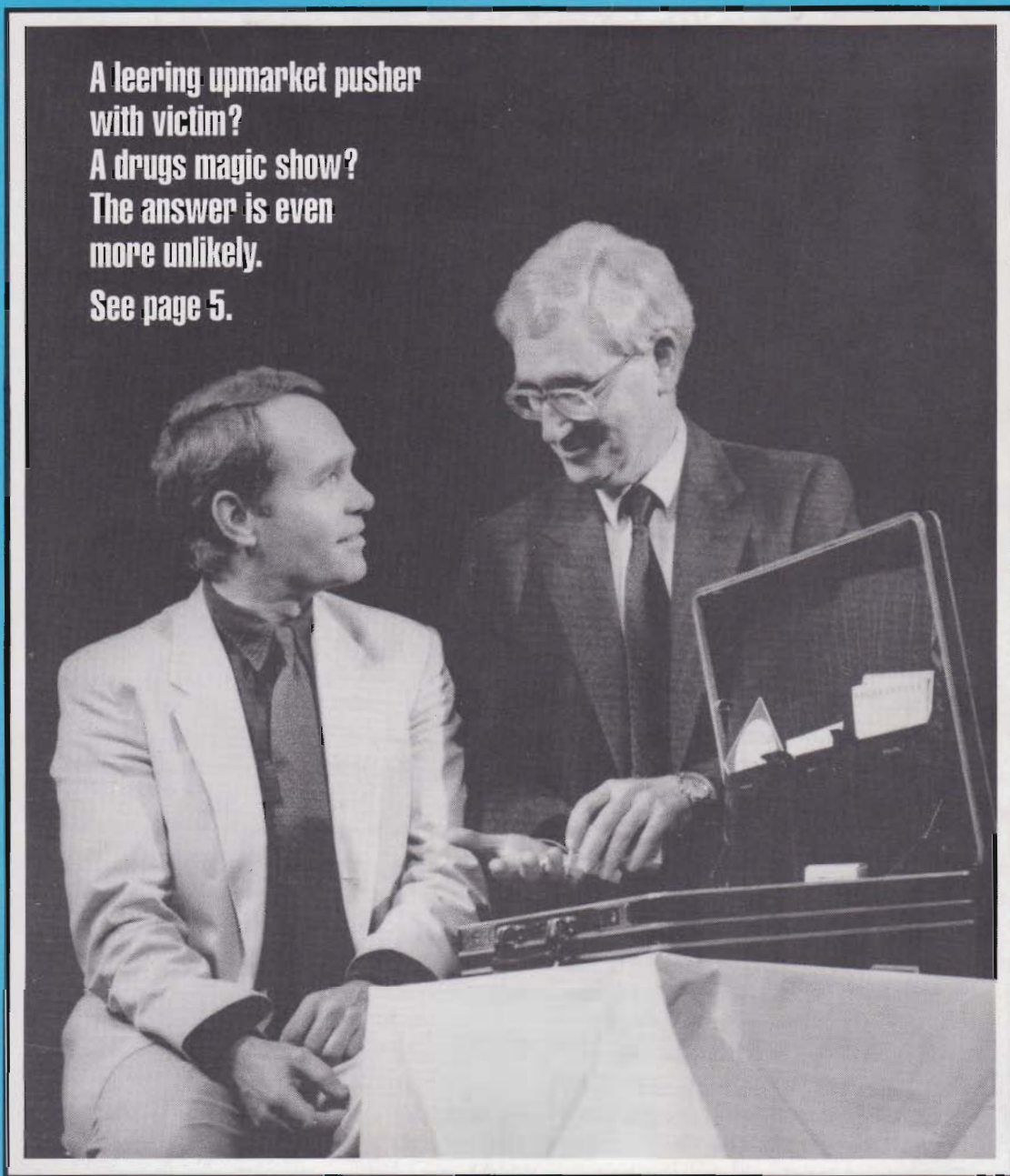


# DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN

July/August 1989

A leering upmarket pusher  
with victim?  
A drugs magic show?  
The answer is even  
more unlikely.  
See page 5.



