things we would like to develop under a Labour government.

We would want to review the whole policy. We think we should be committing much more money to the debate about drugs.
Are you happy with what’s happened over the last ten years? 

I don’t think anybody could be happy with the result. The issue is how do you change things. You know that a large number of young people are exposed to drugs, you know that every school, every town, every village to some extent has a drug problem, and you know that something like 50 per cent of all crime is drug-related. So there’s no room at all for complacency.

I think the record’s absolutely dismal. There’s been very little done in the form of providing a system around the country to help people come off drugs. There are some excellent schemes, and some of them have government funding, but there’s no consistency, no clear pattern.

What would you like the situation to look like in another ten years? 

What we have to aim at is a situation where we have a more favourable position on the supply side than the European countries. I’ve used the term ‘The Singapore of Europe’ before, meaning that it should be known in the international drugs community that Britain is a very difficult place compared to France, Germany or Spain.

We’re going to have to be much more draconian.

At the same time, I realise that is only half the picture. We’ve got to find ways of telling young people more effectively to stay away from drugs. And we can’t do that if a whole lot of commentators and drug prevention lobbyists muddy the water with talk of legalisation.

It happened with smoking, it happened with drink-driving – we’ve now got to get fashion to move very sharply against drug use. Until that happens, we’re not going to make any progress, but that’s what we have to aim for.

I’d like to see the trend of inevitable, increasing drug use move into reverse. And secondly, one of the sources of drug abuse is the often hopeless position some young people find themselves in. If we can get our programmes of training for youth and education running, and give young people more hope for their own future, then drugs won’t be such a seemingly easy way out. You know, in a hopeless life, a life of drugs is not maybe considered by some young people to be such a bad option; but in a life that has a future, that has room for ambition, then drugs become less relevant.

Ideally, I would like to see a generation of young people who do not see drugs as fashionable and I think education is very important to that extent. When I was a student in the 1960s, drugs were just beginning to be fashionable, but actually most students never had a drug and did very well without them in that time. There were different fashions. I hope that drugs will go out of fashion and I think we’re most likely to achieve that through a greater focus on education. But I’m not optimistic. I don’t think one can expect miracles from government.

Do you see ‘drugs’ as a law and order issue or a public health one?

Obviously we understand it’s a health issue because we have an enormous amount of money tied up in drug treatment programmes and in drug education. But I think we tend to reflect the public view that it is a law and order problem.

It isn’t one or the other – it’s both. You can’t ignore the fact that it’s a law and order issue. By the same token it is important to recognise that there are public health issues involved, and to use the most intelligent approach as possible through advertising and education to make young people appreciate the harm that drugs of all kinds can do to them.

I don’t think they’re discreet issues. They’re inextricably interwined and both should play a very significant part in education from primary level upwards.

Education, health education, and quite specific education in relation to drugs is part of a crime prevention policy as we see it, and we therefore think it would be a very good investment to put a substantially greater sum of money into a new policy.

Testing and Treatment Orders

If you set up a separate ‘drug court’, it’s a huge reform that would take ages. It’s simply not necessary in order to achieve what we already have on the statute book, which is conditional sentences.

The best example is in Plymouth, where the judges have decided that they’re going to use conditional community sentences, meaning that they have arranged that certain people who would have gone to jail for drug offences go straight to the top of the queue for treatment. That is something we desperately need to encourage. The problem is getting sufficient confidence between the sentencers, the providers of treatment, the probation service and the police to make it happen.

One of the biggest priorities in the new parliament would be to ensure that the Plymouth example is spread as widely as possible. There’s no point people sitting in prison needlessly, bored to death, taking drugs, when outside they might not be.

We need to work on the principle that not only should people be punished for taking
drugs but that they should also have access to treatment, and the new Testing and Treatment Order will be one tool in helping to combat that. You not only deal with the fact that somebody might have committed a crime to fund a drug habit, but at the same time you deal with the source of that problem which is often an addiction to drugs.

I'm not committing any money at this stage

The probation service is broadly keen to try new approaches. We have already spoken to a number of the drug agencies themselves and I think that they have the programmes and also the capacity to extend the use of those programmes. Obviously, it is not going to happen overnight, but there is a recognition that something needs to be done.

We'll obviously have to look at what resources are available and what resources are required when we're in government. I'm not committing any particular amounts of money at this stage. But it is the case that if somebody can be dealt with in the community and treated in the community that is a lot cheaper than sending them to prison.

 Aren't most of these people dealt with in the community now anyway? That's possible but there are an increasing number that do end up in the prison system who could be treated in the community. I'm not saying that anyone who received a custodial sentence at this time shouldn't have done, but whether we can look at a different approach in conjunction with the courts and other parts of the criminal justice system is something we'd want to explore.

We have recommended pilot projects of American-style drug courts with judicial case management. We think judges would be very interested in doing this kind of work and we think that they could do it very successfully with the assistance of the probation service. It would save a huge amount of money in the long-term.

The problem with the Labour Party's policy is that they don't seem prepared to commit more money to the probation service, and the probation service could not do this job without new money. Furthermore, this has to embrace the whole of the criminal justice system. It's going to need the carrot and the stick, and the stick can only be provided by the court. Probation officers can provide the means of caging the carrot but the involvement of the court and the threat of punishment is essential.

'The Message'

Anyone who knows anything about drugs knows that you can't stop drugs getting to young people; what you can do is try and stop young people getting at drugs. And that is difficult, because at the same time as doing that you have to put out a message which is something approaching Just Say No aimed at all those young people who never or rarely take drugs. We must continue with the message, 'Don't get involved with drugs because they're trouble'.

