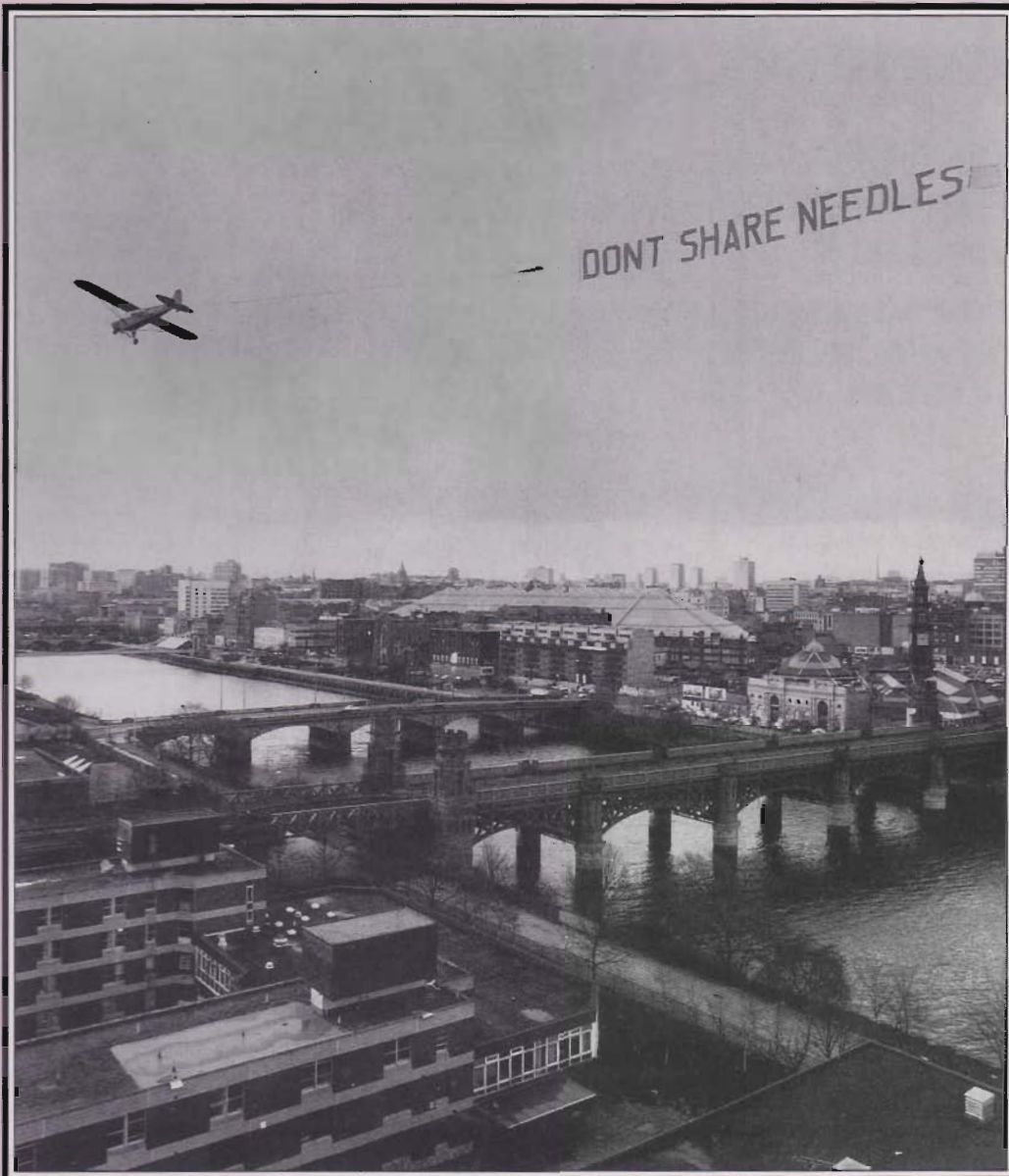


DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN

July/August 1993

isdd
1968-1993
25 TWENTY-FIFTH
ANNIVERSARY



In Glasgow outreach took to the skies. Back on the ground, is outreach losing its cutting edge?

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AUTUMN 1993

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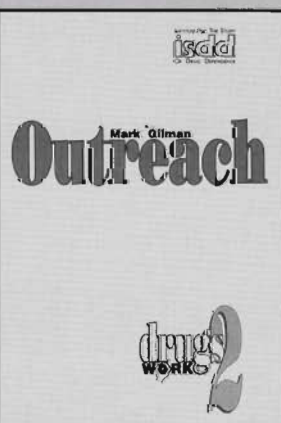
Price: £70 (including lunch, refreshments and training pack)

London	2 November
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For more information and a training programme, contact:

Alasdair Cant (Training Manager), Release, 388 Old Street, London EC1V

Tel: 071 729 5255 Fax: 071 729 2599



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

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

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Production: Jan Hodgman
Deputy editor: Harry Shapiro
Listings: John Witton

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ISSN0305-4349

Cutting edge blunted?

The street corner model of outreach is being challenged by models which have the outreach worker interacting as much with other professionals as with drug users. A cogent exposition of one view on page 13 is countered by a practical demonstration of another on pages 16-17. On pages 14-15, the delicate issue of using drug users and dealers to do outreach.

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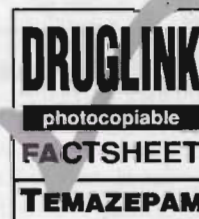
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Cover photo: Courtesy of HIV and Addictions Resource Centre, Ruchill Hospital (041 946 7120).
From a campaign designed by Frank Connolly Design Studios (041 248 7772)



Addicts total increased by 19 per cent in 1992

The total number of notified opiate or cocaine addicts rose 19 per cent to 24,703 in 1992, including a 21 per cent increase to 9663 in the number not previously notified ('new addicts'). This follows a 17 per cent increase in all addicts and 16 per cent increase in new addicts the previous year, indicating that the steep rise in known addicts is not slowing down. In 1992 nearly 800 in every million of the 21-24-year-old UK population were notified addicts.

The Home Office put a positive gloss on the increases. While expressing concern, it was suggested that perhaps the main cause was that "more addicts are coming forward for treatment". Reminders sent for the first time in 1992 to all GPs, hospitals and treatment centres on the need to renotify addicts continuing in treatment may also have caused part

of the increase. In past years reminders to doctors of their legal obligations to notify have resulted in blips in the figures.

It is, however, hard not to believe that a real increase in opiate and cocaine addiction underlies the consistent increase in the figures since a new statistical format was introduced in 1987. Since then, the all addicts total has risen from 10716 to 24703, a 131 per cent increase. Each year this total has risen by between 17 and 20 per cent (see chart).

Over that period there has been an expansion in the availability of prescribing which may have persuaded previously hidden sectors of the opiate addicted population to come forward. Supporting this interpretation is the fact that in 1992 a record 78 per cent of renotified addicts were prescribed a notifiable drug – overwhelmingly methadone

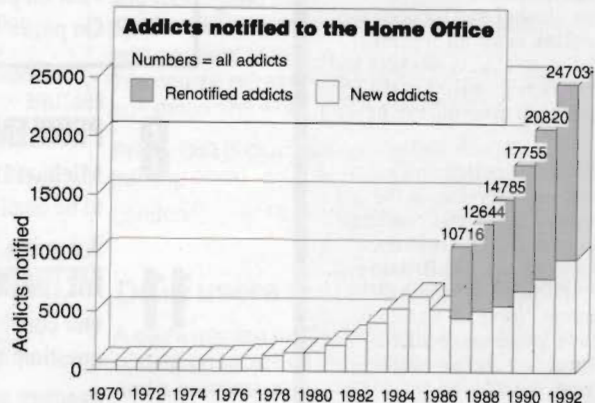
– in the treatment of their addiction, compared to 58 per cent in 1989.

This is a less credible explanation for the increase in new addicts, 59 per cent of whom were prescribed notifiable drugs in 1992, a proportion practically unchanged since 1990.

Eight per cent of all addicts and

12 per cent of just those newly notified were addicted to cocaine, the highest proportions recorded but not a massive increase.

For both new and renotified addicts, the proportion injecting drugs has fallen since 1989 and now stands at 56 per cent and 53 per cent respectively.



Farringdon

A message to Norman

Norman Lamont had his detractors, but Farringdon was not among them. It takes a rare talent to look so precisely like a panda and still contrive to be universally detested. Condemned ever to snuffle through Britain's economic wastelands in search of the elusive bamboo shoots of recovery, he could yet have been saved if only he'd noticed that one sector of the economy has been flourishing for years. We refer, of course, to the drug business.

The foothills of the Andes are covered, not merely with green shoots, but with impressively leafy bushes. WHO recently reported that cocaine was the world's fastest growing industry in the 1980s. Dope farming, of course, has been northern California's biggest earner for a decade or more. World recovery is well underway, led by the ultimate free market entrepreneurs, spiritual heirs to the divine Margaret's dream of a world fit for selfish bastards. Drug dealing is now our best – indeed, only – hope of kickstarting the economy and restoring Britain to her former glory.

Consider what's been achieved so far. Between 1987 and 1992, despite the strangling tentacles of the nanny state, the number of notified addicts more than *doubled* – an amazing rate of market expansion! Many of these new consumers have themselves gone on to start their own small businesses.

Nor are opiates the full story: product diversification and wise investment in research and development have opened up completely new markets. Consider ecstasy, unknown a few years ago, but now adding sparkle to half a million young consumers' weekends. We're not just talking drugs here,

we're talking LIFESTYLE! And lifestyle means money: money for club owners, for T-shirt designers, for record companies – even for those drug services and researchers smart enough to get in on the act.

For the true significance of drugs lies not in their *primary* impact, but in their ability to spawn a huge range of beneficial spin-offs – the 'multiplier' effect. Think of the boost given to struggling small builders and craftsmen by the countless smashed windows and jemmied doors of drug-related break-ins; of the bonanza for locksmiths and burglar alarm suppliers; of the rocketing sales of video recorders and car stereos to replace those recycled by addicts busy about their task of economic regeneration. Consider the meteoric rise in drug agencies, giving new hope to many of the otherwise unemployable.

In these and many other ways, drug dealing is stimulating demand, lighting the blue touchpaper, blasting UK plc back into orbit. All without subsidies, environmental controls, tariff barriers, the Social Chapter, or the Sunday trading laws. A monetarist wet dream! Perhaps unconsciously, but with unerring economic intuition, Norman did his bit to stimulate this hidden economy by making life so hard in the open. So pay no attention, Norman, when the world calls you unkind names. Even as you unscrewed the lightbulbs and took down Mrs L's lace curtains from Number 11, in your heart of hearts you knew, as we knew, that the invisible hand of the (drugs) market was at work and that, sooner or later, you will get your reward.

The spirit of *farringdon*

Farringdon is not a person but a spirit – the spirit of invective, sarcasm, satire and, above all, wit. Send your 500 words to the editor who is sworn to keep your identities secret. Your chance to have your say, and survive.



Frontline troops want negotiated settlement in war on drugs

Metropolitan Police Commander John Grieve ruffled feathers all the way to Downing Street when on 14 May he stood before the audience at the chief police officers' drug conference and invited them to consider licensing a network of official drug suppliers and users.

Although a self-confessed "renegade", Grieve was not alone in his frustration that sentencing thousands of dealers to thousands of years of imprisonment had not made "a jot of difference". Penalties have been racked up to life imprisonment and confiscation of assets "yet all the indicators show the problem is getting worse", said Chief Inspector Richard Miles, also at the conference.

Grieve was reporting back from a workshop which had voted on the proposals of a smaller group looking at alternatives to current laws. That group was 8-1 in favour

of exploring the option of licensing dealers and users of a range of prohibited drugs. The aim would be to reduce the adverse side-effects of prohibition in the form of drug-related crime to fund purchases on the illegal market and the health consequences of impure products and unhygienic injecting practices.