**INSIDE** INNOVATION IN LOCAL CAMPAIGNS **10** DRUGS IN THE  
NEW NHS **14** FACING UP TO THE NATIONAL CURRICULUM **12**

## PRELIMINARY NOTICE AND CALL FOR PAPERS

# Conference

## THE FIRST INTERNATIONAL ON HARM REDUCTION

### THE THEORY AND PRACTICE OF SAFER DRUG USE

THE UNIVERSITY OF LIVERPOOL, MERSEYSIDE, ENGLAND.  
APRIL 9TH - 12TH 1990

Supported by The International Journal On Drug Policy,  
The Mersey Drug Training and Information Centre &  
The Mersey Regional Health Authority

The harmful consequences of drug use, particularly the spread of HIV infection and acquisitive crime, are presenting increasingly serious threats to societies throughout the world. There is considerable debate about the most appropriate response to the drugs problem and a growing danger of a polarization of views. The British Government's Advisory Council on the Misuse of Drugs has recently recommended that services should make and maintain contact with the maximum number of drug users including those that do not want to give up using drugs and should prioritise changing the behaviour of drug users towards safer drug use and safer sex. Such a harm reduction strategy has already been implemented on Merseyside since 1985, including syringe exchange, instruction on safer drug use, maintenance prescribing and outreach work with drug injectors and prostitutes. The Mersey Harm Reduction Model, which relies heavily on co-operation from the police and other agencies, has attracted

world-wide interest over the last few years, therefore Liverpool - the major city of the Mersey Region - provides an appropriate setting for the first international meeting of professionals concerned with devising, practising and evaluating harm reduction strategies and drug policies aimed at promoting safer drug use.

Submissions for papers are requested which cover theory, practice and research in the following domains:

- Alternative drug policies to prohibition.
- Safer drug use and safer sex.
- New drug policies and practices which control the spread of HIV infection, acquisitive crime and other drug related problems.
- Shifting professional and public responses to drug taking from prevention of use to prevention of harmful use.
- Strategies for reducing the problems created by legal and prescribed drugs, as well as illegal drugs.
- Health, education and criminal justice.

For further details please contact, Pat O'Hare, MDTIC, 10 Maryland St, Liverpool, L1 9BX, England. Tel: (44) 051-709 3511 FAX: (44) 051-709 4916.

**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 specialist and non-specialist workers occupationally, professionally, or academically involved in responding to drug misuse in Britain. **Druglink** aims to inform, promote understanding and encourage debate.

**ISDD** provides Britain's national library and information service on the misuse of drugs and drug dependence, and conducts related research. **ISDD's** reference library of books, scientific articles, reports and UK press cuttings is unique in Britain and an important international resource. Services to library users 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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## HRH The Princess of Wales becomes ISDD's patron

The Princess of Wales is proving to be a friend to the drugs field. Already Turning Point's patron, **ISDD** is pleased to announce that the princess has agreed also to be **ISDD's** patron. In a recent speech she helped drug workers by attacking the 'undeserving junky' stereotypes behind much public opposition to setting up services to aid drug users.

## 4 NEWS

Is Britain's major AIDS charity capable of dealing with drugs? Six drug advisers resigning from the Terrence Higgins Trust say no, but the Trust is looking forward to extending its drugs work. See page 7.

## 8 PRACTICE NOTES ► MOTIVATING CHANGE

At Northern Road they use 'motivational interviewing' to coax motivation out of the unmotivated. **Keith Bolton** and **Robert Watt** describe theory and practice.

## 10 REGIONAL ANTI-DRUG CAMPAIGNS

This spring Department of Health money blossomed into creative local campaigns across the UK. **Druglink** reports here and also on page 5.