I personally use the words Just Say No, because I think the message has to be very clear. If you start diluting the message for the benefit of those people who you believe are using drugs, then

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**Plaid Cymru, Wales**

"Plaid Cymru is concerned that left unchecked, many of our communities could in effect fragment, making our task of building the new Wales more difficult. The current problem is one of misuse of all types of drugs, including alcohol and tobacco. Plaid Cymru does not feel that decriminalisation of the softer drugs, such as cannabis, would bring any particular benefit. We are, however, concerned that there should be an open and constructive debate about drug abuse and in particular advocate:

- a national commission into the causes and effects of the use of illegal and legal drugs to make policy recommendations;

- more resources for the police and customs to allow them to work more effectively;

- increased penalties for drug dealers as an indicator of society's disgust. The deliberate dealing of drugs should almost inevitably lead to a substantial custodial sentence;

- better drug education and prevention programmes;

- well-resourced research into the causes of drug-taking, particularly by the young, so that they, as well as the symptoms, can be addressed;

- a ban on the advertising of strong alcoholic drinks aimed at young people;

- better protection for witnesses in court cases."

Plaid Cymru General Election Manifesto 1997

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**Scottish National Party, Scotland**

"Tackling poverty is key in any national strategy on drugs. By dealing with the social and economic conditions which make drug-taking an attractive alternative to the hopelessness and despair which many young people face, we can try to make sure that there is a life worth living without misuse of drugs.

**Strategy:** We need a national drugs strategy in Scotland to direct policy and funding to the numerous, various groups/organisations and authorities working in this field. The problems encountered by a multi-agency approach should be addressed... An audit of drug support facilities is necessary... This is of particular concern with relation to rehabilitation facilities (or lack of them)...

"Any drug strategy must be informed by those who are in regular contact with the drug scene. In order to provide quality, up-to-date information on drug issues the SNP supports the setting up in each Drug Action Team area, teams of people who have direct experience of the drugs scene... to form a 'drugs communication team' to work in schools, with parents and community groups to provide information about drugs.

**Funding:** Funding sources should be stabilised so organisations can plan and exist long-term. Recommendations include: the ring-fencing of Community Care allocations for residential services; the cost of alternative forms of custody in residential units for offenders with drug problems should be borne out of criminal justice rather than health board or social work department funding..."

**Education:** Devolved school management may make delivery difficult and to that extent the SNP support making 'social information' sessions in schools - whether on AIDS, drugs, sex, etc. - the responsibility of community health and community education services, with a statutory responsibility on schools to set aside time for these sessions...

**Law and order:** The SNP do not see the tackling of the drugs issue as primarily one of law and order. The strategy must be one of tackling demand in society. However, the policing of suppliers is an important part of tackling the supply of drugs into the country. To this extent, the SNP gives its full support to customs unions trying to fight job cuts and the removal of drug officers from the coastline of Scotland...

**Law reform:** The SNP acknowledge the logic of this case but feel that any move to decriminalise cannabis at this time would be inappropriate. The SNP do however support recommendations (Scottish Affairs Report: 1994 and Baroness Wooton's report) to reclassify drugs to provide a hierarchy of drugs which is credible to the audience drug campaigns must engage in dialogue. Any redefinition should consider use of cannabis for medicinal purposes and cultivation for own use."

you’ve actually given up, you’ve admitted defeat, and that’s something we can’t do.

There is one message that there’s general agreement on, certainly within the political system: drugs cause harm and there is no possibility that Labour would legalise any currently illegal drug. But at the same time it is important to get across the message that harm reduction strategies of one kind or another have to be put into place.

I also think it’s important that the government, whatever government, gives a lot of thought and takes a lot of advice about how to get the message across. It is important that we maintain a position of Just Say No on the one hand, but I’m conscious of the fact that the heroin campaigns of the 1980s proved what people like me in a blue suit might think would appeal to young people has the opposite effect.

The Liberal Democrat Party is of the view that there are certain drugs which are ‘entry drugs’ and one has to deal with them on the basis that they are as dangerous as more serious drugs because of the entry problem. We also think that there are some drugs which may have very little effect on some youngsters, but on a few will have a terrible effect, and it’s the maximum effect that measures the dangerousness of the drug.

If cannabis is lawful, you may be watching the British Spilliff Test Series

Politics, the media and Oasis

There’s a great deal of political and media consensus on drugs, and I think the reason is that regardless of their own views, the more permissive end of the political spectrum is sensitive to public opinion, and knows that there is a huge weight of opinion against legalisation and you can’t change that attitude overnight.

I’m not surprised that any politician who actually relies on votes takes that view. Now, members of the House of Lords can live in their own fantasy world, unrammed by electoral considerations, because there is no discipline of the ballot box or the circulation figures.

The tabloid media can and sometimes do play a very constructive role in pointing out where the problems are and on occasion how they can be dealt with. Sometimes it gets hysterical, sometimes it’s sensible. It’s absolutely outrageous that role models like Noel Gallagher should seem to make taking drugs just another harmless activity.

The music business is perfectly entitled to address the issue of drugs, and I certainly don’t object to songwriters writing (just as Coleridge wrote) about drugs. It’s a perfectly legitimate literary subject. However, I think that they must be aware of the people who have made masses of personal fortunes for themselves and their companies, that they owe a responsibility to their public, and I hope that those who do not address themselves to that responsibility will be turned on by that.

Most of the media are very responsible actually. Obviously different organs of the press have different styles, but I think the tabloid style is sometimes far more effective than the po-faced style of some broadsheets.

Legalisation

Over the next 20 to 30 years there is very little prospect of us or any other European government legalising drugs. Having come to that position you have to say we are going to fight and win.

People can be worked on, and a lot of very seductive and very rational sounding arguments can be put forward on why it would be a good thing to legalise drugs. But those are coming from people who have already decided that they should be legalised, and we know – in common with the vast majority of the public who haven’t been worked on – that if you legalise drugs you create a massive increase in drug use and therefore drug problems. The idea that the NHS would give all those people unlimited supplies of drugs is complete fantasy. A government which tried that wouldn’t last five minutes.

