VOL 26 | ISSUE 4 | **JULY/AUGUST 2011**

Druglink

REPORTING ON DRUGS SINCE 1975

DrugScope

- potent ecstasy
- drug deaths
- sex workers
- user groups

The female fix

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Druglink

Time out!

It is no great shock that what most people say they want when they come into treatment is to become drug free, They have probably been in the life for four or five years, eventually hit rock bottom and either voluntarily or under pressure from family or the courts, decide that enough is enough. That is the aspiration, but the reality can be quite different. Coming into treatment and losing the chemical crutch that has been a support through years of trauma is a frightening prospect for many who are then more than happy to receive a prescription as part of the treatment regime. That this might be the *only* treatment regularly offered is undeniable; it can be argued that the performance management culture has encouraged compliance over quality to the detriment of the therapeutic relationship.

Yet, most services can put up clients who will genuinely declare that if it wasn't for [insert agency here], I wouldn't be alive today.' And that goes for any intervention you care to name, from the intensively monitored clients who took part in the RIOTT heroin trial through to graduates from abstinence-oriented residential rehab and beyond including all forms of mutual aid.

At the same time, however, *all* of the above will have experienced high drop out rates with little robust longitudinal data on successful outcomes which themselves can be measured in as many ways as there are people to measure and that includes outcomes for pregnant drug users, the focus of this issue. That is the complex nature of addiction. There is no moral high ground to claim here nor any easy benchmark of continued success. Rubbishing one form of intervention as a way of making the case for another is both divisive and dangerous.

Harry Shapiro,
DrugScope's Director
of Communications
and Information

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Druglink is for all those with a professional or occupational interest in drug problems and responses to them – policymakers and researchers, health workers, teachers and other educators, social workers and counsellors, probation and police officers, and drug workers.

DrugScope is the UK's leading independent centre of expertise on drugs and the national membership organisation for those working to reduce drug harms. Our aim is to inform policy development and reduce drug-related risk. We provide quality drug information, promote effective responses to drug taking, undertake research, advise on policy-making, encourage informed debate and speak for our members working on the ground.

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News

FEMALE DRUG USERS SPECIAL

Also in this issue..

Regulars

Feral hack

An article which described drug users as 'vermin', 'feral worthless scumbags' and said that 'if every junkie in this country were to die tomorrow, I would cheer' has been censured after complaints by Irish harm reduction agencies. The Press Ombudsman ruled the column, by Ian O'Doherty in the *Irish Independent*, was likely to cause grave offence and stir up hatred.

Bombay dock

The mandatory death penalty for drug trafficking in India has been lifted, after pressure from harm reduction campaigners. Judges at Bombay High Court, following a petition filed by the Indian Harm Reduction Network, concluded the law was "unconstitutional". A death sentence will however remain an option.

Leaf it out

Bolivia's government has become the first in history to renounce the United Nations' anti-drug convention. Bolivia made the move in protest at the fact the coca leaf in its natural form, a plant which forms an age-old part of Andean culture, is classed as an illegal narcotic.

Women's work

A charity has set up a strategy to improve its support for women after its research found female homeless service users were achieving lower outcomes and more likely to have drug and mental health problems than homeless men. St Mungo's said the survey also revealed that domestic violence and contact with children were key issues.

Aisle help

Parishioners at a Welsh church are raising £240 a month for one of their members to attend rehab. Wellspring Christian Centre in Rhyl asked members to donate after it emerged a female worshipper had a heroin problem.

Young people's drug support hit by 'devastating' cuts

EXCLUSIVE

Andy McNicoll

Young people's drug education and treatment services are being hit hard by government and council funding cuts, with experts warning of the "devastating impact" of axing support.

The future of the Drug Education Forum, a body of experts in the field that has received government funding since 1995, is in jeopardy after the Department of Education opted to cease funding the scheme – currently to the tune of £47,000 – beyond November this year. Meanwhile, at local level the squeeze on council budgets has seen a raft of local authorities cutting drug education work and tier 1 and 2 treatment provision.

The cuts look set to impact further, despite Prime Minister David Cameron declaring in parliament earlier this month that education and treatment were crucial to turning round a "failing" drug strategy.

A dossier of evidence collated from 43 drug education practitioners, seen by *Druglink*, shows that only three have not seen their work impacted by spending cuts. Redundancies and increased workloads among drug education staff were the most common complaints, with some areas reporting a lack of funding for school-based education work. A separate survey recently conducted by the Health Education Partnership, shows that over a quarter of councils have no drug education provision in secondary schools.

Druglink has established that Hertfordshire, Coventry, Swindon and Richmond councils are among the local authorities who have lost staff working in drug education due to budget constraints, with financial pressures intensified by the loss of central government issued Healthy Schools funding and Area Based Grants. The last year has also seen specialist young people's treatment services close in the London boroughs of Hammersmith and Fulham, Newham and Merton, including DASL's highly regarded SPARK project in Newham.

Paul Tuohy, CEO of drug prevention charity Mentor UK, says that cutting drug education and prevention support is a short-sighted measure.

"We're probably in the worst situation for drug education for decades because the current government strategy is fixated on treatment," Tuohy told Druglink.

"There are many drug education organisations closing locally and I don't think we'll see the real impact of that for another eighteen months. You will see a tsunami effect of a complete lack of infrastructure for drug education and that could have a devastating impact."

"There is a great disparity between spending on treatment for people with drug and alcohol problems, and spending on prevention work. We applaud investment in treating people with drug and alcohol problems but without prevention, the next wave of people with substance problems will be knocking at the door."

Tuohy's Mentor UK colleague Andrew Brown, who coordinates the Drug Education Forum, said alternative funding arrangements will be explored in an effort to save the forum and raised concerns over the impact of cuts on frontline services.

"Local areas are making difficult decisions about the sorts of services they can support and we know that in many cases this means that frontline support for drug and alcohol education and prevention is being cut right back," Brown said.

"This has the potential to be extremely damaging - a decade of hard work by schools and communities has seen drug and alcohol use amongst young people fall back, we can only hope that this isn't reversed as the investment in these services is withdrawn."

Public view drug policy as 'ineffective'

Only one in ten British people think the government's approach to illegal drugs is effective, according to an opinion poll. The survey, carried out by YouGov, found 11 per cent believe the current approach is working, compared to 53 per cent who say it is ineffective.

It's official: high potency ecstasy makes a comeback

EXCLUSIVE

Max Daly

- Return of £10, MDMA pills
- Ketamine stimulant "drug of choice" at festival
- Liquid LSD moves onto the scene

Encore: Tests at Glastonbury show old school ecstasy pills are back

Old school ecstasy pills containing MDMA are back, according to an analysis of pills recovered by police at Glastonbury Festival.

The findings from Glastonbury come at the same time a Scottish drug charity issued a warning that original strength ecstasy pills were being sold in Edinburgh.

Avon and Somerset force drug strategy manager Paul Bunt said that evidence from drug arrests, seizures, body searches and amnesty bins at Glastonbury showed that most of the ecstasy pills recovered, in 25 separate seizures, contained high levels of MDMA more common in pills made in the 1980s and 1990s. "It is rare these days to get ecstasy pills that contain MDMA, but this year we were surprised because most of the pills did," Bunt said.

The findings back up mounting anecdotal evidence from around the UK that an increasing number of high strength ecstasy pills are being traded for prices around five times above the average – up from £2.50 a pill to between £10-£15. Users have reported they only require one or two pills to stay up all night, rather than having to take the usual 6-10.

John Arthur, director of Edinburgh drug charity Crew2000 has issued a warning to pill users about the new wave of high strength pills. He told *Druglink*: "We have seen people dropping a number of pills and ending up freaking out. For some people it's their first real ecstasy as they have been used to pills made from BZP and caffeine, they are not used to the real thing. We had some analysis done which proved many of these pills contain MDMA – which we have not seen for some time."

Until now, forensic experts have charted a gradual reduction in the amount of pills, sold as 'ecstasy', that contain MDMA. Instead they have contained a mix of caffeine, BZP, (a synthetic stimulant derived from piperazine), amphetamine and inert substances. It is thought that the scarcity of MDMA on the global stage may have been as a result of a seizure of 33 tonnes of sassafras oil, the key ingredient in ecstasy, in Cambodia in 2008. The rise in popularity of the former 'legal high' stimulant drugs mephedrone was largely triggered by the drop in quality of ecstasy, as well as cocaine.

Police at Glastonbury said that the most popular stimulant drug was not ecstasy, mephedrone or cocaine, but the hallucinogenic anaesthetic drug ketamine. As well as finding the drug in scores of amnesty bins – placed by entrances to give ticket holders the chance to get rid of their stash before being searched – police made 80 seizures of ketamine totalling 500 grams. Crystal MDMA was the second most popular stimulant drug at the festival. The majority of cocaine discovered was of a very low quality. There was a total of two kilos of cannabis found.

Police were also surprised to find that liquid LSD had moved onto the Glastonbury scene. The drug, more commonly seen in micro-dot blotter form, came in a semi-clear light brown solution contained in eye drop bottles. Some of the liquid LSD found also contained liquid ketamine. Liquid BZP, in the form of a pink solution in small phials, was also found.

Bunt said this year there had been no drug-related deaths, no serious drug-related illnesses, although two festival goers were hospitalised as a result of their drugs use, including one person who stabbed himself after taking drugs.

Avon and Somerset's drug policing strategy for the festival is very much seen as a 'softly softly' approach, based on identifying drugs on entry, the use of amnesty bins and a desire to concentrate efforts on drug dealers, not drug users. As result, the number of arrests at Glastonbury are proportionally far lower than they are at other festivals, where police may opt for more aggressive anti-drug tactics. Police made 110 drug-related arrests and made 470 drug seizures during the four day festival, which attracts 175,000 people a year. In contrast the Kendal Calling festival, with 8,000 visitors, last year resulted in 85 arrests.

inside DrugScope

Centre for Policy Studies report

A new report published by the Centre for Policy Studies was rebuked by DrugScope for 'grossly exaggerating' the cost of methadone prescribing in England and Wales. The document, Breaking the habit: why the state should stop dealing drugs and start doing rehab, claimed that £730 million was allocated to methadone treatment while going to say that the cost of people in treatment is £3.6 billon each year.

The findings were described as inaccurate and misleading by the charity, with the reported £730m corresponding to almost the entire sum spent on drug treatment. This includes investment in needle exchange programmes, psycho-social interventions, and residential rehabilitation.

Despite the inaccuracy of the findings, BBC News repeated the figures in its news bulletins covering the story. Martin Barnes, who was interviewed by the news organisation, expressed his misgivings regarding the reliability of the claim to the BBC before going on air. DrugScope has since formally written to the BBC over the fact checking issues.

Sentencing guidelines

Proposals that will guide how courts sentence future drug convictions have been broadly welcomed by DrugScope in its response to a Sentencing Council consultation. The proposals include sentences that distinguish between subordinate and key roles within a criminal organisation, and determining the category of the offence based on the quantity of drugs involved as well as the role of the offender.

However, DrugScope has raised concerns over some of the proposals, including the 'starting point' of a 5 year sentence for drug mules, pressured and intimidated to carry as little as 50g of cocaine. The charity also recommends that drug dependency be included as a mitigating factor in sentencing.

The consultation period spanned 12 weeks, with the final guidelines set to become the main point of reference for the courts when sentencing drug offences. The initial publication attracted controversy however, with the *Sun* newspaper launching a no to soft justice campaign after the consultation was opened in March.