## 12 PLATFORM ► FACING UP TO THE NATIONAL CURRICULUM

Look on the bright side. That's the message from **ISDD's** **Christine James** and **Lorraine Lucas** to drug education coordinators who think the new curriculum will kill drug education.

## 14 WORKING FOR DRUG USERS?

**Mike Blank** explores the implications of the NHS review for drug services and drug users.

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The **Options** video could help persuade doubters about harm-reduction. A critical look at **The Law on the Misuse of Drugs** and **City Road's** **Drug Resource Manual**, the unique how-to-do-it workers' guide.

## 17 LETTERS

**Les Kay** strikes back at his critics among outreach workers; **Rowdy Yates** says needlesticks are *not* inevitable.

## 18 LISTINGS ► PUBLICATIONS. TRAINING. MEETINGS

In this issue the editor chanches his arm with the odd off-the-cuff verdict on what's especially important in the publications listings. Don't forget that you can ring our library (01-430 1993) to check out any of the publications listed.

Cover photo: all will be revealed on page 5.

isdd

INSTITUTE FOR THE STUDY OF DRUG DEPENDENCE

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# Inpatient detox can be a success despite relapses

Treatment workers depressed by ex-patients returning to opiates within days of their discharge may be mistakenly disillusioned about the effectiveness of their efforts. Research at the Maudsley Hospital has shown that inpatient treatment of opiate addiction can be a long-term success despite a high initial relapse rate.

In the first study of its kind in Britain, 77 opiate addicts were interviewed before and after having become abstinent from opiates at the end of a 21-day period of gradually reducing doses of oral methadone. The aim was to see how many relapsed and why.

Study subjects were admitted to the Maudsley and Bethlem's drug unit between late 1984 and early

1986, at a time when the unit did not operate a systematic aftercare programme. Within a week of their discharge, 42 per cent had re-used opiates, rising to 71 per cent after six weeks.<sup>1</sup>

But these lapses did not necessarily herald a return to opiate dependence. Six months after discharge, 40 per cent of those who'd lapsed to opiate use had managed to re-establish abstinence.

Overall, the picture at six months after discharge was far more encouraging than in the initial weeks. Over 60 per cent of the ex-patients were no longer physically dependent on opiates and three-quarters of these were entirely abstinent. With few

exceptions, addiction to opiates was not replaced by heavy use of other drugs.

These encouraging interview findings were confirmed in over 90 per cent of cases by tests for the presence of drugs in urine.

A second report of the same study investigated the reasons given for the resumption of opiate use.<sup>2</sup> Return to opiate use commonly occurred within days of being discharged and in the company of drug using friends.

But explicit 'peer pressure' to use was not considered significant by the subjects of the study. Two-thirds said they had either deliberately decided to go back to opiates or had resumed drug use as a way of coping with boredom and

other unpleasant mood states.

Coping with emotional downs was also the reason most commonly given for continuing with opiates after the initial lapse.

The researchers, all psychologists, believe an analysis should be made of the factors which might prompt each individual to resume drug use. Counselling could then be geared to helping them develop non-drug strategies for coping with these risky situations.

1. M. Gossop *et al.* "Lapse, relapse and survival among opiate addicts after treatment." *British Journal of Psychiatry*: 1989, 154, p.348-353.

2. B.P. Bradley *et al.* "Circumstances surrounding the initial lapse to opiate use following detoxification." *British Journal of Psychiatry*: 1989, 154, p.354-359.

# HIV risk to sex partners of drug injectors

Three recently published studies have delivered a worrying reminder that many drug injectors in contact with services behave in ways that put them and their contacts at high risk of HIV infection. From previous research we know that drug users *not* in contact with services may be running even higher risks.

All three studies spotlight risky sexual behaviour, justifying recently expressed government concerns about drug users forming a "bridgehead" for the transmission of HIV to the heterosexual population. They confirm research indicating that even 'addicts' find it easier to change their drugtaking than their sexual behaviour, and/or that their advisers find it easier to talk about drugs than about sex.