There are often very confused and confusing messages as to what public opinion really is. It’s difficult to know whether in that sense we’ve got it right or wrong.

But whatever public opinion is or is not, it would be irresponsible for a major political party to slip down the path of decriminalisation, because it sends out entirely the wrong message. If you even say as the Liberal Party do that we would like to have a Royal Commission to look at this, then the immediate message is that even if it’s not all right now it will be soon so why not take drugs anyway. The truth is that all drugs cause harm and that message has got to be maintained and reinforced.

As for the argument that alcohol and tobacco kill hundreds of thousands more people than ecstasy, it’s a question of comparing apples with pears. Yes, everybody knows that alcohol and tobacco statistically cause more harm than any other drugs. But, firstly, if you compare tobacco and cannabis, tobacco is not generally considered to be a ‘gateway’ drug into the take-up of heroin or cocaine, whereas cannabis is. And secondly, tobacco and alcohol are already legal and it’s very difficult to criminalise something that’s already legal.

The party’s policy is that there should be a Royal Commission. There are differing views in the party about, for example, cannabis. My own view is that it would be unwise to legalise cannabis. Sometimes people talk about “decriminalise” as though the word means something different from legalise, but it doesn’t: there are no two standards – you make it lawful or you don’t.

If cannabis is lawful, you have to accept that you may be watching the British Spilliff Test Series or the Spilliff Grand Prix, and I don’t want to contemplate that!

The argument which says “Ah, but cannabis is no more dangerous than alcohol or cigarettes” is absolute rubbish. We aren’t starting from that point. Because alcohol has been with us from the beginning of time we have to consider it in a different way.

What would a Royal Commission do, if not recommend legalisation? It would examine all the claims and counter-claims made in relation to drugs; it would produce a qualitative analysis of the dangerousness or otherwise of different types of drugs; and it would make recommendations as to whether drugs should or should not be unlawful.

Would you be committed to carrying out its recommendations? No of course not.
New ideas in the field

With all the politicians outbidding each other as the ‘toughest on drugs’, it comes as something of a surprise to find that there are still a few new ideas doing the rounds in Westminster. Here we present two of the most topical: drug courts, which are being actively touted in one form or another by all the parties; and citizens’ juries, which could finally provide the solution to gauging public opinion more effectively than ever before.

But first, Philip Bean takes a long hard look at a field ripe for change.

A sea change is now underway in the thinking behind the treatment of drug users, and drug-using offenders in particular. The ideology of treatment agencies which has held sway for years and dominated the treatment landscape is currently under siege, being battered with criticisms from the criminal justice system and politicians of all shades.

Fundamental to this attack on the status quo are the twin issues of treatment and coercion. Treatment, the line went, was only appropriate if it was undertaken voluntarily. Those who were coerced into treatment were, it was said, bound to fail.

Unsurprisingly, while this view has held sway, few drug-using offenders have received treatment as a condition of their sentence. Nowhere is this better illustrated than in the Criminal Justice Act 1991, in which the courts could specify drug treatment as part of a probation or combination order. In the first 18 months of the operation of this Act (implemented in the autumn of 1993) only 1400 such treatment orders were made. Was this because the courts were reluctant to use their powers? Was the probation service failing to alert courts that such powers were available? Or was something else afoot? More likely, the combination order fell at the hurdle of the treatment agency and its reluctance to accept such orders.

Conditions of treatment have been resisted by the treatment establishment for decades. And even when they are accepted, things rarely go well, for often there is poor (and sometimes deliberately so) communication between the agencies and the probation service.

Continental drift
All this is changing. Not, I would add, as a result of any radical rethink on the part of treatment agencies. For, in spite of their overt and apparent radicalism, they remain one of the most conservative groups in and surrounding the criminal justice system. The changes are occurring because it is at last being realised that there is no empirical evidence to support the treatment agencies’ beliefs.

The research evidence is clear. Treatment outcomes are not dependent on the reasons for entering treatment, but on the length of time spent in a programme. In other words, it matters less about the reason for going into treatment, and more about the time the offender remains there – 90 days is seen as being appropriate.

When one thinks about this changing attitude, it is fairly commonsensical. After all, until users are exposed to an environment where interventions can occur, and are retained for a sufficient period to produce and maintain positive outcomes, no change can be expected. Nor should one accept the rather simple view that drug users ever make independent choices to accept or reject treatment.

Coercion and pressure to give up a drug habit exist at all levels, whether from family and friends or from court and probation.

Undoubtedly, this realisation will annoy many treatment agencies even if they are unlikely to stand up against the onslaught – and one could include here the mental health specialists who have also resisted taking conditions of treatment on probation orders. Treatment agencies will fight to preserve their orthodoxy and in all likelihood will interpret proposals for change as another example of creeping authoritarianism and insensitivity to civil liberties. Quite forgetting, of course, that treatment as a condition of probation will for many offenders, be an alternative to prison.

New Labour, new order
The Labour Party’s proposal for a Testing and Treatment Order is part and parcel of this rethink. It is based on the view that compulsory treatment is better than no treatment at all, and it supports the belief that treatment resources should be targeted at those programmes which are best able to retain clients more than three months – and if that means by coercion then so be it. At least the ‘short, sharp shock’ is well and truly out of the picture.

Never mind that there are all sorts of problems with these proposals – not the least being that someone needs to do the tests, be paid for them and inform the court of a client’s progress. Never mind too that the reliance on the probation service to police the Order could have serious implications for probation officers’ relationships with other clients.