The group's arguments were convincing enough to persuade 14 of the 29 senior officers in the workshop to vote for researching the licensing option, sending John Grieve as their spokesman back to the podium to present these radical conclusions to the conference.

There was opposition. Conference chair Keith Helawell said the idea was "contentious" and did not enjoy majority support, but Richard Miles spoke to a number of officers who agreed it was time to try something different - an outcome all the more remarkable for the fact

that among the supporters were assistant chief constables and equivalent ranks and that the audience was self-selected to be those officers most involved in drug enforcement. It was not just a case of the frontline troops in the war on drugs wanting to end the bloodshed, but of their commanders too calling for a negotiated settlement.

Hard to ignore, their call was widely reported and the following day drew a response from a Downing Street spokesperson which suggested that, at what John Grieve called this "crossroads" in drug policy, the official preference was to match the increased problem with a further crackdown. Licensing was "ruled out". Despite this, there is every sign that the quiet *de facto* withdrawal from wholehearted enforcement will continue in the form of extending cautioning to those found in possession of any

drug, not just cannabis, and schemes to divert drug offenders out of the criminal justice system.

Chief Inspector Miles, currently seconded to do research at ISDD, chairs the enforcement working party involved in the review of the Metropolitan Police's drug strategy. In a "not too serious vein", his master's dissertation entitled *Ruffling Feathers* foresees a time when the US-inspired moral crusade will have been undermined by that country's diminishing economic power and progressive European states will lead the way to a repeal of current drug laws.

Miles and Grieve are part of a novel development in British police thinking on drugs which is seeing the previously unthinkable become the openly expressed view of significant but still small minority of senior officers prepared to put their careers on the line.

'Caring' minister shares DoH drug and alcohol brief

John Bowis has relieved Dr Brian Mawhinney of responsibility for the detail of drug and alcohol policy at the Department of Health, announced Virginia Bottomley on 15 June. His appointment gives renewed hope to residential services. Mr Bowis was a strong supporter of ringfencing the drug and alcohol element of the community care grant and has expressed support for the services now under threat.

As Health Minister Dr Mawhinney retains responsibility for the "general coverage" of policy on smoking, alcohol and drugs but his new Under Secretary of State takes on what the DoH describes as "casework and detailed policies" on alcohol and drugs.

A Department of Health spokesperson said Mawhinney has the policy "overview" while Bowis does the "day-to-day running". This novel two-tier arrangement was introduced because the withdrawal of ringfencing makes drugs and alcohol a major and integral part of community care policy, for which Mr Bowis is also responsible. With this important element already in his portfolio it made sense to extend his remit across the full scope of the Health Department's drug and alcohol work.

In his pre-ministerial days John Bowis was a leading backbench Conservative opponent of the withdrawal of the promise to ringfence the grant for drug and

alcohol residential. Now he finds himself at the receiving end of his own considerable sheaf of letters to the Department of Health. Already the Labour opposition in the Commons has reminded him of his previous support for the services now threatened by his own department's policy.

In October 1990 Bowis reminded Virginia Bottomley of the "genuine worries about funding" on the part of drug and alcohol rehabs. "Without that service, it is difficult for [detoxified addicts] to find their way back into ... the community."

In the Commons' community

care debate last March Mr Bowis expressed his "personal interest" in residential drug and alcohol services. He joined Tim Rathbone, another leading Conservative critic of the ringfencing U-turn, in hoping that "the fears some of us have are proved groundless".

Mr Bowis asked the Health Minister to "monitor most carefully the effects of his decision" so that "we shall ... be able to put matters right" if the Government's optimism proved unfounded. Now as a junior minister he can himself help "put matters right" as the government's monitoring exercise

reveals a sharp fall in referrals and admissions to residential services.

Those who have met Bowis describe him as an approachable character with a track record in listening and responding to the concerns of drug and alcohol services in his Battersea constituency. Roth's *Parliamentary Profiles* describes him as a "moderate, caring, 'damp' Tory".

As well as alcohol, drugs and community care, he now also has the ministerial brief for other needy groups such as the elderly, the mentally ill and the homeless, and for the voluntary sector.

Interdepartmental 'squabble' threatens coordination

The Lamont reshuffle in May also saw Michael Jack leave the Home Office to be replaced as Minister of State with responsibility for drugs policy by David Maclean, MP for Penrith in Cumbria. On the Thatcherite wing of the party, he came at the request of the new Home Secretary Michael Howard, with whom he previously worked as Minister of State at the Department of the Environment when Howard was Environment Secretary.

There is disappointment at the departure of Michael Jack who appeared to have absorbed some of the messages he received from the drugs field - in particular from drugs prevention team leaders - and pressured colleagues in other depart-

ments when their decisions were seen to threaten the prevention effort.

Bowis and Maclean join the main opposing sides in what on the 25 April the *Sunday Telegraph* headlined a "Cabinet Squabble Over War On Drugs". Top-level coordination between government departments is handled by the Cabinet subcommittee on drugs policy chaired by Tony Newton, who acts as an independent arbiter with no departmental allegiances.

Coordination has recently seemed conspicuous by its absence. The Home Office's prevention activities are threatened by the Education Department's withdrawal of funding for health education coordinators, while the attempt to

divert drug dependent offenders into treatment is being stymied by the impact of the Health Department's community care reforms on residential services.

Not surprisingly there is little love lost among the three departments. Education's non-interest in drugs frustrates officials in both the other departments - "they're a dead loss," said one during last November's Drug Prevention Week, when nobody from Education joined the ministerial line-up at the flagship event. During the same week, Conservative MP Tim Rathbone, chair of the Parliamentary Drugs Misuse Group, described interdepartmental coordination over drugs as "entirely inadequate".

Former prevention team worker withdrew Druglink article after Secrets Act warning



An article on the work of a Home Office drugs prevention team for this issue of *Druglink* was withdrawn by the author – a former team member – after a warning that action could be taken against them under the Official Secrets Act. The warning was, said the author, delivered by a former colleague still with the team at the request of an official at the Home Office's Central Drugs Prevention Unit (CDPU).

The article said Government social and economic policies had so damaged some of the communities targeted by the team that they had to start a bottom-up process of community regeneration before residents could respond positively to drug prevention initiatives.

Residents' priority concerns were poverty, unemployment, crime, community breakdown, poor housing and lack of social amenities. Drugs were not on the agenda. Projects which recognised this reality were, said the article, not favoured by the CDPU, which supervises the teams' activities.

Ironically, the article points out that civil servants at the centre place a premium on activities providing good political PR – almost certainly the reason why it was stopped.

Invited to comment, Alan Norbury, who heads the CDPU, said the Official Secrets Act would be "most unlikely" to apply in this case and found no evidence of a warning being initiated by one of his staff.

Unanimous local support had been expressed for the article at the time it was written but the author's former colleagues became concerned that being indirectly associated with a published article

critical of their employer could have repercussions for them, another reason for its withdrawal.

Team members are often recruited locally and several have a track record in the drugs field. All become civil servants when they join the teams. Although they have a large degree of local autonomy, the central unit at the Home Office controls their public statements.

Articles from any civil servant which were critical of government would be "unlikely" to be approved, said Alan Norbury, "not so much to save ... ministers from embarrassment as to maintain the political neutrality of the civil service".

Low unemployment

Of more concern is evidence that this sensitivity extends to statements about the impact of unemployment and deprivation on drug prevention. Such statements might imply that a government which cannot entirely dissociate itself from the socioeconomic plight of Britain's inner cities bears some responsibility for the drug problems it is attempting to prevent.

After their first year's experience one team drafted a workplan with an analysis similar to that in the withdrawn article but not directly critical of government. After submitting the plan to the central unit, this section was deleted.

Just as important as central control is the self-censorship of team leaders who know, as one put it, that statements relating deprivation to drug misuse or its prevention would be "sanitised".

The effect appears to have been to virtually eliminate any public reference to unemployment or poverty as factors which may form

the breeding ground for drug problems or impede prevention efforts, despite the fact that at least a quarter – probably more – of team leaders hold these views.

Although the teams operate in some of Britain's most deprived areas, the word 'unemployment' appears only once in the Home Office's two annual reports on the teams – and then not in relation to its potential role in drug problems.

Particularly revealing is the description in one of the reports of a project also described in the *Druglink* article. The article made it clear that damage to the community from government policies which created long-term socioeconomic deprivation posed a major obstacle to the team's work, a point missing from the annual report.

In its *Druglink* supplements the Home Office appears to allow greater latitude but even so there has been no explicit reference to the impact of deprivation on drug problems. An article which did raise this issue without directly criticising government was submitted by the then leader of the Birmingham team.

Geoffrey Smith, now a Church of England vicar in Cumbria, says his work was spiked because it was thought politically unacceptable. As in the *Druglink* article, his theme was that "to address drug prevention you first had to look at employment, housing and general social conditions. I was saying that there was a clear connection between poor social conditions and drug misuse".

Alan Norbury denies that the Drugs Prevention Initiative is "suppressing all reference to socioeconomic factors in drug misuse". "What would be the

point", he asks, "when everyone knows that these factors are highly relevant? ... All I expect is that [these] factors are considered in their proper context."

While the central unit will not allow openly critical analyses of government policies, initiatives based on these analyses have not been blocked. The team featured in the article for *Druglink* was allowed to go ahead with its projects and so was the team whose workplan was edited to remove its socioeconomic analysis.

Several leaders are prepared to accept tight restrictions on their freedom to speak or publish because in return they get resources and influence which they feel enables them to do valuable work, a view with which many would agree. Despite their early suspicions, host local authorities now generally welcome the teams in their areas and want them to continue beyond 1995.

Civil servant status restricts their public statements but also gives team leaders a direct route to ministers which some feel has been effective. In a meeting with Michael Jack, then the responsible Home Office minister, leaders warned him that drug prevention would be impeded by the withdrawal of support for health education coordinators and the backtracking on the promised ringfenced grant for drug and alcohol rehabs.

Michael Jack is understood to have shared their anger at these moves and conveyed it to his ministerial colleagues in other departments, but has since been reshuffled to Agriculture, Fisheries and Food, leaving no public sign of his or his former team leaders' opposition to these policies.

■ The Advisory Council on the Misuse of Drugs is considering the results of a Home Office consultation over the council's proposal that temazepam be moved from schedule 4 to schedule 3 of the Misuse of Drugs Act. This would for the first time make unauthorised possession of temazepam in whatever form a criminal offence – currently only possessing the drug in a non-medical form (eg, prepared by the user for injection) is an offence. Other restrictions can be expected to have the effect of reducing temazepam prescribing.

■ Turning Point's monitoring of its own 17 residential drug and alcohol projects has revealed a 40 per cent drop in referrals this April and May compared to the same months in 1992, says their Head of Research John Marsden. Referrals in May were 9 per cent down on April, suggesting further reductions to come. Turning Point's figures are understood to parallel closely the figures being collected by Goldsmiths' college for the Department of Health to monitor the impact of the community care reforms. These figures are a tightly kept secret until 1 August by which time ministers will have had the final report for a week.

■ In a written Parliamentary reply Health Minister Brian Mawhinney said on 8 June that in 1991 seven young people aged under 20 had died in the UK in cases where the underlying cause of death was given as drug dependence or abuse, excluding alcohol, tobacco and volatile solvents. Since 1979 the figure had fluctuated between three and 13 with no obvious upward trend. This figures contrast with solvent misuse-related deaths in the same age group which research shows averaged over 82 a year between 1971 and 1991.