Domestic violence project gains momentum

DrugScope is delivering an innovative four year project across London to develop a cross-sectoral network bringing together domestic violence and drug and alcohol services. The project is being co-ordinated by the London Drug and Alcohol Network (LDAN), which merged with DrugScope in 2009, and it is funded by London Councils. Its purpose is to bring the two sectors together to discuss issues of common interest, provide practical information and support, and facilitate collaboration and partnership.

Initially the project had a focus on working with perpetrators of domestic violence with drug and alcohol problems, but since its launch in October 2009 it has broadened out to engage with services working with victims too.

It was not difficult to make the case to London Councils for funding for this project: the facts and figures speak for themselves. Women's Aid has estimated that betweek 50 per cent and 90 per cent of women attending substance misuse services will have experienced domestic abuse, either in childhood or adult life, or both. Substance misuse services also work with significant numbers of people – generally men – who are perpetrators of domestic violence. Almost two-thirds of women with substance misuse problems who are involved with domestic violence services report that problematic substance misuse began following their experiences

of domestic violence. One survey found that 93 per cent of domestic violence perpetrators had developed drug and alcohol problems before they became domestically violent. But services have not always worked together effectively to address this relationship.

As well as holding regular network meetings for services in London, we have published a special issue of the newsletter LDAN News on domestic violence, and produced a briefing on risk management in partnership with the Stella Project, which works in London to address links between substance use, domestic and sexual violence and to improve service provision. We have also linked up with projects on domestic violence and substance misuse at Adfam and Alcohol Concern.

Resources from the DrugScope project are available on the LDAN web site at www.ldan.org.uk

You can email:
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Emma Ward, Policy and Membership Officer at emmaw@drugscope.org.uk

DEATH BY NUMBERS

Is the UK really one of the major drug death capitals of the world? Well, probably in Europe. **John Corkery** picks apart the statistics.

Readers across the UK opening their papers at the end of June may well have been surprised to learn that apparently, as a headline in the Metro put it, 'Number of drug deaths in Britain among highest in the world'. This headline, amongst others, referred to statistics just published by the UNODC's *World Drug Report 2011*, which had the UK at number six in the global 'league table'.

Based on the UNODC figures, the UK does, with 2,2278 deaths in 2008, appear high up on the league table, behind the USA (38,396), Ukraine (7,597), Russia (7,464), Iran (4,800) and Mexico (4,562). However, when these are related to population size, the UK drops much further down the list. Britain has 55.9 drug-related deaths per million, meaning it drops to 19th in the 'league table' behind not only the five countries already mentioned, but also Kazakhstan, the Czech Republic, Denmark, Estonia, Finland, Iceland, Ireland, Luxembourg, Sweden, Norway, Canada, and the Seychelles.

But what sort of deaths do these statistics cover? Although the UN does point out that definitions of deaths do vary from country to country, it is impossible to make proper comparisons between countries when they are reporting figures taken from different sources and using often unique definitions. as there are many aspects that have to be taken into consideration and understood. In the UK, for instance, this definition has changed over the years, from *deaths related to drug poisoning, involving both legal and illegal drugs* to the present, and narrower, definition of *fatal overdoses or poisoning involving controlled drugs*.

France, with a similar size population to UK, reported only 287 deaths (for 2007). Does this mean that France has a smaller problem than the UK? Not at all. The French figures come from police records, which report a far more narrow range of deaths than the method used in the UK – of using death certificates.

It is only when common definitions and methodologies are used (and there are many obstacles to overcome in this respect as well), that it is possible to make more appropriate comparisons. The European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) has undertaken a lot of research in this field over the last decade and more. Using their definition, it is possible to see where the UK really lies in the European 'league table' – at the top – although even then, they feel it necessary to state that "absolute numbers from different countries are not directly comparable since differences remain in quality of recording methods".

So, does the UK have a bigger problem of drug-related deaths than its European counterparts? A truly definitive answer is not possible. However, the UK General Mortality Registers and the Special Mortality Register (np-SAD) have developed robust methods for case ascertainment over the past 14 or 15 years. It is certainly the case that in the UK overall numbers of deaths having increased greatly over time, irrespective of definition. Heroin, methadone, stimulants, as well as benzodiazepines, remain the main causes of UK drug-related fatalities – usually in combination with alcohol and/or other drugs.

John Corkery is Research Lead, School of Pharmacy, University of Hertfordshire; Programme Manager of the National Programme on Substance Abuse Deaths, International Centre for Drugs Policy, St George's, University of London; and UK Focal Point expert on drug-related death statistics since 2000.

DRUGS QUOTE

The cut of cannabis which teenagers are smoking now across the UK is actually 50 times more potent than it was actually a year ago

Tory MP Nadine Dorries plays fast and loose with the facts on Radio 4's *Any Questions*

Taking skunk cannabis is like holding a revolver to your head and playing Russian Roulette

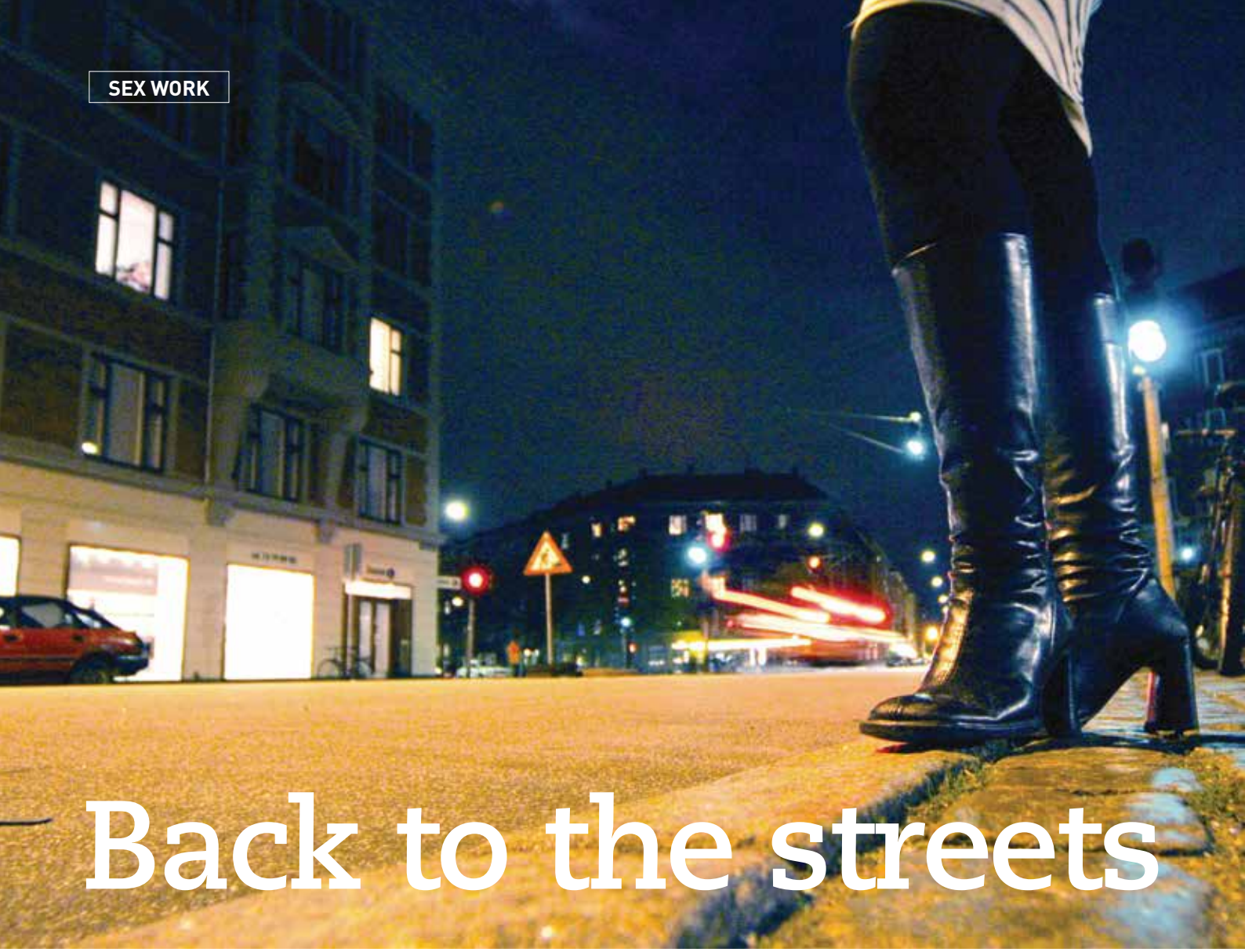
Tory MP Charlie Walker, during a debate in Parliament

He has a lot to offer the scientific community and may well be able to use his scientific ability to benefit other people

Drug dealer Edward Holland escaped a prison sentence after a crown court judge decided his work as a research scientist could benefit society

The man is not dead. Don't call him a ghost. The days that lie ahead are filled with despair, but I have courage and grace and I'm hopeful, and that is sufficient to carry me through

Grammy Award-winning reggae star Buju Banton after being jailed for 10 years in Florida for trafficking 5kg of cocaine



Back to the streets

Lyn Matthews worked as a health researcher in Liverpool's red light district during the late 1980s – at a time when the city opened the world's first drug harm reduction service. In January she found herself, a quarter of a century later, back in the same job. Here, she reports on how the scene has altered, yet in some ways, remains the same.

Going back out on the streets for the first time in 25 years felt strange at first. In 1987, my husband, a drug worker, talked me into becoming involved with a female sex workers project. Despite having no background in this type of work, I agreed to assist in a small exploratory survey of the sex industry on Merseyside. Little did I know that I was to go on to work on this project for the next five years and, during this time, not only established a good service with the clients but also built a strong rapport with the women which gave me a deeper, more meaningful insight into their lives, their problems and I formed relationships on those streets that would last long after I had left the project.

In 1986, Liverpool had initiated the world's first injecting equipment exchange scheme at the Mersey Region Drugs Training and Information Centre (MRDTIC) to prevent the spread of HIV. It is hard to imagine now that the syringe exchange scheme, which was then seen as a radical approach to the problems of drug use, was regarded as

highly controversial and, in the words of one community activist, on a par with giving 'guns to murderers'. Now syringe exchanges have been adopted in many countries. And it still seems exactly what is was to us then – common sense. From its humble beginnings in the ground floor toilet of an office, the harm reduction model that started at MRDTIC flourished. It is now firmly established in drug service provision around the globe.

Even though the syringe exchange scheme was only advertised by word-of-mouth, in the first six weeks of operation it attracted over 300 people. As well as supplying clean injecting equipment, staff at the centre also provided free condoms and advice on safer sex. Among the women who attended the scheme were a few female sex workers who also injected drugs. Initial discussions with these women revealed that sex workers operating in a particular area, near to the city centre, were experiencing difficulties in obtaining sufficient supplies of condoms. It soon became apparent that immediate intervention was needed and more detailed information was required in order to formulate effective prevention programmes for Liverpool's street sex workers. To this end, the street female sex workers outreach project was launched the following year.

So I was surprised to find myself, in 2011, once again working with these women. The opportunity came about following a restructure of the Armistead Centre service earlier this year, where I had been working with the lesbian, gay, bisexual and transgender (LGBT) drug users. In February I started a new role working for Armistead's outreach service for Liverpool's street sex workers, which has been helping women since 2003.