Above all, never mind that the proposal is a typical British compromise, an attempt to undertake on the cheap the more sophisticated operations conducted under the American drug courts programme. What is important is the recognition that we can no longer muddle through as before.

Nor can we continue to pour resources into treatment programmes, and allow those who run those programmes to dictate who they will and who they will not treat; and decide, too, the types of conditions under which they are prepared to operate. If treatment agencies continue to resist the changes, perhaps a redistribution of funding – a metaphorical cold turkey – will help them see the danger of an expensive and ruinous habit.

by

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additional material provided by the editor
DRUG COURTS ARE perhaps the oldest of the ‘new’ developments. Certainly, we featured them in Druglink two years ago. But the Labour Party’s endorsement of the principles behind drug courts - most notably, the link between sentencing and treatment - has (at last) given them a British currency.

Drug courts as we know them were born in Miami, Florida in 1989, partly as a response to the legal log-jam which the War on Drugs had created across America. In the eighties, drug arrests rose four times as quickly as all arrests, to the point where, according to Stanley Goldstein, Miami’s one and only drug court judge, “our criminal courts were totally overwhelmed with possession of cocaine cases, and murder cases and armed robbery cases had to sit on the back burner.”

But it would be wrong to see the drug court as merely a mechanism to process cases more speedily - flexibility was the key, and its innovators would refute any suggestion that they were being ‘soft touch’. The courts may have been criticized for bringing the ‘majesty of justice’ into disrepute and for turning the judge into a social worker, but paradoxically, they are perhaps even more controlling than other methods of sentencing. Their ‘transparency’, with mandatory drug testing and regular treatment reports, mean that people are no longer able to ‘play the system’.

Courting success
“arrestees charged with possession of a so-called ‘hard’ drug. Secondly, they take the offender out of the loop of the American judicial system, which is currently founded on the ‘three strikes and you’re out’ principle. Finally, the court ‘buys into’ treatment and employs the providers to treat people. Such a level of court control distinguishes the American models from any British proposals.

Phase 1 tends to cover the first 21 days, from the time of arrest to the filing of formal charges. The defendant is taken from the courtroom directly to the treatment centre. A personal counsellor is appointed and the report is given their initial treatment before being released (unless they are receiving residential treatment). Every day for the next 21 days, they must invariably report to the treatment centre, be urine tested, meet their counsellor and undergo treatment. After they have been clean for a certain number of consecutive days, they then move on to...

Phase 2, where they attend treatment as required (typically three times a week). They continue to provide urine samples at each visit. At the beginning of this phase, they are sometimes formally charged, to which first-time offenders are encouraged to plead not guilty. Ask a trial by jury and waive a speedy trial (in other words, delay sentencing). This phase is not time-limited, but when it is successfully completed, the defendant moves on to...

Phase 3, which involves counselling and group sessions. They are also encouraged to undertake vocational training and get a High School Diploma if they haven’t already got one.

The whole programme usually takes 12 to 18 months and is closely controlled throughout the court with the defendant making regular scheduled court appearances. On successful completion of all three phases, charges are usually dropped and the record expunged soon after.

If, however, progress is deemed unsatisfactory, they may be returned (while still under drug court supervision) to custody for up to 90 days. The final sanction open to the court is to eject the defendant from the programme, who then returns to a ‘normal’ court and the ‘three strikes’ system.

There are many different models for drug courts (the Labour Party bases its policy on one in Oakland, California) but they all share a number of characteristics.

HOW DOES IT WORK?

first-time offenders on probation who are re-arrested and sent to prison.

And this success seems to come cheap. It costs just $800 each year to sentence an offender through the Miami drug court, while it costs $25,000 to keep someone in a Florida prison. Furthermore, it has also been estimated that for every $1 spent in drug courts, there is a saving of $7 elsewhere in the criminal justice system.

Given this performance, it is little wonder that British politicians have begun eying Miami’s success with envy. But is there a chance that in the act of importing an American initiative picemical, we could inadvertently end up killing the goose that lays the golden eggs?

Lame ducks
Britain’s foremost commentator on drug courts certainly thinks so. Two years ago in Druglink, Philip Bean wrote:

“My fear is that they will be introduced in Britain as a cheap alternative without planning and without care for the complexities involved. Properly undertaken, drug courts are not cheap to run. Too often in Britain we find the easy way out: in this case, grafting drug courts on to the probation system or something like that.”

Under the proposals outlined in Breaking the Vicious Circle, Labour would do precisely this - treatment is given as a condition of probation. This is an approach clearly rejected in Miami: “Probation cannot do anything I cannot do,” Judge Goldstein has said. “And I can do a lot more than probation can.”

Ironically, however, a probation-based initiative may actually prove to be the saving grace of any British system.

This is because the mechanisms which underpin the American drug courts are unlikely to succeed in the British context. Firstly, as Labour Party sources privately recognise, the American drug court system relies heavily on a few super-charismatic judges, people who may be more difficult to find in Britain.

More importantly though, the offender is explicitly under the supervision of the court throughout their treatment and the court retains a high level of control over the entire process. Such a level of control could be anathema to the British courts, something acknowledged by Detective Inspector Hopwood, drug liaison officer for the Association of Chief Police Officers: “The British court system distances itself from individuals after sentencing and delegates its supervisory role.” Perhaps a drug court ‘at one remove’ (via the probation service) is the only answer.

WHILE DRUG COURTS try to introduce civil methods of dealing with the issue of drugs into a court environment, citizens’ juries are an attempt to do the reverse – bringing legal rigour to the community’s discussion of drugs. As such, they have become closely identified with the nineties political buzzwords of ‘empowerment’ and ‘communitarianism’.

