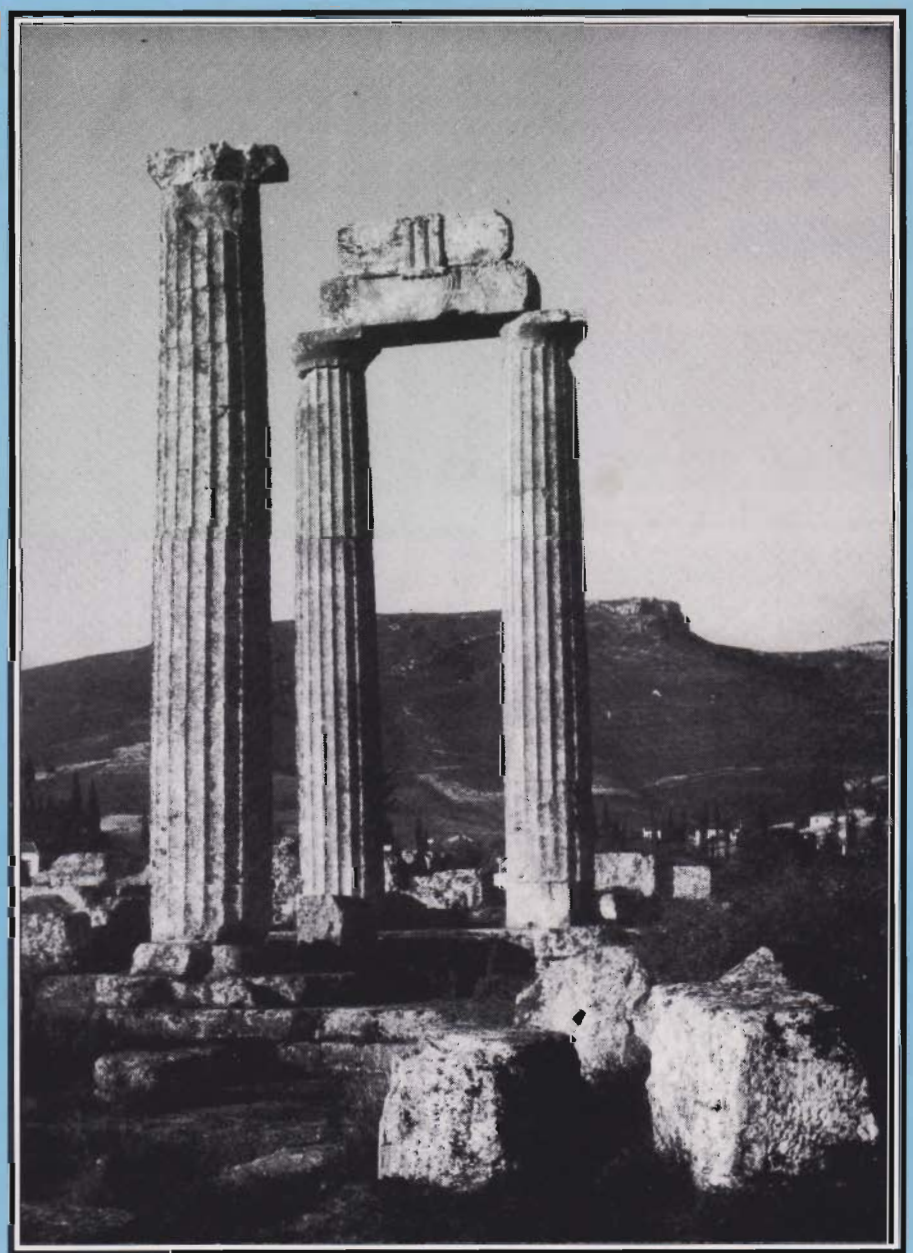
DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN

September/October 1991



Crumbling pillars. Key supports of UK drug policy can't take the strain. See contents page

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THE JOURNAL ON DRUG MISUSE IN BRITAIN

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

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

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

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Crumbling pillars

Drug education in schools and local coordination through drug advisory committees are major pillars of the Government's anti-drugs strategy. Now the Government's own research shows these cannot support the expectations of their originators (pages 12 and 14). A query too over the side effects of a key HIV prevention strategy (page 10).

Cover photo: Courtesy of National Tourist Organisation of Greece.

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Optimism over community care funding

Officials responsible for drugs policy in the Department of Health are believed to support the funding mechanism for residential services recommended in the joint Turning Point/Alcohol Concern/SCODA report on community care. That report emphasised that services would close unless the rehab's home local authority held the community care budget for all the residents regardless of which authority they originated from.

Whether this departure from normal community care funding mechanisms will be acceptable to the department as a whole is unclear. One possibility would be a three-year transition period between 1983 and 1986 during which funding was centralised in the rehab's home local authority, but after which the normal procedures came into force.

This at least would give services time to gear up to the administrative complications of seeking funding from multiple local authorities and to negotiate suitable contracts.

A report released by the Department of Health on 19 July is intended to help drug and alcohol services prepare for the new funding arrangements. The optimistically titled *A Future for Alcohol and Drug Misuse Services* gives guidance on how the services can develop their contractual and working arrangements with local authorities.

FOR MORE INFORMATION

■ **A FUTURE FOR ALCOHOL AND DRUG MISUSE SERVICES.**
Department of Health, 1991.
Available from David Whitfield, DoH, Wellington House, 133 Waterloo Road, London SE1 8UG.

Government abandons plan to control steroids under Misuse of Drugs Act

The government has accepted expert advice first given in 1988 that steroids should not be controlled under the Misuse of Drugs Act. It says this is because the drugs are not addictive and not used for instant self-gratification.

In 1988 it seemed certain that mounting pressure would lead to steroids being controlled under the Misuse of Drugs Act, making unauthorised supply and possession an offence, and banning unlicensed importation. Despite the enthusiasm of the then Sports Minister Colin Moynihan and Home Office Minister Douglas Hogg, this plan has been shelved as the Home Office's own working group followed the Advisory Council on the Misuse of Drugs in advising against the move.

The same working group also advised against extending the Medicines Act to control steroid imports. The announcement made in July instead proposes a new law heralded by the Home Office as "tough action to stop steroids reaching young athletes", but experts say it will do little to strengthen existing restrictions.

Announced after over three years of reports and consultations, the proposal is to prohibit unauthorised steroid supply to under-18s, but this is effectively *already* banned because steroids are prescription-only medicines under the Medicines Act.

In its consultation paper the Home Office asked for responses to its proposal to "make it an offence to sell or otherwise supply or give anabolic steroids ... to minors". The intention is to plug a loophole in the Medicines Act which, the paper says, "arguably" leaves "giving supplies to others (as might be done by sports coaches)... unrestricted by law".

For Medicines Act prosecutions to succeed "unauthorised sale or intent to sell" has to be proved, says the Home Office, but a legal expert at the Pharmaceutical Society – responsible for enforcing the relevant sections of the act – explained this is not the case. Sports coaches giving steroids to athletes to improve performance would almost certainly be committing an offence under existing legislation, says Alan Davidson.

The exceptions are extremely unlikely to apply to the situation targeted by the new law, having to do with whether the recipient is involved in a business to do with drugs.

One potential loophole not mentioned by the Home Office is that the Medicines Act applies only to "medicinal products". But this phrase is interpreted widely to include claims that the substance can improve physical performance. Even just looking like a medicine can be enough.

It looks like business as usual for steroid stackers in Britain's gyms

Maximum penalties available under the new law will be less than under the Medicines Act. Tried before a magistrate the maximum £2000 (soon to be £5000) fine will be the same in both cases, but the Medicines Act also allows for heavier penalties to be imposed on indictment.

Prosecutions for unauthorised steroid supply run at just a handful a year, but the new law is not intended to dramatically raise the probability of offenders being detected. Police "would not be expected to 'go looking for' cases", says the Home Office; convictions in the order of just ten a year are anticipated.

The level of concern ministers themselves helped generate may have created a situation where government felt it had to do something to crack down, but late in the day it seems to have accepted that in reality there was little that could be done.

Pat O'Hare heads the Mersey Drug Training and Information Centre, the drug agency running Britain's only specialised advice service for the use of drugs in sport. He sees the proposals as a sop to the pro-controls lobby which will do little to deter the coaches and gym owners involved in supplying the drugs.

The risk, he believes, is that the only impact will be to drive steroid use further underground.

isdd NOTICEBOARD

Translation pilot project

In association with the Bridge Project in Bradford and the Maze Project in Tower Hamlets in London, ISDD is mounting a pilot scheme to make available drug information for those whose first language is not English.

The initiative started last year with a questionnaire sent to over 200 health promotion units (HPUs) in England. The results showed that in areas where there was a significant ethnic minority population, HPUs were keen on material being made available and that the overwhelming demand was for information in the languages of the Indian subcontinent.

As we had never addressed this area of drug information need before, it was decided to mount two small pilot projects working closely with agencies which had good links with the relevant communities. ISDD already had regular contact with Bridge in Bradford who in turn had produced a tranquilliser booklet in Urdu. We also established that the Maze Project in Tower Hamlets had opened a dialogue with the religious leaders of the local Bengali community about drug issues.

ISDD drafted two leaflets, one on drug use in general and the other on cannabis, to be translated into Urdu and Bengali. Recently these drafts were discussed with the participating projects and circulated to the Black Drug Workers Support Group for comment and emendation. The leaflets are currently in the production stage and will be ready for distribution in September. In Tower Hamlets the Young Muslim Organisation has given its support to the project; this group will be actively involved in the distribution and hopefully will be participating in the evaluation planned for the new year.

Whatever has been learnt from this project will be incorporated into a more comprehensive initiative to provide drug information in languages other than English.

For further information contact Harry Shapiro, 071-430 1991.

Traffickers' £0.9 million to fund UK drugs work

Bids for a share of £0.9 million confiscated through international operations against drug traffickers were being sought by the Department of Health in July. Drug agencies were to channel their bids through their regional health authority. Similar arrangements were made for Scotland and Wales.

Sums available from this source are set to increase as agreements are made with more countries, but already queries are being raised over the ethics of accepting money extracted by controversial laws enacted in countries which may have inadequate legal safeguards.

The £0.9 million is the first fruits of a new fund announced by the Home Secretary in April. Kenneth Baker told an ACPO conference that assets confiscated under international agreements would be "recycled" to support drugs work here and abroad.

This announcement extended the remit of the fund, originally intended solely to offset the costs of expensive international drug enforcement operations. It's estimated that a total of just under £2 million will be available in 1992 of which half will be devoted to anti-drugs work and half to meet the costs of international enforcement.

The agreements on which the fund is based allow for confiscation orders made overseas to be enforced in Britain by British police, if traffickers have assets in the UK. Also to be fed into the fund are payments made in recognition of British help in international investigations.

Britain has implemented confiscation agreements with seven countries and another eight are soon to be added (see panel). New international conventions will provide a stimulus to extending the network.

On 26 September the UN Convention on Drug Trafficking comes into force in the UK following its ratification in July. A Council of Europe convention dealing with cross-national confiscation of traffickers' assets is in the advanced stages of negotiation.

The likelihood is that traffickers' assets will become an increasingly significant source of money for drugs work in the UK, a trend which could be dramatically accelerated if the fruits of domestic prosecutions were also fed into the fund.

International confiscation agreements are extensions of Britain's Drug Trafficking Offences Act, controversial for reversing the burden of proof to the defence over the source of a convicted trafficker's assets. These will be confiscated unless they can be shown *not* to have been the proceeds of drug trafficking.