■ A draft report from CV Services on the first three months of their monitoring of the community care reforms for the Alcohol and Drug Services Alliance (ADSA) confirms the fears expressed by residential drug and alcohol services over the withdrawal of ringfence protection for their funding. Strenuous efforts by services and by many local authorities have been balked by too little money and too little time, leading to confusion and a drop in referrals. This could become terminal in the next three months as pre-April residents leave and take their preserved rights to income support with them.

**BANISH THOSE
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Contact: the Peterborough Community Drug Team, City Health Clinic, Wellington Street, Peterborough PE1 5DU, phone 0733 898385, fax 0733 555763

JOIN THE FESTIVITIES AND GAIN EXPERIENCE

Festival Welfare Services (FWS) have been providing and coordinating welfare provision at festivals since the '70s. We are now extending the network of volunteers and agencies who can respond to events in their own area and we are looking for people/agencies who could help us coordinate teams of volunteers in each region.

Working at festivals not only provides an invaluable service and excellent experience for workers, it also provides an opportunity to publicise the work of agencies.

If you or your service could coordinate a team in your region, or would like to receive advice so that you can provide welfare services directly, please contact us.

Contact: Regional Network Coordinator, c/o Festival Welfare Services, 61B Hornsey Road, London N7 6DG, phone 071 700 5754

**POOL EXPERIENCE AND
IDEAS ON WORKING WITH
GENERAL PRACTITIONERS**

We recently ran a successful training course for GPs in the care and management of drug users and are developing new ways of working with GPs and other primary care staff. I am aware that there are other workers in the drug field who are also trying to develop good working relations between general practices and drug services. Many of us feel isolated in this work and wonder if we are the only people struggling to build these bridges. Please contact me if you would be interested in attending a conference or seminar aimed at sharing ideas and good practice in this field.

Contact: Mike Blank, Manager, Substance Misuse Services, Llanelli Drugs Project, 4A Cowell Street, Llanelli, Dyfed SA15 1UU, phone 0554 756273

BENZODIAZEPINE WITHDRAWAL PROJECT SEEKS CONTACTS

A one-year project has been set up in Clwyd to research the problem of misuse and dependence upon tranquillisers. The project also aims to raise awareness and promote safe practices through an educational programme. I would be grateful for any help in locating resource materials to run this programme and I would also be interested in making contact with any other colleagues working in the field.

Contact: June Lovell, Programme Manager – Benzodiazepine Withdrawal, Clwyd Centre for Health Promotion, Bromfield House, Queen's Lane, Mold, Clwyd CH7 1XB, phone 0352 755543, fax 0352 754353



... and some thanks to you

The inclusion of my request for information on work with steroid users on the *Connections* page has already produced some useful contacts; many thanks for including it in *Druglink* and to all the people who responded.

Hugh Jobber, Regional Development Manager, Problem Drug Use, 1 Vernon Road, Birmingham B16 9SA

Thank you to all the people who took the time to reply to my request for information on policy for under-16s; your help has been most valuable.

Rachel Lennon, Nurse Advisor (HIV/AIDS & Drugs), Regional Drug Problem Team, Northern Rd., Cosham, Portsmouth, Hampshire PO6 3EP

Problem drug use in the North West 1990-1992

Unique trend data from the UK's longest running drug misuse database document the spiralling workload on drug services

INFORMATION FROM THE North Western Drug Misuse Database has been regularly published locally since 1987. Since its inception it has been used by agencies, district and regional drug advisory committees and by other bodies in planning and targeting services for those with drug problems in the communities of the North West. This report examines trends in the profiles of problem drug users reported to the database over the past three years 1990-92.

Databases built on the University of Manchester model (used by regions covering nearly 90 per cent of the British population) collect information (social, treatment and drug profile data) about drug users presenting to a particular service for the first time, or re-presenting to the same service after an absence of at least six months.¹

Each such event is known as an 'episode'. Names and addresses are not collected and double-counting is minimised by the use of an attributor. All drugs of misuse are covered (except tobacco and primary alcohol use), and people with any social, psychological, physical or legal problem are included.² The system collects information from as wide a variety of services for drug users as possible, including all medical agencies, community drug teams, therapeutic communities and many street agencies.

Publication of data outside the North West has so far been restricted but we are beginning to view the trends revealed by these data with increased confidence, for three main reasons. First, there have been few significant changes in the levels of service provision in the region over the last three years; second, the system has been implemented long enough for most agencies to be aware of it and to understand its

operation; third, data from other sources, including work undertaken by our unit and other agencies, confirm the database's findings. Our report gives a foretaste of the kind of information which will become available across Britain as the other databases build up comparable trend data.

Numbers up

The first thing to say is that the overall number of episodes reported continues to increase. In 1990 it was 3076; by 1992 it had increased 81 per cent to 5581. In theory this could just represent the same number of drug users attending more agencies, but in fact the number of individual drug users reported has also increased, up by 68 per cent from 2727 in 1990 to 4590 in 1992.

We are also seeing an increase in the number of *new* users – users never previously reported to the database. In 1992 there

were 2710 new users, 52 per cent up on the figure for 1990. Despite this, the *proportion* of individuals who are 'new' has been falling (from 65 to 59 per cent), suggesting that a higher proportion of clients is re-presenting to services.

Like addict notifications, such data will always be service-dependent, as is most health service data. Nevertheless, the implications for the services are clear: they will not only have to maintain their work with an existing caseload, but will also have to accommodate increasing numbers of new cases.

The distribution of the reports across the region varies enormously, but reflects very closely information gathered from other sources including the police. Last year an analysis³ of the number of individuals reported in each district as a proportion of the resident population aged 15 to 44 revealed the disarming fact that in some areas, notably central Manchester, almost one per cent of the population in this age group not only had drug problems, but had been in touch with services and reported to the database.

GPs take more of the load?

While the increase in episodes reported from community drug teams (CDTs) is about the same as the overall increase (76 per cent), the number reported by general practitioners (GPs) has increased by a considerably greater extent (131 per cent). In view of repeated emphasis in the literature on GP involvement (and concomitant criticism of their role), this finding is of particular significance. We are investigating whether this means more GPs are reporting to the database, or whether more work is being done by a few doctors in each area.

Most reports to the database are from community drug teams – hardly surprising

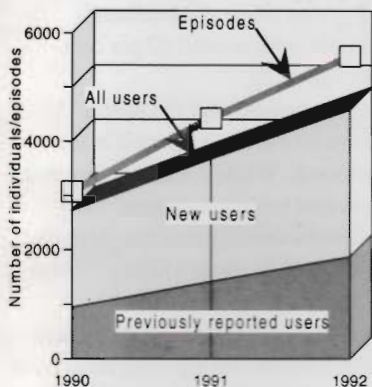
by

**Michael Donmall &
Tim Millar**

Michael Donmall is Director and Tim Millar Database Manager at the Drug Research Unit of the University of Manchester

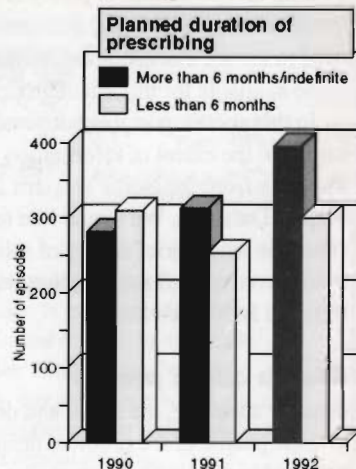
Operative since 1987, the North Western database is unique in its ability to reflect trends. Over the years 1990-92 the number of drug users increased by 68 per cent and new users by 52 per cent. Methadone was prescribed more often and for longer. Reported use of amphetamines, cocaine (especially crack), ecstasy and hallucinogens rose dramatically. Services face the challenge of coping with an increased 'traditional' caseload staying on for longer while responding to new drug use trends.

The increase in reported drug users and in service use episodes



Trends in methadone prescribing by doctors: more often for longer

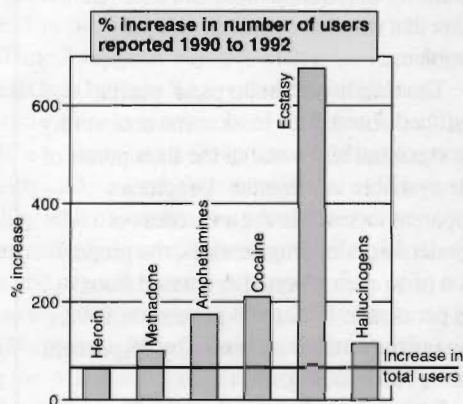
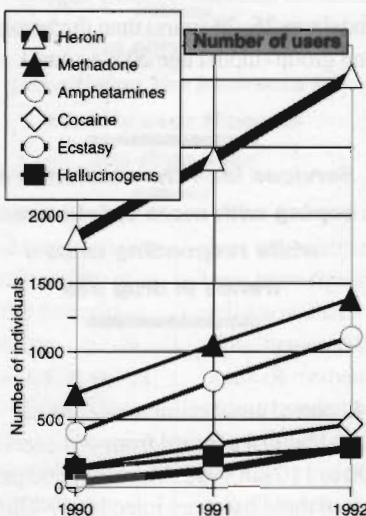
Prescribing reports	Number of episodes		
	1990	1991	1992
Methadone mixture prescribed	758 76%	857 72%	1184 72%
Valid total episodes (of intended prescribing)	995	1183	1651
Duration < 6 months	310 52%	253 45%	300 43%
Duration > 6 months/indefinite	281 48%	313 55%	396 57%
Valid total episodes	591	566	696
Reducing dose	446 72%	501 73%	667 72%
Not reducing dose	95 15%	98 14%	98 11%
Reduction not known	79 13%	86 13%	166 18%
Valid total episodes	620	685	931



Trends in the use of selected drugs: opiate using caseload up plus a dramatic rise in stimulant/hallucinogen reports

	Number of individuals		
	1990	1991	1992
Heroin	1841 68%	2419 66%	3030 66%
Methadone	693 25%	1057 29%	1389 30%
Amphetamines	404 15%	783 21%	1109 24%
Cocaine	151 6%	317 9%	469 10%
Ecstasy	38 1%	132 4%	295 6%
Hallucinogens	137 5%	233 6%	295 6%
Total users	2727	3678	4590

Columns should not be totalled as individuals may be reported to use more than one drug.



as these are now established as the major local resource. Now that it is regional policy that there should be designated weekly medical sessions in each team, they are also the source of much of the prescribing. Given that this is the case, it is encouraging that as much as 33 per cent of the 'regional work' with drug users is carried out by agencies other than the teams. The range of agencies seeing users is also encouraging.

Longer prescribing

The number of clients 'dealt with' by the agency reporting them has increased substantially (2708 episodes in 1990 to 4554 in 1992), although the proportion fell from 91 per cent to 86 per cent. There has been a disproportionate increase in the number of episodes involving liaison with other agencies (from 584 in 1990 to 1431 in 1992) and in those resulting in referral to

other agencies (from 289 in 1990 to 720 in 1992).

These data and other local information indicate an increase in communication between drug help agencies, and suggest that agencies are moving from a 'catch-all' policy to one that filters the work to the appropriate agency. In some cases, however, overburdened agencies may be more likely to refer clients on simply to spread the load.

Where the action planned was agency-based, the number of episodes where a prescribed detoxification was intended has more than doubled from 748 (28 per cent) in 1990 to 1645 (36 per cent) in 1992. In reports from doctors, the number of episodes where methadone DTF was prescribed has increased by 56 per cent from 758 in 1990 to 1184 in 1992. Over the same period the proportion of episodes

where no prescription was offered increased from 10 per cent to 14 per cent, possibly because more amphetamine users were approaching services.

In 1990 48 per cent of methadone prescribing was planned to last longer than six months; by 1992 this had increased to 57 per cent. In numbers, this represents an increase of over 40 per cent (from 281 to 396).

