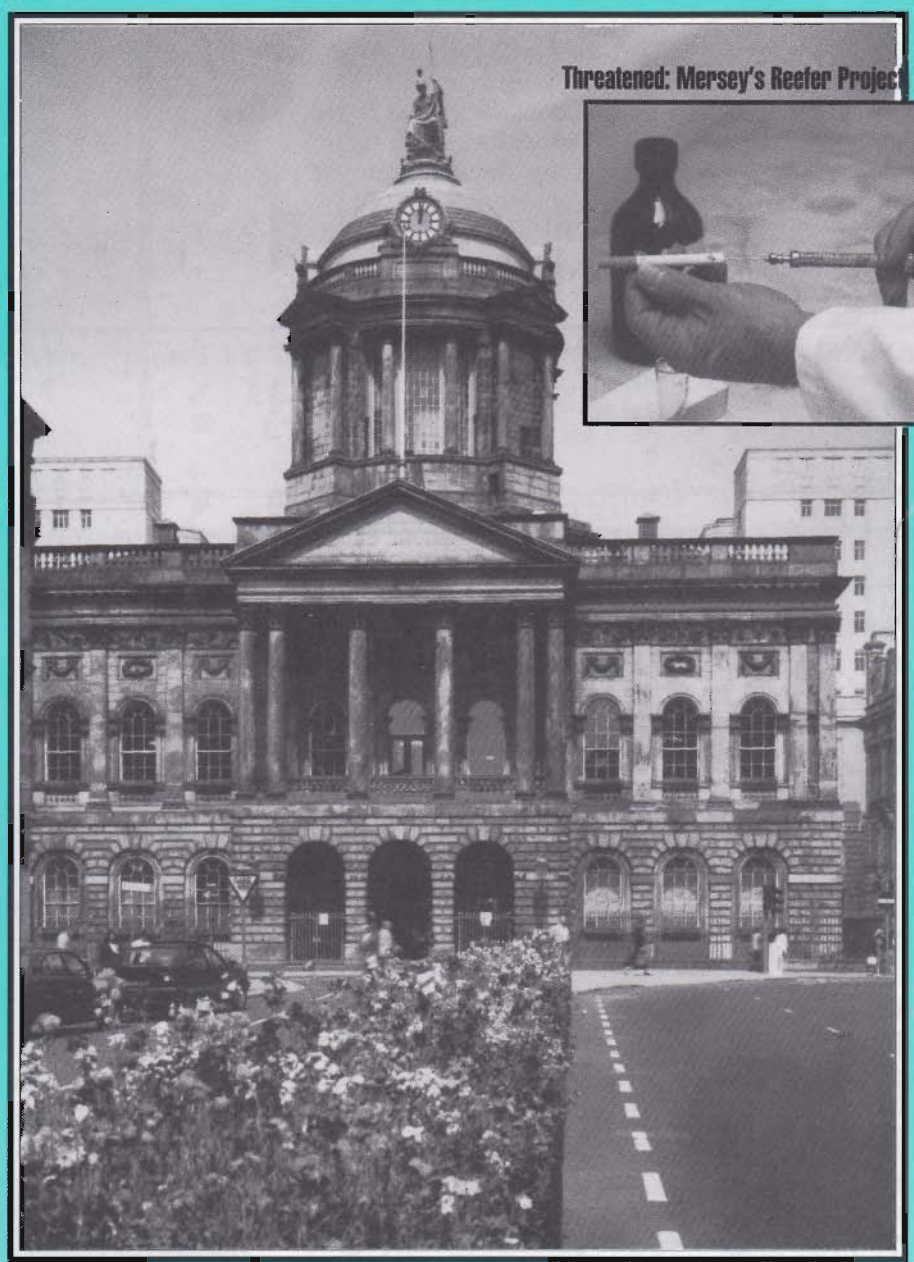
DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN

May/June 1991



Threatened: Mersey's Reefer Project Pages 5 & 10

Civil war on drugs in Liverpool. Page 6

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THE JOURNAL ON DRUG MISUSE IN BRITAIN

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

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

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

Civil war on drugs

With a health authority at the forefront of harm reduction, Mersey also contained a Militant city council determined to be more anti-drug than Thatcher. The mix made drugs a hotter political issue there than anywhere else in Britain: a personal history of Liverpool's drug politics on pages 6-9, current developments on page 5 – and on pages 10-11, a taste of radical Mersey practice.

Front cover photo courtesy of Liverpool City Council

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Encouraging start for community care grant

As many as 80-90 per cent of English local authorities responsible for social services bid to fund drug or drug/alcohol services out of the £1.4 million Department of Health community care grant for 1991/2.

The figure cannot be known precisely because details are not being given of unsuccessful bids, some of which may have been multiple bids by a single authority or made by district councils without social service responsibilities.

Just five more bids were received for alcohol services than for drug services, though 55 per cent more money was requested (see table).

Nearly two-thirds of all bids were rejected. Had they been accepted the grant would have to have been doubled. On drug services alone, local authorities were willing to bid for 76 per cent more than was granted by the Department of Health.

These figures suggest an encouraging willingness by local authorities to fund drug projects, despite being required to find 30 per cent of the money locally. The limiting factor appears to have been the £1.4 million ceiling on the Department of Health's contribution rather than reticence on the part of local authorities to find the other 30 per cent.

The Local Government Drugs Forum found that some councils failed to bid because drug services were not seen as a priority, but others simply had no suitable service within their boundaries – funding was insufficient to start up new residential services. Others were wary of getting involved in an unfamiliar area of work.

Some of the bidders did not have to raid their budgets as the Department of Health allowed the 30 per cent to be raised by the authority from charitable or other sources.

Much more money will need to be found after April 1993 when it's planned that local authorities will fully fund community care, but then there may be no requirement for part of the money to be found locally.

In the interim there will be another round of bids for the 1992/3 grant, but a large slice of next year's money may be needed to support the initiatives funded by the original £1.4 million, most of which had continuing cost implications.

	Bids received	Bids accepted
Drug	£800,017	£453,612
Alcohol	£1,244,415	£750,429
Combined	£731,153	£195,959

Sixties skills may be needed to cope with new generation of trippers

If you've still got them, it may be time to dig out those copies of *International Times* and *Oz* for some good ol' street knowledge about how to deal with the side effects of LSD. That seems to be the message for managers needing to support drug agency workers seeing increasing numbers of young people having problems with the drug.

Since 1989, the advent of 'house' parties and 'raves' has seen a significant rise in the use of drugs such as LSD, Ecstasy and amphetamine sulphate among the young people who attend these events in their thousands. In some areas, too, LSD has become a regular adjunct to youth recreation, from attending football matches to a night out at the pub.

The demand for LSD is mirrored by a fivefold increase in police seizures of LSD from about 45,000 doses in 1989 to nearly a quarter of a million in 1990. Its popularity is also making new demands on drug workers. Many workers recruited in the 1980s are too young to have been part of the LSD subculture of the sixties, which usually lent peer support to its 'bad trip' casualties.

Twenty years ago there was a certain amount of 'street knowledge' about dealing with such adverse effects. In some circles today, being able to 'handle' your trip is regarded in very much the same light as 'handling' your drink – a macho attitude which has little time for 'peer support'.

In the sixties, the golden rule was not to mix acid with speed. Now LSD is often taken with amphetamine sulphate *and* Ecstasy, which itself has hallucinogenic effects.

The Lifeline Project in Manchester has begun to address these issues with cartoon material aimed at young users. The leaflets introduced two characters. 'Floyd' is the sixties hippy dispensing basic harm-reduction wisdom to the new generation of young drug users, who in turn are represented by 'Peanut Pete' – "out of money and out of his brains".

Lifeline's sixties hippy Floyd advises the new generation

However, drug agencies rarely see those who are actually tripping. More likely, users come forward perhaps weeks or months later complaining they feel alienated or detached from the world around them and seeking reassurance that they are not going crazy.

In future, drug workers may need additional guidance on how to help this group of young drug users – on issues such as what is appropriate counselling, and when to elicit the support of psychiatric services for clients who really be suffering from a drug-induced mental illness.

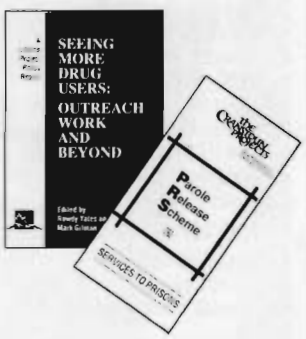
Traditionally, drug agencies have been seen by users as primarily for opiate users. As Lifeline found, a change of image will be needed to attract this new client group. After that, resources will be required to ensure workers feel confident of coping.

But with so much drug agency activity now funded by 'AIDS money', openly reaching out to a group of users not immediately at risk of HIV-transmission might not be a priority, whatever the need on the streets.

isdd NOTICEBOARD

● The literature explosion in the drugs field continues unabated: figures just released by the ISDD library show a 31 per cent increase in the amount of material received to a current record level of over 3000 items a year. The demand for library services is also rising significantly; enquiries were up 20 per cent on the previous year – on average 36 people made contact with the library on every working day, either by phone, letter or personal visit.

● Last autumn, ISDD launched PRINT.PLUS, our design, typesetting and print service for drug agencies. Since then, we have produced materials for Manchester's Lifeline project, Drug Concern in Watford, the Parole Release Scheme, the Local Government Drugs Forum, the Centre for Research on Drugs and Health Behaviour, and East Berkshire Health Authority. If you want to find out more about the service, please contact Mike Ashton or Véronique Séraf-inowicz on 071-430 1991.



Two PRINT.PLUS productions

● Later this year sees the publication of a new literature series – the ISDD *Drugs Work* series. The idea is to produce practical information in a handy booklet or leaflet form for use by people involved in drugs work on a regular basis. The inaugural three titles will cover stress management (for the worker!), outreach, and hepatitis. A number of other titles are being considered, but we would like to receive suggestions for future titles – better still, volunteers to write them! Please contact Harry Shapiro on 071-430 1991.

Fears over Mersey 'retreat' from safer drug use policies

Extraordinary scenes at a WHO-sponsored international conference last November included secret showings of a video on the Mersey Regional Health Authority's drug strategy.

Lookouts at the doors checked for the approach of the official Mersey delegation who had threatened to leave if the video was shown.

Presenting the video was the man who just six months before had been Mersey RHA's Drugs/HIV Coordinator, but the official health authority representative argued that the film no longer represented regional policy.

Events at the conference are being seen as a graphic illustration of the changes at Mersey RHA, for several years at the leading edge of harm reduction practice in Britain. Those who developed Mersey's distinctive approach say the trend now is to 'normalise' the region's radical image and create a more 'mainstream' pattern of services.