There have been many changes since those early days. Back in 1987, Liverpool's red light district was confined to what is now known as the 'Georgian Quarter' of the city. For decades, Liverpool's street sex workers had operated in this area, which once housed many of the city's student and bohemian populations and was known locally as 'bedsit land'. To the women, it was known as 'the block'. But following gentrification of the area, the women were displaced and now work across several different parts of the city, making it harder to identify those who are working and to keep track of the ever shifting scene.

Though the need to fund drug use still remains the main driving force for women to turn to sex work, the nature of their use has changed. In 1987 many of the women were injecting temazepam, which caused terrible physical damage and led to many of them losing limbs. At that time crack cocaine was beginning to emerge and was rapidly gaining popularity amongst the city's drug users.

While crack use is now the norm, the days of temazepam have – thankfully – long since gone and it would appear that injecting drug use has decreased amongst the women over the years, with fewer requests on the streets for injecting equipment. This may be because equipment is more readily available through pharmacy exchange schemes and established services. However, many of those who do inject are at very high risk and the most at risk are the women who are 'speedballing' heroin and cocaine, which increases the risks of an overdose.

HARM REDUCTION IS STILL AS IMPORTANT TODAY AS IT WAS 25 YEARS AGO, ALTHOUGH IT DOES FACE NEW CHALLENGES

Modern technology has made a huge difference, as most people now have mobile phones. When I first went on outreach, mobile phones were only just being developed and the one I had been given was like carrying a brick around. Now mobile phones are used to contact punters and dealers alike. Mobiles are often used as deposits with drug dealers until such time as the debt is honoured. Mobiles have also meant dealing has become more sophisticated and drugs more accessible than ever before.

Although a few street dealers remain, more covert methods are used to distribute drugs with mobile phones playing an important part in this 'deals-on-wheels' culture. And, just like in The Wire, numbers change frequently and old phones are disposed of, as dealers try and avoid detection. In the 1980s, drug dealers also attended the syringe exchange and they too were given harm reduction advice to pass on to their customers. Modern technology has made dealers less visible and harder to reach, as they remain aloof and unapproachable in the safety of their cars.

With so much time having passed and driving along unfamiliar streets it felt alien, as only two streets now remain where I used to work, the rest having been built over. I certainly didn't expect to bump into anyone I had originally worked with. Yet one night I heard a familiar voice. "Hello Lyn, what are you doing back out here?" And there stood Susie. She approached me and we shared a hug. Susie had been a young girl when I had first met her. Like many of the woman who work the streets, she had spent the last two decades in and out of the treatment and criminal justice system. "I am scripted again now so I don't have to come out as much," she said. "I stopped injecting a few years back and I have a flat. I've been homeless a few times and am getting too old now to be on the streets anymore. I don't come out late and just do a couple of mushes (punters), make my money and get off. That's how I have survived all these years."

The next evening I was met by a few more of the women I had first met all those years ago. Word had spread I was back on the scene. This was very humbling for me – two decades on they still remembered me and I felt overwhelmed by their response. I soon found out how things had changed. One woman said: "It's not the same now Lyn, the way the girls used to look after each other doesn't happen anymore, it's dog eat dog out here now."

Despite earlier efforts by the police to tackle the sex trade by simply arresting the women and moving them on, it is clear it has refused to go away. Between 2009 and 2010, the Armistead's street team contacted 304 street sex workers on outreach alone.

Catching up with Susie over the next days and weeks, I heard that some of the women I had originally got to know had become drug free and made new lives. Some had lost their battle with addiction and died while others, like Anne Marie Foy, who I knew very well, had been murdered. Since 1987, nine Liverpool street sex workers have been killed.

The murder of Anne Marie in 2005 caused a big shift in the way prostitution is policed in Liverpool, both on an ideological front as well as operationally. In November 2006, Merseyside Police became the first force in the world to declare that any crimes committed against sex workers would be defined as 'hate crimes'. This is a massive leap forward, as I can still clearly remember the first time I took a victim to the police to report a particularly vicious rape.

The woman had initially been reluctant to report this attack because she had outstanding warrants for her arrest for Common Prostitute Loitering (CPL). I had been assured that she would be dealt with sympathetically as the offence of rape was deemed far more serious than her outstanding offences. However, when she reported the rape to police, she found the desk officer was

High risk: crack use is now the norm among street sex workers in Liverpool

PHOTO: LIVERPOOL ECHO

rude and unhelpful. After a few checks she was arrested for her outstanding charges and spent the night, traumatised and withdrawing from heroin, in a cell.

Now, thanks to the work of Shelly Stoops, the Armistead's specialist independent sexual violence advisor, police attitudes have changed dramatically. Since 2006, when Shelly's role was established, there have been 25 men brought before the courts for violent and sex-related crimes against sex workers, 19 of whom are now serving jail sentences.

Outreach was established to not only encourage people into services, but also to ensure that those who would not or could not enter treatment were monitored and, therefore, provided with a safety net. Despite easier access and improved service provision nationally, I have found there are still those who are unwilling to engage with the treatment system. I recently met one woman – let's call her Jane – who was raped three years ago, but the offender was found not guilty. Deeply traumatised, Jane dropped out of all services but had been recently contacted in relation to another rape committed by the same perpetrator. Jane's case reinforces the need for, and value of, assertive community based outreach projects that maintain contact with those clients who are still reluctant to use more mainstream services.

Having damaged all accessible veins, Jane had begun 'skin-popping' in her legs. The injections in her legs had formed deep abscesses that had turned to badly infected ulcers. I have not seen such extreme injecting-related damage since those early days of harm reduction. Left to her own devices for three years whilst collecting injecting equipment from the chemist, meant that no-one had enquired about her injecting technique. When asked why she did not want a methadone 'script she was very clear: "I get my drugs delivered every two weeks to my door. I have had the same dealer for 17 years who looks after me very well. Why would I want to have to stand in a chemist's every day and be watched while I drink my methadone?" Despite the terrible damage to her legs, Jane was also reluctant to go to hospital because previous experiences had made her feel judged and humiliated.

When I first began this work I spent many a day or night in the A&E departments of hospitals around Merseyside, supporting and advocating on behalf of my clients. I was disappointed to find, whilst trying to get medical treatment for Jane, that, 25 years on, there are still some medical staff that hold the same judgmental attitudes towards drug users as they did all those years ago. The suspicion that drug users present to A&E to get drugs still prevails. In Jane's case, she finally got the help she needed. Even though she was still unwilling to go into drug treatment, the harm reduction advice she was given – try snorting your heroin instead of injecting – helped prevent any further harm and allowed her legs to heal. For me, harm reduction has, and always will, play an important part towards the recovery process for drug users. Harm reduction is still as important today as it was 25 years ago, although it does face new challenges.

Trust still remains an issue, and the women are still suspicious of services if they are pregnant or have children. Now, outreach is far more formalised with many policies and procedures in place and, along with the ever-increasing need for evidence and statistics, more personal information is now required than ever before. Importantly, the one thing that has not changed, and probably never will, is the vulnerability of those women who find themselves in the position of walking dark and lonely streets to sell sex for money to buy drugs.

Under one roof

Michaela's life reached a crossroads when her daughter was born two years ago. She loved her child, but a serious drug problem meant she was incapable of looking after her. **Sam Hart** on a specialist residential rehab unit for families that helps drug using mothers confront their addictions while caring for their children.

On a wintry day in 2009, Michaela gave birth to a healthy daughter, Faith. Three days later she was in court fighting to stop her baby being taken into care. Michaela admits that she was struggling as a parent. Aged just 20, she had been taking drugs for half her life and had been in and out of care since she was nine. "I was really chaotic," she explains. "I was a first time mum. No family, no friends. I was lost. Scared. I wanted to use drugs to mask my feelings."

Michaela was thrown a lifeline when, instead of taking Faith away, social services referred them to a residential rehabilitation service which supports parents to deal with their substance misuse while continuing to live with their children. The service, run by Phoenix Futures Family Services, is based in a large, pleasant suburban house on the outskirts of Brighton. Residents have their own bedrooms and kitchens and access to fully staffed crèche.

Residents typically stay for six months. Michaela left late last year but today has brought Faith, now 18 months old, back for a visit. Staff make a fuss of them both and a delighted Faith is swept away to play in the crèche while Michaela settles into the sofa in the communal living room with a cup of tea and some toast. She looks comfortable, healthy and self-assured but the journey has been tough.

"When I first came in I was on skunk, subutex and diazepam so I had to detox," she explains. "I felt really low. I know that out in the community I wouldn't have been able to do it. Here you've got the support and the staff will have the baby for an hour if you are feeling rough." Withdrawing from diazepam can lead to fits so Michaela had staff with her at critical times such as bathing Faith or carrying her up the stairs.

Dealing with the physical symptoms was just the beginning. Residents are expected to explore the reasons for their substance misuse through an intensive programme of group sessions and one-to-one work based on cognitive behavioural approaches. "There's also homework," says Michaela, "loads of it. You've got to write stuff in your feelings diary."

I HAD BEEN HIDING FROM MYSELF AND MASKING MY FEELINGS BY TAKING DRUGS. I'D BEEN DOING THAT SINCE I WAS NINE YEARS OLD

For all residents, it is a gruelling and challenging process. Michaela admits she had some very difficult moments. "My sister died of an overdose shortly after I came in here," she explains. "That was really tough. I just felt like walking back out onto the streets. I had to really think about my daughter – that's what stopped me going." Being in the service also gave Michaela the chance to rebuild her relationship with her surviving sister: "She's never used drugs and didn't want anything to do with me when I was using. She trusts me now. I can be a support to her which I couldn't be before. We helped each other when our sister died."

The service is run along therapeutic community principles in which service users are given increasing responsibility as they progress through the programme. This responsibility extends to monitoring the behaviour of others and residents are expected to confront and report anyone they see breaking the house rules. "That was one of the hardest things for me," says Michaela. "That's like being a grass and you don't do that where I come from. Now I understand that confronting people's behaviour is helping them. I've got a conscience now and it does my nut in!"

The service is unique in this country in that it offers places to single dads and couples as well as mums. But, in contrast to the national picture in which men make up three quarters of those in treatment, dads are very much in the minority here. This allows the service to cater for women service users who often have different and more complex needs, including domestic violence, prostitution and childcare issues. Fear of having their children taken away can be a powerful barrier to stopping women from accessing services, so the family-centred approach can be a huge incentive. Research has shown that this kind of whole-family approach results in better outcomes for women drug users. And keeping young children with their primary carers throughout their treatment also mitigates against attachment disorders which can result in behavioural and social problems later on.

Self acceptance is a key theme of the community. Residents start the day by reciting the service philosophy: *We are here because there is no refuge, finally, from ourselves*. "When I first came here that was just something I used to say," says Michaela, "but it gradually became to mean something. I think after about 10 weeks I really started to do the programme seriously. I had been hiding from myself and masking my feelings by taking drugs. I'd been doing that since I was nine years old."

Service manager Amanda Walderman says this gradual understanding of the programme and what it has to offer is a common theme. "People might come here initially because they don't want their children taken off them, but they come to realise that it means something. When I walked into my first group session I could immediately tell how long people had been here. People who have been here longer look healthier, they have more confidence. They stop blaming. They are open and not defensive."