The implications for services are significant, both in terms of prescribing costs and agencies' capacities to take on the increasing number of new clients coming forward. In the early 1970s clinics were becoming 'silted up' through prescribing and subsequently moved away from maintenance. If numbers of clients are increasing and if clients are staying in contact for longer periods because doctors are being encouraged to prescribe flexibly,

then the overall workload on drug services goes up on two counts. If policy is to be translated into action then authorities will need to ensure that adequate resources are made available for this client group.

In this short report it is not possible to do justice to the extent of information that is available from the North Western Drug Misuse Database. We would like to conclude with a brief survey of salient points from a trend analysis that will be reported fully elsewhere.⁴

Stable client profile

Broadly speaking, the social and demographic profile of the problem drug users reported to the North Western Database has remained remarkably stable over the past three years. Around three quarters are male and most are in their twenties (modal age group 20–24 years). The vast majority are unemployed, just under half have dependent children, around a quarter live with their parent(s), 35 to 40 per cent reside in local authority accommodation, and over half state that they have no current legal problems.

The stability of the 'typical' profile outlined above does mask some noteworthy changes and also some of the finer points of the available information. Despite an apparent increase in the awareness of gender issues in drug services, the proportion of women reported decreased from 28 per cent in 1990 to 24 per cent in 1992, though the number increased by 46 per cent (from 753 to 1099).

Both the number and the proportion of users who are unemployed has increased, from 1914 (71 per cent) in 1990 to 3316 (80 per cent) in 1992. Nevertheless, 1992 figures show that around 1 in 6 were reported to be working, suggesting a need on these grounds alone for services to consider flexible opening hours.

Data from 1991⁵ indicate that almost 60 per cent of female users have dependent children. Around half of all users with children are reported to live with their children, but our data do reveal a slight

increase in the proportion of users whose children do not live with their drug using parent(s), up from 36 per cent in 1990 to 40 per cent in 1992. The proportion of users whose children are reported to be "in care" fluctuates between three to seven per cent, with no clear trend.

More dance drugs

Examination of data concerning drug use reveals clear patterns in the profiles of reported users. Each year, some 80 per cent are opiate users with around 66 to 68 per cent using heroin. The proportion of heroin users who inject this drug has fallen from 69 per cent (1233 users) in 1990 to 62 per cent (1837 users) in 1992. Reported methadone use has shown a disproportionate increase, having more than doubled from 693 users (25 per cent) in 1990 to 1389 users (30 per cent) in 1992. As one might expect, methadone users are typically slightly older (modal age 25–29 years) than the heroin using group (modal age 20–24 years).

Services face the challenge of coping with more opiate users while responding to new trends in drug use

Reported amphetamine use has increased by 175 per cent from 404 users in 1990 to 1109 in 1992. Most (over 60 per cent) of these users are injecting. While their modal age group is 20–24 years, a substantial proportion (typically around a quarter) are below the age of 20. This increase in reported amphetamine use may indicate that services' attempts to attract this client group are beginning to bear fruit, although what service they will be able to offer to these users remains to be seen.

Reported cocaine use has shown a dramatic increase of 210 per cent, from 151 users in 1990 to 469 in 1992. Much of this is due to an increase in reported use of cocaine freebase. By 1992, 63 per cent of all reported cocaine users were known to be using crack.

Perhaps the most striking change we have observed is in reports of ecstasy use. In 1990, only 38 problem drug users were reported to be using this drug; by 1992, this figure had increased by 676 per cent to 295 individuals, six per cent of all users reported. Thirty-five per cent of these ecstasy users were below the age of 20.

Over the same period, we have observed a 115 per cent increase in reported hallucinogen use, from 137 users in 1990 to 295 in 1992. Again, these are predominantly young people, with around 40 per cent below the age of 20.

Each year, around half the people reported are said to have injected in the previous month. While it is reassuring that this *proportion* has not increased, the *number* of injectors reported has increased by over 75 per cent (from 1172 in 1990 to 2071 in 1992).

The proportion of injecting drug users reported to have shared injecting equipment in the previous month has shown a very slight fall, from 15 per cent in 1990 to 13 per cent in 1992. However, this masks an increase in the *number* sharing. Given that those users in contact with services might be expected to show lower rates of sharing, this increase might be cause for concern; sharing is clearly not in decline.

The challenge for services

Drug services in the North West are clearly starting to encounter a wider spectrum of drug use than in previous years. There is every possibility that this trend will continue. At the same time, it is clear that injecting heroin use is not going out of fashion. Services now face a considerable challenge in continuing to cope with an increased overall caseload including new and long-term clients and an expanding opiate using client group – most of whom are injecting – while responding to the demands placed on them by new trends in drug use.

They also face a range of other important issues, for example, ensuring that services are sufficiently attractive to women. Their ability to rise to these challenges will depend to a large extent on the resources made available to them.

Information from the databases can be used to serve the interests of drug services and ultimately drug users themselves. At the very least, it provides an indication of the minimum demand for services. Used appropriately, it highlights the needs of existing client groups and, in conjunction with local field research, can identify potential gaps in services.

In an environment where services are competing for scarce resources with a wide variety of other deserving causes, the databases can provide them with at least some of the evidence they may need in order to secure the future provision of services for people with drug problems. ■

1. Donmall M.C. *The Drug Misuse Database: local monitoring of presenting problem drug use*. Department of Health, 1990.

2. Advisory Council on the Misuse of Drugs. *Treatment and rehabilitation*. HMSO, 1982.

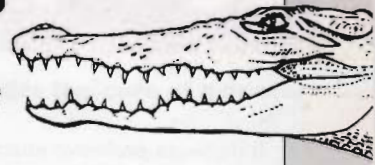
3. University of Manchester Drug Research Unit. *Drug Misuse Database Annual Report 1991*. North Western Regional Health Authority, 1992.

4. The University of Manchester Drug Research Unit. *Drug Misuse Database Annual Report 1992*. North Western Regional Health Authority, 1993.

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Methadone and slippers

Concluding Rowdy Yates' personal history of the Lifeline Project



“A HUNDRED YEARS AGO, it seems, I blew into the city and out of the rain. I was an angry young man. Filled with dreams. And hope. Anxious to be a part of the great changes that would alter the face of the world forever. Only the anger remains. Mostly, it's about the missed chances and blind alleys. We spent our first ten years trying to wrest the dead hand of medicine off the drug treatment industry. We argued that the response to drug use – to pain and despair – should be about caring and community action, not social control through psychiatry. But when the medical profession started cooing in our direction, we began to preen ourselves outrageously and fell off our perch.

For a short while, it seemed things really were changing. New drug services were modelling themselves on organisations such as ours. Prescribing was a very small part of what they offered. Then drug use began to rocket. Crime began to escalate. AIDS began to stalk the outer reaches of our world. Just outside the faint light of our campfire, it growled, coughed, rumbled. And services retreated once more into the safety of tried and trusted practices. Under the shelter of the prescription pad. Medicine, once again, stepped centre-stage.

I see no reason why drugs should not be used to ease the discomfort of withdrawal or to provide a period of stability in the lives of individual drug users. I do not even object to a prescription for life, *if that is in the best interests of the individual*. But increasingly this seems not to be the case. Increasingly, decisions appear to hinge on levels of crime in the community. On the risk of infection transmission into the 'wider' (read: 'non-junkie, non-scum') community.

This, it seems to me, is a betrayal of trust. We have no political mandate to interpret and manipulate social policy. It is also morally corrupt. Drug services are increasingly taking on an infection control remit which prioritises the interests of society over those of the individual drug user.

On our tenth anniversary I wrote the report *Out from the Shadows*. The penultimate page quoted Thomas Bratter discussing methadone maintenance in the USA.

“Scientifically, until the medical issues regarding the short- and long-term physiological effects are answered, methadone maintenance remains an unproven enigma. Medically, to subject approximately 100,000 human beings to a potent chemical without proper controls, is malpractice of the most insidious sort. Legally, to imprison marijuana smokers and heroin addicts as criminally dangerous while concurrently maintaining that methadone addicts are law-abiding, is a travesty of justice. Philosophically, to

confuse, deliberately, the concepts of 'treatment' and 'social control', is fraudulent. Psychologically, to convince addicts that there is a mystical metabolic disorder and that they must remain dependent on a potential poison rather than to strive for their autonomy, is a conspiracy. Ethically, any conspiracy which places people in 'no win' situations and mitigates against their growth and development, must be considered a criminal act.”

I can see no compelling reason to review my support for Thomas Bratter. In the last analysis, I believe dependence on mood-changing drugs is limiting to the human condition. In the last analysis, I hope people will stop using before it hurts too much. It has, of course, been argued that long-term prescribing of substitute drugs will result in many being bored out of addiction. Sir Humphrey Rolleston argued this in the '20s. I'm still waiting.

Time, I suppose, will tell. Many researchers have noted a widespread tendency for drug users to mature out of addiction in

their late twenties. If in years to come this process appears to have been significantly undermined, then we will know. We will know that a policy which took the dangerous street-wise runts, neutered them, and left them at home on the sofa with a bottle of methadone and pap television for company, has indeed condemned many – who might otherwise have stopped – to a life on drugs. Maybe society will feel this a price worth paying for reducing the AIDS threat and the number of videos nicked from urban households. But I don't think they've been asked and we don't have the right to take that decision without them. Even if society did approve, don't expect me to like it. It's not why I started in this business, and I wouldn't find it a good reason to continue.

In the early days, we struggled for an audience. Often, when we found one, it was hostile; usually hurling abuse; occasionally other things. They were tough times to convince an angry and frightened public that drug users deserved a place in this society of ours. Hadn't they, after all, wilfully spurned the opportunities offered?

Now, at least, we can speak and be heard. Even if what we say is derided and uncomfortable. Now, at least, we can speak the dream above the din of voices. That drug users are owed our care and compassion *as a fundamental right*. That drug users are *part* of the 'wider' community, even if that same community insists on shuffling them out to the further reaches of its periphery. That these rights and obligations remain, even without the fear which currently motivates them.

**Drug services are
prioritising the interests of
society over those of
the drug user**

by

Rowdy Yates

Until recently the author was the Director of the Lifeline Project in Manchester where he had worked for the past 21 years. This article has been edited from his book If it weren't for the Alligators (Lifeline, 1992).


Solved

Heroin users helped trace the source of a mysterious spate of deaths by the grapevine

by

Clive Brind, Anthony Farrington, Andrew Fraser

*The first author is a Pharmacy Inspection Officer with the Sussex Police; the second is Clinical Director of the Substance Misuse Directorate of South Downs Health NHS Trust; the third is Director of the Drug Advice and Information Service in Brighton.**

THIS IS THE STORY of how an unusual cooperative exercise between statutory agencies and heroin users helped trace the cause of a mysterious spate of deaths. It started in April 1992 when accident and emergency staff at the Royal Sussex Hospital observed a sixfold increase in the number of heroin-related overdoses.

At least three of these were associated with the rare gluteal compartment syndrome – a potentially lethal condition caused by an unconscious person lying in a position that leads to serious nerve damage.¹ At the same time the local coroner's office received independent notification of three heroin overdose deaths from the same area.

Simultaneously the Drug Advice and Information Service (DAIS), the Brighton-based street agency, was being told by its needle exchange clients that other overdoses were being handled by peer user care rather than by the casualty being sent to hospital. Some of these also had mild symptoms of the gluteal compartment syndrome.

Unlike reports from other areas, none of the overdoses were linked to the concurrent use of drugs such as alcohol, temazepam, or buprenorphine.²

Concern increased as it became clear that the overdoses and deaths involved long-term heroin users, not inexperienced novices or people returning to heroin after a period of abstinence. Both groups would have a low tolerance level, making them prone to overdoses. As one user put it, "all these people had been around smack for a long time and knew what they were doing".

The users of the syringe exchange felt that the problems were due to a harmful

cutting agent such as strychnine, though this theory did not square with the outcome of injecting the suspect material.