First major casualty of the changes may be Mersey RHA's £40,000 funding of the Reefer Project, intended to underwrite the development of techniques for producing smokable opiate cigarettes for addiction treatment (see pages 10-11 of this issue).

Mersey Regional Medical Officer Peter Simpson says the £40,000 was "unused money" clawed back to help the region through its financial problems in the last financial year.

The funding withdrawal has seriously hampered the work of the Liverpool pharmacist organising reefer production. Jeremy Clitherow has had to disengage from arrangements made with laboratories and other suppliers, but has been told there is a high chance of the money being returned in the current financial year. He was unable to confirm a source within the health authority who claimed that the money had been handed back under threat of legal action.

Although baulked by the health authority, Mr Clitherow is favoured by the Government. Addressing the Pharmaceutical Services Negotiating Committee annual dinner last February, Health Secretary William Waldegrave introduced him as the "pharmacist who has done more for syringe and needle exchange than any other".

One of the homes of the Reefer Project is John Marks' Widnes drug clinic, which has now been told to refer clients from outside its area back to their home districts.

Dr Marks is known not just for prescribing reefers but also injectable heroin and other drugs not commonly prescribed in addiction treatment. His belief in maintenance prescribing as a harm-reduction tool is central to his practice.

It seems unlikely that his ex-patients will receive similar long-term treatment elsewhere. Some accustomed to injectable heroin or heroin reefers may sooner rather than later face the more conventional oral methadone regime.

Those behind Mersey's radical strategy fear other services such as the ten district outreach schemes are being starved of support. The suspicion is that declining performance will be used to justify harm-reduction cutbacks, with the money divert-ed to less controversial services.

■ Since the mid-80s, harm-reduction activists in Mersey's health authorities have been at loggerheads with the abstentionist line of the Militant-dominated city council, spearheaded by its Drugs Liaison Office.

Over the last two to three years Militant influence in the council has declined, but the Drugs Liaison Office was allowed to remain a Militant stronghold. The reckoning came in April when the office was closed as part of a package of cuts forced through despite Militant opposition.

Closure of the office plus the trend to mainstream thinking in the health authority could temper the damaging feud between the city council and the health authority.

SEE ALSO

■ **DRUG POLITICS IN LIVERPOOL page 6**
■ **THE SMOKING OPTION page 10**

Volunteering scheme offers route to work

Research by ISDD on a Community Service Volunteers' CSV Action scheme which found volunteer employment for drug or alcohol users has concluded that such schemes can provide a valuable bridge to work for unemployed users.

Even for referrals not found volunteer places, it's claimed that confidence and self-image improve as people regarded as 'no hopers' are offered positions of trust and the chance to perform useful work. CSV say a third of the schemes' graduates went on to find work or training places.

The pilot schemes were originally based in north London and mid-Essex and funded by a three-year Department of Health 'pump-priming' grant from 1986 to 1989.

After a slow start the London scheme flourished, receiving 130 referrals including 98 drug misusers, and finding volunteer slots for 69. Now London-wide, this scheme is continuing with charitable support and receiving 100 referrals a year.

For both schemes building up a referral network proved more difficult than finding placements. But agencies whose clients were placed by the CSV Action schemes were enthusiastic about the therapeutic and practical benefits. For CSV a major selling point is that these benefits are achieved at an average cost of £800 per placement.

After the pump-priming money ran out the mid-Essex scheme closed in 1990, having faced the added difficulties of working in a rural area with poor public transport links and an underdeveloped drug services network. Nevertheless in its last year the scheme received 38 referrals and made 22 placements and CSV believe it had proved its long-term viability.

■ To refer clients to CSV Action in London contact Jo Heywood or Rosie Blake on 071-278 6601.

Client arrested in drug agency's kitchen

Plain-clothes police came "charging" into a south London drugs advice agency claiming to be in pursuit of a man who'd recently committed burglary. A worker then eight months pregnant who blocked their access to a room where clients were waiting to be seen was threatened with arrest for obstruction.

For a year police had allowed Drugline in Lewisham to work unmolested after a period of searching clients outside its premises, but on April 8, shortly after a client had entered for his appointment, the entryphone announced "It's the police".

Thinking it was another client joke, the door was opened and police rushed up the stairs. At first they agreed to wait for the suspect downstairs but a fresh trio of officers insisted on arresting the client in the agency's kitchen. Attempts to search the kitchen were resisted.

Police waiting outside said they were seeking orders on searching the premises. Their justification was that while prevented from entering the waiting room another worker could have removed stolen goods from the client. Police were aware that the agency was a drug project.

Margaret Moses, the project's coordinator, says staff were disturbed by the incident which has been followed by a significant decline in client attendance. The project intends to lodge a formal complaint.

Jane Goodsir, Release's Director, confirmed that even without a warrant police in 'hot pursuit' have the right to enter premises and look for the suspect. Her advice is that in this situation agency staff should politely identify themselves as professionals and make it clear that they do not consider the officers at liberty to carry out a full search of the premises.

SEE ALSO

■ **SEARCH AND ARREST p.15-16**

PART ONE

Drug Politics in Liverpool

a personal account

Allan Parry

Liverpool is Britain's only example of what can happen when drugs becomes a key political issue in a no-holds-barred confrontation between opposing ideologies. Cynical exploitation with drug users' welfare bottom of the agenda became the order of the day as Militant fought to retain its hold on Liverpool's voters. Allan Parry was at the heart of the health authority's response and before that of its bitter opponent, the Militant-dominated city council. This is the first part of his personal account of drug politics in Liverpool.

'LIVERPOOL WATCHERS' will remember the images on TV at the beginning of April as bitter Militant councillors and activists labelled the majority of Labour councillors 'class traitors' for voting through a budget which approved widespread redundancies.

But their real anger was in the realisation that Militant really had finally lost control of party policy in Liverpool and were being manoeuvred into committing political suicide by ignoring the party whip.

Not just the Militants are outraged by the proposed cuts. Among the people of Liverpool it is widely appreciated that the Labour council had no choice – but while the voters blame the Tories, Militant blame their comrades.

But there was hardly a murmur at this March's closure of the city council's Drug Liaison Office (DLO) with its nine full-time staff. Even the most rabid Militant knows that closure of the DLO is a very popular decision. There is to be no Militant-organised 'spontaneous' community campaign to save it.

Why would a local authority, arguably host to the worst drug problem in the UK, get rid of its drugs office? Surely a team of experts is needed by a city where almost any type of drug is widely available and where high quality heroin is sold at competitive prices in the thriving new 'street markets' springing up around the city?

But the response from nearly all of those involved in drug work in a tired city ranges from quiet relief to jubilation. Closure of the DLO means the end of a 'drug service' that many feel has kept its local authority in the dark ages of prevention and drug education, and campaigned using every dirty trick in the book to undermine the local drugs/HIV services that have helped the area remain at the bottom of the national 'league table' for HIV rates among its local injectors.

The realisation is emerging that for ten years the local authority has not been fulfilling what should have been a major role in enabling the city to come to terms with its awesome drug-related problems. Preoccupied with their struggle to keep the city above water, fighting the Tories, and more recently fighting Militant, most 'moderate' Labour councillors simply accepted the views and reports from their now discredited drug unit.

It started in the early '80s when the unprecedented heroin 'epidemic' in Merseyside caught the Militant theorists with their analytical trousers down. At first their reaction was promising How the party eventually opted for the simplistic 'off the shelf' view that it was all the fault of the Tories, and how its leaders' one-track political drive led them to oppose important health authority initiatives, is the subject of this two-part story.

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

Militant rattled

In 1983 I went to a public meeting in Croxteth called by the local Labour wards. It was packed. For the press Croxteth was now 'Smack City' (having beaten the former title holders, Wirral, in a television and newspaper play off!). Croxteth is the Militant power base in Liverpool. Local labour councillors usually received massive public support for their various fights with 'Thatcher'.

At this meeting, things weren't going as smoothly as usual. Usually loyal local supporters were screaming at the experts and councillors on the panel. "What the fuck are you doing about these drugs all the kids are using, they're all on the heroin and they're all going to die, aren't they?" There was desperation in the voices of parents, some of whose sons and daughters had sold everything in the house to buy heroin. Their panic was fuelled by grotesque media imagery of dying teenage junkies hooked after one smoke, of drug-crazed fiends prepared to murder to get that fix.

After the meeting local parents described their ordeals and fears to the much respected Militant MP Terry Fields. He listened intently, visibly unnerved at hav-

September 1984: "No apologies" from the *Liverpool Echo* as it puts a blowtorch to Mersey parents' fears over heroin.

No apologies: This is only the end of the beginning

Echo Comment

NEVER before has the Echo devoted so much space to a single issue as we have this week to the problem of drug abuse on Merseyside.

Never before has there been such an instant and overwhelming reaction to an Echo investigation.

Our pages made shocking, gloomy reading but they also touched a nerve among parents throughout our area.

Letters from drug users and from drug-blighted families began to arrive with the first post on Tuesday. The telephone of Peter Trollope, who led the Echo investigation, has scarcely been silent.

Many calls were moving but, without exception, they have contained messages of gratitude and of hope.

The mother of an 18-year-old Noctorum youth whose son has been hooked on heroin for the last two years said: "Words cannot express the gratitude I feel.

"For the last two years I have felt so terribly alone. Nobody seemed to care. I have spent thousands of pounds actually buying heroin for my son to try and control how much he takes and to try and get him off it and keep him out of trouble.

"They have been sheer hell. They have all but destroyed me, and then I saw the Echo this week. I cannot tell you how your courageous work has made me feel. You have given me hope and the inspiration to go on.

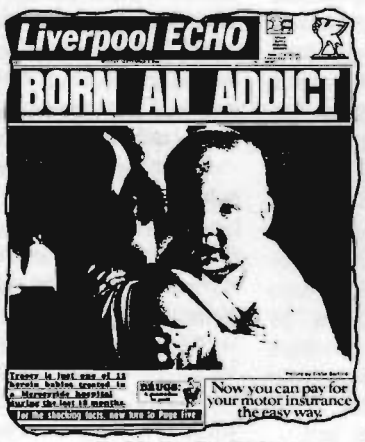
"I would ask every Wirral mother to support your campaign, after all, it could be their child next."

If this series achieves nothing else, it will have been worthwhile — a problem shared is not a problem cured — but it is a burden eased.

There is no doubt that publicity is the first step in countering drug abuse.

Our investigation has taken the problem out of the shadows; stripped it of the false glamour that immature young people sometimes mistakenly invest in drug taking.

But it is only the first step on a long road — and a road which no country or city has yet travelled with real success. In American cities, for example, where drug-taking years ago reached the level Merseyside is now approaching, none of the remedies tried from intensive policing to greater welfare help has proved the complete solution.



The Echo Page One, Monday.