As well as addressing their substance misuse, residents are expected to run the house and care for their children. The rota of chores is completed by 9am each morning and residents are encouraged to challenge each other if they feel someone is not doing their fair share. According to Amanda, "staff run the programme, but the residents run the house". The parents are also given advice on childcare: "Many of our residents had parents who were drug users," explains Amanda. "So some have not experienced good, consistent parenting skills themselves. No interaction, no stories, no nursery rhymes, no real idea about healthy eating and cooking."

Michaela admits that she didn't have much of a clue about how to run a house before coming to the service. "Actually I am still a really bad cook," she says ruefully. And she says that at first she found it difficult to take advice from the staff. "They would try to tell me stuff like I'd run out of nappies and I used to get defensive. But they were only trying to help me."

Part of the programme is resettlement and residents put into place plans for when they leave. Supported by the staff, Michaela sorted a flat for herself and Faith, some support groups to attend as well as childcare for two days a week, "so I can do my housework and shopping". But she says that coping on her own was tough, "I couldn't wait to leave here but when I did I was really lonely." Her sense of isolation was made worse by the fact that she had to avoid former drug using associates and even her parents, both drug users themselves. "I have to keep them at arms length. It's hard but I need to put Faith above my relationship with them. I've realised that I can't save my mum and dad."

Now, using the skills developed during her programme, Michaela is starting to shape a new life for herself. She attends several support groups a week and is enjoying spending time with her sister. She also says that her relationship with social services is much improved. "Before I was fighting them all the time. Now I realise that we can work together and they want what is best for me and Faith." She is also doing voluntary work with a view to eventually becoming a drugs worker herself: "I think that people who have been there and done it are amazing at what they do. I would love to help people in the same situation as me."

Sam Hart is a freelance journalist

SHOOTING THE ULTIMATE TABOO

Tough choices: the character of Alice in *Hollow*

The overwhelming pull of addiction versus the prospect of motherhood provides the hook for *Hollow*, a short film by the award-winning London film director Rob Sorrenti. **Michael Simpson** looks at how the highly stigmatised dilemma of being a drug-addicted mother has been portrayed on film.

Condemned by the then US presidential candidate Bob Dole as glorifying heroin use, Danny Boyle's 1996 film *Trainspotting*, which followed the fortunes of a group of heroin users in late 80s Edinburgh, attracted it's fair share of attention. While it would claim to be outlandish and transgressive with its stylish roster and culturally laden wit, the film contained enough of the misery and desperation to suggest that heroin addiction is not chic or subversively cool.

Lead character Renton's poetic liberation is met head on in the street by the sudden turning of his bowels, while Mother Superior's quest for a vein takes him below the waist, ultimately costing him his legs. However it is Tommy, the well adjusted one with the girlfriend and clean flat, whose end is the darkest, contracting HIV even as Renton receives the all clear despite, as he says, "several years of addiction right in the middle of an epidemic."

The film's turning point – where the stylised highs tumble into stylised lows, the over active camera work is pared down, and the clambering rush of Iggy Pop's *Lust for Life* is replaced by the dreary seediness of another Iggy tune *Nightclubbing* – comes with the sudden death of Baby Dawn. Lesley, the baby's mother, has a brief but significant role in the film. She is the one who discloses early on that a hit of heroin "beats any fucking cock in the world." She says this even as a forgotten Baby Dawn giggles and tumble rolls in the next room. The hard edge of the scene, however, is Renton's offer of a hit to Lesley, after one himself, begged for by the grieving mother. Only then does she calm down.

Though Lesley does not feature in the film again, the theme her character raises is an interesting one. The word junkie is uncomfortable for many reasons, often implying a kind of dehumanised detachment where the

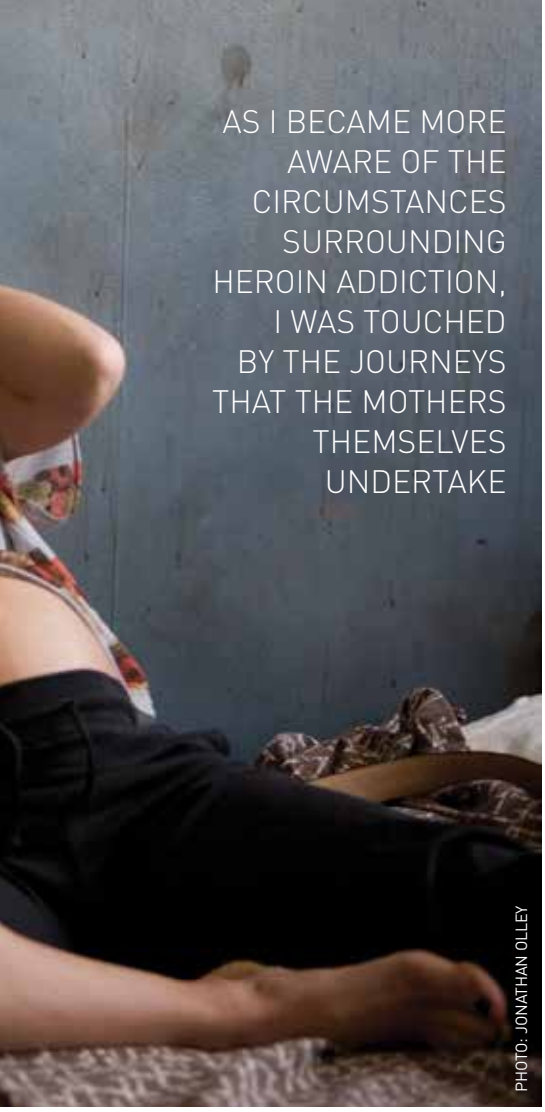


PHOTO: JONATHAN OLLEY

individual has lost their sense of self, and now, beholden to heroin, acts on craving and impulse. There is a succinct, tabloid simplicity to this view that becomes even more pronounced when the 'junkie' also happens to be a woman. Taking leave of your senses is one thing, but to completely abandon the needs of another is something else entirely.

Plenty of other films have touched on this subject matter. Two in particular, SherryBaby and Clean, released within a couple of years of one another, take up the perspective of a mother trying to reconnect with her child after a period in prison. The contrast between the two couldn't be starker, one 'white trash' the other, inexplicably, a gleaming toothed former presenter on a channel not unlike MTV. However, the themes of cleansing and redemption are strongly laid out in both films. Sherry, in time honourable Western fashion, undergoes a Native American ritual, while her celluloid counterpart Emily overcomes her difficulties with a flight to Paris and back.

Both are unsatisfying for many reasons. The journey that each character has to make is obvious from the beginning. Similarly, both of their children are living seemingly contented lives with relatives. For the most part, both mothers have it their own way. Drug addiction is overcome through sheer maternal resolve. The other pieces, such as employment and housing, are swiftly put to together with help from the supporting cast. For all the edginess of the subject matter, the films correspond to a basic story telling principle. Though there are no sunsets, the happily ever after is satisfyingly delivered by the time the credits roll, even if the viewer does have to accept certain caveats.

Were it this easy, it is hard to imagine how an organisation like Project Prevention, which has paid to have drug addicted mother's sterilised, could find any traction. While its mission may have stalled in the UK, Barbara Harris, its founder, has endured as a compelling media figure both in the broadsheets and the tabloids. Her longevity is easy enough to explain. Though we may have strong ethical reservations regarding Harris' aims, it would be impossible for any decent minded person to not feel deeply disturbed by the thought of children born into impoverished homes possibly locked, as the sector refers to it, in a cycle of dependency.

Hollow tackles the issue of addiction head on. The director was drawn to the issue by an article he read in 2007. The piece, he said, "described the heart-breaking ordeal babies suffer". Though he found the stories deeply shocking, there was one positive he could take from the piece. "As I became more aware of the circumstances surrounding heroin addiction, I was touched by the journeys that the mothers themselves undertake."

This became the focus of the film. Alice and Marcus are two lovers blighted by their battle with heroin. All we see of their lives is a grey, drearily insulating flat, devoid of any furniture. However, they are dramatically brought out of their isolation when Alice discovers that she is pregnant. The numbing weariness of their addiction is briefly supplanted by the joy of expectation and parenthood, leading the two to resolve to overcome their destructive existence and look to begin the process of rebuilding their lives.

Hollow sets out a simple premise then – even in the throes of addiction, surely the hope and promise of motherhood is enough to bring about change in a woman's life? Simple solutions seldom are however, and Alice, like her partner, is unable to stop from relapsing. This situation, sadly, is not uncommon. Much emphasis has been placed on pregnancy to act as a catalyst for pregnant women to give up drugs. Indeed many, with utmost sincerity, will say that giving up drugs is what they want to do.

Addiction is not so easily overcome, however. With this in mind, it's probably worth remembering that as many as 27 per cent of women still smoke when they come to give birth. Though it might be a stretch to compare a nicotine habit with the lifestyle chaos that can result from severe heroin dependency, there are nonetheless well founded risks attributable to smoking that are unobserved by a sizable portion of new mothers.

In abstinence, as Alice is in the film, the urge is even more powerful. The neuro-psychiatrist and former government advisor David Nutt describes these feelings as akin to a 'deep-seated memory' which, as anyone with the six month cigarette craving can attest, are possibly "the most powerfully positive ones a person may ever experience." The pull of relapse, then, is strong even when faced with the responsibility of bringing a child into the world.

Significantly, *Hollow's* Alice does not take the easy way. After her relapse she makes the decision to give up her baby for adoption, and, in the final scene of the film, resolves to seek treatment. Director Sorrenti says he hopes *Hollow* "gives audiences hope that people who have lived in the dark can turn their lives around."

Michael Simpson is Communications Officer at DrugScope

For a link to video clips of the film, information on screening *Hollow*, or licensing the film for your group or training, email: info@futuretimepictures.com and put "Drugscope inquiry" in the subject line.


Cult hit: a clip from *Trainspotting*

Mother care

Pregnant drug users not only have to battle stigma and moral panic, but also prejudice and confusion among those professionals charged with supporting them. **Joe Lepper** on a new guide which aims to navigate a path towards improved help for mothers.

"Some of the nurses looked down at me. The way they spoke to me made me feel really uncomfortable," says 28-year-old Angela of her experience of being pregnant and dependent on methadone.

Angela, who is still on a methadone programme and gave birth to her daughter last year, says hospital staff also had little regard for her confidentiality. "When I had visitors they would mention that I had an appointment to do with the methadone programme right in front of them. I thought that was really out of order, a real breach of my privacy," she adds.

According to Anne Whittaker, nurse facilitator for NHS Lothian and author of *The Essential Guide to Problem Substance Use During Pregnancy*, Angela's experience is still far too common for pregnant women with drug and alcohol issues. "There is still a prejudice among some professionals – and that is why a running theme in the guide is the importance of not making judgments."

Whittaker says one of the key themes of the book is the importance of empathising with what can be very complex lives. "They are pregnant, they have an addiction, there may be social care involvement with other children. They may also have housing problems, money problems. There is a lot to deal that those supporting them need to understand," she explains.

This range of issues means that successful support needs to involve professionals across health, social care, drug and addiction services as well as other areas such as housing. While most areas in the UK offer this multi-agency support to pregnant women with drug and alcohol issues, schemes vary in scope, specialist involvement, investment and organisation.

In Edinburgh, NHS Lothian and Edinburgh City Council run the Prepare service for high-risk pregnant drug users in the city, whereas in Manchester support is offered through a specialist midwifery service that also helps pregnant women with mental health problems and Aids/HIV. No two areas offer exactly the same service and there is little research into which model works best.