All the major British political parties are toying with versions of the citizens’ jury as a way of involving local communities in the decision-making process and of gauging informed public opinion more closely. As such, they mirror the focus groups which political parties use themselves to get a clearer idea of ‘what feeling’ than an opinion poll ever can. In an age of spin doctors, juries are also a clever way of making unelected bodies accountable to the community through public consultation.

Citizens juries

Unlike drug courts, citizens’ juries are not exclusively an American invention, as they were also pioneered in Germany as a model of government-sponsored public consultation on issues as diverse as planning, the environment, transport and other social issues such as drugs.

By mimicking a court of law, the quasi-judicial citizens’ jury is designed to seek out community opinion without being hijacked by special interest groups. The idea is that – given enough time and information – ordinary people can make valid decisions on complex issues. The sponsoring organisation (a health authority or local council for instance) can then act on the jury’s recommendations.

Typically, 16 jurors are recruited to consider an issue of local importance, and as such, they will have been chosen to reflect the demographic profile of the local community. Over four days they hear evidence and are allowed to cross-examine expert witnesses, and they can also request additional information or call extra witnesses. By the end of the process (and helped by independent mediators) the jury draws up recommendations which the sponsoring body must take into account when formulating policy.

Home-grown jury

In Britain, a number of citizens’ juries have already taken place, but the key citizens’ jury as far as drugs go was the one formed by Lewisham Council in April 1996. It was the first large scale jury run by a British local authority, and was part of the Lewisham Listens ‘democracy initiative’. By choosing to discuss such a ‘controversial’ issue, the Council was effectively testing the concept of the citizens’ jury to destruction – such an emotive subject would prove

Juries show that public opinion is not immutable

whether the jury is an effective decision-making forum or just a fashionable talking shop.

As Judith Armitt, the initiative’s director, points out, ‘drugs is an issue “which politicians are often reluctant to debate openly because of the assumptions which are made about public opinion.”’

Crucial to the success of the Lewisham jury was the provision of information – at the start of the process, only four of the 16 jurors felt well-informed about the issue; by the end, 15 did. Only five jurors remained fixed in all their ideas.

This demonstrates that public opinion is not immutable, and that when exposed to the substance of an issue, the actual concerns and views of ‘ordinary people’ can perhaps emerge more clearly. At the end of the process, one juror said, “I came in with many preconceived ideas. My views have almost somersaulted over.”

Such a Damascene conversion was not, however, appreciated by all involved:

“I’m a little mystified, because I did have a clear line of really how I think it should be done and how it should be tackled, but the more evidence I hear, the more I do U-turns and am second guessing myself”.


Community cares?

The jury considered the issue of “drugs and community safety”, a phrase which says volumes about the uses to which citizens’ juries can be put and the way in which their terms of reference can be directed at a single aspect of a larger problem. The concept of community safety, of course, being one which has been picked up by the major political parties.

The primary question considered also gives a clear indication of the direction in which the jury was expected to travel, with an explicit commitment to harm reduction.

What can be done to reduce harm to the community and individuals from drugs?

Such a focus may of course influence the jury to favour one particular interpretation over another. For instance, after four days of hearing evidence and cross-examining witnesses, 15 of the 16 jurors agreed with both the following statements: “young people will try drugs; the best thing we can do is teach them about the real dangers”; and “drugs are here to stay – teach young people how to take them safely.”

Obviously, not everyone will welcome such messages.

LEWISHAM DECIDES:

Jury recommendations:

• policy should reflect the link between drugs and crime;
• soft drugs should be considered for decriminalisation;
• educate the whole community about drugs;
• education should carry a harm reduction message;
• create an education-focused Drug Reference Group;
• eliminate hypocrisy over legal/illegal drugs by giving information on all drugs;
• target suppliers rather than users;
• extend arrest referral schemes;
• widen treatment options;
• pilot prescription of drug of choice;
• provide more treatment options for non-opiate users.

Council action:

• establish a community drugs awareness programme with local schools as the focal points;
• set up a specialist education team to run the programme;
• ensure the programme uses different methods for different groups, including peer education;
• endorse the Met’s policy of targeting dealers;
• advocate the use of arrest referral schemes;
• advocate a thorough reassessment of current treatment options;
• lobby for trials of prescribing options;
• push for more resources for the treatment of non-opiate users.
Preventing confusion

The interview with Tony Newton in the last Druglink raised the possible confusion of the place in Tackling Drugs Together of the Drugs Prevention Initiative and asked whether it was relevant. But the DPI has an important part to play in the strategy, says its head, and here she explains the philosophy behind the initiative and the work it does.

Ever since the launch of Tackling Drugs Together, people have asked, 'So what does the Drugs Prevention Initiative actually do? How does it fit in with the strategy?'. The short answer to this can be encapsulated in one word: development. I hope that this article will provide a longer answer.

The first and most important point to grasp about the DPI is that its national function is developmental. In other words, it aims to turn the experiences of some localities to national advantage, demonstrating what can be done more generally. In this respect, it runs alongside Tackling Drugs Together, both nationally and locally.

The next thing to understand is that in the remaining two years of the DPI’s current remit, the Initiative’s focus will become increasingly ‘external’, as the emphasis shifts from developing programmes on the ground to developing good practice findings from the local projects and making them widely available. To do so, the DPI will need to engage the interest, support and participation of practitioners and policymakers across the country to answer the following question: what sort of information, presented in what formats, for which audiences is most likely to result in good prevention practice being replicated throughout the UK? Hardly a simple task.

Initiative’s initiation

To understand the DPI’s work more fully, however, it is necessary to look at what it has achieved.

The first phase of the DPI’s workplan ran until March 1995, and involved the setting up of community-based drug prevention work. Drug Prevention Teams were given no blueprint from the centre, nor any instructions as to what the work should look like. What they did have were local support and advice, a small grants budget and a central support and management unit based in the Home Office.