Agencies observed that the problems were confined to heroin users in a very small area who knew each other and shared regular suppliers, suggesting a single source for the suspect material.

The street agency advised users that it could not recommend specific risk reduction strategies without having a genuine sample of the drug for analysis. Sussex Police saw the problem in a 'public health' rather than an 'enforcement' context and

**Police were willing to
arrange confidential analysis
of the suspect material**

were willing to arrange rapid analysis of any sample provided confidentially through DAIS.

Within 24 hours a wrap of the suspect heroin was delivered to the agency. Intravenous injection of half this sample (purchased as a £10 bag) had produced an overdose in a long-term heroin user – "a real bluey," was an eye witness's graphic description.

The half-used wrap contained just over 200mg of a light tan coloured powder. Speedy analysis by the forensic laboratories at Aldermaston showed it was 74.6 per cent pure heroin and contained no harmful adulterants.

An average £10 bag from the area

usually contained 100mg of a mixture of heroin cut to a purity of 20-35 per cent; the average heroin content was 20-35mg. Suspect bags contained eight to 15 times this quantity – more than enough to cause the overdoses, complications and deaths reported! The problems had no connection with adulterants – they were entirely due to a simple and highly unusual case of heroin being sold much too strong and much too cheap!

This information spread rapidly through the heroin using community via peer group leaders who used the syringe exchange scheme. Effective and immediate risk reduction was the result. No more deaths, complications or overdoses associated with this material were reported by any agency.

Piecing together information from several different sources produced a plausible explanation for the overdose epidemic. Unnoticed by his employer, a drug wholesaler's courier (not himself a heroin user) had skimmed off a few ounces of heroin from a consignment in his care. Unaware that this was 'uncut' heroin of a strength not normally dealt on the street, he bagged it for a quick sale, placing what he naively believed to be a reasonable quantity in each bag.

He sold most of the material from one of two locations almost in the centre of the overdose area. Knowledge of this new heroin outlet passed by word of mouth within a small peer group of users – hence the close geographical proximity of both the overdoses and the deaths.

Survival in the covert world of the heroin user relies on an efficient information network.^{3,4} Previously this network has been harnessed for the effective spread of risk reduction HIV messages.⁵ It has now proved its value in coping with an epidemic of heroin overdoses. If the UK political climate is ready for it, making the analysis results of 'suspect' material available to drug users could be a cheap and efficient way of spreading relevant and topical risk reduction messages. ■

1. Perez-Avila. In press, 1993.

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3 TEMAZEPAM MISUSE

This leaflet is for those using temazepam without being under the care of a doctor

What is Temazepam?

Temazepam, known variously as Tems, Temazzies, Eggs, Jellies, Norries (from trade name Normison), Rugby Balls, etc, is a sedative drug from the benzodiazepine family. Similar drugs include Valium, Librium, Ativan and Mogadon. They are usually prescribed by a doctor for insomnia and sometimes anxiety. Some people also use them to get high, or to ease the come-down from other drugs like ecstasy, speed or cocaine.

What are the effects of temazepam?

Benzodiazepines like temazepam reduce anxiety, relax muscular tension and make you sleepy. The effects of higher doses are similar to alcohol so people behave in ways that they wouldn't if they were not under the influence of the drug.

- Inhibitions are reduced – users may become overly affectionate or amorous.
- Behaviour is exaggerated – users may become talkative and over-excited, sometimes even hostile and aggressive.
- Judgment is impaired – users gain a false sense of confidence.
- Tolerance develops quite quickly – users may be tempted to increase doses to dangerous levels.

What is the law on temazepam?

Benzodiazepines are controlled by the Misuse of Drugs Act (in class C, the least heavily penalised). However, even if you don't have a prescription, you cannot be prosecuted for possessing temazepam in the original medicinal form. It is an offence to possess benzodiazepines if they are not in their original form (such as if they have been prepared for injection) and this carries a maximum penalty of two years' imprisonment. The maximum penalty for supplying benzodiazepines is five years' imprisonment.

What are the risks?

Inability to assess the risk of a situation makes those misusing downers like temazepam highly vulnerable while under the influence of the drug. They might walk out into traffic, or go shoplifting believing they look inconspicuous, though in reality their exaggerated gestures make them appear highly suspicious.

When inhibitions are reduced, some people may be more likely to have unprotected sex. This can result in unwanted pregnancy or sexually transmitted diseases like gonorrhoea, hepatitis or HIV, the virus that causes AIDS.

Benzodiazepines like temazepam can also cause dependence if taken regularly. When you stop using temazepam, you may suffer withdrawal symptoms. These can include sleeplessness, anxiety, panic attacks, loss of appetite, feeling sick, tremors and, in extreme cases, hallucinations. These symptoms can last for weeks or even months – far longer than say for heroin. Abrupt withdrawal from high doses may cause convulsions similar to epileptic fits, so anybody wishing to stop using the drug should seek medical advice.

High doses of benzodiazepines can cause overdose, especially if you mix them with opiate drugs like heroin or methadone, or if you drink alcohol. Another risk is that users can vomit while asleep and choke on the vomit. Users should avoid taking temazepam when alone, and never leave a friend who is under the influence until they know the effects have worn off.

Some people take temazepam by injection into a vein. This is extremely dangerous. If you miss the vein and inject under the skin, temazepam will cause abscesses or ulcers. Injecting temazepam tablets has caused such bad injuries that the manufacturers developed gel-filled capsules to stop people injecting. But people carried on just the same, risking perhaps even worse injuries. Even if you hit the vein, the gelatine solution in the capsules can resolidify in the vein, causing thrombosis and collapsed veins. If you inject temazepam into an artery, this blockage may cause gangrene, leading to the loss of a hand, a foot, even an arm or a leg.

If you inject with other people, the effects of the drug may make you careless or forgetful. This can result in needles and syringes being mixed up, increasing the possibility of becoming exposed to infections like hepatitis or HIV.

Because of the risk of fits, if you are pregnant, DO NOT come off temazepam abruptly. Withdrawal is best done under medical supervision. If you are still using at birth, there is a chance that the baby will have withdrawal symptoms and be difficult to settle for some while.

Points to remember

- Used in a social setting, temazepam (or other sedatives) may produce a volatile atmosphere, leading to aggression and violence.
- As with many drugs, use of temazepam can lower sexual inhibitions, possibly leading to sexual intercourse. Both men and women should be aware of the need to protect themselves and their partners from infections like HIV. One mistake could be fatal. Remember to always carry (and use) condoms.
- Benzodiazepines can be addictive. If you do use them, avoid using them on a regular basis.
- Injecting temazepam increases the risk of overdose and can lead to HIV infection, hepatitis, thrombosis, abscesses and gangrene.
- Never try to drive, operate machinery or engage in other dangerous activities while under the influence of temazepam (or any other drug).
- Mixing downers with alcohol or other drugs increases the risk of overdose. Never mix drugs. If somebody loses consciousness and cannot be aroused, lie the person on their side with the head turned to one side and call an ambulance immediately. When the ambulance arrives, tell the medics what drug the person has taken.
- Remember, the only way to avoid the risks is not to use the drug. If you decide to do so, be aware and take care.

The**touch***Qualifications do not an
outreach worker maketh –
it takes the personal touch*

NEW REGIONAL MONITORING units mean the work of many outreach services is now open to scrutiny. Their contact figures vary so dramatically that something is obviously amiss. How can one team log 800 contacts and another a mere 20? Clearly many such services are failing to make and maintain contact with a majority of injecting drug users in their areas and failing to move clients through a hierarchy of harm reduction goals. I believe the major reason for these failures is that most managers have little understanding of the day to day reality of drug use, so are unable to identify achievable goals or to translate objectives into workable programmes.

Outreach work has been a prime example of this failure. Starved of effective supervision, many workers spend more time in the office, at conferences or in the ubiquitous 'meetings', than they do on the streets. Others sit around in the homes of existing contacts, or provide a free taxi service for drug users, rather than reaching out and making new contacts.

Such workers claim they are doing 'quality' work and that their 'caseloads' deserve the same quality of service other clients receive. Such claims are indefensible. The point of outreach work is to contact the hidden sector to facilitate changes in risk behaviour. This means reaching as many people as possible to educate them and to provide the means for behaviour change. These objectives seem to have fallen foul of a workers' agenda: the desire for status, job satisfaction, and, most crucially, the inability to make contacts.

Professionalisation

The success of some early programmes was largely due to the personalities of the people appointed. The key skill for this work is the ability to contact people who would not otherwise use services. Even the worst of drug dependency units can attract clients by dishing out drugs. Attending these demoralising units is a small price to pay compared with having to go thieving every day, getting robbed, or getting arrested and separated from your loved ones behind prison bars. Many long-term clinic clients suffer such low self-esteem that they do not expect to be treated with dignity.

Drug users in the hidden sector may be a different kettle of fish. The fabric of their daily lives articulates the 'great refusal' of Britain's criminal underclass. Their lives are totally dominated by drugs, either earning the money to buy them or using them. These people probably constitute the

by

Peter McDermott

The author is the editor of the International Journal of Drug Policy and has personal experience of being a client of drug services.

greatest HIV risk group. To make contact and be accepted in such circles, trust is essential; middle aged, middle class professionals just can't cut it.

Once outreach workers were appointed for their personal abilities to make contact and establish rapport; since then, outreach work has been subject to professionalisation – a process used to restrict the access of *outsiders* to resources and opportunities. Today this is generally achieved by insisting on academic or professional entry qualifications. Many employers now seek outreach workers with qualifications which may actually render them unsuitable for the job. In some areas only outreach workers with a nursing qualification are being hired, yet nursing training often makes people uniquely unqualified for such work. Nurses are trained in the rigid hierarchical world of the hospital, where the consultant is God and the patient is little more than a child.

Sick people are usually happy to abdicate responsibility for their health care. Drug users are different. Of course, many do present to services seeking help with their lives in a mess, mentally and physically in need of care. But outreach workers are employed to reach those who *aren't* asking for any help. If workers continue to see these drug users as people whose experiences, opinions, skills, knowledge and insight count for less than their own 'professional' training, then the failure to achieve outreach objectives can only continue.

Management failures

One of the biggest barriers to HIV prevention is the fact that most workers would be unable to gain entry to the places where HIV risk behaviour occurs – dealing locations, shooting galleries, crack houses, etc – and even if they could, they would feel threatened or uncomfortable.

But the biggest problem of all, and the most important issue to get right, remains that of management. One of the key manifestations of managerial inadequacy is a tendency to appoint workers in one's own image. Sober, middle class professionals will appoint clones completely unsuited to the work; they lack the judgment to identify somebody who will make it on the street. Very few managers have the experience of the workings of the illegal drug scene needed to effectively supervise their staff. Some don't have a clue what a worker should do or should be able to do, leaving outreach workers to set their own agendas.

Of course, there is a group of people who are accepted by the hidden sector, who already know a great deal about drugs, about services and about HIV risks. Other countries are beginning to make use of the euphemistically termed 'indigenous worker'. It needs evaluation, but the advantages of using current drug users over so-called professionals appear to be enormous. ■

User to user

Drug user volunteers were the solution to the outreach conundrum in rural Essex

MANY DRUG WORKERS enlist the help of drug users informally and often covertly – for example, by tapping their clients' knowledge of the local drug scene, or by encouraging them to pass on information to their friends. In North East Essex we adopted a more formal approach by recruiting and training a team of volunteer outreach workers, many themselves current and former drug users. The scheme has not been without its difficulties, but does appear to have had a positive effect on local drug users, and some unexpected spin-offs.

The volunteer scheme was one of several initiatives addressing the problems of the 'solo outreach worker'.¹ North East Essex is a rural district where drug dealing and drug use take place behind closed doors in flats and houses, rather than on the streets or in pubs. It soon became apparent that street-corner style outreach was inappropriate. The fact that amphetamine is the drug most commonly used and injected presented further problems, since amphetamine users tend to be difficult to contact.