Fay Macrory, a consultant midwife who manages Manchester's service, says the management and infrastructure of services is less important than ensuring they offer non- judgmental and honest support. "When I say honest I mean we don't mince our words. We tell it how it is around issues such as safeguarding children and explain the consequences of not protecting children or looking after themselves," says Macrory.

She agrees with Whittaker that empathising with patients' often chaotic lives is also vital. "You have to understand what is going through their head. They may have a probation meeting, need to pick up methadone. If you want them to go to an antenatal class as well you have to be aware of all these pressures and stress its importance. "One of the biggest compliments I had was one of the women saying, that I was 'alright' because I was 'like one of them but without the drug problems'."

Understanding what Macrory

THE LOWDOWN

The latest in DrugScope's series of resource books for professionals, *The Essential Guide to Problem Substance Use During Pregnancy*, is now on sale. This unique text was written by Anne Whittaker, a Nurse Facilitator working for NHS Lothian who specialises in drugs, alcohol and blood borne viruses. It's the go-to reference guide for all practitioners who provide care to women who use drugs or alcohol before, during and after their pregnancy. The book establishes a 'framework for care,' synthesising the latest good practice advice, official guidelines and research knowledge from the UK and abroad. In 12 concise and accessible chapters, it delivers information and intervention strategies on a range of topics including:

- the management of substance use during pregnancy;
- drugs and their effects on the developing baby;
- the signs, symptoms and treatment of Neonatal Abstinence Syndrome;
- blood borne viruses and pregnancy;
- appropriate breastfeeding advice for women with substance misuse issues;
- the management of risk and child welfare concerns during pregnancy.

The book also features 11 leaflets and factsheets for use by professionals and service users.

DrugScope members can claim a 10 per cent discount off the cover price of £16.95 by citing their membership number when ordering the book from HIT. To order a copy, you can call HIT on 0844 412 0972, email them at stuff@hit.org.uk or visit their homepage at www.hit.org.uk. Discounts for multiple purchases may be negotiated.

describes as many patients' "deep rooted antagonism against social workers" – often arising from childhood experiences, is also important. Such fear had meant women in the past would not engage with support services and present themselves to midwife services late into their pregnancy. There is still a fear of engaging with services and in particular social workers, although the difference now is that because specialist services are in place it is easier for those such as Macrory to target women and address those concerns. This also makes it is harder for pregnant women with addiction issues to evade support. The kind of specialist support coordinated by Macrory and her team was not as widely available across the UK as it is today.

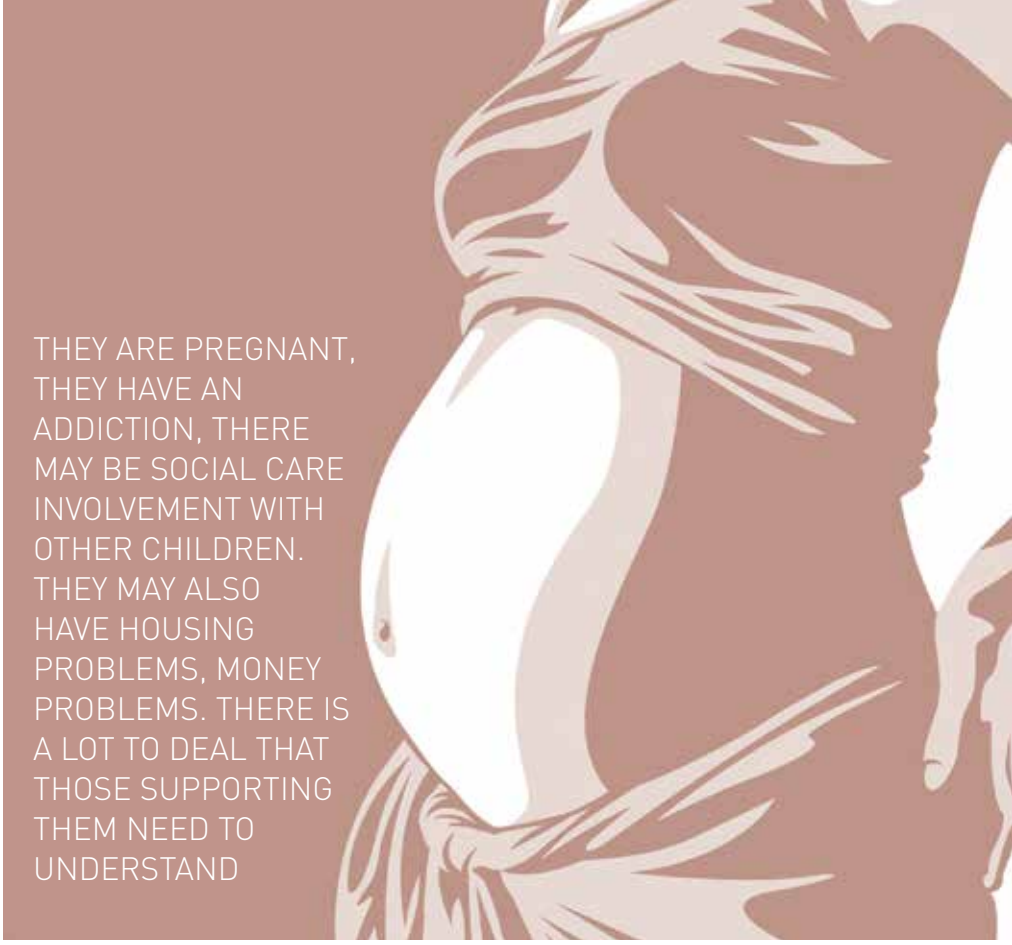
"Some are very antagonistic about social workers and may be worried their baby will be taken away. You need to understand and address those fears. They cannot be ignored if you want them to engage in the service," says Macrory.

While Angela encountered prejudice from some hospital staff, she praised the understanding approach of NHS Greater Glasgow and Clyde's Special Needs in Pregnancy (SNIPS) service, the specialist programme that supported her during her pregnancy. "They were really good, I felt supported and they took me to appointments as well," she says of the service, which includes social workers, midwives, nurses and addiction workers from the charity Addaction.

Whittaker concedes though that barriers remain in providing specialist support, and lack of resources across the public sector is one of them. "I would be very surprised if there was any area where most women in this situation were seen by a specialist drug and alcohol service midwife. They will most likely be seen by a general midwife," says Whittaker.

She concedes it would be unrealistic to expect increasingly tight public sector coffers to fund a dramatic increase in the number of specialist midwives. "This is why the book is aimed at generalists as well across health, social care and addiction services. It is they who will be offering the support," says Whittaker.

Another barrier is access to training for generalists to cover the complex array of issues facing pregnant women with addiction issues. Whittaker says: "There are some very good courses out but there is no national standard. Areas are doing it themselves. In some cases specialist midwives are running courses aimed at generalists. There is a demand, but it can be hard for people in already demanding jobs to get time off to attend courses."



THEY ARE PREGNANT, THEY HAVE AN ADDICTION, THERE MAY BE SOCIAL CARE INVOLVEMENT WITH OTHER CHILDREN. THEY MAY ALSO HAVE HOUSING PROBLEMS, MONEY PROBLEMS. THERE IS A LOT TO DEAL THAT THOSE SUPPORTING THEM NEED TO UNDERSTAND

Across the UK Scotland has the most coherent approach to training. The Scottish government has commissioned the University of Glasgow and Drugscope to run Scottish Training on Drugs and Alcohol (STRADA), the country's drug and alcohol training body. The body, which does not have an equivalent in other UK regions, covers issues such as challenging prejudice and clinical problems associated with drug use.

Such clinical issues, which are also covered in Whittaker's book, include neo-natal abstinence, where babies are born addicted to the drug the mother is using and go through a period of withdrawal.

Inserting a module covering drug and alcohol addiction, pregnancy and family life in all entry- level courses across health, addiction services, education and social care would help improve professionals' knowledge markedly, says STRADA head Joy Barlow.

Already STRADA runs a University of Glasgow elective course for trainee teachers on supporting families that have drug and alcohol issues. "But this is just one course, it's not compulsory and its for just one profession," Barlow adds.

The public sector's "silo mentality" is another barrier to effectively supporting pregnant women with drug and alcohol issues, says Barlow. She welcomes the focus of Whittaker's book on the importance of partnerships involving all professionals involved with pregnant drug and alcohol users. "Currently teams of social workers and drug advisers still work in their silos even if they work in the same building. That needs to be addressed," says Barlow.

A high proportion of drug users will have been through the care system at some stage as children. Problems of high staff turnover, overworked frontline social workers, social workers working in a silo and not engaging with partners in health were the kind of issues they would have faced when they were children. Such issues are still commonplace in some areas. Another focus of Whittaker's book Barlow welcomes is the importance of involving fathers: "Pregnancy is about relationships, between couples, between parents and a child and with professionals. The father is part of this."

For Whittaker, she is convinced that where support services for pregnant drug users are coordinated, work well in partnership and offer a stigma-free service then "women find it invaluable" and a help in tackling their addiction. Angela agrees: "Before I had my daughter I was topping up on the methadone with heroin. I don't do that anymore. I have to think about my daughter, put her first and make sure I'm there for her."

■ **Joe Lepper** is a freelance journalist

ARE YOU EXPERIENCED?

Little by little, drug users are developing a growing influence on the international policy stage. And Australian users are showing the rest of the world how it's done at a national level. **Eliot Albert** on the rise of global drug user activism.

For the first time in three decades of activism by people who use drugs, we have an internationally recognised organisation, seen by many as being the voice of the global, drug using community. That group, the *International Network of People who Use Drugs* (INPUD), is now partnered on the international stage by the major players campaigning against the appalling situations in which people who use drugs around the world live. Focusing on injecting drug users, the sector of our community that faces the greatest human rights abuses and the most acute health problems, INPUD aims to provide a voice for a heavily marginalised, deeply oppressed community of some 26 million people globally.

In 2005, frustration at the poor facilities for drug users at the Belfast *16th International Conference on the Reduction of Drug Related Harm* became the catalyst for an invigorated international network and led to the inception of INPUD. It was formed around a mission statement called the 'Vancouver Declaration', endorsed at a meeting of user activists at the 17th International Conference on the Reduction of Drug Related Harm in Vancouver.

Although this was the product of many activists' efforts, a working group including representatives from Asia, Europe, Latin America, North America and Oceania undertook the initial process of transforming INPUD into a legal entity. The UK's Department for International Development provided funding for the development of INPUD, as part of a larger grant to the International Harm Reduction Association (IHRA).

After some initial struggles INPUD is developing into the organisation that many of us, and our predecessors, have been fighting for over the last few decades. INPUD's early phase encountered some constitutional difficulties and concerns about process. A subsequent crisis meeting was held at *Harm Reduction 2008: IHRA's 19th International Conference* in Barcelona, which led to a successful re-foundation General Meeting hosted by the Danish Drug Users' Union (*BrugerForeningen*) in Copenhagen at the end of October 2008 where a Consensus Statement and a clearer infrastructure were both agreed to. Since then, a representative from INPUD was invited to give a formal address as part of the UK delegation to the United Nations' Commission on Narcotics Drugs (CND) in April 2009, while several other members attended as part of various NGO delegations. INPUD has now become recognised as the voice of the international drug users' movement by most of the major organisations, NGO's, and donors in the harm reduction and HIV/AIDS fields.