That is a cause for concern, but not a cause for despair.

One mother rang to say her son had broken down in tears when he read Monday's Echo and confessed he had been taking heroin.

"I was absolutely shattered. I couldn't believe it. He is seventeen. We sat down and talked and read the Echo all week and he told me he was going to stop. I am so grateful to the Echo because imagine what might have happened if I had not found out until it was too late. At least we can face the problem together now."

Merseyside police said in our series yesterday that drug abuse is a matter not just for them but for parents in particular and for the community as a whole.

They are right. Only parents and a community that co-operates with the police and that makes its disapproval of drug-taking crystal clear, can hope to turn back the tide.

Dr. Griffith Edwards, the head of the drug addiction research unit of the Institute of Psychiatry, has said: "In no country that I know of is drug use not related to culture and economics, to the state of the nation. If we don't get society right, heroin is going to be rife in the ghettos of our cities."

Authorities are slow to acknowledge a positive link between the hopelessness of unemployment, lack of education, poor living conditions and drug-taking coupled with crime to finance the addiction.

Commonsense says that, while drug abuse now permeates all levels of society, the boredom, aimlessness and the lack of self-respect of many of our young people makes easier the work of the drug merchants.

The Echo cannot change the country's economics. It cannot bring about alone and overnight the changes in society that are necessary to make tolerable the dole-queue world in which thousands of youngsters find themselves.

But, as we said on Monday, we would be letting down very badly baby Tracey — one of 12 born addicted to heroin at one Merseyside hospital — and other vulnerable youngsters like her if we merely reported on the drug problem for a week and left it at that.

We do not intend to let Tracey down. Turn the page and you will see the positive steps the Echo now plans.

Turn to next page

ing no remotely satisfactory answers. Asked what the party was doing about this issue, he admitted ignorance, but was now determined to tackle it. I offered to assist as I was once a chaotic user, had worked in the field, etc, *and* I was on the left of the party – essential if one wanted to be listened to at all.

Soon he'd contacted the Merseyside Trade Union and Unemployed Centre in Liverpool – which the party regarded as its 'community action' wing – asking them to shape a 'community' response to the issue. One of Militant's most experienced community activists, Phil Knibb, was to monitor the new venture.

Promising start

For the next few years I was convinced that, under its socialist leadership, I would witness Liverpool becoming a model of sound municipal planning leading to pragmatic, humane and effective drug policies and practices.

In 1983 'Degsy' Hatton (deputy leader of Liverpool city council and *de facto* in charge) and Tony 'Snapper' Jennings (leading Militant councillor responsible for protecting the DLO) allowed me a lead role in establishing the Merseyside Drug Education, Training and Research Unit (MDETRU) – a unique attempt by the regional and local trade union and labour movement to educate itself and draw up strategies for dealing with the dramatic escalation of heroin use.

At first everything went superbly. Training courses for shop stewards, councillors and party activists were very well attended; it seemed the trade union and labour movement locally had finally responded to its fear and confusion surrounding drugs. I made it clear that scaremongering was not on our agenda and that some painful truths had to be faced – that drugs are here to stay and that much of their fear had been generated by the media and by 'war on drugs' propagandists. It looked like a sensible political analysis would be arrived at and acted upon by the council.

Attempts to cash in on our drug problem were swiftly dealt with. In 1984 'professional fundraisers' conned a local drug agency into putting their name to a lottery to raise 'hundreds of thousands' of pounds for the agency. We soon discovered that the people responsible for this venture were notorious for their exhorbitant 'administrative costs'.

The lottery sheets appeared in a major local department store. Our delegation of community and political representatives explained the situation to union representatives in the store who made it clear to the store's management that action would be taken unless all the lottery sheets were instantly removed. That day they were removed and the fundraisers were dumped by the now embarrassed drug agency!

This type of community action led many of us to think that the trade union and labour movement could be a fruitful area for development, and that working class organisations could rise above the usual hysteria and respond pragmatically.

Political fight for Phoenix

My first real clue that 'integrity' as a malleable concept had entered Liverpool's drug politics was when I organised negotiations over the possible establishment of a Phoenix-managed therapeutic community in Liverpool.

The Militants wanted a therapeutic community but, like any other project they became involved with, they also wanted control over its local management committee. I pointed out that they did not have the necessary skills or experience. Their response was that I could advise them on the 'therapeutic' content of the programme while they would manage the 'political' aspects.

It was soon obvious that they wanted to use Phoenix to attract funding; then via management committee control and my knowledge, they would design a 'socialist' programme with 'educational' sessions that would help clients achieve a political analysis of drug problems and come out the other end as activists!

They moved quickly, aware that such a venture would achieve enormous publicity for a 'caring council'; a property was allocated, councillors briefed, and it looked like we would soon have a therapeutic community in Liverpool.

But when Phoenix became aware of these plans, they ran a mile. In fact, a couple of miles, over the Mersey to Wirral, where the Tory-controlled council were just as keen to expand their new drug prevention empire, and as aware as the Militants of the political mileage in being seen to be doing something about drugs.

The discovery that the Executive Director of Phoenix had been meeting representatives from Wirral enraged the Militants; some offered their 'services' as persuaders to bring Phoenix back to Liverpool.

Phoenix's Director had let it be known that he was active in his local Labour Party ward somewhere in London. The plan was

Now heroin has come to Croxteth, like one of the plagues of Ancient Egypt, to add to the impact of mass unemployment, poor housing and poor standards of health.

But it has come, many people there feel, to a community that has already begun to fight back.

For Phil Knibb, still one of the leading figures in the running of Crocky Comp, there seems little doubt that the last two years—including the fight for the school and Liverpool's budget crisis—have raised the consciousness of local residents.

"People are much more aware of their environment—and they are prepared to fight back," he says.

And for Tony Jennings, the county councillor for Gillmoss Ward since 1981, the attempts of local people to organise against their heroin problem are part of the same process that began with the occupation of the school by parents in 1982.

"The turning point was the situation at the school," he says. "People really came together over that. Then there was the drug problem—there is no doubt that it is very big in Croxteth.

"But people have decided that they are not going to let their children suffer at the hands of the pushers."


DRUGS: A generation in peril

People versus the plague

By Nick Bunker

babies become addicts

Peter Trollope

Action Line

Liverpool Echo, **September 1984: Militant leaders ally the community's response to drugs with the fight against cuts and unemployment**

And, above all, you hear about the people—the people of Croxteth who are fighting for a better life amidst the new poverty of the nineteen eighties.

to contact the Militants in his ward or branch and expose the fact that a socialist had preferred to put Phoenix under the control of a Tory council rather than a good socialist council like Liverpool! I suggested that in the final analysis, did it really matter where the community was based, as long as it was accessible to all Merseyside users.

They looked at me as though I was stupid. I'd failed to understand that their motivation in seeking to bring Phoenix to Liverpool was to achieve sympathetic publicity for a beleaguered Council. They lost Phoenix, and my less than rabid support for their threats led them to begin to regard me with suspicion. Until then I had viewed their manoeuvrings to gain control of the new trade union drugs centre as probably a sound move. Wasn't it better to have committed working class socialists running agencies rather than middle class professionals?

I was beginning to have my doubts: one of the councillors on the management committee demanded that the unit should not work on the Wirral, as a bizarre way of punishing the Tory council which had enticed Phoenix away. I pointed out that the unit was funded by the county council and had a Merseyside-wide brief; his response was, "It's their [Wirral Tories] problem, let them deal with it!" For many of the Militants I came to know well, it was bitterness and hatred for anything Tory that appeared to drive them, not compassion for their class or a desire actually to create a humane socialist state.

'War on drugs' exploited

Shortly after the Phoenix debacle I was invited to another meeting with senior councillors (who I subsequently discovered were now the 'new management' of the MDETRU). I was being honoured with an invitation to lead a youth campaign highlighting "Thatcher's plan to sedate working class youth" by allowing drugs to swamp the city. Such blatant exploitation of an issue then causing acute distress to the whole of Merseyside came as a shock.

Seeing me as one of them, the Militants overseeing the development of the MDETRU frankly presented their dilemma. Extremely politically astute, until then they had been very supportive of the pragmatic harm-reduction orientation of our training.

But they were also sharp enough soon to realise that tolerance, harm reduction and pragmatism were hardly the messages besieged Labour councillors would want on a manifesto going into the homes of people terrified and confused by media stories. These would be the last people to wish to see tolerance and humanity shown to 'druggies', who they perceived as

"I went into the meeting regarded as a very useful ally; I came out with daggers in my back"

largely responsible for the crippling wave of drug-related crime that had spawned vigilante groups on many of the affected estates.

The Militants cynically deduced that signing the city up for a 'war against Thatcher's drugs' would appeal to the thousands of frustrated and angry heroin 'afflicted' families – increasing the Labour vote at a crucial time for the Militant leadership as they prepared to take the government head on over the city council's ever-expanding budget.

The tactic worked, producing even more support for what was still a very popular socialist council.

People who, after all the training, really did understand the issues, were now telling me that we should abandon presenting pragmatic, non-dramatic solutions to a fear-paralysed city. From now on the MDETRU was to become a propaganda unit playing on people's fears about drugs to generate support for forthcoming political battles with the government. This was the antithesis of everything we had been trying to do to help the citizens of Liverpool come to a more rational analysis of a complex issue.

In 1985 I was asked to lead a march organised by the Young Socialists, with banners attacking Thatcher for allowing drugs to "swamp" our city's youth to divert their political anger into the cul-de-sac of drug-induced stupor.

There is a case for linking the actions of a Government not particularly known for its concern for the youth of cities such as Liverpool with the high levels of drug use among their young unemployed. But presenting the issue in such simplistic terms as "Get rid of Thatcher and then we will see the back of the drug problem" is a cynical trick to play on the people who voted for you.

There was genuine surprise when I said as much at the meeting. The faces of those I had previously regarded as friends changed as the meeting went on. They had made a mistake in 'grooming' me for the position of drugs advisor to the Labour Group, and now they knew it!

I told them that I would rather leave the unit than agree to such political posturing on an issue I cared deeply about. I went into the meeting regarded as a very useful ally; I came out with daggers in my back. There is no middle ground with Militant; if you are not a friend you are an enemy.

What had happened was now becoming horribly clear. Our training had described how politicians all over the world historically had benefitted from media hysteria by taking extreme anti-drugs positions. In the process we had revealed a vote-winning strategy to our own local politicians, desperate to maintain grassroots support for a 'high-noon' showdown with government.

To attempt to counter media images of drugs and government exploitation of the issue, while at the same time trying to drum up support locally, was quite correctly regarded as political suicide. To our horror, we had actually shown Militant how to cash in on the drug war!