An added concern is that British drug agencies may profit from the enforcement of confiscation orders made in overseas countries with inadequate civil liberties records.

Officers from Britain's National Drugs Intelligence Unit say enforcement of overseas confiscation orders will not be automatic. Even if Britain has a mutual confiscation agreement with the country, the documentation from the case will be scrutinised for legal flaws.

Britain has confiscation agreements with:

- USA
- Canada
- Spain
- Mexico
- Australia
- Bahamas
- Gibraltar

Soon to be added are:

- Anguilla
- Italy
- Sweden
- Nigeria
- Hong Kong
- Montserrat
- Bahrain
- Caymans

Police drug searches triple since 1986

The number of police searches for drugs recorded under the provisions of the Police and Criminal Evidence Act tripled between 1986 and 1990 while the success rate fell from 19 to 16 per cent. The evidence of the successes suggests most of the searches involved stopping people in the street, a long-standing source of friction between police and sections of the public at the receiving end.

In England and Wales in 1990 police recorded nearly 98,000 searches of people or vehicles for drugs and found drugs in about 16,000 cases. Between 1989 and 1990, 18,700 more searches were recorded which netted just an extra 2000 finds, a 'marginal' success rate of less than 11 per cent. More searches were made for drugs in 1990 than for any other reason.

Jane Goodsir, Director of Release, the national agency specialising in drugs and the law, believes this increasing pool of people affected by drug searches has contributed to a general crisis of confidence in the police.

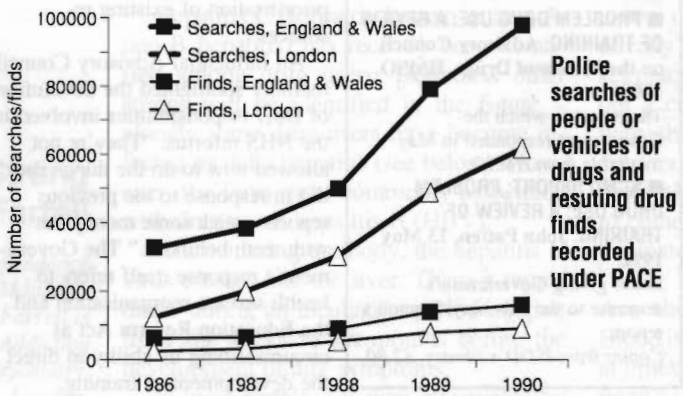
London's Metropolitan Police accounted for two-thirds of the drug searches made in 1990, making five times as many searches as in 1986. The search rate approached 1 in 100 of the capital's population. Less than 1 in 6 of the searches resulted in a drugs find. Searches of all kinds increased in the late '80s but the rate of increase in drug searches was nearly 40 per cent higher than for non-drug searches.

In 1989 – the latest year for which figures are available – over 80 per cent of drug seizures in London involved cannabis and less than 20 per cent involved class A drugs.

When ***Druglink*** reported on the increased London drug search rate in 1988, police sources attributed the rise to the new territorial support groups looking for easy arrests to demonstrate effectiveness (***Druglink***, Nov./Dec. 1989). The Home Office instead attributed the rise to the eight new area drug squads, but neither explanation accounts for the continuing rises in 1989 and 1990.

A Metropolitan Police spokesperson knew of no force-wide policy to step up drug searches, explaining that each area developed its own policy.

A theory with some credence among drug workers in London is that the crack scare generated by a US drug enforcement agent in April 1989 sparked more stop and search operations in inner-city areas with high black populations. The following month the head of the Met's drug squad responded to predictions of a crack epidemic with the promise that "the public will now see an increase in drugs raids... The [crack] dealers tend to be in black areas". (***Druglink***, Sept./Oct. 1989).



Police searches of people or vehicles for drugs and resuting drug finds recorded under PACE

Research in Lewisham, an inner-city London borough with a high black population, concluded that "the police have targeted black people and black communities in their operations directed against crack and cocaine misuse", after finding that 95 per cent of crack users arrested by police were black while 85 per cent seen by other agencies were white (Mirza H.S. *et al*, *Drugs People and Services*, Drug Information, Project 1991).

Academics emphasise that part of the increase in search figures could be due to a higher proportion being recorded. Professor Geoffrey Pearson of Goldsmiths' College was an author of the Lewisham research. He points out that the introduction of a cautioning policy – as in recent years for minor drug offences – invariably leads to an apparent increase in crime simply because police record more of their activities. Cautioning allows the incidents to be processed without the resource limitations imposed by court proceedings.

Criminologist Robert Reiner of the London School of Economics adds that the crack scare may have legitimised the recording of previously unrecorded stop and search incidents.

Solvents focus for new local campaigns

Locally-based initiatives will spearhead the latest of the Government's anti-drugs campaigns. In July Department of Health Parliamentary Secretary, Baroness Hooper, announced that "the focus of the campaign should be changed from national mass media work to a series of locally-based campaigns which are nationally signposted ... The object will be to highlight local problems and local methods of prevention, including the information needed by parents, the roles of teachers and schools, and the work of local voluntary bodies".

This year there will be a special focus on the problems of solvent misuse. Recently an All Party Solvent Misuse Prevention Group was established, but a DoH spokesperson said they have been concerned for some time about the continuing level of solvent deaths and that their decision to highlight solvents in the current campaign has not been 'politically driven' by the new group.

Baroness Hooper also announced that "a package of measures will be undertaken in Scotland to complement and support GB-wide activity".

In July 1992 the UK takes over presidency of the *European Community* and will use the opportunity to stage a "major campaign on drugs prevention" during the rest of the year, though what this will involve is as yet undecided.

£4 million has been set aside by the Department of Health for the 1991/92 campaign, comparable to the sums allocated in previous years. A proportion will be soaked up by the advertising agency Ogilvy Mather, employed in June to undertake the 'national signposting' of the campaign and to focus attention on solvent misuse. Much of the rest will be channelled through health authorities to mount locally-tailored awareness campaigns.

An additional £500,000 will also be available for the funding of local projects which might face increased demand for their services as a result of the campaign. Again, this money will be allocated by health authorities, presumably on the basis of bids received from projects.

Local campaigns instigated by the Department of Health clearly risk conflicting with the work of Home Office drug prevention teams in the areas where they are operating. However, officials from both departments were at pains to assure *Druglink* that there has been full inter-departmental consultation.

Government's 'no money, no action' response to ACMD's training report

The Government's response to *Problem Drug Use: a Review of Training* is likely to create dismay among the report's authors on the Advisory Council on the Misuse of Drugs. A meeting of the working group that produced the report, due in early September, is expected to complain that the Government's hands-off attitude fails to give the essential national lead to the development of drug training.

Issued in May – a year after the report was published – the response from Home Office Minister John Patten explained that "the Department of Health now has only a very limited role in relation to training," before listing the professional bodies responsible for considering the report's various recommendations.

Nowhere in John Patten's letter is there a commitment to government action implementing the report's recommendations. Specifically rejected is the creation of a new national training development agency for the drugs field, which the Advisory Council said was needed to upgrade training practice. No new pump-priming money is promised nor will health authorities be instructed to allocate resources for training.

Sources on the Advisory Council contrast this response to that given to previous ACMD reports on treatment and AIDS, which were followed by government circulars asking health and other authorities to implement the recommendations and providing cash incentives to action.

"It's not that they've failed to provide a lead but that they do not even recognise they have a leadership role," commented one working group member. "In practice the Government are giving no priority to drug training ... they've said it's not appropriate for them to *have* priorities."

Dr Gerry Stimson of the Centre for Research on Drugs and Health Behaviour is an Advisory Council member who did not serve on the working group. He believes "the Department of Health has a responsibility to get things going and shouldn't use the argument that it doesn't interfere with professional training". Their track records suggest professional bodies would respond better with a push from the centre, argues Dr Stimson. He points out that beyond the basic level, drugs training often needs to be multidisciplinary, placing it beyond the remit of any single professional body.

Ideally the push would come in the form of new 'pump-priming' grants to fund innovative demonstration projects, but the Advisory Council's report said many of the recommendations "simply require an act of political will in the prioritisation of existing resources".

An influential Advisory Council member spotlighted the devolution of DoH responsibilities involved in the NHS reforms. "They're not allowed now to do the things they did in response to the previous reports – stick some money out with teeth behind it." The Government's response itself refers to health service reorganisation and the Education Reform Act as circumscribing its ability to direct the development of training.

FOR MORE INFORMATION

■ PROBLEM DRUG USE: A REVIEW OF TRAINING. Advisory Council on the Misuse of Drugs. HMSO, 1990.
The report to which the Government responded in May.
Available from HMSO.

■ ACMD REPORT: PROBLEM DRUG USE: A REVIEW OF TRAINING. John Patten, 13 May 1991.
Letter giving Government's response to the Advisory Council's report.
Copies from ISDD's library, £2.30.

■ Heroin addicts in Spain were detoxified on clonidine and then prescribed either naltrexone for six months or switched to a placebo after a month.[1] Naltrexone is an opiate antagonist used to deter heroin use by making the drug ineffective, but the researchers found it was no better than the placebo on all the treatment outcome measures used.
1. San L. *et al.* "Follow-up after a six-month maintenance period on naltrexone versus placebo in heroin addicts." *British Journal of Addiction*: 1991, *86*, p.983-990.

■ An evaluation of short-term outpatient methadone detoxification treatment for heroin addiction "raises questions about the continued reliance upon this type of intervention" within the UK, say researchers at London's Maudsley Hospital.[1] Their study compared outcome in patients allowed to negotiate their methadone dose during withdrawal as opposed to those on a fixed six-week schedule. Against expectations, flexibility did not improve outcome, but the main finding was that just 13 per cent of the 82 patients assessed as suitable for detoxification actually completed the programme, and a high proportion were continuing to use illicit heroin.
1. Dawe S. *et al.* "Should opiate addicts be involved in controlling their own detoxification?" *British Journal of Addiction*: 1991, *86*, p.977-982.

■ Writing in the *British Medical Journal*, Dr John Strang of London's Maudsley Hospital drug clinic has reported the snorting of crushed buprenorphine (Temgesic) tablets.[1] Patients report sniffing the drug up the nose gives a rapid and marked psychoactive effect.
1. *British Medical Journal*: 20 April 1991, p.969.

■ An alternative explanation has been suggested of findings implying that children of mothers given pethidine or other pain-relieving drugs in labour may be 'imprinted' with a propensity to opiate addiction.[1] Clinical pharmacologist Dr Andrew Herxheimer has linked the findings to a study revealing that babies of mothers given pethidine in labour tended to fail to develop proper sucking behaviour.[2] Dr Herxheimer suggests that feeding difficulties may lead to personality structures predisposing to addiction.
1. Jacobson B. *et al. British Medical Journal*: 10 November 1990, p.1067-1070.
2. Righard L. *et al. Lancet*: 3 November 1990, p.1105-7.

The other virus: hepatitis explained

Before HIV there was hepatitis – a potential killer affecting a third of Britain's injectors

Hepatitis is an infection and inflammation of the liver. Hepatitis B is the most important strain in drug users. About 1 in 20 of those infected develop chronic disease with a high risk of cirrhosis and liver cancer. Hepatitis B virus is spread in the same way as HIV but is much more infectious and harder to kill. Preventive measures involve safer drug use and safer sex practices, but effective vaccination is also available though expensive. New treatments are being developed.