Most critically though, they had their own knowledge, imagination and enthusiasm — as Home Office teams — some freedom from local agency relationships and conflicts and expectations. The Teams succeeded in bringing together a wide range of partnerships in a large number of very diverse projects. Granted, by no means could all of these be deemed successes (even in ‘process’ terms) and it must also be acknowledged that it is quite difficult to assess precisely what the drug prevention effect may have been in a number of cases. But an independent review concluded that the model could develop worthwhile prevention activity, provided that the projects were more long-term and more substantial in order to test effectiveness more rigorously.

Perfect practice

Phase two, which began in April 1995, provides this long-term commitment. The Teams were expanded so that there were a dozen, covering a much larger area of the country. The first nine months (the gestation period, if you will) were spent mapping the new areas, assessing needs and developing proposals for projects in partnership with local people, including Drug Action Teams and Drug Reference Groups. The plans were further honed and coordinated across the Initiative so that there was a real chance of creating a programme of work which could collectively achieve some real progress.

This process — laborious as it often seemed at the time — enabled the Initiative to develop a coherent programme of activities grounded in local experience and responsive to local circumstances. But more than this, it was also based on the Initiative’s already existing good practice findings (many of which have been published as research reports and guidelines) and was capable of learning and disseminating lessons which might be generally applicable.

Through more than 70 projects, this second phase is addressing some of the most fundamental questions about prevention. For instance, what is the role of parents in the prevention of drug misuse? Do parents benefit from being provided with accurate, up-to-date drug information or is a more proactive approach required? How can communities support school-based drug education and should prevention elements be introduced to out-of-school activities? And how can ‘hidden populations’ and especially rural communities be reached by drug prevention?

Hopefully, if not answers, then at least suggestions will be available to these questions in the not too distant future. And we can all benefit from the work of the Initiative — practitioners, policymakers and Drug Action Teams alike. In fact, the DPI already provide a great deal of good practice support and advice to the Drug Action Teams in their areas. The challenge in the next few years will be to deliver that guidance more effectively to Drug Action Teams and others across the country.

by Lorraine Rogerson

Head, Central Drugs Prevention Unit

If you would like to know more about the DPI, please contact Gary West at the CDPU, Horseferry House, Dean Wind Street, London SW1P 2AW

DrugLink March/April 1997 - ISDD - Institute for the Study of Drug Dependence
Substitute prescribing

Social policy or individual treatment?
(and why we must make the decision)

The need for a cohesive prescribing strategy is abundantly clear. Prescribing is a very tangible therapy about which most people have strong but often inconsistent opinions. For example, doctors are seen on the one hand as the instruments of benzodiazepine dependence but, on the other hand, too resistant to opiate prescribing. The ‘British System’ has meant that prescribers are not usually wedded to rigid programmes, but equally may be divorced from treatment informed by the available research data. It is timely, therefore, not least for the reason of preserving the British System – which with the demise of the Addict Index is once more in the spotlight – to re-examine the philosophical quandaries at the heart of substitute prescribing.

Behind every prescribing decision there should be a clear understanding of how the chosen medication works and its expected efficacy. Writing a prescription for methadone demands the same clinical rigour as writing a prescription for any other drug.

There is, however, a problem in that the purpose of substitute prescribing is controversial and vigorously debated even within the addiction field. Essentially the question is whether prescribing methadone is an act in support of a social and public health policy, or – alternatively – a medical treatment for individual opiate users. Confusion, sometimes obfuscation, exists at both policy-maker and practitioner level about how to reconcile these two elements.

The Lewisham Citizens’ Jury concluded that methadone was more dangerous than heroin. If the educated general public think this, can substitute prescribing have much of a future? Duncan Raistrick proposes a framework within which it can flourish.

by
Duncan Raistrick
Clinical director
Leeds Addiction Unit

Summary
The rationale for substitute prescribing can be characterised as either a ‘social policy’ or an ‘individual treatment’ model. In practice, doctors rarely stick to either model, but such an arbitrary approach is no longer tenable, since NHS reform requires transparency of objectives.

Freedom and responsibility
Doctors in the UK have always enjoyed a large measure of clinical freedom and those specialising in the treatment of dependence have argued in favour of retaining this freedom and having available as wide a therapeutic repertoire as possible, including diamorphine and injectable preparations, at least until such time as research demonstrates unequivocally that these treatments have no place.

Few doctors would argue against clinical freedom, but many are circumspect when it comes to defining clinical responsibility. Clearly, prescribing opioids which are in themselves dangerous not least because of their dependence potential, risk of overdose and risk of illegal diversion, cannot be compared to prescribing aspirin or penicillin. Substitute prescribing is different from other prescribing because it impacts on the community as a whole not just an individual.

Arguments in favour of the ‘unthinkable’, the decriminalisation of heroin use may have gathered momentum in recent years, but are so far off the political agenda that they don’t bear much practical discussion. What seems to have been missed, though, is that heroin, cocaine and other powerful drugs are already available legally on a doctor’s prescription.

So the policy question for the next century (especially as we will no longer have the Addict Index to monitor us) really is whether doctors...
will remain capable of self-regulation. Whatever the answer, policy makers, doctors and the whole drug field need to agree on what our 'British System' is expected to deliver. Current opinion ranges from tight, American-style control to the prescription of drugs of choice on demand - in effect, a form of regulated legalisation.

**Messing with methadone**

Methadone is very much a ‘gold standard’ for substitute prescribing: it is of relatively low potency compared to other opiates, it is normally taken orally and is not rapidly available at opiate receptors in the central nervous system. It has a long half-life so that the loss of the drug’s effect and any withdrawal symptoms are slow and usually delayed by two to three days following a significant reduction in dose. Finally, as with all opiates, it has a low plasticity, which is to say that its effects are predictable and fairly independent of the environment.