Narrow escape

Shortly before these episodes I was asked to join the city council as principal officer advising on drugs. But I had become too aware of what I'd become involved in to want to get even more involved – particularly as initially I would have been based in Derek Hatton's Central Support Unit (CSU).

Staffed by a dozen or so well-known senior Militant activists, the CSU was the coordinating point for the implementation of 'policy' in the council. Although a supporter, I was wary about joining what was regarded by almost everyone who knew about it as Hatton's 'Politbureau'.

But it was tempting. To avoid any 'interference' by other party councillors, the new Drugs Liaison Office was to be based in the City Solicitor's Office. As this was the only department not under the control of any council committee, we would be able to work without recourse to democracy. Later this was exactly how the Drugs Office was established.

During this period Militant were not a small group of international revolutionaries, but still a very popular movement in Liverpool. Most were impressive in their commitment to changing Liverpool from what Alexei Sayle once likened to a "Beirut with job centres". But within two years this commitment had, for example, been perverted enough for the Militant-led DLO to successfully threaten to evict a parent-led voluntary agency if they dared set up a syringe exchange.

In part two – how the people's council came to threaten health authority and other initiatives intended to save the lives of the people it professed to protect. ■

In the next issue – the bitter feud between the city council's Militant caucus and the health authority radicals that brought Merseyside to the international leading edge of harm-reduction practice.

The smoking option

Controversial, innovative, but it could help prevent HIV spread – prescribing smokable opiates to opiate addicts

For two years two Mersey drug dependency units have been prescribing smokable methadone or heroin to opiate injectors to encourage them to move away from injecting. Smokable cocaine or amphetamine are also prescribed. Smoking simulates the 'rush' from injecting and may be suitable for injectors unwilling to settle for the milder effects of taking drugs orally. Pilot research and clinical experience suggest prescribing smokables may be a viable alternative treatment for some patients.

John Marks, Andrew Palombella & Russell Newcombe

John Marks is consultant psychiatrist at Halton and Warrington drug dependency units. Andrew Palombella is the coordinator at Halton. Russell Newcombe is Honorary Lecturer in Public Health at Liverpool University and a researcher at Mersey RHA's Drugs and HIV Unit.

SMOKABLE HEROIN, methadone, cocaine and amphetamine cigarettes have been prescribed by Halton and Warrington drug dependency units since 1989. The aim is to help clients switch away from injecting these drugs because of the greater risks of this mode of administration – particularly HIV infection.

We adopted this innovative policy in the context of the Home Office's estimate that at least 80 per cent of opiate dependents (and probably an even higher percentage of those dependent on stimulants) are not in treatment – a reflection on the 'pulling power' of current treatment practices.

Current treatment policy is also associated with the widespread injection of adulterants and with HIV infection rates in drug addicts above 50 per cent in some areas, particularly where harm-reduction initiatives have in the past been eschewed.

There is an alternative

Injectors who may be willing to forego injecting, but not drug use, are usually given only one option: oral (swallowed) drugs. In the vast majority of drug dependency units, this means oral methadone to substitute for injectable opiates, though a few also prescribe oral amphetamine to amphetamine injectors.

However, pills and liquids are not the only alternatives to injectable drugs – most popular drugs can also be produced in sniffable or smokable forms. Indeed, for illicit drug users these two routes of administration could provide the most effective alternative to injecting for two reasons. First, many opiate injectors have indicated that they do not like the taste of oral preparations such as methadone mixture, and some say that oral preparations make them feel nauseous.

Second, most illicit drug users, whether injecting or not, take drugs by smoking or sniffing them – these are familiar, acceptable practices. The behaviours and experiences underlying these two routes of administration – chopping up powder and 'snorting', or lighting up, inhaling and tasting the smoke – are also valued by drug users.

But smoking has a major advantage over the nasal route as an alternative to injecting. Sniffing powdered drugs onto the nasal membrane does produce the desired psychoactive effects more quickly than swallowing, but smoking produces these effects as rapidly as injecting – in seconds rather than minutes.

"Smoking drugs most closely simulates the injecting 'rush'"

One of the main attractions of injecting is the 'rush' (an accelerated, intense entry into intoxication). Smoking drugs provides the closest simulation of the injecting 'rush' so could be the most effective alternative for committed drug users who nevertheless agree to try to give up injecting. If this is the case, we might expect positive changes in criminal as well as health-related behaviour.

Practicalities

We call the smokable drug prescriptions 'reefers' – packs of herbal or tobacco cigarettes which contain heroin, methadone, cocaine or amphetamine. The reefers are produced by Rankins Pharmaceuticals in Liverpool and distributed to local pharmacies. Production involves dissolving the prescribed drug in chloroform, and injecting the solution into the tobacco/herbal material in a cigarette. The chloroform evaporates in a few minutes, leaving the dissolved drug behind – a process which also stains the cigarette paper green,

distinguishing the reefers from standard cigarettes and helping prevent inadvertent use.

How many reefers are prescribed and how strong they are depends on the client's needs, though current prescribing in relation to opiate users averages about 180 to 240mg of smokable opiates per day and rarely exceeds 300mg. Usually the reefers are dispensed weekly, in quantities sufficient for two to six cigarettes a day. More frequent dispensing may be required if patients prove unreliable.

It is important to note that up to two-thirds of the drug in a reefer may be lost through sidestream smoke or poor inhalation technique. With this in mind, each of our reefers contains either: 60mg or 100mg of heroin; 60mg of methadone; 40mg of cocaine; or 30mg of dexamphetamine.

For roughly equivalent prescriptions, oral methadone costs the health service £100-200 per patient per year, injectable opiates £1000-2000, and reefers £300-600.

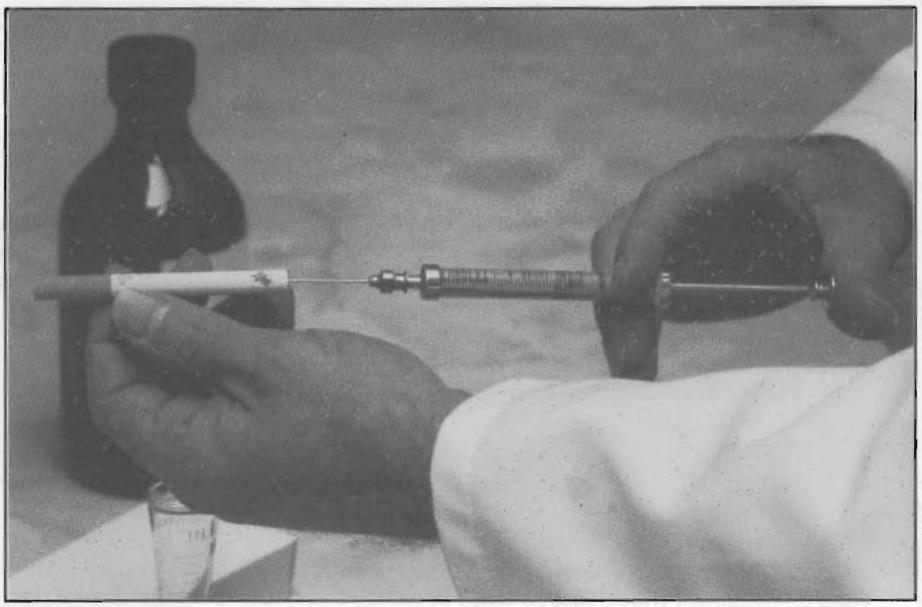
The standard 'filling' for the cigarettes is herbal – typically Honeyrose herbal cigarettes (containing coltsfoot), or, if available, Potters Asthmatic Cigarettes (containing datura stramonium). Clients who prefer tobacco supply their own cigarettes to the pharmacist, who can then use these to prepare the prescription. It is advised that only low-tar cigarettes should be accepted for clients opting out of the standard herbal-based prescription.

Misuse of Drugs Act regulations governing the supply of drugs to addicts refer only to the drugs, not to how they are to be administered. A special licence is needed to prescribe heroin or cocaine (or dipipanone) for addiction, but doctors with this licence can prescribe these in smokable form. Any doctor can prescribe methadone or amphetamine for addiction in any suitable form – oral, injectable, or smokable.

Prescribing drugs in smokable form does not relieve doctors of their obligation to notify heroin or cocaine addicts to the Home Office.

The issues

Who to prescribe to? Most patients we prescribe smokables to are long-term opiate injectors who wish to try to stop injecting. Smokables are less likely to be prescribed to more short-term injectors as these may be weaned off injection by more conventional means. The absence of physical addiction with stimulants means prescribing these as smokables is also less likely. But newer opiate injectors and stimulant injectors are both at risk of HIV infection and other injection-related illnesses, so are not excluded from the programme altogether.



Better than injecting into the body – preparing a heroin reefer Bradford Telegraph and Argus

Reefers can be prescribed on their own, or combined with other prescriptions, to cater for the different needs of a wide variety of injecting clients. For those who cannot immediately give up injecting drugs, a combined injection and reefer prescription can be given, with, when appropriate, a gradual reduction in the injection component and a gradual increase in the reefer component. For those clients able to move toward stabilising on oral prescriptions, a combined oral and reefer prescription can be given, with a gradual reduction in the reefer component and a gradual increase in the oral component. Reefers are not prescribed to non-smokers.

A deeper hook? Even in smokable form, heroin is for many people easier to withdraw from than oral methadone. The half-life of methadone is much greater than heroin but the withdrawal symptoms are less severe. Some addicts find heroin's 'short, sharp' withdrawal much easier to handle than methadone's 'long-drawn out niggle'.

Passive smoking? Are you at risk of inhaling significant quantities of heroin while sitting next to an addict smoking their reefer? Even with tobacco the evidence of increased cancer risk from passive smoking is debatable – and exposure to tobacco smoke is likely to be far greater than could ever arise from the relative handful of opiate smokers.

Smoking-related disease? As we prescribe only to people who already smoke tobacco or cannabis, we consider the increased risk from opiate/stimulant reefers to be negligible – particularly compared to the risks of injecting.

Does it work? So far we have only our experience and pilot research to go on. Larger scale independent research is planned.

Halton drug dependency unit has 30 clients with long histories of intravenous drug use who are now maintained on either reefers or reefers and methadone syrup. They are monitored regularly for signs of intravenous use and urine samples are taken randomly to check that no other drugs are being used.

As previously reported,[1] between 1989 and early 1990 the percentage injecting dropped from 65 per cent to 51 per cent, a reduction which has since continued.

All clients seem to be coping well and none has returned to intravenous use. Their health has improved, relationships are now much more stable, and partners and families are relieved that worries about intravenous drug use have ceased.