John Strang
Michael Farrell

John Strang is Director of Drug Dependence Services at the Bethlem Royal and Maudsley Hospitals in London. Michael Farrell is Senior Research Registrar at the Addiction Research Unit of the Institute of Psychiatry, London.

HIV HAS FORCED a fundamental reappraisal of many aspects of clinical practice. One deficiency which has come to light has been the delivery of general health care to drug users. Any independent observer would have mistakenly concluded that before the arrival of HIV there were no infections transmitted by sharing injecting equipment. But in years to come, we may look on the spread of hepatitis B as the great overlooked epidemic.

There are several similarities between hepatitis B and HIV. Both are transmitted among drug injectors and their sexual partners by the sharing of injecting equipment and by unprotected sexual activity. Both have the unusual characteristic of being able to spread through the body, initially bypassing its defensive immune system. Both may result in undetected initial infection and a subsequent carrier state at which stage the virus can unwittingly be passed on to others. Both result in long-term major health consequences which may not be evident until years – or even decades – later.

Hepatitis is an infection and inflammation of the liver resulting from infection by the hepatitis virus. One common strain among the population at large is hepatitis A. Infection can be caused by poor hygiene, eating infected food, or drinking infected water. The effects are unpleasant, but rarely dangerous, and hepatitis A does not persist.

Hepatitis C (formerly known as non-A, non-B hepatitis) has recently been identified among drug users. Doubtless other strains will be identified in the future – already some drug users have become infected by delta hepatitis (see below). However, the form most commonly associated with drug use is hepatitis B (HBV).

After entering the body, the hepatitis B virus crosses into the liver. There it reproduces during an incubation period ranging from six weeks to six months before the development of any symptoms.

In most people it is then inactivated by the body's immune system, but in about 10 per cent of men, and a higher proportion of women, the virus persists. As a result the individual may be infectious to others and will be at major risk of later developing cirrhosis (scarring and destruction of the liver) or primary cancer of the liver – primary in the sense that the cancer develops in the liver itself rather than secondary to cancers elsewhere.

Transmission routes

How is hepatitis transmitted? The transmission routes are the same as for HIV, but the hepatitis B virus is more infectious. Blood is the body fluid which is almost always involved in infections, though this may be small amounts transferred during sexual and other intimate contacts (especially with highly infectious individuals).

Evidence from studies of accidental needlestick injuries suggests that the amount of virus and body fluid required for infection to occur is a great deal less for hepatitis B than for HIV. The hepatitis virus is also tougher than HIV. It may survive heat, cold and drying out – even HIV precautions such as immersion in boiling water will not kill hepatitis B.

Who is at risk? Those mainly at risk of becoming infected are the same groups most at risk of contracting HIV – injecting drug users, those whose immune systems are already impaired, those engaging in unsafe sex practices (generally penetrative sex without a condom), those in intimate contact with chronic carriers, and infants born to carriers. Also at risk will be health care professionals or any other individuals likely to come into contact with potentially contaminated blood.

Are there degrees of infectivity? Yes. Blood is the main risk fluid and is infectious at times when the protein of the virus ('antigen') is detectable in blood.

Following the initial infection there is an incubation period of about three months during which the individual will be symptom free but may be at their most infectious. Many hepatitis-infected people never develop any detectable illness at this stage, even though a substantial minority will go on to become chronic carriers.

How the disease develops

Different individuals will go down different pathways of hepatitis infection during which they either eliminate the virus or become chronic carriers (see figure).

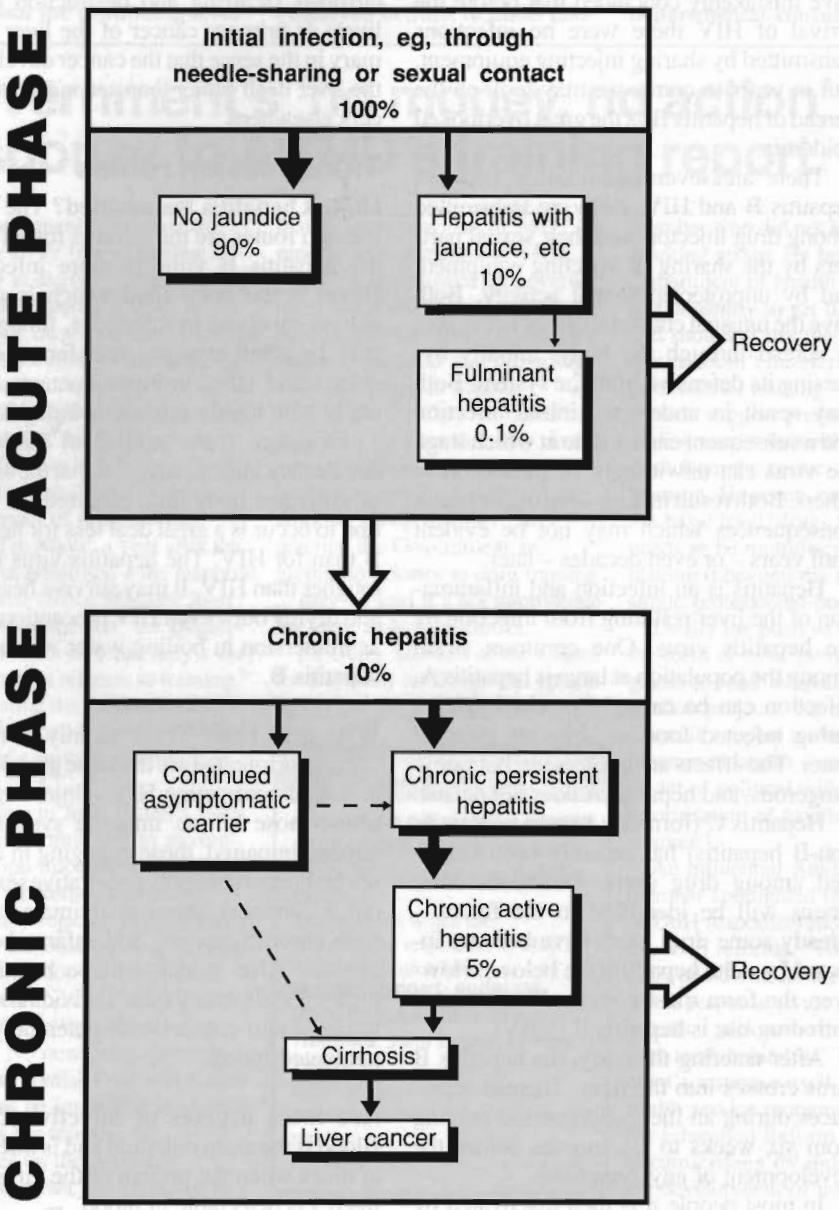
Hepatitis B infection may be mild and go unrecognised, may result in jaundice and general malaise, or rarely may result in a fatal fulminant hepatitis. Approximately 5-10 per cent of those infected go on to develop chronic infection which is likely to result in chronic liver disease such as chronic active hepatitis. This in turn may progress to cirrhosis of the liver and consequent liver failure or cancer.

In the following description, the clinical conditions are described either as *acute* (the months following the original infection) or as *chronic* (continuing over a longer period of time).

Acute phase

In the acute phase of the illness there are a number of possible symptoms and outcomes. The most obvious distinction is between those who develop jaundice and those who do not.

1. **No jaundice**. The individual may exhibit general malaise with fatigue and loss of appetite and weight, or alternatively may have no symptoms at all. The outcome may be clearance of the virus or on the other hand the development of chronic hepatitis.
2. **Ill with jaundice**. This may end with clearance of the virus and recovery or alternatively develop into chronic hepatitis. A very small percentage of people develop full-blown 'fulminant' hepatitis which leads to death in 80 per cent of cases.



Chronic phase

People with impaired immune responses seem more likely to become chronic carriers.

Individuals with chronic hepatitis may nevertheless be asymptomatic showing no signs of disease. Most asymptomatic carriers have normal liver function tests but it is uncertain what will happen in the long term: some will carry the virus for many years without ever developing severe liver disease; others will go on to develop chronic hepatitis and cirrhosis.

Another group of chronically infected individuals do show signs of ongoing liver disease. This occurs when the virus continues to replicate. Chronic *active* hepatitis is associated with symptoms of fatigue and reduced appetite and is more commonly seen in women. Most of these people will eventually develop cirrhosis.

Cirrhosis of the liver involves the progressive destruction of liver tissue which is replaced with fibrous scarring. It is important that ongoing liver disease is detected before extensive cirrhosis has developed as recovery of the liver tissue is not possible once scarring has taken place.

Chronic hepatitis B infection is now the most common cause worldwide for primary liver cancer. Chronic hepatitis B carriers are 250 times more likely to develop this cancer than those uninfected. This occurs mainly in men, often preceded by cirrhosis. Surgical removal of this form of liver cancer is rarely possible making it more difficult to treat.

Additional complications

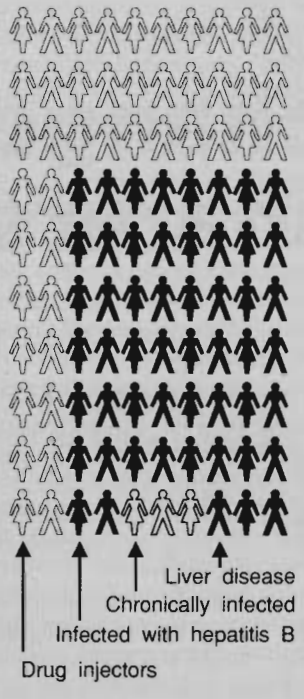
Co-infections. There seem to be different strains of hepatitis B which result in epidemics of different severity. In addition, there are other infections which if they happen at the same time ('co-infection') may alter the severity of hepatitis B infection. Hepatitis C is one example, but the most notable co-infection during the last decade has been the hepatitis delta virus (HDV).

When infections with hepatitis B and with the delta virus occur simultaneously (co-infection) or when the delta infection occurs on top of previous hepatitis B infection (super-infection), the result is a more serious variant on hepatitis B infection with a higher rate of illness and death.

Delta infection can also occur in individuals who are hepatitis B carriers but not exhibiting any signs of illness. Here again the delta virus can transform a quiescent infection into an acute crisis.

In some parts of the world it is becoming increasingly common for injecting drug users to be infected with the delta virus as well as with the hepatitis B virus. For example, in the mid-80s in New York more than half the drug users who had been infected with hepatitis B had also been infected with the delta virus; in Dublin this figure was over 60 per cent. In London the presence of delta virus

Many injectors are infected with hepatitis B but few develop serious illness



is as yet unusual with the proportion only now approaching 10 per cent.

The health consequences of such co-infections should not be under-estimated. For example, in a study of a hepatitis B outbreak in the US state of Massachusetts, eight out of nine deaths from fulminant hepatitis involved co-infection with delta hepatitis.

Hepatitis C was previously known as non-A non-B hepatitis. Originally thought to be mainly transmitted through injecting and blood transfusions, it is now thought also to be sexually transmitted. Hepatitis C infection takes longer to develop than hepatitis B infection but can be more amenable to treatment. It appears to be particularly concentrated among drug injectors.

Pregnancy. During pregnancy, hepatitis B infection can be passed from the mother to the unborn baby. This is particularly likely if the mother has the core protein of the virus present in her blood. The likelihood of infection of the child decreases if the mother has already been a long-time carrier of the virus. Policy in the UK is to selectively screen mothers for antigens of hepatitis B. If the test is positive for surface antigens and there is evidence of viral replication, then the infant is immunised with globulin (see below).