**Under the ‘social policy’ model the nature of dependence is irrelevant**

So methadone is well suited to the needs of substitute prescribing, but it is itself addictive. Though less addictive than heroin and some other opiates, people often find it difficult to withdraw from methadone because of its high receptor affinity and long half-life. A doctor’s client may be keen to start methadone, but will have legitimate cause for complaint when it comes to withdrawing if the prescribing doctor has not fully alerted them to its dependence-forming potential and long duration of withdrawal syndrome.

All prescribers will be familiar with this dilemma of ‘getting stuck’ - after a period of stabilisation, reductions in methadone dose are made, but at some point further reduction is resisted. This prompts the question, when does substitute prescribing stop being a treatment and become no more than a legalised opiate supply?

**Policy or treatment?**

Prescribing methadone as a public health or social policy measure is not necessarily incompatible with prescribing for individual treatment. Social policy prescribing can be characterised as having the reduction of crime and prevention of the spread of infectious diseases by injection as some of its main objectives, while individual treatment aims to reduce opiate dependence and its harmful consequences to the individual by gradually moving towards a drug-free state.

Supporters of prescribing as an individual treatment are likely to conceptualise opiate dependence as a psychological state rather than illness, but, crucially, a state which is inconsistent with mental health. From this perspective it is unethical to prolong dependence by prescribing methadone in higher doses than necessary for longer than necessary. It is implicit that, to succeed in treatment, individuals will need to make significant lifestyle changes and, additionally, difficult psychological problems may need to be dealt with. It would normally be expected that if ‘treatment’ failed it would be discontinued.

Supporters of prescribing as a social policy measure, on the other hand, are likely to conceptualise opiate dependence within a public health model or as illness. From these viewpoints, the nature of dependence is irrelevant, individual goals are incidental and there is little expectation of an individual being able to change their drug use. It follows that long-term, high-dose prescribing of oral methadone or possibly higher-tariff drugs is indicated in order to achieve the desired social and public health gains. Therapy, counselling and more practical social care will be seen as a bonus.

**Who pays? Who stays?**

Society versus the individual is all well and good, but in the real world, prescribing doctors are pragmatists and the circle is squared behind the closed door of the consulting room. Initially, this works well, broadly following a series of ‘stabilise-and-deal-with-problems-then-reduce-methadone’ steps. The substitute prescribing often brings about an early and dramatic improvement in physical and mental health, as well as reducing criminal behaviour.

The problems arise when progressive reductions in methadone are accompanied by a relax into illicit opiate use. This is when the purpose of prescribing can seem confused because the social and individual goals become incompatible - there are legitimate arguments for saying that either the prescribing is now a failed ‘individual treatment’, or that it should continue - possibly at a higher dose - to reduce the probability of high risk behaviour and criminal activity.

Such an arbitrary approach is no longer acceptable, since the NHS reforms and ubiquitous performance indicators require a transparency of objectives which the ‘consulting room fudge’ can no longer substitute for. That said, methadone programmes that have a single objective, rather than allowing clinicians to achieve the optimal result across all outcome objectives, might in turn pose difficult questions for the NHS internal market.

The ‘individual treatment’ model holds that people need to make significant lifestyle changes

Suppose a criminal justice system purchaser wanted to buy a prescribing programme solely to reduce the harm caused by criminal activity. In order to maximise this single outcome, prescribing would probably be high dose, long duration and include high-tariff drugs such as diamorphine and injectable preparations. Such a strategy would be at the cost of health gain in terms of reducing dependence, but without necessarily reducing high risk drug use behaviour.

The uncomfortable logic of accepting this individual versus society model is that those who are prescribed for an ‘individual treatment’ ticket will have their prescription stopped if they are unsuccessful at achieving lifestyle change, while those prescribed for a ‘social policy’ ticket will have their prescriptions increased or changed to a higher-tariff drug if they continue to offend or use drugs in a high risk manner.

In other words, staying in a programme may well depend on who is paying and on who - the drug user apart - is benefiting. Perhaps it is now time for us all to shoulder the financial burden of substituting prescribing with the national health service, the criminal justice system and social services paying their way according to the benefits which they accrue. Without considering such an option, high cost, yet effective, substitution prescribing could become a thing of the past.

 THIS ARTICLE IS BASED ON A VERSION OF A PAPER FIRST PRESENTED AT THE "PRESCRIBING METHADONE" CONFERENCE IN LIVERPOOL, 1993.

Paul Lockley quite rightly acknowledges in this 266 page book that support groups are not the only way to help families of drug users and they are not the ideal method of support for everyone. However, anyone who follows the very thorough and detailed guidance here on facilitating and developing group support will have a head start in providing effective and appropriate help for this challenging group. Working with Drug Family Support Groups is aimed specifically at people who will be facilitating support groups and concentrates very much on group work. Therefore, it is not appropriate for self help groups, and accordingly, does not cover such practical subjects as publicity, funding, working with professionals, suitable venues and group management and co-ordination. Lockley, in fact, advises groups to use an external facilitator whenever possible. Nevertheless, despite being ‘provider-oriented’, the book is easy to read.

The book follows a logical structure moving from planning and facilitation, through to initial work (covering such areas as working on feelings, anxiety reduction, sharing in the group and self esteem) and further group work and development (including group functioning, communication, family behaviour, co-dependency, personal coping and problem solving). The only negative aspect is that the chapters are much too long while chapter headings are inadequate and don’t act as very useful signposts, making the book difficult to dip into.

That said, there is a particularly excellent section covering all aspects of facilitating, including interventions, ethics, rule enforcement, group safety, evaluation, and the importance of proper support for the facilitator.