Dr Russell Newcombe of Mersey RHA's Drugs and HIV Unit has conducted a small-scale pilot study comparing oral opiate medication with opiate reefers.[2] His findings suggest reefers are a viable alternative for reducing injecting behaviour. Unanalysed interviews with patients give the impression that a 'horses for courses' approach is appropriate, with some people preferring oral medication, others injectables, and others reefers. ■

FOR MORE INFORMATION

■ **THE AUTHORS.** Andrew Palombella can be contacted on 051-423 5247.
■ **FURTHER INFORMATION ABOUT REEFERS** – costs, dispensing pharmacies, etc – can be obtained from Rankins Pharmaceuticals 061-228 3262.

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2. Newcombe R. *Preliminary findings of the Halton smokable prescriptions study*. Unpublished, October 1990.

HIV outreach in Britain

Surveying all Britain's HIV outreach projects provided some clear guidelines for future developments

A survey of HIV outreach projects in the UK in 1988 found 122 projects of which 96 responded. Two-thirds targeted drug injectors and most worked to harm-reduction objectives. In practice, the projects' activities matched their objectives. Contact with clients was maximised by 'cold' contacting, matching workers' characteristics with those of their clients, and investment of sufficient resources.

Tim Rhodes, Janet Holland, Richard Hartnoll, Sara Jones & Anne Johnson

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HIV OUTREACH health education has become a fast expanding field, with drug users – as one of the major hard-to-reach groups – often featuring as the primary target. Elsewhere we have outlined the development of HIV-related outreach strategies in the United States and Netherlands[1,2]. In comparison, development of similar strategies in the United Kingdom is in its infancy, but is increasingly regarded as essential to wider HIV prevention initiatives.

In 1988 the Drug Indicators Project was funded by the Department of Health to survey HIV outreach projects in the UK[3,4]. The aim was to gain insight into the nature and extent of outreach work and to generate policy and practice guidelines. On the page opposite we briefly summarise some of the survey's main findings, but our main objective here is to explore some of the implications.

The survey included only projects whose outreach work was significantly HIV-related. Outreach work was broadly defined as "any community-oriented activity aiming to contact individuals or groups not regularly in contact with existing services".

In all 141 outreach projects were identified and sent a confidential postal questionnaire. Nineteen did not undertake outreach work leaving 122 of which 96 replied – a response rate of 79 per cent.

In this article we concentrate on a subset of these projects – those undertaking *detached* work out on the streets, in pubs, cafés, etc, as opposed to *peripatetic* outreach based in institutions such as prisons, schools, and welfare agencies.

Findings from a postal questionnaire are inherently limited, since they cannot capture important but elusive variations which determine the local character of outreach intervention, but we hope our findings provide some grounds for recommendations for future policy and practice.

Our findings indicate that outreach health education is a feasible way of identifying and contacting hard-to-reach populations in which HIV transmission behaviours are considered prevalent. In general, detached projects were effective in reaching their target groups during the week before completing the questionnaire, although few attempted to contact specific ethnic groups.

Some target populations are clearly easier to access than others. For example, youth-oriented projects were able to contact far more clients than HIV or drug-oriented services.

Sheer numbers of contacts, however, is not necessarily a guide to the quality of the contact nor to the services offered. Providing a service of adequate quality can involve extra investment of time and resources both to make and to maintain contacts. It is often impossible to assess realistically the proportion of target populations actually reached, since estimates of their total size are in general crude. We know how many people we see, but usually cannot know how many we *don't* see. Part of the role of outreach itself is to determine the accessibility of target populations – the extent to which they are in fact hard-to-reach – and to assess how far they are in need of services.

Outreach intervention offers realistic opportunities for service provision outside the clinic or office and in the community. Within the broad objective of attempting to prevent the further spread of HIV infection, most projects aimed to provide risk-reduction advice and information, counselling, and to a lesser extent opportunities for client referral. The services actually provided to clients were in accordance with these stated aims. This suggests that projects *are* implementing risk-reduction

main text continues on page 14

Profile of HIV outreach provision

A snapshot summary of the extent and nature of HIV outreach services in late 1988

All projects

These findings are based on the full sample of 96 projects.

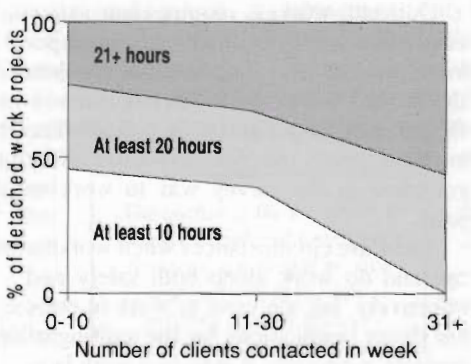
- **Regional distribution.** Projects were better represented per million of the population and per known cases of AIDS in Mersey and West Midland RHAs. Projects were worst represented in North East Thames RHA, followed by North West Thames, South East Thames and Wessex.
- **Service context.** A quarter each undertook only *detached* work (outside of any institution, on the street etc) or only *peripatetic* outreach work (based in institutions outside the home agency); the remaining half did both. Most (62 per cent) were based in the voluntary sector. Nearly 40 per cent described themselves as drugs services, a third as HIV and AIDS services, and a quarter as youth-oriented services. A third had developed specifically in response to HIV and AIDS.
- **Staffing.** The average number of staff per project was 4.8, with an average of half these undertaking outreach work.
- **Targets.** Most projects (78 per cent) aimed to target adolescents or young people considered at 'high risk' of infection, two-thirds targeted drug injectors, 28 per cent women prostitutes, and a quarter rent boys. Few projects said they targeted specific ethnic groups.
- **Objectives.** Making new client contacts was a major objective for only half of the projects. 62 per cent aimed to educate on harm minimisation, 55 per cent to provide clients with appropriate services, but only 15 per cent to facilitate client referral.

Detached work projects

Findings based on the 68 projects which undertook outreach work on a detached basis outside of any institution (in pubs, cafés, on the street, etc).

- **Working practices.** Snowballing was the most common way of contacting clients (58 per cent); half approached clients 'cold', 37 per cent relied on client-initiated contact, and 31 per cent contacted through other agencies. Less than a third (30 per cent) of the projects' outreach workers always worked in pairs, a third always worked alone, 36 per cent worked sometimes in pairs and sometimes alone. 40 per cent of detached projects had no specific guidelines to ensure worker safety, a quarter relied on 'common sense', while the most commonly cited safety guideline was working in pairs.
- **Service provision.** Nearly all (94 per cent) of the detached work projects aimed to provide information and services on risk reduction, two-thirds aimed to provide referral, 54 per cent to provide HIV counselling, 48 per cent to provide condoms and 34 per cent to provide injecting equipment. In practice in the week prior to completing the questionnaire, 72 per cent had provided risk-reduction advice, 32 per cent HIV counselling, 53 per cent had distributed condoms, and 36 per cent had supplied injecting equipment.
- **Client contacts.** 1297 clients were contacted in the previous week, an average of 26 clients per project. Of these, 27 per cent were new clients, 22 per cent drug injectors, 12 per cent women prostitutes, 4 per cent rent boys, 9 per cent 'other at risk', and 31 per cent were not identified as being in any of these categories.
- **Factors influencing extent of client contact.** Projects made more client contacts when they had more outreach workers; allocated more time to outreach; used aggressive contacting strategies; had longer experience of undertaking detached outreach work; matched worker characteristics with those of their clients; and when workers tended to work alone rather than in pairs.

One of the central messages of the research – the more time projects invest in detached outreach work, the more contacts were made with clients



strategies. The extent to which these affect the rate of HIV infection among their target populations has yet to be determined.

Review evidence, particularly from the United States, suggests that outreach strategies aiming to provide risk-reduction services directly in the community should be seen as complementary and not contradictory to strategies which aim to improve contact with existing services[5]. Before innovative contacting strategies are developed, it is essential that existing services are critically examined – how accessible are these services, and are their services and style of delivery appropriate for attracting hard-to-reach clients?

Although most (88 per cent) of the projects in the survey undertook some form of monitoring of service delivery and of client contact, these were often little more than simple activity records. There is a need for projects to incorporate more detailed monitoring and evaluation. Ideally this should integrate statistical analysis (quantitative) with more descriptive evaluation of the quality of the intervention (qualitative). To gain most from the evaluation it is best to employ both process (what is done) and outcome (what is achieved) measures.

Evaluations may prove most useful if they are included in the overall design of a project from the outset and developed in conjunction with workers and managers. Action-oriented research can quickly feed back results which inform the ongoing formulation and implementation of the intervention rather than simply delivering a verdict some time later.

Maximising contact

It is almost axiomatic that outreach workers should be accessible to their target populations. It follows that communication with target groups may be aided by using indigenous workers, or at least workers sharing characteristics with client groups in relation to gender, sexuality, class, race and life experience.

The survey indicated that detached projects which matched workers' and clients' characteristics did in fact achieve greater outreach contact. But, unlike many outreach projects in the United States, only 9 per cent actually employed indigenous workers. Outreach workers should also be approachable by the range of services involved in dealing with HIV or drugs – statutory health services, local authorities as well as voluntary, community and self-help services. 'Professional' and community workers also clearly have a role in outreach in negotiating with different service sectors and providing professional services. A plurality in approach is therefore recommended.

"More contacts were achieved from 'aggressive' approaches such as 'cold' contacting"

Our survey findings show that a variety of factors affected the extent of contact with both new and established clients. Clearly there is a point at which the level of investment in outreach workers and the time allocated to outreach work becomes critical to the effectiveness of the intervention. This critical level will depend partly on the size and nature of target populations within specific catchment areas.

As a minimum, projects require enough core workers to be able to retain a presence and maintain contact with clients regularly and consistently, to cover in case of illness, to work safely and comfortably, and to provide support for fellow workers.

Since the proportion of time which workers invested in doing outreach work affected the extent of client contact, it is of central importance that an efficient and economic division of labour is established within a project. For outreach work to be effective, enough resources must be available to allow workers as much time as is feasible and manageable for undertaking such work.

More outreach contacts were also achieved when direct and 'aggressive' approaches, such as 'cold' contacting, were employed. 'Cold' contact should remain a priority in project objectives, backed up with adequate resources to deal with an ongoing and increasing client load.

Outreach workers require clear safety assurances and guidelines from management or funders. For example, when should they work in pairs? When and how should they negotiate with police? The most frequently mentioned specific safety guideline in the survey was to work in pairs.

There are circumstances when workers can and do work alone both safely and effectively, but the need to work in pairs has direct implications for the staffing of projects, especially if detached work is to remain regular and consistent, and if individual workers are to remain accessible to target populations.

OUR FINDINGS and their implications can be summed up in five major guidelines for the planning of future outreach programmes.