Preventing the disease

Changing behaviour. Prevention involves reducing the extent to which infection occurs in the first place. Today in the drug field several of these approaches would be termed 'harm minimisation' or 'risk reduction'.

These may involve attempts to reduce the extent of drug use or to bring about a shift away from particularly risk-laden drugtaking behaviour. Like HIV, the behaviours of concern around hepatitis are unsafe sex and the sharing of injecting equipment.

Hygiene. For both workers and drug users, the infectivity of hepatitis B demands high levels of hygiene in situations where there is a risk of contact with body fluids such as blood which may harbour the virus. Unlike HIV, there is a significant risk of hepatitis B being transmitted via unwashed shared cutlery, toothbrushes, etc, as well as through transfer of blood or sexual fluids.

Passive immunisation. Another prevention approach which has been available for many years has been passive immunisation, involving the injection of antibodies to the virus. The procedure does not stimulate the body's own defences against hepatitis, so although the protection is immediate it is also temporary.

Passive immunisation is applicable after exposure to hepatitis B (such as a needlestick injury with an infected needle). Antibodies in the form of gamma globulin (which has been taken from a human donor and stored) can be given by an intramuscular injection and confer immunity which may last a few months – sufficient, for instance, to protect a worker over the period of possible infection from a needlestick injury.

Further antibodies in the form of anti-hepatitis immunoglobulin should be given as soon as possible – certainly within 24 hours if possible. Active immunisation should also be started immediately after exposure.

Active immunisation involves administering a vaccine which stimulates the body's own defences against hepatitis, conferring long-lasting protection. This has become available during the last decade – initially with the development of a vaccine from human donors (eg, HB Vax) and more recently with the development of a synthetic vaccine (eg, Engerix B). These attack the envelope of the hepatitis B virus and prevent the establishment of the initial infection.

Early concerns about the transmission of other infections (such as HIV) through the human donor vaccine have proved unfounded and are not applicable to the synthetic vaccine.

It is probable that the expense of the course of three injections of the vaccine (over £30) has restricted its availability to drug workers as well as to drug injectors and their sexual contacts, even though the vaccine has been shown to represent effective prevention for over 90 per cent of the individuals who receive the course.

It is important to note that vaccination against one form of hepatitis does not protect the person from other forms.

Treating the disease

As with prevention, the story of the treatment of hepatitis B infection shows remarkable similarities to the story so far with HIV.

The key message for people with chronic hepatitis is that they need to *abstain from all alcohol* to preserve their liver function. People are also best advised that careful attention to general health and nutrition may benefit overall response to such infections, but there is no clear evidence to indicate that this is actually the case.

Clients need to be encouraged to attend a liver specialist so that progression of the disease may be monitored and to be assessed for the viability of new forms of treatment now becoming available.

Until recently there was very little which could be offered to chronic carriers of hepatitis B. However, in a few centres, specific anti-viral drugs (such as derivatives of interferon) are being given to selected individuals with ongoing liver disease such as chronic active hepatitis.

While such treatment is highly expensive and must be monitored carefully, it would appear to be effective in clearing the circulating virus and hence preventing or reducing not only the risk of infection to others but also the likelihood of progression of the disease.

THERE ARE MANY reasons on personal and public health grounds why hepatitis B should be taken seriously by drug users and drug services. With the identification of the avoidable routes of transmission, and more recently with the development of a highly effective vaccine, it is possible for individuals (and through them their contacts) to be offered protection from the virus and from the associated long-term consequences. For these reasons services which are in contact with drug users should give serious consideration to offering testing for hepatitis B. ■

FOR MORE INFORMATION

■ **KEEP CHECKING DRUGLINK**
Watch out for the announcement of our *Drugs Work* booklet on hepatitis which will build on this article to present a practical guide with handouts for clients/workers.

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

The syringe exchange sharers

Disturbing evidence that attending a syringe exchange can increase syringe sharing

The 'inconvenience factor' involved in attending syringe exchanges or pharmacies means there is a continuing demand for used injecting equipment. Syringe exchange attenders may be at the receiving end of this demand. Research in the North West shows that regular exchange attenders not in treatment pass on their injecting equipment significantly more than injectors not attending exchanges. There is a case for more rigorous monitoring of equipment returns.

ONE CONTINUING concern about needle exchanges is the possible risk of their sustaining – perhaps even encouraging – injecting as a method of administration.[1] Those in favour of the schemes emphasise their potential for risk reduction and look for evidence that the sharing of injecting equipment is falling among their users. This does seem to be the trend in certain populations of users in contact with drug treatment services.[2,3,4] But it may be that sharing is declining generally among exchange scheme non-attenders as well as attenders.

A postscript to the national evaluation of injecting equipment exchange schemes[5] has asserted that these have had some impact on the HIV-related risk behaviour of certain groups, though not those who may be most at risk. However, the contribution of syringe exchanges to risk reduction is difficult to evaluate. Behavioural change is the consequence of several factors. For example, injectors have been targeted as a 'high-risk group' – few can be unaware that they are being 'watched'. General media coverage of HIV and AIDS and specific educational messages have increased injectors' knowledge to levels that enable them to avoid infection if they so choose.

Demand for used syringes

Another key factor may be the increasing cooperation of pharmacies in providing access to injecting equipment and, in some cases, exchange facilities as well. Inevitably this has tended to dilute the educational impact of needle exchanges. Pharmacies are likely to be more widely used because they tend to be more conveniently placed and offer a greater degree of anonymity than needle exchanges. Inaccessibility is a particular problem for clinic-based rather than mobile syringe exchange schemes.

Pharmacies and needle exchanges have one feature in common: at times of high demand – in the evening and at night – they are generally closed. This 'inconvenience' factor must limit the extent to which needle exchanges and even pharmacies can reduce sharing. Forward planning is required to ensure a supply of needles and syringes at the right time – an organisational attribute that many injecting drug users do not possess.

A respondent in our research into injecting drug users in north-west England[6] put it this way: "When you're desperate for a fix and you're in somebody's house and there's only one needle and you're pretty sure the other guy hasn't got AIDS... well, you're not going to run 20 minutes to the chemist".

Users short of injecting equipment are likely to look for a convenient out-of-hours supplier. A partner, friend or associate may oblige, but someone known to attend a needle exchange is also a potential target. Regular attenders can become the focus of requests, sometimes from casual callers, to pass on their needles and syringes.

About a third of our interview sample of over 300 injectors regularly attended a needle exchange. Of these regular attenders, nearly 60 per cent reported passing on their injecting equipment in the previous six months, compared with 42 per cent of injectors not attending exchanges – a statistically significant difference. On the other hand, there was no significant difference between attenders and non-attenders in terms of their use of other people's equipment.

Closer analysis revealed that regular attenders not in contact with treatment services were passing on their needles and syringes significantly more than those in treatment.[7] In the vernacular of a market economy, they were filling a gap between supply and demand. In contrast, attending a syringe exchange was not associated with increased sharing if the attender was also in long-term treatment.

Some of our respondents who were using needle exchanges tolerated the pressure to pass on their equipment, others were irritated: "Even though works are dead easy to

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get hold of ... and free now... you still get people coming here, coming to the door ... no way we were going to give them the works we'd got ... told them we'd got a bucket of works people had used ... they wasn't bothered ... they took it like".

Some simply refused the requests to supply their used equipment; a few took pride in providing a 'service' to the younger, less experienced users, which they justified on the grounds that they knew themselves to be 'clean'. But sometimes 'donors' adopted a less admirable 'buyer beware' attitude, abdicating responsibility for the consequences of their actions. "It's up to them, they know the score," was a typical response.

Others agreed to pass on their equipment because they might need the favour returned in the future. Their motivations were fundamentally about mutual dependency, not lack of concern for others.

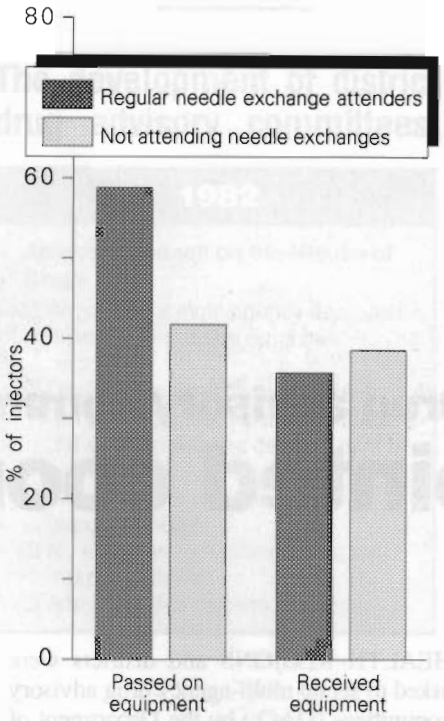
Need to monitor returns

Increased passing on of injecting equipment is an unforeseen and unwelcome outcome of needle exchanges, presumably related to the liberality of the exchange's dispensing and exchange policy. If used equipment returns are not fairly rigorously monitored, this creates an opportunity for uncontrolled 'private dispensing' that may go unnoticed.

The dilemma is whether, despite this risk, a free-handed policy is justifiable if greater watchfulness might deter clients from attending the scheme.

There are implications here for services. Injectors whose needs are urgent when services are closed, who do not wish to identify themselves as drug injectors by using needle exchanges, or who are simply not motivated to go out of their way to find them, are potential consumers of used equipment from injectors who *do* attend exchanges. While these demands exist, needle exchange workers should consider whether there is a need for greater vigilance in the dispensing of injecting equipment.

Persuading clients to resist demands to pass on their equipment may be difficult, so



Clients not in treatment account for the increased rate of passing on of injecting equipment among needle exchange attenders. See text for details.

a more stringent check on returns might be necessary despite the risk of some alienation. Clients not in treatment seem more likely to agree to such demands and might therefore require closer monitoring.

Risk of HIV transmission may be minimal in most cases involving the re-use of needle exchange equipment, since the time interval between use and re-use may be considerable. But there are implications beyond HIV transmission if such private dispensing is indiscriminate and extended, perhaps unwittingly, to those not yet injecting.

Supporters of exchange schemes would argue that they have value beyond the exchange and return of injecting equipment. Most offer more than a simple trading relationship with clients. A forgiving, non-judgmental ambience, companionable advice and help on health and social problems are often available. There is a potential in such interactions for considerable influence on drug users' behaviour. If the schemes attract those who would not otherwise be in touch with services, they may be of value for this reason alone.

"Needle exchange workers should consider whether there is a need for greater vigilance in the dispensing of equipment"

Nevertheless, at this stage in the development of needle exchanges, while policies are still variable and uncertain, it would be wise to monitor more effectively what happens to injecting equipment after it is dispensed.

Increasing access to needles and syringes is likely to have played a key role in HIV prevention – but, like any other innovation implemented with little time for evaluation and modification, there may have been unplanned and potentially damaging consequences.

ACHIEVING A consistent and enlightened policy for the dispensing of injecting equipment requires a greater investment in research into current practices and their consequences. Providing a 'user-friendly' service to attract a wider clientele may or may not be compatible with careful monitoring of the disposal of injecting equipment, but the issue needs to be addressed. While strategies that increase control over the distribution of dispensed equipment are lacking, needle exchanges will be open to fair criticism from their opponents. ■

FOR MORE INFORMATION

■ **THE SHARING OF INJECTING EQUIPMENT AMONG DRUG USERS ATTENDING CLINICS AND THOSE USING NEEDLE EXCHANGES.** **Klee H. *et al. British Journal of Addiction*: 1991, *86*, p.217-223.**
Research paper presenting the data on which this article is based.
Copies from ISDD's library on 071-430 1993, £1.61.