Lockley is obviously very experienced in support group facilitation and uses this experience to help the reader work through possible group situations and strategies, often by using illustrative dialogue. Lockley is also admirably clear that support groups are not therapy groups; members aren’t ill or weak or failures. Indeed, what they’re facing is having to cope with a situation they find extremely difficult and almost unmanageable.

Underpinning this useful and comprehensive book are key points integral to the provision (and funding) of drug related family support. In particular, families of drug users are deserving of help in their own right, and society’s stigmatisation and rejection extends to drug user’s families – not just drug users themselves.

While groups aren’t for everyone, the advantages from belonging to one that’s effectively run (the reduction in personal anxiety, stress and isolation, the feeling of belonging and support in making changes and decisions) can be a lifeline for some. Support group facilitation is not easy – perhaps reflecting the small numbers of people currently willing and able to undertake this type of work. Read this book if you’re planning to support families in this way or, indeed, if you’re already doing so. Highly recommended.

Anne Marshall
Director, ADFAM National, charity for families and friends of drug users


I saw David Emmett on a video about solvent abuse some years ago, and it struck me then that he had a peculiar fascination with the mechanism of the misuse of solvents, to the extent of giving demonstrations of how to sniff and almost sticking a marker pen up his nostril. He shows a similar fascination with the mechanism of drug misuse and this book contains detailed descriptions of how to use a ‘hot knife’ and several pictures of bhongs.

Unfortunately he and his co-author do not show a similar interest in drug users themselves, and therefore give a very one-sided account of drug use. I had hoped that we had gone beyond the stage where drugs could be considered in isolation from the people who use them – especially in a book subtitled “A Handbook for Parents, Teachers and other Professionals”. It is this lack of interest in the people – coupled with the authors’ obsessive desire to categorise drugs, list in exhaustive detail so-called slang words for drugs, and provide flow diagrams for drug using scenarios – that makes this book so arid and unhelpful.

The first 10 chapters – over 200 pages of this 320 page book – give detailed and largely accurate descriptions of various drugs, although ISDD’s Drug Abuse Briefing, or former Police Officer David Stockley’s Drug Warning are better illustrated and more balanced. Chapter 13, about managing drug-related incidents, describes seven scenarios that an adult may have to deal with. Each has a neat flow chart for action with notes. It’s as if the authors, bewildered as they are by young people’s drug use, are trying to create a safe, structured world where drugs can be fought without dealing with the complexities of people’s lives. Real life is complex and messy and helping people find solutions to their drug-related problems can’t be reduced to formulas.

The next chapter combines reasons for drug use with treatment options (a strange combination) and the penultimate chapter gives a tedious list of drug slang (when faced with disorder, make a dictionary). The last chapter provides final evidence of the authors’ blinkered view of drugs with an ill-informed and one-sided discussion of the “legalisation debate” (of course, you know what conclusion they reach).

I am weary of the war on drugs and I’m wary of the self-appointed commanders who urge the troops on to further battles. Emmett and Nice’s military manual for misguided war-mongers has no place in a ‘Tackling Drugs Together’ framework.

As Thucydides, writing in the fourth century BC, put it: ‘That war is an evil is something that we all know and it would be pointless to go on cataloguing all the disadvantages involved in it.’ I’d therefore prefer not to have any war, but if the military metaphor is such a spur to action for people and government, then let’s use it to get things done. If we must have a war, then instead let us have a war on some of the causes of problematic drug misuse. We don’t know all the reasons why people have problems with drugs, but we can be sure that poor housing, family break-up, and psychological problems are some of the enemies in our ‘fight against drugs’. And while we can’t be sure that good self-esteem protects people against problematic drug use, we could at least strive against the forces – poor educational achievement, lack of employment, a feeling of not belonging to society – that lead to low self-esteem. These are the real battles that need fighting which (unlike the war on drugs) we have some chance of winning. But I’d still prefer to echo Milton, who said: ‘Peace hath her victories no less renowned than War.’

Richard Ives
Independent consultant on young people and drugs
**PUBLICATIONS**

**Treatment**


**Crime**


**Education/Prevention**

- **PREVENTING DRUG MISUSE. SOCIAL CURRICULUM GUIDANCE FOR SCHOOLS**. Essex County Council Education Department. Chelmsford, 1997. £6.50. Available from Essex County Council Education Dept., P.O. Box 47, Chelmsford CM1 1LD.

- **A SURVIVOR’S GUIDE TO DRUGS AND CLUBBING**. Scottish Drugs Forum & Enhance RDP, Scottish Drugs Forum, 1996. Available from Scottish Drugs Forum, Shaftesbury House, 5 Waterloo Street, Glasgow G2 6AY.

- **NEW DRUGS AWARENESS POSTCARDS FOR CLUBS**. Crew 2000, Edinburgh, 1997. 6 postcards. £0.35 per card. Series of postcards covering issues from ‘Women and Drug Use’ to ‘Drugs and Driving’. Available from £1, E. Skelton, 32 Cockburn Street, Edinburgh EH1 1DP, phone 0131 220 3404, fax 0131 220 4446.

- **CHECK OUT THE FACTS: DRUGS & VOLATILE SUBSTANCES/ALCOHOL-HYDROCARBON**. TACADE, Salford, 1996. Series of six booklets, £0.52 each.


**Development**


- **CONFERENCE**

**Mainliners**

- **MAINLINERS – 2ND INTERNATIONAL CONFERENCE ON HEPATITIS C**. 10 March 1997, Commonwealth Institute, London, £80. Details from Patricia Purcell, Mainliners, 205 Stockwell Road, London SW8 1UQ, phone 0171 738 4656.


- **DRUGS – WHO CARES? 18-19 March 1997. Cumbrian Hotel, Court Square, Carlisle. £50 per day, £75 both days. Details from The Steven Boyd Trust, Carlisle City Council, Carlisle, phone 01228 512500.


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