- Outreach should be encouraged as a feasible and valuable strategy for identifying and reaching hard-to-reach populations, for offering feedback about clients' needs and perceptions of services, and for providing community-based health education services.
- If interventions are to be effective they require adequate resourcing in terms of investment in staffing and time.
- Workers require succinct guidelines and assurances in relation to working practices and safety.
- Outreach must remain committed to innovative, direct and aggressive methods of contacting clients if it is to be continually effective in reaching the hard-to-reach.
- There is a need for systematic and ongoing monitoring and evaluation of service development and delivery in order to match service response to client need. ■

FOR MORE INFORMATION

■ **THE AUTHORS can be contacted at the Drug Indicators Project, Birkbeck College, 16 Gower Street, London WC1E 6DP, phone 071-631 6246.**

■ **A SURVEY OF HIV OUTREACH INTERVENTION IN THE UNITED KINGDOM. Hartnoll R. *et al.* Drug Indicators Project, Birkbeck College, 1990. £3.50.**
The full report on which this article is based.
Available from the authors, address above.

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

■ **HIV OUTREACH HEALTH EDUCATION: NATIONAL AND INTERNATIONAL PERSPECTIVES. Rhodes T. *et al.* Drug Indicators Project, BirkbeckCollege, 1991. Free of charge, send sae with £0.33 stamp.**
A summary of Department of Health-funded research, 1988-1990.
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■ **REACHING THE HARD TO REACH. Tim Rhodes *et al. Druglink*: 1990, 5(6), p.12-15.**
International outreach developments.
Copies from ISDD's library on 071-430 1993.

■ **HARD TO REACH OR OUT OF REACH? AN EVALUATION OF AN INNOVATIVE MODE OF HIV OUTREACH HEALTH EDUCATION. Rhodes T. *et al.* Drug Indicators Project, Birkbeck College, 1991 (forthcoming).**
Concerns outreach work among sex industry workers and drug injectors in central London.
Contact the authors (address above) for availability and price.

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

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LAW IN PRACTICE

2

Guidelines for drug users and drug workers

SEARCH AND ARREST

Jane Goodsir

POLICE IN BRITAIN enjoy extensive powers and wide discretion. In contrast, members of the public have few enforceable rights. How people – including welfare workers – are treated depends on whether the police sympathise with or respect them. Young, poor black people, for example, are treated differently from the white middle class. The first group find it more difficult to exercise their rights. Insisting on theoretical rights can be difficult without support, information, and some insight into how police are likely to react. This second in the LAW IN PRACTICE series deals with two of the most fraught points of interaction between police and the drug using public – the search for drugs and arrest.

Legal framework. The most important law covering police powers to stop, search and arrest, is the Police and Criminal Evidence Act (PACE). It also sets out conditions of detention in police stations, and codes of practice on treatment of prisoners, including drug users.

Initial contact. When dealing with the police on the street, the best strategy is to be as polite as possible. Minimise conversation. Aggression is unhelpful and often leads to trouble.

Give your name and address. Simple explanations will sometimes help avoid difficulties – but if the police look as though they are going to take action anyway, and want to ask difficult questions, silence may be best. Try not to appear nervous, don't volunteer information, and avoid making matters complicated. Try to look and behave like a reasonable person, and make sure the police understand that you're able to take an intelligent interest in what's going on.

From 1 April 1991, new codes of practice come into operation clarifying police powers and duties under PACE.

Street stop and search. Police can stop and question people whenever they wish. They are supposed to rely on public cooperation but it may be very difficult for individuals on the street to avoid initial questioning. Before searching people, police are supposed to ask questions to decide whether grounds exist for a search. A satisfactory explanation for 'suspicious' behaviour should, according to police codes of practice, make a search unnecessary. In practice, police stop and search at will – and justify their actions later.

Police can stop people to search for firearms and ammunition, poaching equipment or stolen goods, and, of course, for illegal drugs. They can also search to protect certain kinds of wildlife, for prohibited articles such as weapons, and for tools adapted as offensive weapons or for housebreaking. Police can search for alcohol at sporting events such as football matches.

Police often try to get consent by describing a search as 'just routine'. In fact, 'routine' searches are illegal unless done with consent. Searches with consent may be more thorough than those without, as there are rules governing conduct of searches without consent. Searches without consent can only be done on 'reasonable suspicion'. This may, among other things, be based on furtive or other unusual behaviour, the time or place of an activity, and tip-offs. Your ethnic group, unusual dress, or police knowledge of previous convictions, do not count as reasonable grounds.

Before searching someone against their will, police must:
- identify themselves;
- explain their grounds for suspicion;
- detail what they are looking for;
- inform the suspect that a copy of the

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search will be available if requested within a year.

If the search has been voluntarily agreed to, there is no obligation to record it.

A public search should only be a superficial inspection of outer clothing. A more detailed search should be done in a private place and by a police officer of the same sex. Searches for drugs may involve a detailed search at the police station and police can take suspects to a police station without a formal arrest.

Dealing with street stop and search

- Ask the officer for identification
- Try to avoid being searched by being polite
- If asked to consent, politely refuse. Say you will cooperate, but will not consent
- If asked to go to a police station to be searched, politely make it clear that you are not going of your own free will
- Keep conversation short
- Ask for the reason for the search, and for a record

Key points

- **Be reasonable, calm, and polite**
- **Make it clear you withhold consent, but cooperate**
- **Avoid unnecessary conversation**

Searching vehicles. Vehicles can be stopped on 'reasonable' suspicion. Police often claim to be making 'routine checks' but this is not adequate grounds for a check in law. But police can stop and search cars near the scene of a particular crime, or in connection with 'patterns of crime' in a particular area.

Searching premises. Police can search premises at any time *with* consent. But without consent, police can only enter and search:

– to execute a warrant (an authority from the court);
– to arrest someone for a serious offence or an offence that is visibly taking place, or if they are in hot pursuit;
– to prevent a breach of the peace;
– to recapture someone at large;
– if the premises are in the immediate vicinity of a 'serious arrestable offence' (such as robbery, supply of drugs, or a serious wounding).

A search warrant is a form signed and dated by a magistrate (or judge) specifying the premises to be searched, what police are looking for, and the grounds for the warrant. Valid for up to a month, they should be returned to the court after use or expiry. It's worth checking the warrant to ensure all details are correct.

Police should first serve a notice of powers and rights on the occupier when approaching to make a search. However, they may be excused if the occupier is away, or if the officer in charge believes that serving the notice would frustrate the object of the search or endanger officers. In such cases the police should still leave a copy of the notice and warrant with the occupier after the search has been executed, duly endorsed.

This means police can just burst in if they feel that delay will lead to disposal of evidence (eg, drugs). Evidence acquired during an unlawful search will still be admissible in court. In practice, police often claim that they had consent to unforeseen actions. An invitation on to premises to discuss, for example, the loss of a bicycle, could become a search for drugs if police became suspicious.

If you believe that the police have no legal power of entry, theoretically you can use force to prevent them entering or to throw them out. But charges of assault, obstruction, or worse could result. Once inside, police should not damage property or cause unnecessary disturbance. They can remove not only stolen property and illegal drugs, but anything believed to be evidence of an offence, or that may have been obtained through criminal activity.

Cash, jewellery and other goods are frequently removed, even when there is strong evidence that they were acquired legally, as are documents like bank books and address books. Police often retain property during investigations and sometimes until court proceedings are concluded. Receipts should be provided for property seized.

When searching premises, police often search individuals, even visitors, on the premises. Usually they have the legal power to do so. They often ask questions which may amount to an interrogation.

Special rules apply to police searches on premises concerned with confidential personal counselling, medical or welfare services. But people taking work home with them may find that files that would have been legally protected at work are unprotected at home.

Dealing with police seeking entry

- If police approach without a search warrant, open the door on the chain and keep them talking at the door
- If there is a warrant, check it
- Make it clear that you do not consent to a search
- Be aware of what's happening and make notes of things taken away
- Avoid answering questions. Conversations may be recorded by the police.

Searches at the police station. Once at the police station, most suspects are searched, even if they have already been searched on the street. A strip search can be authorised by the custody officer if it's considered that a person may be in possession of an article that should be removed during detention (eg, for their own or other's safety). Such a search should be done by an officer of the same sex, in a private place.

Drug searches. Police may take someone suspected of being in possession of controlled drugs to a police station for a detailed search without a formal arrest. A police superintendent can authorise an intimate search of body orifices if it's thought that a suspect has hidden a class A drug such as heroin or cocaine. Such a search must be conducted by a doctor or nurse on medical premises such as a hospital. There should be written authorisation. The search should be done with consent, although unreasonable withholding of consent may be taken into account at court. ■

FOR MORE INFORMATION

■ **FOR MORE ON THE LAW IN THEORY AND PRACTICE** contact Release on 071-729 5255.
■ **FOR IMMEDIATE HELP** in relation to a particular incident phone your solicitor or Release's 24-hour emergency line on 071-603 8654.

Beyond 'the black worker'

Quick-fix 'solutions' to make services attractive to ethnic minorities ignore the diversity of the non-white

RESEARCH NOW appears to be validating the long-felt perception by many drug services that there is a problem 'out there' among non-white drug users – and that services as they stand are in some way unable to provide for their needs. However, drug services should beware of holding too simplistic an idea of the 'needs' of the non-white drug using population, and as a result providing an automatic but relatively ineffective response.

The most common response is to suggest services employ more non-white personnel. While undoubtedly desirable at the level of equal opportunities objectives, this may not be the blanket answer it is often asserted to be.

Take the hypothetical case of a street agency in a multi-cultural area where the population consists of a high proportion of 'Asians', say around 10 per cent. Add to that people of Afro-Caribbean origin at around 4 per cent and a fast growing Vietnamese and Chinese population. Would appointing a 'black' worker have the desired impact of attracting a *representative* selection of non-white clientele? I think not.

Moreover, if we assume that as these populations 'integrate' (or whatever disingenuous term is used to signify the merging of cultures) they become increasingly vulnerable to drug use, then the pattern of non-white needs will vary over time. The effect will be to render a particular 'black' worker more or less useful as the situation changes.

Neither can the problem of how a particular 'black' worker corresponds to the various target groups be resolved simply through recourse to outreach workers. However sensitive and successful the workers, inevitably some groups will remain out of their reach. To fund a whole set of workers of different ethnic origins is a luxury unlikely to be realised.

Further complications arise when we consider differences *within* cultural/ethnic groupings and between the self-perceptions of clients. An individual's 'ethnicity' – their lifestyle and self-perceptions in ethnic terms – may relate more or less closely to their 'ethnic origin'. In turn this will alter how they experience the world, including health care provision. Arguing that negative experiences of health care provision prevent non-white drug users seeking help can only be part of the story for some of the people.

The agenda underlying this argument is that provision of non-white workers would automatically enhance non-white experience of service provision – and that it is racism or the expectation of racism which makes services unattractive. This too is only a part of the story.