■ **INJECTING EQUIPMENT EXCHANGE SCHEMES. FINAL REPORT. Stimson G.V. *et al.* London: Monitoring Research Group, 1988.**
Research report presenting findings of the government-funded evaluation of pilot syringe exchange schemes.
Available from Centre for Research on Drugs and Health Behaviour, 200 Seagrave Road, London SW6 1RQ. £7.00.

■ **AIDS AND DRUG MISUSE. Strang J. *et al, eds.* Routledge, 1990.**
Book of readings with papers from leading British and international experts.
Available from ISDD on 071-430 1991, £13.75.

■ **AIDS-RELATED INTERVENTIONS AMONG DRUG USERS IN THE NETHERLANDS. Buning E. *The International Journal on Drug Policy*: 1990, *5*(1), p.10-13.**
In the Netherlands syringe exchange is integrated into an overall harm-reduction programme which has reduced needle sharing.
Copies from ISDD's library on 071-430 1993, £0.92.

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

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Drug advisory committees in practice

Disjointed coordination

Coordination was their main mission, but were the obstacles too great?

Drug advisory committees were established in 1985 to coordinate local drug services, but without some of the elements originally recommended by the Advisory Council on the Misuse of Drugs. In practice the committees work well as information-sharing forums but frequently fail to provide clear guidance on the development of services. Performance could be improved by measures including clarifying objectives, widening membership, and providing support and training for the members.

Peter Baker

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HEALTH REGIONS and districts were asked to set up multi-agency drug advisory committees (DACs) by the Department of Health (DoH) in 1985. Detailed guidance was issued in the following year, but since then government has shown little interest in the workings of what are supposed to be key agencies in the local and regional coordination of drug services. What's clear is that the committees have not lived up to their expectations or potential.

According to DoH guidance, district DACs should include representatives of the health service, social services, police, probation, local education authority and the non-statutory sector (including parents' and self-help groups). Their roles were to include: monitoring the local prevalence of drug misuse; assessing preventive measures, services, and training; proposing improvements; and promoting liaison and coordination at working level between the various agencies, professions and groups concerned.

DACs' proposals were, in the words of a 1986 departmental circular, to be "regarded as an important input to the work of joint consultative committees, joint planning teams and appropriate planning groups within the local authority".

Effective inter-agency working is known to be difficult to achieve in any area. The government's White Paper on community care, for example, acknowledged that joint planning has been a "modest success [that] falls far short of the aspirations of the mid-1970s".

Drug advisory committees have experienced many similar problems. Most are prone to serious weaknesses including inadequate status in the joint planning machinery, over-domination by the health service (and uneven representation from other sectors), irregular attendance by members, vague or ill-defined terms of reference, and a lack of commitment by members to genuine joint working.

While they may function well as forums for sharing information, drug advisory committees frequently fail to provide clear guidance for the development of local services. At best they could be described as no more than a modest success.

Some suffer from an even more damaging flaw: they simply don't exist, often having collapsed after the departure of an energetic chairperson or having been undermined by the bureaucratic nightmare of non-coterminous boundaries. Actual hostility to inter-agency cooperation – sometimes from consultant psychiatrists nurturing an outdated 'medical-led' approach to treatment and sometimes from local authority chief officers – has also led to the demise of DACs or to their stillbirth.

Ways forward

Health service and community care reforms are putting new strains on drug advisory committees and it is not clear how their role will now develop.

Anyone who shares the prevailing 'reformist' problem drugtaker analysis of the nature of drug misuse – and most practitioners now do – must be aware of the importance and necessity of inter-agency liaison. The record of some DACs shows they can achieve positive outcomes; front-line workers have found them a useful means of inputting into policy development in a forum including senior local and health authority officers. In any event, the DoH is not about to recommend the abolition of DACs; they will continue to exist in some form.

So what is the best way forward for drug advisory committees? How should they respond to the purchaser/provider split in the health service? Should the DoH be more prescriptive and ensure that properly constituted committees are set up in each district? Or should local agencies be left to determine what suits them best? Should the committees be given more powers, or should their limitations be recognised with an accept-

ance that they function most effectively 'merely' as talking shops?

Preliminary research commissioned by the DoH and conducted by the London Research Centre and the Local Government Drugs Forum – and the conference at which the research report was launched (March 1991) – signposted the moves committees may have to make to become more effective. In many, implementation of several basic organisational changes would result in a marked improvement in performance.

Membership of DACs should be more widely drawn, both vertically and horizontally. More agencies should be encouraged to participate. There is a particular need for greater involvement by the non-statutory sector, especially as it provides the bulk of front-line services in many areas. Self-help and parents' groups are not known to be represented on any DAC and their participation could also be helpful. DACs would benefit from a greater input by local authorities, especially social services and education departments and possibly environmental health and housing too.

There should also be a greater mix of members from different levels in their organisations' hierarchies. To deal with the difficulties of decision-making in larger committees, wherever possible work should be delegated to subcommittees – a course of action consistently recommended by the Drug Advisory Service.

Clarify objectives. It is essential that more committees draw up clear aims and objectives and a strategy statement. In particular, DACs should press for a clear position in the local joint planning machinery and also decide what role they should play in the allocation of resources to local agencies.

The Drug Advisory Service has recommended that DACs should play a major role in advising health and local authorities about resource allocation. District drug advisory committees may now have to decide whether to act, for example, as advisors to the purchasers of services, as agents of the services themselves, or as a forum for both providers and purchasers. These changes will help committee members clarify their roles and responsibilities.

Support and training. Like any other properly run committee, DACs require more than just a place to meet. Administrative support – to arrange meetings as well as to produce and circulate minutes, discussion papers and an annual report – is essential. Effective administration can also make collective work more fruitful by helping to implement decisions.

The role of the chairperson also appears to be crucial. Some committees might find the appointment of a 'neutral' chairperson to be helpful; the much-lauded East Sussex Drug Advisory Council is, for example, chaired by a dentist. It has also been suggested that chairs should be democratically and annually elected by the whole DAC.

It is often said that a 'charismatic' leader can transcend the difficulties inherent in joint working and create an effective committee. Charismatic people are few and far between, but there is surely a role for the training of DAC chairs in the skills necessary to run a committee efficiently. Similarly, training for other members is also likely to be useful, particularly to encourage joint working – not a natural skill.

Our survey showed that two-thirds of DAC members were men. It is well known that men find it harder to work cooperatively, a problem that might be rectified by appropriate development work. The Yorkshire Regional Health Authority has so far run two study days for drug advisory committee members. These revealed widespread problems as well as possible solutions. Such meetings might prove useful for all regions. For similar reasons, Colin Smart, Director of South Tyneside Social Services, has mooted an annual conference for DAC chairs.

Client focus. However DACs seek to improve their performance in the climate of the new reforms, they must do more than function well in administrative terms. It is not difficult to imagine a highly efficient committee that meets regularly, has an appropriately wide range of members and dynamic subcommittees, yet achieves little as far as drug users themselves are concerned.

DACs may need to develop performance indicators that revolve around meeting the client needs, both in terms of front-line service delivery and effective preventive strategies. This will also require *all* DACs to regularly review their own performances – currently done only by a small minority.

GIVEN THE CURRENT direction of government policy, it is highly unlikely that the DoH will attempt to regulate the work of drug advisory committees – that would neither be practical nor desirable. Instead, the department is likely to continue to expect DACs to do what they were asked to do when they were set up, and occasionally to take on additional functions, such as working more with prisons (as happened in 1988) and being involved in the establishment of regional drug databases (1989). It will remain up to local agencies to make DACs work. Despite the difficulties (and some of the cynicism about DACs these have caused) the examples of best practice suggest there is a potential for improvement – that drug advisory committees can move beyond being talking shops to play an important and necessary role in the development of drugs services. ■

The development of district drug advisory committees

1982

Advisory Council on the Misuse of Drugs

- ❑ Argued for a multi-agency approach based on 'problem drugtaker' model
- ❑ District drug advisory committees proposed as main local mechanism for coordinating the development of services
- ❑ Wide range of members recommended
- ❑ No executive or funding allocation responsibilities
- ❑ Administrative costs to be funded

1985

Department of Health letter to RHAs

- ❑ Asked health authorities to establish multi-agency drug advisory committees by the end of the year
- ❑ Committees to be based on regions as well as districts
- ❑ Health authorities to be lead agencies

1986

Department of Health circular

- ❑ Committee's remit to include health education and prevention
- ❑ Recommended drug advisory committee composition more restricted than originally proposed – excludes housing and youth services, CHCs, training agency, industry
- ❑ No requirement for DAC administrative costs to be funded
- ❑ Committee proposals should be an important input into joint consultative committees, joint care planning teams, local authority planning groups

FOR MORE INFORMATION

■ **COORDINATING DRUGS SERVICES: THE ROLE OF REGIONAL AND DISTRICT DRUG ADVISORY COMMITTEES. Peter Baker and Dorothy Runnicles. London Research Centre and Local Government Drugs Forum, 1991.**
Available from the LRC, 81 Black Prince Road, London SE1 7SZ or the LGDF, 35 Great Smith Street, London SW1P 3BJ.

Could do better an evaluation of drug education

Britain's first national evaluation of modern drug education approaches

A government-funded evaluation of drug education in Scotland surveyed a quarter of Scottish mainstream secondary schools and nearly 1200 pupils. Packs aiming to improve decision-making skills were the dominant form of drug education. The study found drug education had no effect on attitudes to drugs or use of drugs but did improve knowledge. Better practice would involve acknowledging that drug use is not incompatible with high self-esteem and providing information not heavily weighted to a decision not to use.

Niall Coggans, David Shewan, Marion Henderson & John B. Davies

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THE LAST HALF of the '80s saw the initiation and development of drug education programmes for use in schools throughout the UK. The Scottish Education Department was instrumental in the development of materials and training and also funded an independent evaluation of the impact of drug education.

The evaluation took place between 1987 and 1989 and represents the first major UK assessment of the 'skills-based' approach to drug education dominant in current thinking. The body of this article deals with the implication of the findings; see page 16 for a summary of the research itself.

A key aspect of school-based drug education initiatives across the UK was the use of standard drug education packages, which largely replaced reliance on *ad hoc* forms of drug education using information and fear-arousal materials including pamphlets, videos or strict homilies from teachers.

The packages in greatest use in Scotland were *Drugwise 12-14* and *DrugWise 14-18*. Both eschewed the fear-arousal approach and minimised the informational content of the teaching. Instead these packs aimed to assist young people to clarify their attitudes and values; to develop decision-making, rejection and dissuasion skills; and to raise awareness of alternatives to drug use.

US studies have reported that such skills-based approaches have had some positive impact in preventing initiation into smoking,[1] but the Scottish evaluation clearly showed that the impact of these recent developments in drug education are, at best, of minor significance. Although the education raised levels of drug-related knowledge, there was a neutral impact on attitudes to drugs and on reported use of illegal drugs, alcohol, tobacco and solvents.

Some will conclude from this that drug education has been a waste of time. However, the value of evaluation lies in the willingness to learn from findings. This will entail a fresh look at what we expect from drug education, at how we target primary prevention attempts to prevent drug use, and at how we address the needs of those young people who will nevertheless experiment with drugs.