Drawing inspiration from the 'The Vancouver Declaration' and the widespread adoption of the slogan 'nothing about us without us', INPUD has forced partners to recognise that acknowledging and listening to the experiential knowledge that comes from the lived experience of being a user of illicit drugs is key to seeking solutions to the public health catastrophes, and human rights abuses, that prohibition drives. The full involvement of those who have first hand experience of living under the stigma and marginalisation that comes from being criminalised just for using your drug of choice is essential.

INPUD HAS MANAGED TO TRANSFORM THE SLOGAN 'NOTHING ABOUT US WITHOUT US' INTO A SUBSTANTIAL REALITY

Bottom of the pile: Problem drug users in countries such as Indonesia have severely restricted human rights, which can lead to some (overleaf) being chained to posts as a form of treatment

This privileged information is crucial to forging innovative public health and human rights policies that can begin to ameliorate the conditions in which so many members of our community live.

For so many years, the drug using community was a minor partner in the harm reduction agenda. Increasing recognition of the failure of the policies and programmes that were being delivered, and constant demands to be heard, ensured that the involvement of people who use drugs in the formulation of policy became crucial. The growing maturity of INPUD has allowed us to begin to negotiate on our own terms. It is no longer possible for the global discussion on current drug policies to continue without the full involvement of those who are most acutely affected.

Certainly, INPUD has been forced to 'grow up' in the public spotlight and is proving itself more than adequate to meet the task. INPUD has negotiated partnerships with dozens of international NGOs in the public health, human rights, harm reduction, and HIV/AIDS fields and is rapidly becoming a fixture within public discourse on drug policy. Crucial to securing our ability to do this has been delicate negotiations with funders and major donors including the Department for International Development, the World Bank, Global Fund, and the Open Society Institute. That such major organisations are now prepared to sit down with and fund an organisation representing such a criminalised, marginalised, and heavily stigmatised community as ours is considerable testament to the tenacity and maturity that we are now demonstrating. It has also been made possible by the overwhelming success and widespread acceptability of harm reduction messages, and recognition of the impossibility of finding solutions without involving those most profoundly affected.

In June, INPUD members took part in the United Nations High Level Meeting on AIDS. The meeting is an especially important one as it marks three decades since the HIV epidemic broke out, one decade since the UN adopted time-bound measurable objectives, and five years since the commitment to achieve universal access for all to comprehensive HIV programmes by 2010, a commitment that has not been met. INPUD will be especially keen to ensure that those delegations that are becoming hesitant about "including specific, time-bound and measurable targets for prevention, treatment and financing in the UN High Level Meeting outcome document" do not backtrack.

The final document issuing from the meeting, *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*, explicitly recognises the need to address HIV transmission amongst people who use drugs, and includes a specific target of reducing HIV transmission amongst people who use drugs by half by 2015. However, this commitment is undercut by the statement that this must be done "in accordance with national laws".

Erin O'Mara, editor of drug user magazine Black Poppy and an INPUD organiser said: "The engagement with the entire HLM process via the civil Society task force was, though cliche, a real rollercoaster. It hamstrung our movement and its voice with the inference that we were unable to speak openly about criminalisation – something that is at the heart of every single issue that affects people who use drugs. for INPUD, it was a another watershed moment for us on the global stage, and repeatedly showed donors and leaders of international organsiations, just how our participation is key in an effective HIV response and resourcing our user networks will be crucial in the years ahead."

In an effort to draw increased attention to HIV-related harm reduction and injecting drug use, INPUD will join Harm Reduction International (formerly IHRA) to launch the 'Beirut Declaration on HIV and Injecting Drug Use' (named after the venue of the last international harm reduction conference). INPUD will also be keen to emphasise the importance of including injecting drug users as a key affected population. A major step towards this was the inclusion of people who use drugs as a key affected population in the International Council of AIDS Service Organisation's selection procedure for the Civil Society Task Force on HIV/AIDS, which met in April and included an INPUD member.

In conclusion, since the adoption of 'The Vancouver Declaration' in 2006, INPUD has managed to transform the slogan 'nothing about us without us' into

a substantial reality, with INPUD now a firmly established presence at the major international policy forums. However, in an atmosphere in which harm reduction is coming under increasing attack once again from the resurgent 'abstinence or nothing' lobby, we cannot afford to rest on our achievements thus far. While on the one hand, the edifice of prohibition is showing substantial cracks, and the human rights abuses suffered by people who use drugs are becoming increasingly recognised. On the other, many countries that were once bastions of harm reduction practice are starting to backslide, not least the UK and the Netherlands. INPUD, with its partners, will continue to press its agenda until the iniquities of prohibition have become a faint memory, one more nightmare in the annals of human folly and cruelty.

Dr Eliot Ross Albert, PhD is INPUD's Membership Secretary

To join INPUD, please write to membership@inpud.net and to read more go to our website http://www.inpud.net

AUSSIE RULES

How a drug user's league in Australia is leading the way in national co-ordiantion

While organisations of people who use drugs have existed in countless countries worldwide for three decades, few have reached the longevity and degree of influence that can be attributed to the Australian Injecting and Illicit Drug Users League (AIVL). A national body representing people who use illicit drugs, AIVL covers "issues of national significance for people who use or have used illicit drugs". It has existed for 21 years, and been a fully funded organisation for fourteen of them. Throughout their history AIVL has consistently lobbied, and provided a voice for people who use illicit drugs in Australia. AIVL, as a peak organisation, does not accept individuals as members but is instead made up of a number of state and territory drug user organisations, providing them with a unifying national platform.

AIVL has focused much of its energy on making interventions into, and being involved in, national government policies and strategies in all areas that concern people who use drugs, on the basis that "without good drug policy at the government level, there is no effective drug treatment or needle and syringe programmes".

AIVL received its first significant national funding in 1998 for a two-year national Hepatitis-C education and prevention programme for people who inject illicit drugs, and ever since, its focus has been on injecting drug users, identifying them as being the sector of the drug using population most subject to human rights abuses, stigmatisation, and health problems. This initial programme was so successful that it has continued to be funded up to now on a rolling one-year funding cycle.

One area of national policy in which AIVL has had particular success was in its involvement, between 2000 and 2005, in the campaign to prevent the introduction of retractable syringes. The company pushing for their introduction advocated for them on the basis that because the needle 'retracted' after use, it would lead to a reduction in the transmission of BBVs. Having studied the technology, AIVL discovered that in fact the syringes could be reused, but couldn't be washed, and so concluded that rather than preventing BBVs, they would, in particular in prison environments, foster their transmission. AIVL were invited onto the national committee convened to discuss the technology and having lobbied heavily against their introduction were successful in persuading the government to cease piloting them and indefinitely postpone the AUSD$17.5 million retractable needle & syringe technology initiative.

AIVL's success in this area is a seminal example of how a well organised national interest group of people who use drugs can, through involvement in the political process, rigorous lobbying, and grassroots activism, influence policy on a crucial issue affecting the lives of people who use drugs.

...meanwhile in Britain

It is ironic that whilst the UK was one of the first countries to embark on the provision of widespread harm reduction services, and can for good reason claim to be the birthplace of harm reduction, it has never had an equivalent to AIVL. The reasons for this absence are complex and manifold. Since the 2001 Health and Social Care Act there has been a statutory obligation for health and social services to involve service users in the course, design and delivery of treatment. The National Treatment Agency for Substance Misuse Treatment (NTA), also established in 2001, has been responsible for implementing this requirement in the drugs field. User involvement is expected at all levels within treatment systems and resources are provided to support it. However, most of the user activism in the UK over at least the last decade has been tied to a model of treatment consumerism rather than the wider issues of drug users' rights.

The last attempt to establish a national, activist-based organisation led by people who use drugs and based on human rights principles, the (now defunct) National Drug Users Development Agency (NDUDA) received little support. Ultimately, its inability to gain funding led to its demise. There are, however, flourishing local groups, which have reached beyond a treatment consumerist agenda, and the UK is home to a number of prominent international activists. Attempts to build a national organisation have been mired in debates over direction and at present the closest thing we have is the unfunded National Users' Network which exists only as a virtual network and whose activities are largely limited.

Lands of the legless

The young Frederick Engels, in his late-1840s visit to Manchester, described how on a Saturday evening he had "seldom gone home without seeing many drunkards staggering along the road or lying helpless in the gutter... It is easy to see the consequences of widespread drunkenness – the deterioration of personal circumstances, the catastrophic decline in health and morals, the breaking up of homes."

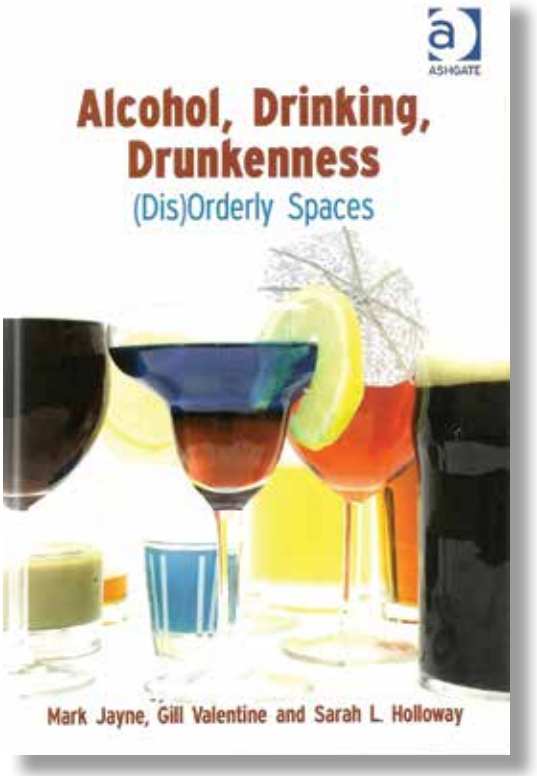
Reviews

Professor Jonathan Chick, School of Health Sciences, Queen Margaret University, Edinburgh

'The City' is the opening chapter of Jayne *et al's* 'geography' of drinking and drunkenness, and Engels' comments are recognisable today, like the description given to him by a Sheriff Allison that in Glasgow on a Saturday night there would be "30,000 drunk workers". When the Great War ended, and despite the recession, Will Fyfe could still sing 'I belong to Glasgow', noting that at times he felt 'Glasgow going round and round', and ending his music hall song with the famous lines: 'If I've had a couple of drinks on a Saturday, Glasgow belongs to me'.

So we should not be surprised that geographers expect their discipline should be able to make a contribution to understanding drinking and drunkenness. Most British cities, and villages too, recognise the places where people drink and places where people get drunk. This book is a wonderful anthology of those places around the world. Some 'places' get exported (if that is not an oxymoron!), such as the ubiquitous Irish pub now seen (and heard with its lively Irish music) in city centres round the world. And yet, how should we disentangle the anthropology of drinking from its geography?

The authors show us with numerous illustrations, how 'place' can signal relaxation of social relations – music festivals are an example. It is, of course, not only the pharmacological effects of the beverage that affect behaviour, but 'the scene', the company, 'the craic' (Irish for good conversation and repartee) – in sum, the set and the setting.



THE BOOK PROVIDES A RICH PAGEANT OF DRINKING SETTINGS AND CUSTOMS. BUT, IN THE END, THIS IS DESCRIPTIVE WORK, FOR GENERATING RATHER THAN TESTING HYPOTHESES

The authors quote their own investigative work using interviews and observation, and define differences between the sexes in how drinking places and events are perceived. The book provides a rich pageant of drinking settings and customs. But, in the end, this is descriptive work, for generating rather than testing hypotheses.