People who are relatively confident, knowledgeable and articulate are much more capable of exploiting the health services than those who are not, and so have more chance of positive experiences. For instance, middle class women – whether white or not – make better use of preventive resources such as breast and cervical screening. Experience within categories, be they race, gender or class, varies considerably. The reasons why non-white drug users attend drug services so sparsely are not simply reducible to racism or racist structures.

One issue which comes up time and again, however, is visibility – in this case, the visibility of the agency. Those who use drugs are often either unaware of the services available, unaware of how they can help, or believe them to be for 'junkies' or others, but not for themselves.

"The assumption is that while white people differ, all non-white people can be lumped together"

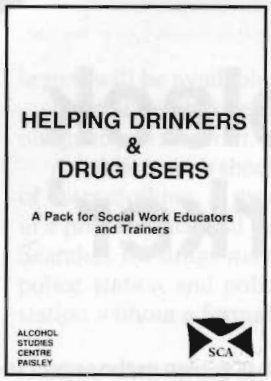
Combine this with a drug using population less involved with the 'user networks' which used to provide information about services; with possible cultural, or even language barriers; and with the fact that 'problems' may be differently defined and thus experienced. In this context, low take-up rates begin to have greater meaning.

Problems of 'visibility' also apply to potential clients. As with the white drug users, evidence suggests that some members of the non-white drug using population find it more difficult than others to be 'visible' users and to be seen to have a problem. This may differ between cultures, but most clearly appears to affect women.

DRUG SERVICES need to be sensitive to the heterogeneous needs of a heterogeneous drug using population. They also have to attend to the perennial problem of not being visible and/or being misunderstood. Neither challenge is susceptible to quick-fix solutions based implicitly on the assumption that while white people differ, all non-white people can be lumped together. ■

Ross Coomber

The author is a lecturer in sociology at Thames Polytechnic in London and a co-author of Drugs Services in England and the Impact of the Central Funding Initiative.



A useful resource for in-service and pre-vocational social work trainers

HELPING DRINKERS AND DRUG USERS – A PACK FOR SOCIAL WORK EDUCATORS AND TRAINERS. The Scottish Council on Alcohol and Alcohol Studies Centre, 1990. 80 pages. £36.50.

The gap in social work training where drugs and alcohol ought to be has long been a cause for concern. It has contributed to the frequent grumbles that social workers are unwilling, unskilled, or nervous about uncovering or handling drug and alcohol problems among their clientele. The authors should therefore be congratulated for producing this pack aimed at social work educators. The pack's objectives are to increase students' knowledge of drug and alcohol use and associated problems, awareness of appropriate methods of intervention and skills and confidence in responding to alcohol and drug problems. It applies existing skills to work with problem drinkers and drug takers and provides some additional specialist knowledge and skills.

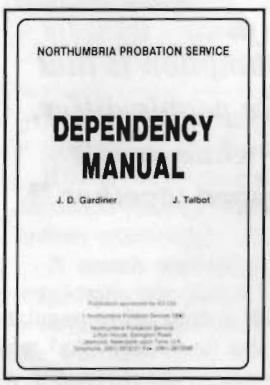
The pack consists of nine short chapters, each followed by what the authors describe as a 'range' of exercises and a section on evaluation, designed to check how much the students have learnt. At the back of the pack are a selection of booklets on drugs and alcohol, some case outlines and OHP transparencies for use with the exercises.

The materials are in two parts and, on the whole, the pack gets better as it proceeds. Part 1 (chapters 1-4) provides a background to substance use and problems. Chapter 1 offers a rather sketchy account of drug use in various cultures and would have benefitted from tighter editing. Chapter 2 is a description of drug effects which draws on ISDD's invaluable *Drug Abuse Briefing*, but makes no reference to 'newer' drugs such as temazepam, temgesic, cyclizine or Ecstasy. Chapter 3 looks at some of the ways drug, individual and environment interact to shape the drug experience, while chapter 4 explains the notions of experimental, recreational and dependent drug use and the problem drug taker.

Part 2 (chapters 5-9) deals with how to work with clients with drug and alcohol problems. This starts with a useful discussion of the difficulties social workers face in raising the topic with clients and how these might be overcome and follows with chapters on assessment, giving up drugs and alcohol, relapse, brief intervention and self-help approaches. The emphasis throughout is upon the applicability of social learning theory to work with drug and alcohol problems, drawing on the work of the major theorists. This section of the pack provides a clearly written summary of this influential approach, together with research on problem drinking, although the authors have managed to maintain a reasonable balance between alcohol and the other drugs. There is a sensible stress on the need to agree goals with clients, rather than automatically assume that abstinence is the only desirable outcome, but no discussion of harm reduction approaches in the light of HIV. Given the disastrously high rate of infection among drug users in parts of Scotland, this is a little surprising.

The pack is sensibly, if rather dourly, produced with the various elements colour coded for easier access. The general effect is a bit cramped and utilitarian, but the pack is none the worse for avoiding unnecessary fripperies.

Brian Pearson
Drugs and HIV Training Officer, North West Regional Drug Training Unit, Manchester.



Pioneering guide for probation officers

DEPENDENCY MANUAL. J.D. Gardiner and J. Talbot. Northumbria Probation Service, 1990. 76 pages. £17.20.

Most probation areas face the regular challenge of supervising offenders with dependency problems. Many have prepared policy papers and practice guidelines but Northumbria Probation Service has broken new ground. It has published a comprehensive manual which seeks to enable front-line workers to offer an informed service to offenders.

In the past, many probation officers felt deskilled when drugs were mentioned. Fortunately, the relevance of general helping skills are now acknowledged, but this manual goes much further in showing generic workers just what can be done with thought and careful preparation.

The manual provides just enough factual information about different types of drugs (including alcohol, solvents and tranquillisers) and offers a practical framework for case management stressing that probation officers will often be able to offer what is needed.

This guidance is supported by clearly explained and practical exercises for helping those with dependency problems. Strategies outlined for working with drug users include advice on motivational interviewing, various role plays and logical approaches to problem solving. Oblique approaches to anticipated denial of problems are suggested and the need to plan for relapse is explained.

The chapter on solvent abuse offers useful hints at tackling underlying issues and then addresses the ethical dilemmas of a "casualty reduction" approach.

Relevant information is provided on dealing with emergencies such as overdoses, and while some of the resource information is specific to Northumbria, much of it gives useful national references. Since the manual is loose-leaf, other services could easily add their own local information.

Accompanying the manual is Northumbria Probation's "Notes of guidance for working with dependency issues", an attempt to explore the legal dilemma of supervising offenders whose continuing drug use is itself an offence. How should probation officers handle this conflict? The manual does not provide the definitive answer, but it will start an important yet under-rehearsed debate.

The alcohol section makes special reference to women's issues but no such reference is made in the drugs' section despite continuing concerns about the likely negative attitude among professionals towards drug using mothers. Many of the exercises would be usable in the prison setting, although again, no direct reference to prisons and their challenges is made. Equally, there is no reference to the increasing need to evaluate effectiveness of services, nor to some of the management challenges relating to partnerships and multi-disciplinary working.

However, these comments do not detract in any way from the real value of what is provided. It is a first-rate practical manual for those involved in day-to-day supervision of drug using offenders, whether it be through individual counselling, group work in a day centre or prison, or perhaps in a hostel. The manual succeeds in demystifying the subject and would be equally useful in staff supervision or training courses, both pre- and post-qualifying.

Mike Hindson
Assistant Chief Probation Officer, Greater Manchester Probation Service.

Praise for new primary school personal and social education (PSE) pack

SKILLS FOR THE PRIMARY SCHOOL CHILD. TACADE, 1991. £44.95.

This is a resource aimed primarily at teachers, education advisers and others who have an interest in developing PSE materials for 5-11 year olds.

It deals with a number of sensitive issues such as bullying, child abuse and substance abuse and provides a positive, skills-based approach to preventing abuse and promoting the protection of children. It consists of four sections; the Manual, Schools Workshops, Parents' Workshops and Lesson Cards.

The manual contains a collection of ideas and current theories to stimulate thinking and encourage the planning and implementation of PSE in primary schools, and sets out some of the basic principles which underpin the resource. These include 'promoting positive self-esteem' and the need to teach children skills that will 'enable them to make wise and healthy choices'.

Included in the Appendix are numerous practical activities and learning games which are used throughout the resource. These should be of particular use to any newcomers to the area of PSE and health education as well as those, who, up until now, have escaped the delights of a 'wiggle handshake'.

The mere presence of two separate sections on Parents' Workshops and Schools' Workshops reflects the importance of providing adequate support and training for those at home and at school. Great emphasis is placed upon the development of a working partnership between parents and teachers – a message which cannot be repeated enough.

I acknowledge that the resource has been written as a "child protection/abuse prevention programme..." but prefer to view it in relation to its wider and more positive contributions to the overall personal and social development of children.

I suggest, therefore, that a better starting point for a series of workshops using the manual might be to look at its broader aims and rationale rather than focus on issues of 'What is Abuse?...' and/or 'Promoting a Whole School Approach to Preventing Abuse'. In this way, 'abuse prevention' can be seen as firmly set within the broad context of personal, social and health education.

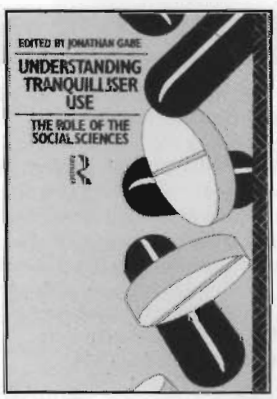
In general terms, both the Schools' and Parents' Workshops sections contain detailed guidance on how to facilitate the workshops, providing clear and well presented instructions, background information and various resource sheets.

Lesson cards are on separate laminated sheets arranged into a number of sections such as Me a Special Person, Feelings and Emotions, and Facing Challenges. Each is so comprehensive that in some ways it comes close to 'teaching by numbers' and reflects the constant dilemma of those writing curriculum materials – ie, too much or too little.

While primary prevention is predominantly the main aim of the resource, it is heartening to see activities such as It's OK to Make Mistakes and Taking Risks which encourages children to "look at a variety of potentially risky situations and consider ways of minimising risks".

At £44.95 for the set, this resource is certainly not cheap but it compares favourably with the TACADE publication *Health Education – Drugs and the Primary School Child* and with the HEA's *Health for Life* 1 and 2. I feel sure that it will make a positive and significant contribution to the promotion of PSE in primary schools across the country.

Ron Greer
Health Education Coordinator, London Borough of Ealing.



A clinical pharmacologist responds to the sociologists

UNDERSTANDING TRANQUILLISER USE: THE ROLE OF THE SOCIAL SCIENCES. Jonathan Gabe *ed.*, Tavistock/Routledge, 1991. 215 pages. £40.