It was felt that local people involved in the drug scene would be better placed than a professional to plan and implement the most effective outreach strategies. The proposal was approved by the senior health authority managers and by police, who recognised that it would be impractical to exclude user-dealers as almost all users dealt to help maintain their own drug use. The aims of the scheme were simple: to contact drug users not in contact with services in order to reduce drug-related harm.

Rocky start

The volunteer scheme was designed to include current drug users, former users and non-users in equal numbers, since it might be difficult to provide a consistent service if it was staffed only by current drug users.

Four groups of volunteers have been recruited since the scheme first started in April 1990; 31 volunteers have completed the initial training and 24 have stayed in regular contact. They were recruited from

outreach contacts, current and former clients of the drug agency, and by advertising in the local press. The main recruitment criteria were that candidates should be caring and non-judgmental, have some knowledge of the local drug scene, and accept harm reduction principles.

From their points of view, former and current drug users volunteered because the scheme gave them a chance to help fellow drug users and to use the knowledge and skills acquired in their own drug using careers.

Training consisted of two days and 14 evening sessions on topics such as drugs and their effects, law, HIV and AIDS, safer injecting and safer sex, first aid, welfare rights, treatment options, outreach methods, motivational interviewing, and confidentiality. Police ran the drugs and the law sessions, the first time some of the drug users had been on 'human' terms with the

by

**Keith Bolton &
Annette Walling**

The first author is the Drugs Outreach Development Worker at the Community Drugs Team in Colchester; the second is the Research Fellow at the Policy Studies Institute in London who evaluated the scheme described in the article.

For more information or a copy of the research report phone Keith Bolton on 0206 48481.

Street-corner style outreach was inappropriate in a rural area where drug dealing and drug use take place behind closed doors in flats and houses. In response a team of volunteer outreach workers was recruited and trained, many themselves current and former drug users. Drug using volunteers incorporated outreach into their daily lives and conventional supervision proved impossible. However, research showed that the outreach service was well known and valued by injectors and had a positive influence on risk behaviour.

law and for many an eye-opener showing police were concerned with drug users' welfare as well as with their lawbreaking.

When it came to what outreach activities each volunteer should undertake, we decided the volunteers themselves were best placed to decide what would be effective. This approach also enabled individuals to take on only those responsibilities with which they felt comfortable. Initially volunteers sought more guidance than we were prepared to give, but after several frustrating meetings individual members of the group gradually identified how they could contribute to the outreach service.

Drug using volunteers have incorporated their outreach work into their daily lives by promoting safer practices among their peers and have established an informal syringe exchange service, distributing equipment from their homes or delivering it to friends and acquaintances who do not use fixed-site services. Former users and non-users help staff the fixed-site syringe exchanges.

The volunteers have also adopted a variety of other roles in the outreach service. For example, they help make up packs for the pharmacy-based scheme and empty the needle dump installed in a local public toilet, investigate reports of used syringes found in public places, and represent the outreach service at meetings and conferences.

Difficulties there have been, but the fact is that the drop-out rate has been highest among the non-drug users in the scheme.

The drug users stayed on because their outreach efforts were rewarded relatively quickly and with a significant number of effective interventions. Already they were part of the close-knit local drug using community and could readily make contacts and be accepted as a credible, non-threatening source of information. The non-drug users, on the other hand, faced many unrewarding hours attempting to make contacts and even then would probably lag behind the contact rates achieved by drug users.

A researcher appointed to evaluate the volunteer scheme identified a number of limitations, not least of which was the problem of 'accountability'. Monitoring the performance of the current drug using volunteers by conventional means proved impossible. Almost by definition these are people wary of authority and unwilling to accept bureaucratic procedures. It is this attitude that puts them on the same wavelength as their fellow drug users not in touch with services and makes them such valuable outreach potential. This potential would be lost if we insisted on their filling in contact forms or attending regular supervision sessions.

Positive outcome

The research did, however, provide evidence that the outreach service is well known and valued by injectors and is having a positive influence on risk-behaviour, even among injectors not in contact with the service.

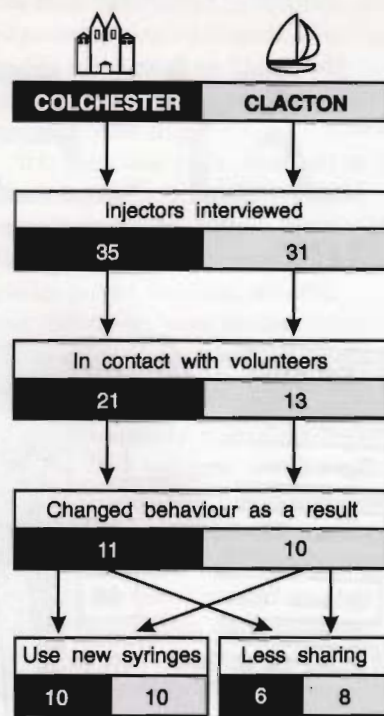
Surveys of injectors in Colchester, where the volunteers had been operating for 18 months, and in Clacton during the first six months of the scheme, found that most of the respondents (46 out of 66) had heard of the volunteer outreach service and that over half (34) were in regular contact with a volunteer. Most of these (23 out of 34) were not in contact with other drug services.

All respondents who had met outreach volunteers had obtained sterile injecting equipment from them; most had also received information on HIV and AIDS, safer injecting and on local drug services.

Two-thirds of those who were in contact with volunteers said that as a result they had changed their injecting behaviour. Of these, two-thirds said the volunteers had improved their access to sterile syringes and that they were therefore less likely to reuse or share syringes and needles.

A follow-up survey of injectors in Clacton six months after the initial survey found encouraging evidence of a reduction in sharing. Twenty-three of the initial sample of 31 were re-interviewed: 17 were still injecting. At the second survey just one person had borrowed injecting equipment in the past three months compared to four who had borrowed and six who had lent in the initial survey. Respondents said this was because the informal syringe exchange network established by the volunteers had improved access to sterile syringes,

Research findings



particularly out of hours when pharmacies were closed.

Our aim was not just to change the behaviour of direct contacts, but also to shift drug use culture towards safer use. The local nature of trendsetting in drug use makes it important to work with key opinion leaders on the local scene who could influence drug use norms towards more informed and healthier practices.

Drug users stayed on because they were rewarded quickly with effective interventions

An example of this happening is the dramatic shift seen from frequent admissions of recent sharing to a situation where any talk of having shared is strongly disapproved of.

Challenges and benefits

The research suggested there are not only fewer admissions of sharing, but also a decrease in sharing behaviour. It also suggested that drug users are very well informed about HIV transmission routes and that if they share, it is in spite of this knowledge. This finding strengthened the belief that information-giving without peer pressure is not an effective intervention.

Using drug using volunteers for outreach has some clear advantages but also poses some challenges for drug service managers.

Among these challenges are:

Lack of accountability It has been impossible to maintain any system for recording volunteer activities. Volunteers do not want to keep records or report to someone on what they do. We came to realise that the attempt to install monitoring procedures was mainly to safeguard the paid workers, not to help the volunteers. Volunteers who were being most successful in drugs outreach were the ones most opposed to monitoring.

Strong personalities Anyone in drugs work will know that the drug scene contains strong personalities; much debate and confrontation can be expected in a group which includes current and ex-users.

Safer sex Our research showed little change in the sexual practices of the research group; in common with many agency workers, volunteers find safer sex difficult to raise with contacts. Many volunteers are comfortable with and effectively implement a role model approach with respect to safer injecting but it is not so easy to role-model condom use.

Among the benefits of accepting these challenges are:

More workers More outreach workers available in a greater variety of settings.

Peer pressure Outreach workers can build on existing relationships to shape the behaviour of others.

Availability Volunteers are more likely to be around at unsocial hours, including 2.00am in the morning.

Help when help is most needed For example, advice given at the time when someone is struggling to get a vein is often more effective than advice given the next day at the clinic.

Continuity If a worker leaves a more traditional outreach scheme, the successor has to start establishing relationships afresh; the volunteer scheme provides greater continuity of service provision.

One of the most interesting aspects of the scheme has been the ease with which the volunteers, particularly current drug users, have incorporated their role as outreach workers into their daily lives. A fear was that the volunteers would be adversely affected by their new roles, perhaps increasing their own drug use, but on the whole they have found it to be a positive experience, affording them increased self-esteem and enhanced social standing. ■

1. Bolton K. and Selleck S. "Out on your own: making solo outreach work." *Druglink*: 6(4), p.9-10.

MORE

than just a number

OUTREACH DRUG WORK is often seen exclusively to involve going out into the community to meet drug users, encouraging them to make use of services, and providing education on safer drug use and safer sex. There is, however, so much more to outreach work than hanging out in pubs, cafes, bus shelters and parklands. In many cities across Britain vast resources and organisations are available for us to tap into. Direct contact with drug users is important but these community resources can be used to reach far greater numbers.

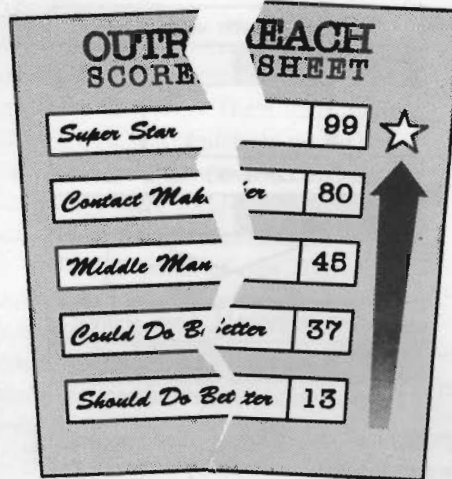
South Glamorgan Community Drug Team in Cardiff employs three outreach workers. One has a brief to work with prostitute women and the other two are outreach drugs workers. Each is also designated a 'development' worker. Together they have found that there also other ways of 'reaching' more people than you would on a rainy day on a street corner.

These are some of the outreach/development tactics employed in South Glamorgan since the outreach initiative began in 1989.

Community education services

Community education premises across South Glamorgan have been made available to the community drug team in Cardiff to use for whatever purposes may be appropriate – a policy commended as "exceptional and applicable elsewhere" in a Drug Advisory Service review of local services. A number of community education centres have taken up this option at the discretion of the community education officer.

South Glamorgan has approximately 25 community education premises on various estates. We have tapped in to projects such as unemployed drop-in groups where attendance can be as high as 50 attenders per group and averages about 15-20. An outreach worker attends such groups and is available to the attenders for needle exchange, counselling, support, referral to other agencies and general information on safer drug use/safer sex.



The youth service A well attended youth club will consist of anything from 10-100 young people, all in the 'experimentation' phase of growing up. Our reasoning (though in the nature of things, it can't be proved) is that if we can reach people at the recreational stage of their drug use we may be able to steer them away from dependency and all the difficulties this brings.

The outreach worker holds drugs/HIV workshops and debates, and is available to both the youth club staff and to its members for counselling, support, etc.

by

Phil Coles & Richard Pates

Phil Coles is the Outreach/Development Worker and Richard Pates is the Coordinator of the South Glamorgan Community Drug Team.

Outreach workers can use community resources to reach far more drug users than they could directly contact. In South Glamorgan workers attend unemployed drop-in groups and youth clubs. They educate staff and residents at a hostel for the homeless where a needle exchange has been established. Training accident and emergency staff benefits drug users who attend these services. This wider role should be encouraged and supported.

Hooking in to community resources may be the most effective outreach strategy

Homeless hostels Cardiff's YMCA has 120 residents. Outreach workers train staff and educate staff and residents on drugs/HIV issues. There is also ongoing support for residents and staff, and a referral route between the YMCA and the drug clinic.