Whether geographers will stimulate experimental studies remains to be seen, but there are opportunities for exploiting natural experiments: for example, when there are non-synchronous changes in alcohol-related legislation in differing licensing zones. Such research could give much needed sustenance to beleaguered prevention workers. In 1999, the research scientist Harold Holder showed this was possible in his seminal monograph on the Californian community prevention research programme, *Alcohol and the Community: A Systems Approach to Prevention*.

I recommend this book to alcohol researchers, as well as researchers on youth behaviour, gender and ethnicity. As an anthology of drinking practices and places, it is a mine of information.

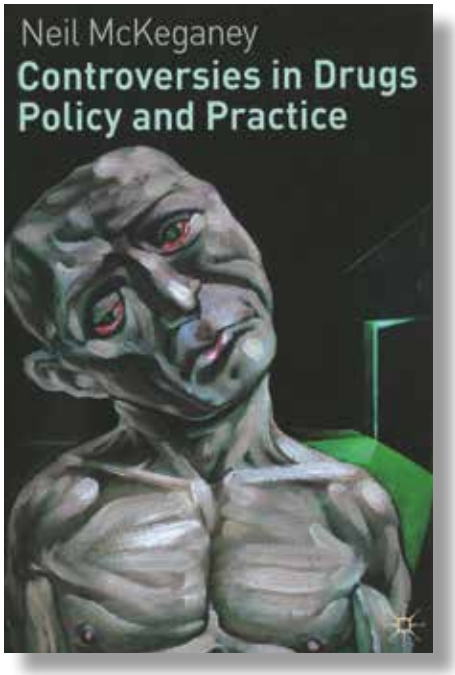
ALCOHOL, DRINKING, DRUNKENNESS: (DIS)ORDERLY SPACES
Mark Jayne, Gill Valentine and Sarah L Holloway
Ashgate Publishing Limited, 2011
Hardback, 158 pages, £50.00
ISBN 978-0-7546-78160-2

What's morality got to do with it?

When I did a Google search for 'Neil McKeganey', the first page of results included a quote from him saying that prescribing heroin "makes doctors like dealers" and a suggestion reported by BBC Scotland to "pay addicts not to have children".

Reviews

Marcus Roberts is Director of Policy and Membership at DrugScope



CONTROVERSIES IN DRUGS POLICY AND PRACTICE
Neil McKeganey
Palgrave Macmillan, 2010
208 pages, paperback
ISBN-10: 0230235956

In this book, McKeganey recounts various run-ins. A session with drug workers at a treatment agency in Glasgow ended "with very little sense of a common understanding", while one of his reports was dismissed by the Scottish Drug Policy Forum as "unhelpful and manipulative". He writes of being subject to "intolerable harassment" from civil servants in the Scottish Government when his research was not delivering the results they were after (and it does sound like he had a pretty unpleasant time). In short, he is no stranger to 'controversies in drug policy and practice'.

The Acknowledgements section of this book suggests that he believes in the inherent value of controversialism – he thanks a very heterogeneous group of people for shaping his thinking. The list includes – for example – Danny Kushlick and Steve Rolles (Tranform Drug Policy Foundation), Roger Howard (Chief Executive of the UK Drug Policy Commission), Professor John Strang (Institute of Psychiatry), Kathy Gyngell (Centre for Policy Studies), Deirdre Boyd (Chief Executive of the Addiction Recovery Foundation) and Mary Brett (UK Spokesperson for Europe Against Drugs). McKeganey notes that the list includes people who would agree with "most, little and nothing" that he says, but observes that "debate does not need to find agreement to be helpful in furthering one's own thinking." He later declares that "sitting on the fence is decidedly not what this book is about".

Neil McKeganey begins by sounding an alarm: the drug problem, he suggests, may be as big a threat to society as climate change or global terrorism. Since 1994, McKeganey has been Director of the Centre for Drug Misuse at the University of Glasgow (he founded the Centre), and is a member of the Greater Glasgow Drug Action Team. The fact that he lives and works in Scotland may have contributed to his sense of impending social meltdown.

"In the late 1960s Scotland barely had a drug problem worthy of the name," he writes, "and yet by the turn of the century it has become the drug capital of Europe." In 1968 there were four people in inpatient drug treatment and 13 people in outpatient treatment in the whole of Scotland. In 2008 there were over 55,000 problem drug users, with estimates suggesting that four to six per cent of children were growing up with a drug dependent parent. In 2002 a leading Scottish drug dealer was shot dead within two weeks of hosting a fundraising dinner for the Scottish Labour Party. In 2010 Stephen Purcell, the leader of the Labour Council in Glasgow, was forced to resign following revelations about his cocaine use.

THERE IS THE WIDELY HELD BELIEF IN OUR SECTOR THAT WE HAVE AN ETHICAL RESPONSIBILITY TO REDUCE HARM, WHICH HAS PROVIDED A CLEAR MORAL COMPASS FOR DRUG POLICY

McKeganey argues that this escalation of drug problems reflects the failures of harm reduction and pragmatism. For him, the foundation stone for an effective and robust approach to drug policy is to reject pragmatism and to view drug use itself in moral terms. This is the connecting thread that runs through this book, which concludes with a chapter entitled, 'So what's morality got to do with it?'

Starting from a moral point of view, he proposes – for example – that we should consider limiting access to treatment services to people who are serious about recovery and potentially closing the doors to those who are not; paying drug dependent parents

not to have children; permanently re-locating children from drug-dependent households if their parents do not respond to drug treatment (over, say, 18 months); installing close circuit TV in homes as a child protection measure and continuing to stigmatise drug use. As for law reform and enforcement, he argues for a "zero-tolerance approach towards illegal drugs".

It is not possible in a short review to discuss these arguments at length, and they merit detailed scrutiny and consideration. I agree with McKeganey that there is a moral dimension to drug misuse, but I would nonetheless want to reject many (but not all) of the policy prescriptions he derives from his moral perspective. I would also suggest that recent drug policy has had a strong ethical basis.

First, there is the widely held belief in our sector that we have an ethical responsibility to reduce harm, which has provided a clear moral compass for drug policy. McKeganey declares that "we need to see drug use for what it is – a profoundly harmful domain of human experience that threatens society in a multitude of ways". But surely this is precisely the perception of drug use that has driven a lot of recent drug policy? And surely a commitment to reducing this harm has provided it with a strong ethical grounding?

Second, it is a sign of moral progress that we have extended the notion of entitlement to evidence-based and quality health care to such a marginalised and stigmatised section of the community. McKeganey's discussion of restricting access to treatment will be particularly unsettling, although he is to be applauded for pointing to a rather large elephant in the room of current policy debate (if we are going to transform quality of provision, where is the money going to come from?).

He argues that the road to recovery is a long-term and resource-intensive business, and improving quality may have to be at the expense of quantity. "We may conclude", he says at one point, "that there is little point in attracting more individuals into drug treatment who are not committed to their recovery and we may seek instead to limit access to treatment services to those who are serious about their recovery." But access to drug treatment improves (and can save) lives, benefits families and communities, brings people into the ambit of services who might otherwise be lost entirely, and is often a necessary step to developing a long term commitment to sustainable recovery.

ONE OF THE GREAT MYTHS OF OUR FIELD IS THAT APPROACHES TO DRUG POLICY ARE NOT OR SHOULD NOT BE BASED ON VALUES

Finally, McKeganey says that we need to recognise the use of illegal drugs "as a behaviour that is self-focussed and which disregards the views and needs of others …[and] … as a behaviour that is about putting one's own needs and desires above those of the wider society, one's family, friends and community". He makes this case with particular force and passion with respect to child protection. In my experience, however, drug workers and service users often do recognise and engage with these moral issues, but they also see drug use as a destructive behaviour that is adopted to cope with experiences of abuse and neglect, exclusion and marginalisation.

The risk of a discussion of morality that does not explicitly situate "self-focussed behaviour" in a wider social context is that it can end up with an unattractive and implausible moralism, that places the blame on those who do not have access to the necessary resources for not living well. Again, I'd say we have made real progress in recognising and addressing these social issues. (McKeganey does argue that we can morally condemn drug use without morally condemning drug users, but, on his terms, I'm not sure this is possible.)

McKeganey embodies many classical liberal values as a controversialist, and would recognise J S Mill's "first duty to follow his intellect to whatever conclusion it may lead". But I can't help feeling that the buzz of iconoclasm and the glare of controversy may itself be habit-forming, contrasted with the grind of equivocal conclusions and the plod of more gradualist and piece-meal recalibrations of policy and practice.

Perhaps the critical division at the moment is between those who believe we need to rebalance drug policy and practice, building on what has been achieved, and those who believe the current approach has simply and comprehensively failed and that we need to start again (paradoxically, a view shared by some drug legalisers and some sections of the 'recovery' lobby).

For me, there is plenty to build on, but also plenty to do. One of the great myths of our field is that approaches to drug policy are not or should not be based on values, and can get all the nourishment they require from an evidence-based rationalism – but it's an old epistemological chestnut that you cannot derive an 'ought' from an 'is'. The question is not so much whether morality has any place in drug policy, but whose ethics, which morality, how interpreted and what role?

McKeganey is right to raise the issues of morality, and to break cover at a time when the value base of drug policy is being contested in important ways that will profoundly impact on practice but often fall beneath the sector's radar (and may not always be consciously recognised by some of the people having the debates). All in all, this book is certainly 'helpful in furthering one's own thinking' whether one agrees with 'most', 'little', 'nothing' or – as in my own case – some of what it says.

Coming of age

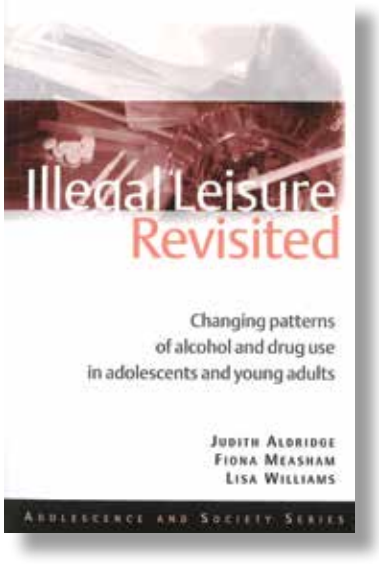
No-one could seriously accuse this book of being 'dumbed-down'. It traces a group young people from north west England and presents broad and extremely detailed analysis of their drink/drug habits over several years. From 14-year-old novices to grown-up, more streetwise consumers of booze and narcotics.

Reviews

Jeremy Sare is a freelance journalist and government consultant

From the outset, the book is a somewhat verbose academic treatise where, for the first few sections, the subjective insight into drug-affected lives is buried under a mountain of stodgy evidence. The subject matter for the book is very well-chosen. Following a cohort of teenagers into their 20s allows policy-makers to uncover valuable factoids on that old conundrum 'why do people start and stop taking drugs?'

It is an issue on which any sensible government would deploy significant research resources. But doesn't. To do so would leave ministers vulnerable to being portrayed by a reactionary media as acknowledging nay, tolerating, drug use and all its associated misery.



The authors (Aldridge, Measham, Williams) are senior lecturers in Law or Criminology from the North West (Manchester and Lancaster) and the surveys and interviews have been carried out in that region. But what emerges is effectively a national experience – the same patterns of drug-taking could have been measured in London, Bristol or Liverpool.