Lessons for teacher

What accounted for the lack of impact of drug education found in our study? A number of issues were identified that have relevance to good drug education practice.

Maintain credibility. Drug educators have an important role as credible sources of information and should at all times avoid tendentious input. Misleading assertions, such as passing off opinions as fact, will detract from the success of an educational programme, especially where the target audience is knowledgeable about the drug scene, as many young people are.

Avoid stereotyping. There is a widespread assumption in drug education materials that young people take drugs because they lack self-esteem or are weak in the face of peer-group pressure. However, this assumption of personal or social inadequacy is often simply negative stereotyping of drug users.

There is evidence that people with positive health practices do have higher self-esteem[2] – but positive health practices and high self-esteem do not necessarily preclude the use of drugs. Other studies have reported that often those with a leadership role in their peer group are the first to experiment with drugs[3] and are more likely to try out new experiences.[4] The role of low self-esteem in drug use has been over-simplified to the point that use of the concept sometimes appears to be code for moral inferiority.

Inform decisions, don't make them. A key feature of drug education is 'decision-making': that is, providing the kinds of information needed for an individual to make

an informed choice about drugs. *But the assumption is always that an 'informed choice' must be to choose to say 'no'*. In reality, 'decision-making' sessions are decision-implementation sessions, with the decision to say 'no' supplied by the teacher.

Even in drug education packages emphasising the life skills approach, there were cases where the 'say no' message was implicit or explicit in the content. Particularly in the hands of an insensitive teacher, *telling* young people not to do something they find attractive runs counter to good educational practice – it simply will not work. Many young people reject, or even resent, being told what to do.[5]

Incorporate harm reduction. The type of drug education evaluated in our study (because it was the type in circulation at the time) was primary prevention aimed at preventing initiation into drug use. This objective is inappropriate for young people who are already experimenting with drugs. Given the variable levels of drug experimentation in different schools, there is a need for drug education which enables young people to understand drugs and how to avoid harm from drugs, as well as education that seeks to prevent use.

Towards 'whole school' health

Our study clearly provides lessons for drug educators to learn and it would be of some concern if school-based drug education did not develop beyond its present form. But there is some reason to be optimistic. School drug education has, to some extent, attempted to take on board the findings of previous evaluations – in marked contrast to mass media campaigns which still subject us to the old fear-arousal messages of personal and social disintegration, despite evidence that this approach has no positive impact on people likely to take drugs. The recent *Drugs – the Effects Can Last Forever* campaign is an example of this approach.

Since our evaluation report was submitted, the Health Education Board for Scotland (formerly SHEG) has published wide-ranging proposals for promoting good health, emphasising the need for a whole-school approach which coordinates policy and permeates health education throughout the curriculum.[6]

> ***"The assumption is that an informed choice must be to say no"***

This is a heartening development. Case studies in the evaluation highlighted the need to establish a healthy school system, in which various aspects of the 'hidden' and the formal curricula work together to produce an environment conducive to health promotion. In addition to any formal drug education agenda, these aspects include teacher-pupil interactions and the standards and values implicit in the way the school operates.

For example, attempts to enhance decision-making skills will be undermined in schools where all the decisions have already been made for the pupils. A whole-school approach is a necessary precondition of effective health education, whatever the focus. Nonetheless, the extent to which these proposals will be adopted remains to be seen.

READERS OF *Druglink* will recall an article[7] which predicted the ineffectiveness of primary prevention and the need for harm-reduction strategies. Since then the same team have developed a harm-reduction package, *Taking Drugs Seriously*.[8] It will be interesting to see how far this or similar materials penetrate into schools. After all, parents of young potential drug users should surely want to know if the needs of their children are being catered for. And this is a sizeable constituency. ■

"WRONG ANSWER TOMPKINS, IMPROVE YOUR DECISION MAKING SKILLS, BOY!"

Michael Linnell

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FOR MORE INFORMATION

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■ **CHECK DRUGLINK for the announcement of ISDD's publication of the *National Evaluation of Drug Education in Scotland* by Niall Coggans *et al*, the research report on which this article was based.**
Available from ISDD later this year.

■ **PREVENTION. Advisory Council on the Misuse of Drugs.**
A report from the government's advisory body. The emphasis is on broad-based health education.
Available from ISDD, £4.20 inc. p&p.

■ **DRUG EDUCATION. Michael S. Goodstadt. US National Institute of Justice, 1991.**
US review including evidence of effectiveness and recommendations.
Copies from ISDD's library, £0.92.

■ **A REVIEW OF 127 DRUG ABUSE PREVENTION PROGRAM EVALUATIONS. Schaps E. *et al. Journal of Drug Issues*: 1981, 11 (1), p.17-43.**
Influential review concluding drug education programmes of the time had little effect.
Copies from ISDD's library, £3.22.

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

Research findings overleaf

FINDINGS OF THE NATIONAL EVALUATION OF DRUG EDUCATION IN SCOTLAND

The Scottish evaluation[9] started by identifying the range of drug education experience to be found among pupils in their second, third or fourth years of secondary schooling (13-16-year-olds). This was carried out by surveying 106 mainstream secondary schools, a quarter of all these schools in Scotland. In each a senior member of staff responsible for drug education provided extensive information about the materials used, which pupils participated, and the training teachers had undertaken.

Subsequently, a total of 1197 pupils drawn from 20 schools completed questionnaires. Teachers were not present while the pupils completed the questionnaires, but members of the evaluation team were available to answer any questions.

Within the pupil sample four categories of drug education experience were represented (see panel).

Underlying this categorisation is the assumption that exposure to the full programme of a package should be more effective than (in descending order of impact) partial exposure, non-pack drug education, or no drug education at all. It was possible to test this hypothesis using the sample of pupils. The schools selected were either urban deprived or urban non-deprived. Social class was defined both at the level of the whole school and at the level of the individual pupil.

The prevalence of the *Drugwise 12-14* pack made it impossible to include any groups of second-year pupils who had experienced drug education which was *not* based on this programme. Nonetheless, there was a sufficient range of drug education experience to answer the following questions:

- ? Does the level of drug education influence the impact on target populations?
- ? Is the effect of drug education influenced by age?
- ? How do the effects of drug education relate to social class?
- ? Are there sex differences in the outcome of drug education?

Our main interests were in establishing whether drug education in the late '80s had made pupils less likely to take drugs, more knowledgeable about drugs, and whether as a result of the education they became more anti-drug in their attitudes.

Comparison groups

- ❑ **Complete package** – these pupils had experienced complete package-based courses such as *Drugwise 12-14*, which consists of eleven 'period-sized' lessons.
- ❑ **Partial pack education** – pupils whose drug education experience had been based on parts of standard packages rather than completing the programme recommended in any single pack.
- ❑ **'Non-pack' drug education** – pupils who had experienced drug education based on information leaflets and/or a video such as *Minder*.
- ❑ **No drug education** – pupils who'd had no drug education in school.

What teachers believed drug education achieved. A sample of 97 senior secondary school staff were asked about the impact of drug education on pupils' drug-related knowledge, attitudes and behaviour. Each was responsible for the development and implementation of drug education in their respective schools, including the schools from which the pupils were drawn. As no objective measures underlied their responses, it has to be assumed that these were based on beliefs or opinions.

These teachers expressed considerable confidence that as a result of the education pupils knew 'slightly more' or 'much more' about drugs; 69 per cent believed that pupils were 'more' or 'much more' anti-drugs; and 72 per cent believed that pupils were 'less likely' or 'much less likely' to take drugs.

What drug education actually achieved. Statistical analysis assessed the effects not only of drug education but also of age, sex, and social class on levels of knowledge, attitudes to drugs and reported drug use. The analysis controlled for any confounding effects of the other background factors.

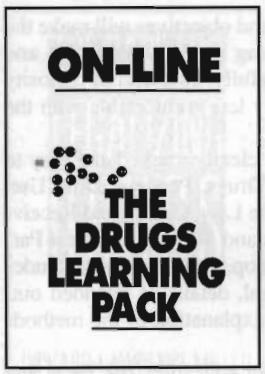
What we found was that drug education only had an effect on drug-related knowledge; its impact on both attitudes to drugs and reported drug use was neutral. For illegal drug use, the finding of no decrease in usage may simply reflect the fact that use levels were already low. The same could not be said of alcohol and tobacco where use levels were relatively high; here too, education failed to reduce usage.

Given that the drug educators' aims were to have a broad impact in terms of all drugs, legal and illegal, it is of some concern that there was no effect on consumption of these more widely used drugs.

Belief and reality. The finding that drug education had a positive influence on levels of drug-related knowledge supports the vast majority of teachers in their view that pupils knew more about drugs as a consequence of drug education.

In the case of drug-related attitudes, the outcome finding does not support the majority view of school staff that pupils are more anti-drugs as a result of drug education – though on average the young people in the study had fairly stereotypical anti-drug perceptions and attitudes, regardless of their drug education experience.

On likelihood of drugtaking, the findings are in marked contrast to the beliefs of the majority of school staff that pupils would be less likely to take drugs as a result of drug education. *Drug education had no effect on levels of drinking, smoking, solvent abuse or illegal drug use.*



An attempt to provide cross-Commonwealth youth work training materials

ON-LINE: THE DRUGS LEARNING PACK. London: Commonwealth Secretariat, 1990. 188 pages, £7.50.

On-Line was produced as a result of the Commonwealth Youth Programme on drug issues held in Malaysia in 1989. Looking easy to use and well-signposted, it contains 40 activities and photocopiable handouts to help trainers develop the drug-related knowledge, skills and attitudes of trainees who work with young people. Many of the activities are also intended for direct use with young people.

The pack is organised into 12 sections, each focusing on an aspect of prevention and/or early intervention. An introduction to each section identifies 'the problem' and then provides a summary of activities covered, their purposes, the training method, and whether the activity is suitable for work with young people. It is intended as a resource base to be dipped into as and when needed, much of the responsibility for selection, adaptation and the introduction of local examples being left with the trainer.

The first section, covering drug facts, includes the type of exercises with which we are all familiar, and provides handouts to support the target audience. These are designed to highlight the 'evils' of drug use. No mention is made of social contexts and the relative acceptability of some drugs within some communities. The handouts appear to be prepared on the principle of 'give them the hard facts and these will change attitudes'. The accessibility and readability of the handouts (not to mention their context) would need to be reviewed before I would feel ready to use them with groups of young people. Also it is unclear to me why some activities have been labelled as unsuitable for use with young people. For example, why should this group be excluded from thinking about policy issues? There are many gaps in the information provided – no mention of the effects of passive smoking in the tobacco handout, nor of cultural or gender dimensions in any of the information sheets, etc.

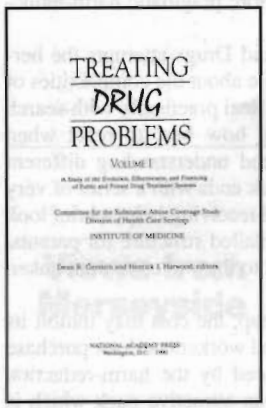
In Section 2 there are two activities aimed at raising awareness of gender issues and of cultural and religious attitudes to drugs. However, the trainer will need to be very knowledgeable on a range of equality issues to avoid the outcome being the reinforcement of stereotypes. These exercises are based on the knowledge and attitudes learners bring to the learning environment; in my experience, a training manual needs to provide more support than is evident in this pack.