CASH (Cardiff Action on Single Homeless) is a crisis intervention shelter for single homeless people. One outcome of maintaining contact with CASH and agreeing working practices has been the establishment of a 'satellite' needle exchange/information clinic based at the shelter. Located in the 'red light' district of Cardiff, these premises also provide a more comfortable and confidential setting for the prostitutes' outreach worker to meet women and chat about relevant (or sometimes irrelevant) issues.

Fairbridge This organisation is a charity which provides opportunities for young people aged 14-25 to get away from their immediate environment and take up the challenge of outdoor pursuits. Fairbridge concentrates on building character, developing social skills, and improving confidence. Fairbridge have proved to be a useful referral point for young people who are unemployed and bored, who probably use drugs on a recreational basis, but do not have a 'drug problem'.

Fairbridge themselves use knowledge gained from the community drug team in their work with drug users referred to them by social services, probation, youth clubs, etc. Close links have now been established with Fairbridge and a number of young people have been referred to them by the relevant outreach worker, who also attends the Fairbridge drop-in centre on a weekly basis.

Raves and pay parties These events require a minimal intervention approach in the form of readable, educational material. Inspired by Lifeline's *Peanut Pete* character, the drug team organised volunteer artists to create a rave-scene-goer called *Dave the Rave*. A comic strip leaflet on

safer ecstasy use has been produced and is being distributed not only at pay parties, but also to record shops and rave clothing shops in the city centre. Such information needs to be given early at raves or pay parties or before people go to them because after the first two hours most ecstasy users are too 'out of it' to listen to the outreach worker.

A5 fliers do the same job in far more basic way. A cheap resource, they are easy to produce on a computer and can then simply be photocopied.

Steroid users In May 1991 the outreach workers established contact with a steroid user who in turn introduced a worker to the customers at a city-centre gymnasium. As a result, steroid users started to use the needle exchange at the clinic. To date we have about 30 attenders, most of whom also take injecting equipment for their friends. A recent survey indicated that through these attenders, and through a contact of the outreach worker who in turn supplies 20 other users, we currently reach about 60 steroid users.

The Bizz *The Bizz* is a factual, educational magazine inspired by *Lifeline's Smack in the Eye* but aimed at 14-25-year-old stimulant or non-opiate users, though it also covers all other drugs.

It is distributed on the street and to all other relevant agencies with which the outreach worker has contact. Initially *The Bizz* was put together by workers but now articles, poems, drawings and other contributions are being received from clinic clients and from other people from the community.

A&E departments Clients regularly report 'attitude problems' encountered at accident and emergency units when all they want is to be treated for something like an abscess. Recently we became involved in post-graduate nurse training for accident and emergency work, which includes training on attitudes to drug users and a basic understanding of street drugs and their effects. Outreach workers are probably the most appropriate members of staff to provide such training as they are all too well

aware of prejudices and judgments made toward their client groups.

This type of training hopefully alleviates peoples' fears and misconceptions of drug users and creates a warmer, friendlier environment for drug users who attend for emergency treatment.

SOME GOOD outreach workers would be lost if funding was solely linked to contact figures. Accountants and managers who decide where next years' money is going may not think that what seems relatively few contacts a year warrants a full-time outreach worker post. What we've tried to demonstrate is that there are ways of reaching more people which, though not reflected in direct contact statistics, do have significant prevention pay-offs.

Managers should realise that outreach workers do (or should do) more than hang out with the 'beautiful (or not so beautiful) people'. They should encourage this wider role and support this style of work when outreach services are being evaluated. ■

LETTERS

YAP cards misunderstood

Dear Editor,
While we can understand Adrian King's criticisms of our YAP cards (*Druglink*: May/June 1993, p.19) given the context in which he saw them, we need to make the following points:

- The cards are signposts, not intended to give harm reduction advice but to open dialogue between young people and workers. Adrian King in his review asks why the Type 2 (binger) rock addict is "worse" than the Type 2 (daily user). This is exactly the kind of question the cards were designed to stimulate, paving the way for conversation and debate to develop. The cards are normally sold with T-shirts at raves and we have a range of other printed materials which detail harm-reduction advice. We do not believe that printed materials stand alone. Our service is based on a large-scale outreach programme with young people; the cards are only one part of that strategy.
- The cards were written and designed two years ago when information about ecstasy was far more limited. Sorry you got them late!
- The cards were written by young people, designed by young people and, as Adrian acknowledges, work extremely well with young people.
- Newham Drugs Advice Project was one of the first to work with rock cocaine users in this country and has had major casework experience with them over the past three years. Adrian doesn't understand rock use and that's a problem. His definition of "occasional" is inaccurate and dangerous (occasional/recreational use of rock cocaine over an

extended period of time is recognised as one variant of dependence). He should read the research from Yale University. Viv Reid is a recognised leading practitioner in work with rock users and was consultant on these two cards. The cards are based on our experience with hundreds of users; they are part of a pack and not designed to be read in isolation.

- YAP has worked with 2500 young people in workshops so far this year and has a counselling service with a caseload of 150 school-age clients. The cards have played a major part in establishing that contact.

This is the first criticism we've had of the cards in two years and 6000 sets and we think Adrian King has misunderstood their purpose.

Colin Cripps

Drugs Education Coordinator, London Borough of Newham and chair of the Newham Drugs Advice Project

Adrian King replies:

I am considerably reassured by Colin Cripps' comments about his project's use of the cards. As part of a larger-scale outreach strategy which includes more up-to-date and detailed harm-reduction advice, the cards are doubtless effective, and clearly both Newham's young people and maybe others have found them so.

Two of my concerns remain, however. First, the fact that the ecstasy card is based on 1991 knowledge and needs updating. Secondly, the fact that the cards are neither intended nor effective as a standalone resource. I wonder whether all the presumably many purchasers realised these limitations and are equipped to ensure they are not read 'in isolation'? I suspect not. Revision of the cards and

some guidance as to their use would make them safer to market.

After all, any gaps in my understanding of rock use don't matter much but if young rock users don't understand it, that's serious.

Farringdon skit trivialised conference

Dear Editor,
I subscribe to the ISDD journal because of its informative and balanced approach to drug dependence. I was disappointed by the *Farringdon* column in the latest issue with its undergraduate 'humour' approach (underpants and vomit jokes) to the Rotterdam harm reduction conference.

You may not know it, but there were 600 visitors from 30 countries (including the Third world). The conference was reported factually in the German and Dutch press but from your magazine one could learn nothing.

Was this because it was too international for you? Your excessively British approach surprises me. I'm sorry but I don't know who Vinnie Jones is.

My own paper at Rotterdam described official and unofficial state executions of drug users and formed part of a session on abuses of human rights of drug users. Is it really appropriate to laugh at people suffering cruel punishments, poverty and the total abuse of human rights described by such professors as Ernest Drucker?

People working in the field could profit from a dry account of the conference which was certainly 'state of the art'. At the end of the *Farringdon* piece I was left wondering on whose backs the writer had made his or her career, to afford to go to Rotterdam

Letters should normally be less than 500 words in length and may be abridged at the editor's discretion. Contributors must supply name, address and occupation/affiliation, but can ask for their letter to be published anonymously.

(about which they made some patronising comments) and presumably also to the 5th International Harm Reduction Conference.

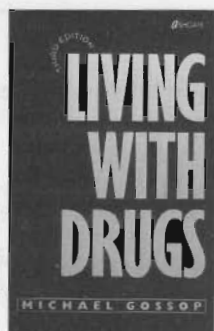
You can do better than this. More international coverage, and not of the 'we know best' type please.

Timothy Jacob Gluckman
Journalist, Koln, Germany

The Editor replies:

Thank you for your kind remarks about Druglink and our regrets that the May Farringdon caused offence. Druglink is subtitled The Journal on Drug Misuse in Britain, so I make no apologies for its UK focus, though I would welcome more material from overseas if this was relevant to drugs work in Britain. Another reason for not overdoing the international content is that Britain has another magazine/journal - the International Journal on Drug Policy - which majors in this area.

It certainly was not our intention to laugh at drug users or people infected with HIV and I can see nothing in the Farringdon column that could be read that way. In the unedited draft there was one sentence that might have been construed that way. I edited it out for the reasons you give. The column's target was drug workers - a hardy breed who can survive (and perhaps benefit from) a little friendly satire in the context of a supportive magazine.



This "classic" survived the '80s to emerge refreshed in the '90s

LIVING WITH DRUGS. 3rd edition. Michael Gossop. Aldershot: Ashgate, 1993. £9.95.

The first edition of *Living with Drugs* appeared in 1982 when some of its messages appeared quite radical. The general tone was liberal and progressive and stereotyped views about addicts and the addictive process were strongly challenged. Dr Gossop's book rapidly found its way on to most drug workers' bookshelves; my own views on drugs and addiction were modified in several ways as a consequence of reading it.

When I received the third edition for review, I decided to try to identify the latest revisions using only my memory of the first edition as a guide – with very mixed success. Repeatedly I identified as new sections of text that in fact had remained more or less unaltered between 1982 and 1993. It is apparent therefore that Dr Gossop's text has stood the test of time extremely well.

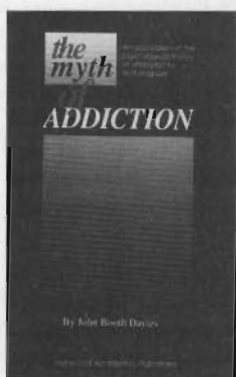
The fact that the third edition bears more than a passing resemblance to the original illustrates simply that the book is a classic. For anyone wishing to bring them-

selves up to date with the main themes in current conceptualisations of drug use, it is still hard to beat. The book has kept its freshness remarkably well and remains essential reading for all those with an interest in this area. It is, however, a matter of concern that arguments presented in 1982 remain largely unheeded and indeed unheard of by large sections of the media, by most of the public, and by many of those involved in the treatment and management of drug problems.

If I have a regret at all, it is a minor one. On the cover of the first edition, in large type, appeared the message, "One way or another we must all learn to live with drugs". At a time when prevention increasingly takes the form of a righteous war on drugs, I regret that the publishers of the third edition did not pin the same banner to the masthead with equal prominence. In a very real sense, this is the most important message.

Professor John B. Davies

Addiction Research Group, University of Strathclyde
Living with Drugs is available from ISDD at £10.95 inc. p&p.



An eloquent demolition of one myth – and perhaps the start of another

THE MYTH OF ADDICTION. John Booth Davies. Harwood Academic Publishers, 1992. £14.

This book is intriguing and well-written, but its title is misleading. The author challenges the accepted version of addiction as a scientific truth and presents it instead as a convenient (functional) explanation for a set of behaviours. 'Addiction's' usefulness is that it absolves the perpetrator by categorising their behaviour as beyond their control. As such, it is the *explanation* of addiction which is mythical, not 'addiction' itself. To doubt that God created the world is not the same as saying that the world does not exist.

Davies eloquently demonstrates that the legal and social censure directed at drug users together with their own needs for self-justification invite this group to explain their drugtaking in terms which minimise personal responsibility. The more extreme their drug use and the greater the possible penalties, the greater the pressure to exonerate themselves by favouring 'loss of control' explanations.

To support his arguments, Davies delves deep into attribution theory and applies it faultlessly to addiction. Attribution is the cognitive vehicle by which people construct causes, either to make sense of behaviour and events or to bolster their preconceived ideas. In this light, addiction is not a substantive phenomenon like diabetes but rather a way of explaining habitual drug use which employs factors with the most functional (self-serving) value.

Addiction defined as personal (rather than environmental), enduring (rather than transient) and beyond the individual's control (not his/her fault), is no more open to censure than diabetes or migraine.