The text has the non-judgemental odour of the social clinician. It is strong on methodology, but eventually the colour of the outside world is able to permeate the social laboratory of the early chapters. The book may be more for students and academics than the casual reader, and the flow of the narrative is spoiled by a series of heavily numbered tables and complex graphs which would clearly belong in a substantial annex at the back

It only really becomes fully engaging by Chapter 6 (Journeys: Becoming Drug Users), which explores the array of social pulls and pushes toward and away from drug use – when experimentation and laughs can eventually evolve into regular use and addiction. Here it is clear how entrenched drug use is in British youth culture. Drug supply seems to be almost exclusively through mates without profit so rather undermining a politician's portrayal of susceptible teens at the mercy of devious peddlers in dark alleys.

Although the book adopts convoluted language which many drug users would find unfamiliar, the authors succinctly establish the series of choices and risk assessments they take: the high and its duration; the cost; safety and health issues; peer and family response and more generally whether they like the 'scene'. It is this "dynamic framework" where we can learn most about the drivers to and away from use.

IT WOULD SEEM GETTING MARRIED AND HAVING CHILDREN IS A MUCH STRONGER EFFECT THAN THE THREAT OR REALITY OF ANY PRISON, LET ALONE A THOUSAND TALK TO FRANK COMMERCIALS

For many, there is a finite period where they choose to tolerate an environment of "people monged off their heads". Ultimately the desire for others to simply be able to function during the working week becomes a higher priority than long ecstasy-fuelled weekends. For a route to stopping, particularly for stimulants, it would seem getting married and having children is a much stronger effect than the threat or reality of any prison, let alone a thousand Talk to Frank commercials.

The final chapter takes a grander overview of the progression to the normalisation of recreational drug use and includes some spikey, but no less valid, opinions on the political failure of the war on drugs. The main conclusions are that drug choices are rational and feed into structured decision-making processes, but in an environment which is increasingly prohibitionist.

I wouldn't contend with the main conclusions drawn in this book, which appear soundly argued. It is not the kind of book you fall into casually, the prose lacks flair. It is certainly comprehensive, perhaps worthily so.

ILLEGAL LEISURE REVISITED

Fiona Measham, Judith Aldridge, Lisa Williams
Routledge, 2011
Paperback, 264 pages
ISBN-10: 9780415495530
ISBN-13: 978-0415495530
ASIN: 0415495539

drugworld DIARIES

HELEN SANDS

Counselling assessment referral advice and through care (carat) worker

Lifeline

HMP Durham

It's a busy morning for me in the jail. Then again, being a CARAT worker is a fast-paced vocation, especially when based within a remand prison. This morning I am assisting with the prisoner induction process. Around 40 new prisoners came into custody over the weekend, and each have to be seen by a number of different departments. I work my way down the list of names, calling them to be interviewed individually. There are some familiar faces and some new ones. We discuss overdose awareness and harm minimisation. I explain what CARATs is and ask if anyone would like to engage with our services. I call the name of a client I have worked with many times before, and it's good to hear that he has not relapsed on heroin since being released for his previous sentence, and he wishes to engage with CARATs.

I currently have 30 clients on my case load, all of whom are at different stages of their treatment pathway. Some are due for release within a matter of days, where as some are considering their plans and setting goals for longer periods in custody.

I have received a new referral (we usually get one or two a day) and go to see him. We discuss and agree a confidentiality compact, revise harm reduction, complete a 'nodal' map of his substance history and health and devise any immediate care plan goals. Nodal mapping was introduced to the CARAT team in April as an efficient way of collating client information and of exploring their routes to recovery. It has been well received by colleagues and clients, as it has increased our client contact time, definitely a welcome change. Completing these maps allows the client and I to identify reasons around his offending and substance use, and highlight areas where he may benefit from further support. We identify more intense treatment goals.

Group work is on my agenda today and although have six out of a possible 12 clients attending, we run the session. It gets off to a good start; participants appear keen and eager to contribute. We identify aims and objectives and generate a good level of discussion.

An older participant attempts to motivate our younger participants further by sharing a personal story. He describes how a friend of his was using LSD heavily, when he experienced a bad trip and began to mutilate his head as he thought it was an orange. Though the story upsets a few people, it does get everyone talking. Session feedback is positive and as facilitators, we observe a particular client's attitude shift from being ambivalent to change to being more optimistic about change.

I CALL THE NAME OF A CLIENT I HAVE WORKED WITH MANY TIMES BEFORE, AND IT'S GOOD TO HEAR THAT HE HAS NOT RELAPSED ON HEROIN SINCE BEING RELEASED FOR HIS PREVIOUS SENTENCE

Several of my clients require a second assessment, which must be completed within 15 days of initial assessment. I visit a client who has been in custody for two weeks. We complete 'nodal' maps on offending history, reasons and motivations, and personal and social functioning. In this instance my client would benefit from engaging with mental health and housing, therefore I signpost on accordingly. We also plan for us to complete one-to-one work around triggers and cravings and amphetamine awareness. Adopting a multi-agency approach is an essential part of being a CARAT worker, as it ensures clients receive support where needed.

It can be quite challenging when working with a client who has substance misuse problems and mental health issues. I was recently stopped by a client who was fairly distressed and asked to speak with me. He was convinced that all staff and prisoners were out to get him; he also explained that god had given him the lottery numbers for this weekend and he'd written them down on paper and swallowed them. I ended up sitting with him for some time as he was frantic about getting these lottery numbers out, I eventually managed to calm him down before contacting the mental health team, and informing the landing officer.

A client of mine is nearing his release so I pop to see him to complete his release plan. I have arranged an appointment for him to attend DIP (Drug Intervention Programme) and his probation on release, and he was pleased with this. I've worked with this client for two years, and he has made excellent progress while in custody. He is extremely positive about being released and has a lot of family support in the community. We explore ways of maintaining his motivation and possible triggers for using drugs.

I fax a copy of the release plan to the DIP so they are aware of his needs. A couple of days after I saw this client he sent a CARAT service feedback sheet to the office, he wrote that he'd really liked working with me and thanked me for the help I'd given him and the plans I'd put in place for his release. He also thanked me for wishing him luck on his release. I find it really rewarding to receive positive feedback from clients and it helps keep me motivated in my role.

HeadSpace
...drugs from the left field

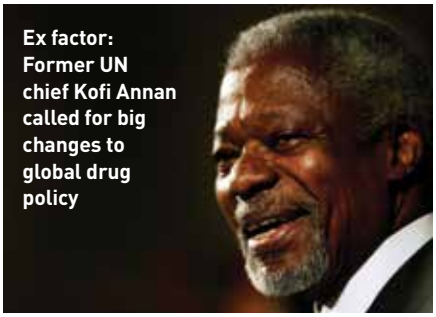
Don't mention the war

In early June a very eminent body, the Global Commission on Drug Policy, comprising ex-Presidents and former UN Secretary-General Kofi Annan among others, called for "a major paradigm shift in global drug policy". It put forward a number of recommendations including the legal regulation of drugs. So they could not have been surprised (and may even have been pleased) to see their report headlined, 'Ex-presidents call for drug legalisation' or words to that effect.

The rest of what they had to say was ignored by the media. The trouble is that the key word here is 'Ex'. The British and American administrations dismissed it out of hand. No politician who carried any diplomatic heft publicly supported the report either. Why? Because even among those MPs who in private (according to law reform groups) might support reform, they are scared to publicly 'come out'. Particularly in the UK, they know they would be chewed up and spat out by the media attack dogs – and disowned by their party.

Much of the problem lies in the framing of the argument. As soon as you mention 'legal regulation', 'legalisation' or even 'decriminalisation', those in power refuse to engage and the debate immediately shuts down. Reform groups claim that cracks are appearing in the current, American-influenced international stance on drugs. To a degree they are correct. Several countries have moved away from strict adherence to the US-style prohibitionist approach of previous decades. But even this can be prey to the winds of political change.

The eleven American states that decriminalised cannabis in the 1970s, all retrenched, under threat of the withdrawal of federal funding by the Reagan administration. Following the election of a more conservative government, The Netherlands has significantly reined in its coffee shop culture. And who is to say the same won't happen in Portugal, where drug possession has been largely decriminalised, despite all the apparent public health gains?



Ex factor: Former UN chief Kofi Annan called for big changes to global drug policy

For all the talk of 'unintended consequences of drug policy', those in power don't seem to be minded to do much about it. At least if the conversation begins and ends with the 'L' word

The narrative of anti-drug campaigners has it that these u-turns, back to less 'liberal' policies, occurred as a direct result of public health concerns. Wrong. Reversing drug laws is an easy target for an incoming administration, or one facing an election, which is out to prove how tough it is on law and order.

Is there a way to break the impasse? Firstly, the focus should be on those experiencing serious drug problems rather than drug users in general. And that community might be much better served if the attention was taken away from call after call for law reform and instead focussed on redressing the imbalance between the resources allocated to law enforcement as opposed to public health.

This might not sound very radical for a UK audience, but it could have a massive impact on people with drug problems living in many parts of the world. Law reform can begin a process of changing social attitudes by sending a message to society about changing norms. For example, it is unlikely we would have made the progress we have in the arena of gay rights, but for the repeal of the Sexual Offences Act in 1967. But for all the talk of 'unintended consequences of drug policy', those in power don't seem to be minded to do much about it. At least if the conversation begins and ends with the 'L' word.

But the rest of the Global Commission report has other recommendations that could make a real difference to the lives of millions of people such as the rigorous application of human rights and harm reduction principles, the availability of multiple treatment options and a serious attempt to rewrite the public discourse on addiction. Even in the UK, with a relatively pragmatic approach to the prosecution of the Misuse of Drugs Act and heavy investment in treatment, the hostility in some media towards those with drug problems is almost a daily occurrence.

'Shared responsibility' has been a laudable but unrealistic slogan for reducing supply of and demand for cocaine. How about a new type of 'shared responsibility' between governments aimed at implementing other key planks of the Commission's 'paradigm shift'? Think how much better life could be for those living in countries where chaining users to radiators is seen as perfectly legitimate treatment.

Harry Shapiro is Director of Communication and Information at DrugScope

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GP0003_A11_01

The Essential Guide to Problem Substance Use During Pregnancy

"An excellent framework for good clinical practice. A must-read."
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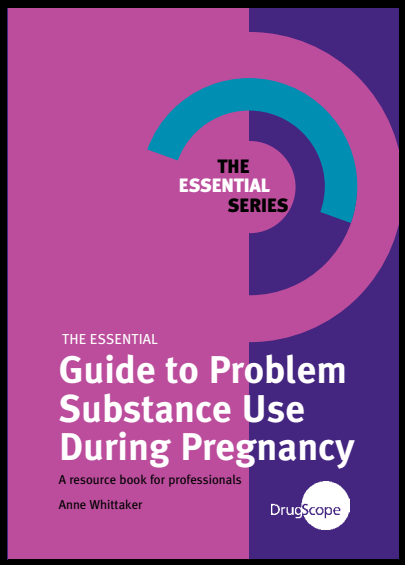

The latest in DrugScope's series of professional resource books, *The Essential Guide to Problem Substance Use During Pregnancy* is the go-to reference guide for all practitioners who provide care to women who use drugs or alcohol before or during their pregnancy.

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