On Line is a resource that might help experienced trainers who are used to modifying and developing resources, because it will increase their repertoire. But it is not, nor does it claim to be, comprehensive. Given my reservations, I would instead guide newcomers to other training materials such as ISDD's *High Profile*.

Parin Bahl

Assistant Director (Community Education), London Borough of Newham

On Line *is available from Commonwealth Secretariat Publications, Marlborough House, Pall Mall, London SW1Y 5HX*



Lessons for Britain from a comprehensive US study

TREATING DRUG PROBLEMS. VOLUME 1. A STUDY OF THE EVOLUTION, EFFECTIVENESS, AND FINANCING OF PUBLIC AND PRIVATE DRUG TREATMENT SYSTEMS. Gerstein D.R. *et al eds.* Washington: National Academy Press, 1990. 332 pages.

The effects of the introduction of an internal market into Britain's NHS are now becoming visible. Some of the ideas behind these reforms were borrowed from the US. This book is particularly timely therefore since it provides information about the way the health care system works in the United States with regard to treatment of drugtakers.

A British audience might best place this study by seeing it as somewhat similar to a report from our own Advisory Council on the Misuse of Drugs, but on a larger scale and involving more professional researchers. It is the product of a committee of distinguished experts (practitioners, researchers and scholars from a range of disciplines and institutions) supported by a study directorate. The result is a typically thorough and substantial investigation, highly recommended.

The background was the Anti-Drug Abuse Act (1986) which called on the Institute of Medicine to study the extent and adequacy of provision for the treatment and rehabilitation of drug abusers and to recommend the means by which the needs identified could be addressed.

In the US as elsewhere, an increasingly important consideration in health care provision is identifying and attaining the best possible balance between costs and benefits. Increasing pressure on resources makes it appropriate to aim for the best value for money.

However, in the USA as in the UK, the aim reaches far ahead of practice. It seems there too there is a lack of information and of systematic research and evaluation. It is generally the case that "program effectiveness measures are virtually unused in the management of treatment systems". Only on the use of methadone is there any reasonably reliable published literature. There is a dearth of information on chemical dependency programmes modelled on the Alcoholics Anonymous 12-steps format. This study comments that the aggressive marketing of such programmes has created some suspicion in the US, which could be alleviated through objective research. Interestingly, however, the programmes about which least is known seem to command the greatest resources: "Chemical dependency is the treatment modality with the highest revenues, probably the second largest number of clients and the smallest scientific basis for assessing its effectiveness" – a testimony perhaps to the continuing significance of mystery in the treatment and care of drugtakers.

In Britain, steps have recently been taken to provide some foundation for evaluative research through the establishment of regional databases. The questions identified in this book to guide future research are also ones we could utilise. What client and programme factors influence treatment-seeking behaviour, treatment retention and efficacy, and relapse after treatment? How can these factors be better managed? Studies based on these questions, though complex and difficult to implement, provide the most incontrovertible evidence about comparative treatment effects.

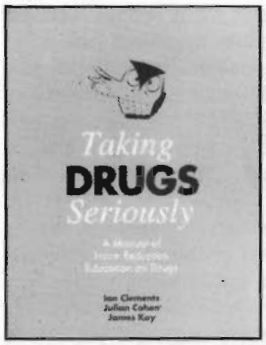
Most importantly, the study focuses on the inadequacy of the public tier of provision in the United States, its overall shortage of capacity and the regional variations. There may be a glimpse of Britain's future health system in the public services left after opting out.

In the US people without medical insurance are routinely and revealingly described as "indigent": this is the category whose access to care is limited and who form the most visible manifestation of the general inadequacy of the US health care system. The committee recommends an overall increase in public sector drug treatment services but this must be combined with: ways to end delays in admission; improved retention rates, so far the best indicator of performance; better outreach for pregnant women and young mothers; and expanded treatment opportunities for criminal justice clients. The same conclusions might emerge from a similar study in the UK.

Susanne MacGregor

Reader in Sociology and Social Policy, Birkbeck College, University of London

Treating Drug Problems *is available through bookshops*



Harm reduction in treatment is accepted practice – but will it import into the school?

TAKING DRUGS SERIOUSLY: A MANUAL OF HARM REDUCTION EDUCATION ON DRUGS. Ian Clements, Julian Cohen and James Kay. Healthwise, 1990. 102 pages. £49.

Most educational strategies aimed at young people and drug use are based on demand reduction in an attempt to reduce the numbers of those using drugs. Such strategies are popular with many who work with young people because they attract moral, legal and ethical approval. Because many drug substances are illegal or have a set of legal conditions attached to their use, drug education which aims to prevent illicit use is usually seen as the first (or in some cases only) response for caring, responsible adults to make.

The authors of *Taking Drugs Seriously* have produced a training pack which encourages people to experiment with harm reduction as opposed to demand reduction in the belief that the former may prove to be as or even more effective. This training pack will be relevant to all those who work with young people and, although most are designed for use in groups, the exercises and materials could be adapted for one-to-one work. Many professionals are undecided about the appropriateness of harm reduction in education, let alone its effectiveness, and will be helped to clarify their ideas by completing the early sections on Programme Planning and the Work Context Checklist which considers management/parental/young people's support for the proposed work as well as possible legal implications or areas of conflict.

> *"This pack starts from the position that drug use is a part of some young people's lives and will not be prevented by education. If drug use by young people is going to continue for the foreseeable future then it is something that young people should be taught about. They should be given as much information and develop as many skills as possible, with the minimum pollution by others' morality. This pack aims to do this."*
>
> ***– Taking Drugs Seriously***

Compiled in a loose-leaf folder, the exercises and materials are mainly aimed at young people aged 14-25. Licit as well as illicit drugs are covered, with great emphasis given to the individual and the context in which drug use takes place rather than the substances used. The authors suggest that particular exercises can be selected to meet certain needs or can be matched with other materials to make up a longer programme containing a harm-reduction element. This process is intended to educate young people about drug use and develop as many skills as possible "with the minimum pollution by others' morality". I suspect that such aims and objectives will make the pack instantly attractive to drug workers and youth and community workers and, hopefully, an object of curiosity for those who are traditionally less comfortable with the pack's rationale.

The individual sections are clearly marked and easy to follow covering Facts about Drugs, Personal Drug Use, Attitudes, Harm Reduction, the Law, Giving and Receiving Help, Community Action and Suggestions for a Parents' and Community Workshop. Each exercise includes an estimate of the time needed, details of intended outcomes, materials and a clear explanation of the methods involved.

For those familiar with drug education, the Facts and Attitudes sections will contain little that is new. One exception is the exercise on Gender and Drugs which aims to promote an awareness of gender differences in drug use as well as the effects of sexism and stereotyping. For trainers, it is the sort of exercise which sets your flipchart flapping and makes you itch to try it out with a variety of groups.

The section on harm reduction, arguably the core of the pack, is comprehensive and thoughtful, covering its role in reducing harmful drug effects and other associated risk factors. Any conclusions about safer ways of using drugs will be reached by young people through self and/or group discovery based on accurate, factual information and increased awareness, rather than through a series of tips and hints passed on by the trainer. This may help to resolve the dilemma faced by many who work with young people who are torn between the morally attractive demand-reduction approach and the more pragmatic harm-reduction approach.

The section on The Law and Drugs attempts the herculean task of informing people about the complexities of drug laws, equipping them to deal practically with search or arrest situations, knowing how best to react when confronted with the police and understanding different attitudes to drug laws. The pack ends with a series of very useful exercises on giving and receiving help, a brief look at community action and a detailed structure for parents/community workshops linked to the exercises undertaken by young people.

At £49, the pack is not cheap; the cost may inhibit its uptake among poorly resourced workers or deter purchase by those not entirely convinced by the harm-reduction approach. Nevertheless, it is an attractive pack which is easily adapted for use in a range of settings with different groups. Hopefully, it will encourage adherents of demand reduction to try alternative methods and approaches.

Barbara Howe

Regional Coordinator for alcohol and drug misuse services, Northern RHA

Taking Drugs Seriously *is available from Healthwise, 4th Floor, 10/12 James Street, Liverpool L2 7PQ. £49 + p&p*

Wheelchair-friendly?

Dear Editor,

I am writing to highlight the difficulties I have faced in finding a rehabilitation unit which can provide the necessary access *and* facilities for a wheelchair-bound client.

In the SCODA directory some units state that disabled access is part of their services, but upon contacting them this would appear to relate only to the entrances and exits and *not* to full provision of the services on offer to the able-bodied person. Bridge House in Bradford is the only unit I know offering a complete package for the disabled client.

Paul Templeman

Student nurse, Frederick Rd Drug Dependency Clinic, Hastings

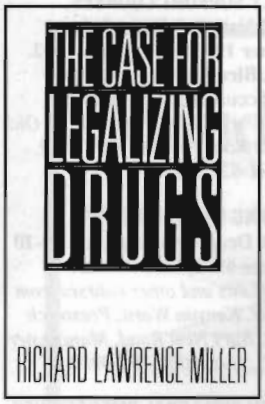
Help needed with under-16s

Dear Editor,

Hammersmith and Fulham Druglink are trying to put together a policy document for work with under-16s. We are interested in hearing from other agencies about their policies or guidelines plus any comments or ideas from those working with the under 16s.

Natalie Edwards

Project Worker, Hammersmith and Fulham Druglink, 153 Hammersmith Road, London W14 0QL, phone 081-748 9294



How relevant is the US legalisation debate to the milder British drug climate?

THE CASE FOR LEGALIZING DRUGS. Richard Lawrence Miller. Praeger, 1991. 247 pages. £19.95.

In a fine polemic, Richard Miller presents an uncompromising denunciation of prohibition in all its aspects. Not for him the weak-kneed pragmatism which admits ruefully that drug use is a bad thing but drug law is worse. Miller dismisses the social cost of drug use as mostly fictitious and will have no truck with paternalism. He deals firmly with pharmacology, psychology and criminology to demonstrate that popular notions are mistaken or grossly exaggerated.

Why then do Americans cling to beliefs which have no anchor in reality? Predictably, the answer lies in scapegoats and the vested interests of politicians and bureaucrats. Some readers of Thomas Szasz may not have been convinced that drug law is best regarded as a search for scapegoats to fill a deep need for self-justification and social cohesiveness. Miller's account of the vicious, petty, and racially tainted actions of zealots against users in the United States gives the impression that Szasz did not exaggerate.

To expose the fallacies of prohibition is easy. To make a positive case for legalisation is harder, and here Miller will please believers but not critics. He claims, "We do not have to guess the consequences of legalisation. We know them already," and proceeds to quote examples from different societies and different times, in which the free availability of some illicit substances created no social problems. But the US before 1903 is not like the US today, and what works in Amsterdam may not transfer to the Bronx.

On the practicalities of legalisation, Miller is specific but brief. Legalisation means that all aspects of the use and trade would be legal. Drugs would be sold without prescription, over the counter, but regulation could be introduced if needed. This position is defensible but is not shared by all legalisers, and critical readers will need more convincing.

Drug professionals will not find much that is new, but Richard Miller has read a lot and writes well. More should be made of the baneful effects of American drug policy in the wider world, but this is an American book for home consumption. British readers will wonder whether it has bearing on drug policy in the UK.

The case for legalisation is easily made in the US where the evils of prohibition are plain for all to see. In the UK, drug problems do not typically lead to violence on the streets. The commonest sort of drug-related death is not murder. Corruption and political opportunism have never been a feature.