In 1895, Oscar Wilde wrote, "The truth is rarely pure, and never simple". What is the 'truth' to questions predictably asked by earnest researchers such as 'Why did you first seek treatment?' or 'Why did you first use drugs?' There is no 'truth' – or rather, no truth beyond the functional attributions made by our clients. Instead of seeking a scientific explanation for addiction, we should start to develop a new myth – that of the competent (controlling) rather than incompetent (helpless victim) drug user. Why? Because out-of-control attributions lead to behaviour which consolidates the self-fulfilling prophecy of a helpless addiction.

Despite the author's plea that attribution is not a "user-friendly word for lying", I fear that his view of drug using behaviour as essentially voluntary and self-serving will be grist to the mill of the 'hang 'em and flog 'em' brigade. However, at the same time this book exhorts service providers and researchers to develop an alternative myth which empowers the drug user and allows them to admit to competent and volitional drug use without censure.

Michael George

Chartered Clinical Psychologist and Director of the Options Project in Worthing



An account of outreach at the (very) heavy end

HARD TO REACH OR OUT OF REACH? Tim Rhodes, Janet Holland and Richard Hartnoll. Tufnell Press, 1991. £5.50.

Hard to reach or out of reach? describes a three-year evaluation of outreach health education as planned and practised by Central London Action on Street Health (CLASH). The book is divided into eight discrete chapters. This means you can dip into any of the chapters without having read the others – a good way of ordering the material as it is a very exhaustive and exhausting read.

For me the book's strongest point is its coverage of 'targeting'. The importance of being sure exactly *who* among the hard to reach you are reaching out to can never be overstated. Here the targeted groups were male and female prostitutes and drug injectors in central London, many of them homeless and/or transient young people. The drug users targeted by CLASH are at the heavier end of the drugs world – fully paid up members of 'group A', in the now conventional terminology.

Here there are no 'group B' users all 'E'd up and ready to rave'. The images of the working environment conjured up are those associated with heartrending documentaries about the sad and seedy worlds of Kathies who should come home and Johnnies who should go home. Nervous rent boys shuffle around railway stations and prostitute women sit around Soho flats in body stockings, waiting for business. One is reminded of the similarities between outreach workers and missionaries. The CLASH team enter these nether worlds to offer condoms and syringes and to spread the word about safer sex and safer drug use. The Christians do likewise, offering hot soup and the word of the Lord.

Though not light and entertaining reading, at £5.50 this book is very good value and deserves a place on the bookshelves of anyone seriously interested in HIV prevention work.

Mark Gilman

Prevention Development Officer, Lifeline, Manchester.
Hard to Reach or Out of Reach is available from the Tufnell Press, 47 Dalmeny Road, London N7 0DY, £5.50.

PUBLICATIONS

Client handouts

JELLY TIME? Crew 2000, 1992(?). Booklet. £3 for 10.

Harm reduction advice on temazepam from drug user group.
Available from Crew 2000, PO Box 2000, Edinburgh EH2 4RU, phone 031 332 2314.

GETTING IT TOGETHER: A GUIDE TO SAFER INJECTING. Rotherham Health Authority, 1993(?). Leaflet.
Available from the Health Promotion Department of Rotherham Health Authority.

GOING TO COURT.

AT THE POLICE STATION. Release, 1992. Leaflets. £0.20 each. From the drugs and the law experts. Available from Release, 388 Old Street, London EC1V 9LT, phone 071 729 5255.

Prevention/education

SAFER DANCING. 5 postcards, £3 for 10 sets; poster, £3.50.

IN THE ZONE. Booklet. 10 for £3. Lifeline Manchester, 1993. Cartoon-style health education. Booklet deals with LSD and cannabis. Available from Lifeline, 101-103 Oldham Street, Manchester M4 1LW, phone 061 839 2054.

SEX. Video. £5.99.
DRUGS. Video. £5.99.

CHOICES. Booklet. Free with videos. Deform Pictures and Turning Point, 1993. Health education videos co-written with clients of the ROMA drug project. Available from Deform Pictures, 9 St. Marks Studios, Chillingworth Road, London N7 8QJ, phone 071 700 3812.

AMPHETAMINES AND COCAINE.
TRANQUILLISERS.
OPIATES.

Scottish Drugs Forum, 1993(?). Leaflets in the *Check Out What You Really Know About ...* series. Knowledge-testing educational handouts. Available from SDF, phone 031 220 2584.

YOUNG PEOPLE AND DRUGS. A MULTI-DISCIPLINARY TRAINING MANUAL. Mike Carr and Rosie Higgins. Longman, 1992.

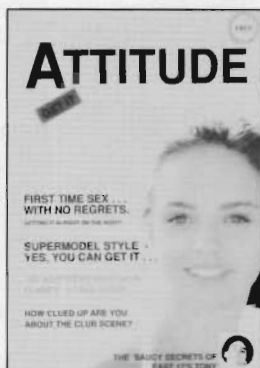
For training professionals. Available through bookshops.

YOUNG PEOPLES' PEER TRAINING INITIATIVE EVALUATION. Colin Todhunter et al. The University of Liverpool and Wirral Drugs Prevention Team, 1992.

Available from Wirral DPT, 40 Woodside Business Park, Shore Road, Birkenhead, Wirral L41 1EH, phone 051 650 0563.

ATTITUDE. Lifeline Project Ltd., 1993. Magazine. £1.30.

Youth mag-style sex/drugs health education for teenage girls. Available from Lifeline Project, Globe House, Southall Street, Manchester M3 1LG, phone 061 834 7160.



Wallcharts

DRUG MISUSE WALLCHART. ISDD 1993. Illus. wallchart. £6.

Now nearly twice the size with illustrations of drugs covered. Available from ISDD.

DRUGS RECOGNITION CHART. Metropolitan Police, 1993. Illus. wallchart.

Available from the Central Drugs Prevention Unit, Home Office, Horseferry House, Dean Ryle Street, London SW1P 2AW, phone 071 217 8631.

Drug users/research

WOMEN DRUG USERS. AN ETHNOGRAPHY OF A FEMALE INJECTING COMMUNITY. Avril Taylor. Oxford: Clarendon Press, 1993. Book. £22.50.

Participant observation among female drug injectors in Glasgow. Available through bookshops.

MERSEYSIDE DRUGS COUNCIL LIVERPOOL PROJECT: THE CLIENTS' VIEWS. Colin Todhunter et al. University of Liverpool, 1992.

Research report. £3.50. Available from Colin Todhunter, University of Liverpool, 19 Abercrombie Square, Liverpool L69 3BX.

ANABOLIC STEROID USE IN GREAT BRITAIN: AN EXPLORATORY INVESTIGATION. Pirkko Korkia. Centre for Research on Drugs and Health Behaviour, 1993. Research report.

Available from CRDHB, 200 Seagrave Road, London SW6 1RQ.

ASSESSING THE NEEDS OF BLACK DRUG USERS IN NORTH WESTMINSTER. Janaka Perera et al. Turning Point, 1993. Research report. £8.

Interviews and participant observation. Available from the Hungerford Drug Project, 32A Wardour Street, London W1V 3HJ, phone 071 437 3523.

Other

ADDICTIONS: PERSONAL INFLUENCES AND SCIENTIFIC MOVEMENTS. Griffith Edwards ed. London: Transaction Publishers, 1991. Book.

Interviews with leading international figures in drugs research/work. Available through bookshops.

NATIONAL AUDIT OF DRUG MISUSE IN BRITAIN 1992. Mike Ashton comp. ISDD, 1993. 83 pages. Book. £8.

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GUIDELINES FOR THE PREVENTION AND TREATMENT OF BENZODIAZEPINE DEPENDENCE. Justin Russell and Malcolm Lader eds. Mental Health Foundation, 1993(?). Booklet.

For GPs. Available from MHF, 37 Mortimer Street, London W1N 7RJ.

E FOR ECSTASY. Nicholas Saunders, 1993. 318 pages. Book. £7.95.

By the author of "In defence of ecstasy" (*Druglink*, March/April 1993). Available through bookshops or from N. Saunders, 14 Neal's Yard, London WC2H 9DP, £9 inc. p&p.

COCA, COCAINE AND THE WAR ON DRUGS. Catholic Institute for International Relations, 1993. 34 pages. Booklet. £1.20.

Argues that social and economic policies lie behind drug production and demand. Available from CIIR, Unit 3, Canonbury Yard, 190A New North Road, London N1 7BJ, phone 071 354 0883.

MEETINGS

DURHAM 1993. Addictions Forum, 27 September-1 October 1993, Durham. £215/£235.

Addictions Forum annual conference. Details from Ms Joyce Greig, Alcohol Research Group, University of Edinburgh, Morningside Park, Edinburgh EH10 5HF, phone 031 447 2011, ext. 4509.

SECOND EUROPEAN SYMPOSIUM ON DRUG ADDICTION & AIDS. Italian Society for Drug Addiction. 4-6 October 1993, Siena, Italy.
FIRST EUROPEAN METHADONE CONFERENCE. Social Disease Study and Intervention Association.
October 1993, Pisa, Italy.

Details from Ufficio Congressi, University of Siena, Via S. Vigilio, 6, 53100-Siena, Italy, phone 0577 298379.

DRUGS AND YOUNG PEOPLE IN THE 1990s. Lifeline/Cohen and Clements Associates. 8 Oct. 1993, London. £80.

How schools and colleges can respond to drug misuse. Details from NWRDTU, Globe House, Southall Street, Manchester M3 1LG, phone 061 834 7160.

COCAINE TODAY. Society for the Study of Addiction. 18-19 November 1993, Glasgow.

Details from Division of Addictive Behaviour, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE, phone 081 672 9944 ext. 55719/56253.

COURSES

MOTIVATIONAL INTERVIEWING SKILLS TRAINING. Various dates.
FIVE-DAY COUNSELLING. Various dates from July to December 1993.
SEXUALITY AND SEXUAL HEALTH. 22-26 November 1993. £250.
National AIDS Counselling Training Unit, London.

Details of these and other courses from NACTU, St. Charles Hospital, Exmoor Street, London W10 6DZ, phone 081 968 8514.

ACCESSING HOUSING. AIDS and Housing Project. 30 September 1993, London. £80.

On helping HIV infected people get appropriately housed. Details from Lesley Thomson, AIDS and Housing Project, 16-18 Strutton Ground, London SW1P 2HP.

ORGANISATIONS

EURO-METHWORK.

European forum for those involved in prescribing methadone to drug users. Contact Euro-Methwork, Bureau International Contacts GG&GD, Nieuwe Achtergracht 100, room 510, 1018 WT Amsterdam, The Netherlands, phone 31 20 55 55 307.

BATON.

Drugs/alcohol training/consultancy. Contact BATON, c/o Bradford Drugs Prevention Team, 8th Floor, Forster House, Forster Square, Bradford BD1 4SU, phone 0274 741274.

FOR MORE INFORMATION ...

- ☎ ON THE PUBLICATIONS LISTED HERE: phone ISDD on 071 430 1993.
- ☎ ON MORE NEW PUBLICATIONS AND ARTICLES: order *Drug Abstracts Monthly* - £16 p.a. from ISDD, phone 071 430 1961.
- ☎ ON A PARTICULAR TOPIC: phone ISDD's library on 071 430 1993.
- ☎ ON NVQs: phone Sara Wilson at the Standing Conference on Drug Abuse (SCODA) on 071 831 3595.
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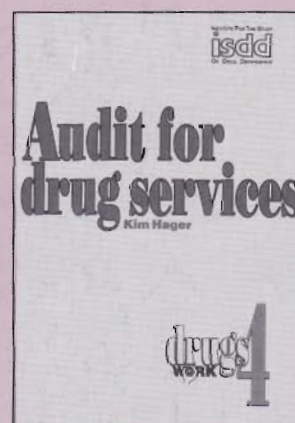
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