The aim of this book is to show that disciplines outside medicine – in particular, the social sciences – can contribute to understanding the widespread prescription of benzodiazepine tranquillisers over the past 30 years, and the consequent large population of long-term users.

The editor observes that much of the literature on benzodiazepines has been written from the clinical perspective. He attributes to clinicians an overemphasis on the so-called 'biomedical' model of tranquilliser use and dependence, and argues that this model is inadequate for a comprehensive understanding of the phenomenon. Accordingly, he has assembled representatives of a range of social science disciplines from several countries to discuss the issues involved.

Some chapters provide revealing glimpses of the distinctive ways in which different disciplines view the same problem. Of particular interest in these days of medical audits and QALYS (Quality Adjusted Life Years) is the economic assessment by Alan Shiel of the value of long-term tranquilliser use compared with alternative treatments, such as counselling. On a cost-benefit basis, counselling turns out to be more expensive mainly because counsellors (or psychologists) are costly while benzodiazepines are relatively cheap.

However, the premises on which this analysis is based do not take into account factors such as the high morbidity of long-term tranquilliser use, with its attendant costs of hospital investigations and absence from work.

In his chapter on the sociology of long-term tranquilliser use, Jonathan Gabe examines some of the reasons why people (mostly women) take tranquillisers and why doctors prescribe them, pointing out that these drugs are often taken and prescribed for social rather than medical reasons.

However, he seems to underestimate the sociological insight of clinicians. Medical practitioners from time immemorial have prescribed placebos, vitamins, tonics and tranquillisers in the full knowledge that they are treating social rather than medical illness. If doctors *had* adhered to a 'biomedical' model and prescribed more scientifically, the present population of dependent benzodiazepine users might not have arisen.

Whatever the social meanings of tranquilliser use, the fact remains that benzodiazepines are potent psychotropic drugs which can give rise to withdrawal symptoms even in those without anxiety or unusual life stresses.

To the practitioner working with benzodiazepine users, this book contributes little of practical value. Nevertheless, the broad perspective covered is timely in view of the present litigation against the pharmaceutical companies. In this context, a chapter covering the medicolegal issues would have been appropriate.

Perhaps the main value of *Understanding Tranquilliser Use* is to serve as a warning against too ready acceptance of the next generation of (non-benzodiazepine) anxiolytics already appearing on the market.

Heather Ashton
Reader in clinical psychopharmacology, Newcastle University.

PUBLICATIONS

Drug services

■ **HIV OUTREACH HEALTH EDUCATION: NATIONAL AND INTERNATIONAL PERSPECTIVES. Tim Rhodes *et al.* Drug Indicators Project, 1991. Booklet. 31 pages. Free with s.a.e.+£0.33 stamp.**
Summarises the project's outreach research plus implications for policy and practice.
Available from DIP, 16 Gower Street, London WC1E 6DP.

■ **COORDINATING DRUGS SERVICES: THE ROLE OF REGIONAL AND DISTRICT DRUG ADVISORY COMMITTEES. Peter Baker and Dorothy Runnicles. London Research Centre and National Local Authority Forum on Drugs Misuse, 1991. 60 pages. Research report.**
DoH-funded research finding drug advisory committees are often less than effective.
Available from National Local Authority Forum on Drugs Misuse, 35 Great Smith Street, London SW1P 3BJ.

■ **COMMUNITY CARE IN THE 1990s: CHANGE, CHOICE AND CONFLICT FOR DRUG SERVICES AND PLANNERS. Philip Fleming *ed.* Wessex RHA, 1991. 46 p. Conference report. £1.**
On the implications of the internal market in the NHS for drug services.
Available from the Regional Drug Problem Team, Northern Road, Cosham, Portsmouth, PO6 3EP.

■ **RESPONDING TO NEED. Jane Carrier and Peter Child *eds.* NW Thames RHA and Turning Point, 1991. 40 pages. Seminar report.**
Needs of HIV-infected drug users and meeting those needs.
Available from Turning Point, 9-12 Long Lane, London EC1A 9HA.

■ **SWANSEA DRUGS PROJECT: AN EVALUATION. Bill Rees. Swansea Drugs Project and Mental Health Foundation, 1990. 68 pages. Research report.**
Says the project's volunteer training programme is a "model of its kind".
Contact Mental Health Foundation, 8 Hallam Street, London W1N 6DH.

Youth Work

■ **HIGH POLICY. ISDD Research and Development Unit. ISDD, 1991. Pack with manual, youth work materials and drug facts booklet. £6.99.**
Follows up the successful *High Profile* youth work materials with a how-to-do-it manual for youth work managers.
Available from ISDD.

■ **P.I.P.: PARTICIPATION IN PREVENTION PILOT TRAINING PROJECT IN GWENT OCTOBER 1989-APRIL 1990. Helen Oliver and Victoria Wilson. Youthlink, 1990. 25 pages. Project report.**
Describes and evaluates a youth work project involving young people in drug/alcohol prevention.
Contact Youthlink, Ty Siriol, 49 St Martins Road, Caerphilly, Mid Glamorgan, CF8 1EG.

Other

■ **METHADONE MAINTENANCE IN THE MANAGEMENT OF OPIOID DEPENDENCE: AN INTERNATIONAL REVIEW. Awni Arif and Joseph Westermeyer *eds.* New York: Praeger, 1990. x, 115 pages. Book. £30.95.**
Collection of papers from World Health Organisation.
Available through bookshops.

■ **DRUGS, PEOPLE AND SERVICES: FINAL REPORT OF THE DRUG INFORMATION PROJECT. H.S. Mirza, G. Pearson and S. Phillips. London: Goldsmiths' College, 1991. Unpaged. Research report.**
Focuses on Lewisham in south London. Findings include ethnic breakdowns of arrestees and service clients.
Contact Drug Information Project, Goldsmiths' College, University of London, London SE14 6NW.

MEETINGS

■ **DRUGS: ISSUES AND POLICIES TOWARDS. Birkbeck College. 18 May 1991, London. £16.**
Seminar on the role of drugs in society and future trends.
Details from Stephen Parrott or Jean Devaney, 071-631 6657.

■ **HIV AND PRISONS. SW Thames Regional Drug Problem Team and Parole Release Scheme. 29 May 1991, Guildford.**
Details from Mike Trace (071-267 4446) or Mari Otteridge (081-672 9944 ext. 56137).

■ **WOMEN AND DRUG USE. Scottish Drugs Forum and Drugs Training Project, Stirling University. 3 June 1991, Stirling. £15.**
Seminar with workshops.
Details from SDF on 041-221 1175.

■ **WOMEN AND HIV/AIDS. Leicestershire Social Services Dept. 10 June 1991, Leicester. £30.**
Seminar with papers on clinical aspects, HIV, prostitution, black women, adoption, and women as carers.
Details from Annita Eddison, Leicester Social Services,Towers Hospital, Gipsy Lane, Leicester LE5 0TD, phone 0533 460460, ext. 2733.

■ **EUROTOX 93 – DRUGS, VALUES & POLICIES. Commission of the European Communities *et al.* 13-15 June 1991, Belgium.**
International conference aiming at a cross-European understanding of drug problems.
Details from Infor-Drogues, 302 Chaussée de Waterloo, 1060 Brussels, Belgium, phone 02 537 52 52.

■ **THE CRIMINAL JUSTICE BILL: IMPLICATIONS FOR DRUG & PROBATION SERVICES AND SENTENCERS. Wessex Regional Drug Problem Team. 26 June 1991, Winchester. £10/£15/£35 depending on service and region.**
Speakers from Home Office, Netherlands, probation, Release, judiciary.
Details from Regional D.P.T., Northern Road, Cosham, Portsmouth PO6 3EP, phone 0705 388298.

■ **THE ENIGMA OF ADDICTION. Centre for Research on Drugs and Health Behaviour. 3 July 1991, London.**
Lecture by Dr Jim Orford .
Contact Dr Christine Franey, Centre for Research on Drugs and Health Behaviour, 200 Seagrave Road, London SW6 1RQ, 081-846 6589.

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

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

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

COURSES

■ **DRUGS AND THE LAW IN PRACTICE.**
20 May 1991, Glasgow.
22 May 1991, Edinburgh.
Release. £35.
Details from Release, 388 Old Street, London EC1V 9LT, phone 071-729 5255.

■ **SETTING UP A SERVICE. 23 May 1991.**
■ **FAMILY DYNAMICS AND DRUG MISUSE. 20 June 1991.**
■ **FAMILY SUPPORT SKILLS. 26 September 1991.**
ADFAM National. London. £45 per day or £110 the series.
Family support services training.
Details from ADFAM NATIONAL, 82 Old Brompton Road, London SW7 3LQ, phone 071-823 9313.

■ **DRUGS INFORMATION UPDATE AND HARM REDUCTION. Drugs Training Project, University of Stirling. 10-13 June 1991, Perth, Scotland.**
Residential workshop.
Details from Drugs Training Project, University of Stirling, Stirling FK9 4LA, phone 0786 73171.

■ **MOTIVATIONAL INTERVIEWING. 26-28 June, 1991. £150.**
■ **TRAINING THE TRAINERS IN MOTIVATIONAL INTERVIEWING. 22-26 July 1991. £250.**
Drug Training Unit, Parkside Health Authority. London.
Details from Brian Whitehead, Drug Training Unit, Central Middlesex Hospital, Acton Lane, London NW10 7NS, phone 081-968 8514.

■ **PRACTICE SUPERVISORS' COURSE. 2-4 December 1991, Ripon. Residential £112.**
■ **ADVANCED COURSE IN THE MANAGEMENT OF SUBSTANCE MISUSE. 2 days per week 6 January 1992 to 11 September 1992, Leeds. Leeds Addiction Unit.**
The first is to equip senior staff to supervise substance misuse work; the second is an ENB/CCETSW-accredited day release course.
Details from Gillian Tober, Leeds Addiction Unit, 19 Springfield Mount, Leeds LS2 9NG, phone 0532 316930.

ORGANISATIONS

■ **CENTRE FOR RESEARCH ON DRUGS AND HEALTH BEHAVIOUR.**
New address 200 Seagrave Road, London SW6 1RQ. All phone/fax nos. unchanged.

■ **RELEASE**
New address 388 Old Street, London EC1V 9LT. Office hours advice line 071-729 9904, admin/publications 071-729 5255. 24-hour helpline no. unchanged (071-603 8654).

■ **ENGLISH NATIONAL BOARD FOR NURSING... HIV/AIDS EDUCATION AND TRAINING PROJECT.**
Establishing an information network for nurses in relation to HIV/AIDS inc. newsletter.
Details from Ian Hicken, ENB, Woodseats House, 764A Chesterfield Road, Sheffield S8 0SE.

FOR MORE INFORMATION ...

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

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

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

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

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