Although the Drug Trafficking Offences Act (1986) breached one of the most fundamental tenets of natural law by reversing the onus of proof from the accuser to the accused, few people regard drug law as a serious threat to British civil liberties. We have been spared zealots such as Hamilton Wright and Harry Anslinger. Mr Stutman has not visited recently. Rightly or wrongly, we believe that there is sufficient common sense in Britain to limit the damage which prohibition can cause.

The relative absence of dogmatism in the UK allows maintenance by prescription, needle exchange schemes and other harm-reduction techniques, all of which remain illegal or highly controversial in the US. Easements in drug policy have been achieved by stealth and the application of common sense. *De facto* decriminalisation might be just around the corner. It is therefore open to a British critic to argue that many of the benefits which Mr Miller claims for legalisation could be achieved by other means, with less risk.

Richard Stevenson
Department of Economics, Liverpool University

LETTERS

Views from Merseyside

Who's to blame?

Dear Editor,
I was very interested to read my old friend Allan Parry's articles on the recent events in Liverpool drug politics. Conspiracy theories in this field undoubtedly have some validity.

For example, in the period prior to John Marks' replacement at the Liverpool drug dependency unit, there were attempts to cease all prescribing of injectables. I was told by the consultant in charge that the decision was being made on the grounds of cost, but I remain unconvinced.

However, Allan's interpretation of events seems to ignore many other factors. At one point, support for his efforts came from the highest levels. I can remember the government's Chief Medical Officer, Sir Donald Acheson, visiting the area. The only person outside regional headquarters that he wanted to meet was Allan Parry.

There was opposition to Allan, but he also had the support of the chairman of the regional health authority. How else does somebody without professional qualifications travel so far, so fast?

I would like to point out to Allan that, when seeking to initiate radical and controversial initiatives, perhaps one's managerial style and personal behaviour should be neither radical nor controversial. If the quality of some drug services in the area is now in decline as a consequence of increasing medicalisation and professionalisation – and I agree that to some extent this is the case – then Allan must bear some of the blame.

Your jubilant but naive servant,

Peter McDermott
Liverpool

Priorities unchanged

Dear Editor,
In response to your report headed "Fears over Mersey 'retreat' from safer drug use policies" (***Druglink***, May/June 1991), I would certainly question the assertion that harm reduction is no longer a priority in Merseyside.

With regard to the services with which I am involved, harm reduction continues to be our guiding principle and we believe we are continuing to evolve innovative drug treatment services which are reaching record numbers of drug users.

Dr Tim Garvey
Consultant in drug dependence, South Sefton, Merseyside

Phoenix avoids political fallout

Dear Editor,
From what Allan Parry says in "Drug Politics in Liverpool" (***Druglink***, May/June 1991), it would appear that Phoenix House made the right decision in establishing its Merseyside centre on the Wirral. Had we located in Liverpool, under the terms he implies, I suspect that the service we offer would have gone the same way as that of the Drug Liaison Office.

Instead, since May 1987, Phoenix House has been offering a service which, apart from some initial 'seeding' money, has been unsupported either by Liverpool or Wirral local authorities or the district or regional health authorities.

Throughout this time Phoenix House has been able to stick to its therapeutic philosophy and not have it tainted by any 'political' influences.

Surely now the local and health authorities should stop playing this restrictive political game with the lives of drug users and seek to provide as wide a range of services as is possible.

While prevention and harm reduction are the declared aims of the health authorities in Merseyside, they need to acknowledge that the ultimate harm reduction exercise must be abstinence, and allocate some funding to its pursuance.

P.N. Crean
Project Director, Phoenix House, Wirral

PUBLICATIONS

Therapy/services

■ **SOLUBLE PROBLEMS: TACKLING SOLVENT SNIFFING BY YOUNG PEOPLE. Richard Ives, *ed.* National Children's Bureau, 1991. 131 pages. Booklet. £5.99.**
Available from NCB, 8 Wakley Street, London EC1V 7QE.

■ **HARD TO REACH OR OUT OF REACH? Tim Rhodes *et al.* Drug Indicators Project, 1991. Research report. £5.50.**
Evaluation of an HIV outreach project for sex workers and drug users.
Available from DIP, 16 Gower Street, London WC1E 6DP.

Health education

■ **PROMOTING GOOD HEALTH. Scottish Health Education Group and Scottish Consultative Council on the Curriculum, 1991. 68 pages. Policy booklet.**
Recommends whole-school approach to health education.
Available from HEBS, Woodburn House, Canaan Lane, Edinburgh EH10 4SG.

■ **1+1. Comic. £1.50.**
■ **1+1 USER'S GUIDE. Groupwork guide. £2.50. Terrence Higgins Trust, 1991.**
Comic strip-style HIV/AIDS education.
Available from THT, 54 Gray's Inn Road, London WC1X 8JU, phone 071-831 0330, add £1 p&p.

■ **SHARP SOUND CLEAN SMART. Mainliners Ltd, 1991. Set of four posters. £8.**
Illustrate responsible sex and drug use practices.
Available from Mainliners Ltd, PO Box 125, London SW9 8EF, phone 071-274 4000, ext. 315.

■ **NEEDLE EXCHANGE. North West Regional Drug Training Unit. NWRDTU, 1991. £2.50. Poster.**
Guide to needle and condom use.
Available from NWRDTU, Kenyon Ward, Prestwich Hospital, Bury New Road, Manchester M25 7BL, phone 061-798 0919.

■ **HOW TO ENJOY SEX, TAKE DRUGS AND NOT GET HIV/AIDS. Booklet.**
■ **USER'S GUIDE TO CLEAN WORKS IN GREATER LONDON. Leaflet. Brent Community Drug Service and Healthy Options Team, 1991.**
Comic-strip style health education and directory of syringe exchanges/ pharmacies.
Available from HOT, phone 071-377 7740; prices depend on print run.

Laws and policy

■ **THE CRISIS IN DRUG PROHIBITION. David Boaz *ed.* Washington, D.C.: Cato Institute, 1990. viii, 148 pages. Book. £10.30.**
Critiques of US policy.
Available from the Cato Institute, 224 2nd St., SE, Washington, D.C., USA.

■ **THE CASE FOR LEGALIZING DRUGS. Richard L. Miller. London: Praeger, 1991. xi, 247 pages. Book. £19.95.**
Critique of American drug policy.
Available through bookshops.

■ **AGENCY OF FEAR: OPIATES AND POLITICAL POWER IN AMERICA. Edward Jay Epstein. London: Verso, 1990. ix, 352 pages. Book. £10.95 pbk; £32.95 hbk.**
Revised account of Nixon's unsuccessful war on drugs.
Available through bookshops.

Other

■ **DRUGS AND THE LAW. A COMPREHENSIVE GUIDE TO DRUGS LEGISLATION IN THE UK. Booklet. 16 pages. £1.50 inc. p&p.**
■ **DRUGS AND THE LAW. Two-part wallchart. £4.50+p&p. Jane Goodsir. Release Publications, 1991.**
For drugs/youth workers.
Booklet available from ISDD. Both available from Release, 388 Old Street, London EC1V 9LJ, phone 071-729 9904.

■ **A HANDBOOK OF DRUG TRAINING: LEARNING ABOUT DRUGS AND WORKING WITH DRUG USERS. Dave MacDonald and Vicky Patterson. London: Tavistock/Routledge, 1991. xiv, 185 pages. Book. £12.99.**
Practical guidelines from Stirling's Drugs Training Project.
Available through bookshops.

■ **INFECTIONS IN INTRAVENOUS DRUG ABUSERS. D.P. Levine and J.D. Sobel *eds.* Oxford University Press, 1991. 395 pages. Book.**
Available through bookshops.

■ **THE INTERNATIONAL HANDBOOK OF ADDICTION BEHAVIOUR. Ilana Belle Glass. London: Tavistock/ Routledge, 1991. xiv, 366 pages. Book. £14.99.**
Collection of short papers.
Available through bookshops.

MEETINGS

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

■ **RURAL DRUGS AND ALCOHOL SERVICES: CURRENT STRATEGIES. Mid Glamorgan Health Authority. 2-3 October 1991, Powys. £98 residential, £30/day.**
Details from Dieter Kessel, phone 0443 224455.

■ **DRUG EDUCATION FORUM. 30 Oct. 1991 and 10 Feb. 1992, London.**
Lobbying/networking group.
Details from Colin Chapman, phone 081-599 3007, ext. 5282.

■ **BENZODIAZEPINES INTO THE 1990s. Hamlin and Hammersley. 10 October 1991, London. £65.**
Details from Hamlin & Hammersley, Southbank, Grants Lane, Somerset BS28 4EA.

■ **DRUGSCAPE: THE COMMUNITY AND THE LOCAL CHURCH. UK Band of Hope. 2 Nov. 1991, London. £10/£15.**
For clergy and education/youth workers. Role of church in prevention/care.
Details from UK Band of Hope, 25F Copperfield Street, London SE1N 0EN, phone 071-928 0848.

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

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

COURSES

■ **TRAINING COURSES. London Lighthouse. Dates from September 1991 to January 1992. London.**
Range of courses on meeting the needs of those affected by HIV disease.
Details from London Lighthouse, 111-117 Lancaster Road, London W11 1QT, phone 071-792 1200.

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

■ **TRAINING METHODS. N.W. Regional Drug Training Unit. 19-20 September 1991, Manchester.**
Details of this and other courses from NWRDTU, Kenyon Ward, Prestwich Hospital, Bury New Road, Manchester M25 7BL, phone 061-798 0919.

■ **HEALTH AND LEGAL EMERGENCIES. 30 Sept., Winchester; 3 Oct., Bristol; 4 Oct., Mid Glamorgan. £40/£80.**
■ **COURT REPORT WRITING. 14-15 Oct., Oxford. £90/£180.**
■ **HARM REDUCTION: PROFESSIONAL RESPONSIBILITIES. 23 October, Oxford. £40/£80.**
■ **DRUGS AND THE LAW FOR OUTREACH WORKERS. 7 Nov., London. £40/£80. Release. 1991. Prices non statutory/ statutory.**
Details from Alasdair Cant, Release, 388 Old Street, London EC1V 9LT, phone 071-729 5255.

■ **DIPLOMA IN ADDICTIVE BEHAVIOUR. St George's Hospital Medical School and SW Thames RDPT. Oct. 1991-June 1992, London.**
Course for GPs.
Details from Division of Addictive Behaviour, St George's Hospital Medical School, London SW17 0RE.

■ **TAKING DRUGS SERIOUSLY. ICTC. 12-13 October 1991, Beaconsfield; 11-12 November 1991, Great Malvern. £195+VAT residential.**
Training for trainers on the new harm-reduction education pack of the same name (see review in this issue).
Details from ICTC, 104 Cherry Crescent, Rossendale, Lancs., BB4 6DS, phone 0706 229537.

■ **CERTIFICATE IN DRUG DEPENDENCE. 22 weeks full-time from January or June 1992.**
■ **MANAGEMENT OF PROBLEM DRUG USE. 15 weeks part-time from January 1992. S.E. Thames Regional Drug Training Unit. London.**
Multi-disciplinary courses for specialists and new/non-specialist staff respectively.
Details from Drug Training Unit, 4 Windsor Walk, London SE5 8AF, phone 071-703 6333.

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.

PRINT: RAP, 201 Spotland Road, Rochdale OL12 7AF • 0706 44981