Two of the studies investigated patients attending London drug dependency units. The first involved interviewing all 116 injectors who took up the offer of attending a health clinic in the 12 months up to November 1987.<sup>1</sup>

Nearly half reported "casual" sex in the past year but just a quarter of these always used a condom on these occasions. All but 11 of the patients had been sexually active in the past year and 40 per cent had partners who did not use drugs.

The potential for sexual spread of HIV from this group is reinforced by their sharing of injecting equipment. In the three months before attending a drug treatment unit nearly half had shared equipment, and 20 had shared outside their immediate circle of friends and sexual partners.

Sharing was common among

younger injectors. Two-thirds of the group said they'd shared equipment for their first injection, highlighting the risks run at the start of an injecting career.

High-risk sexual behaviour and continued sharing of injecting equipment were also the findings of a study at St Mary's Hospital drug dependency unit.<sup>2</sup>

The previous study found as yet low levels (4 per cent) of HIV infection in its subjects. But in the St Mary's study nearly a fifth of the 74 users were already infected with the virus. That was in 1986. Since then another 80 clinic attenders have been tested, raising the overall level of HIV infection to nearly a third.

These high rates of infection look even worse in the light of the fact that just 60 per cent of the 74 drug users were injecting. A quarter were currently sharing injection equipment. In this and in the previous study non-availability of fresh equipment was the reason most often given for sharing.

Over three-quarters of the drug users at St Mary's were sexually active but just 13 per cent used a condom. A fifth had sold sex for money, including four of the 14 people known to be HIV positive. Twelve of these 14 were sexually active at the time of the interview. The fact that nearly 40 per cent of the total sample had a history of sexually transmitted disease confirms the risk of sexual spread of HIV.

The third study amplifies the results of the Monitoring Research Group's evaluation of the government's pilot syringe exchange schemes.<sup>3</sup> The research was done between April 1987 and

March 1988.

The group's new report draws out the implications of their work for the non-injecting sexual partners of drug injectors. The 142 syringe exchange clients in the study were interviewed around the time of first attending the exchange schemes and again two to four months later.

At this second interview there had been slight reductions in the number with multiple sexual partners. Nevertheless over a fifth had two or more sexual partners in the previous three months.

During this time three-quarters of the total group had been sexually active but over 60 per cent had not used a condom. Nearly 40 per cent had sexual partners who themselves did not inject, an increase since they'd first attended the exchange.

This increase in the number of non-injecting sexual partners represents a reduction in the risk of the (mainly male) syringe exchange clients becoming infected with HIV, but probably an increased risk of their transmitting

the virus beyond the drug injecting population.

From earlier reports it's known that over a quarter of this group were still sharing injection equipment months after attending the syringe exchange. Most shared with only one other person.

The research at St Mary's emphasises that sharing with one other person is not a failsafe precaution if that person also shares with other people. At St Mary's this was shown to be commonly the case.

On the basis of their results, the Monitoring Research Group hazards a guesstimate that in a three-month period nearly 83,000 non-injectors are potentially at risk of HIV infection through sexual contact with an injector.

1. G.J. Hart *et al.* "Risk behaviour for HIV infection among injecting drug users attending a drug dependency clinic." *British Medical Journal*: 1989, 298, p.1081-1083.

2. G. Mulleady *et al.* "Lifestyle factors for drug users in relation to risks for HIV." *AIDS Care*: 1989, 1(1), p.45-50.

3. M.C. Donoghoe *et al.* "Sexual behaviour of injecting drug users and associated risks of HIV infection for non-injecting sexual partners." *AIDS Care*: 1(1), p.51-58.

It isn't easy...

Mike Linnell



■ Mersey Regional Health Authority's drug training and information centre is to become a private company contracting training services to health authorities in the region. Current management will become directors of the company. The training centre is the second to become independent in Mersey.

■ Research done in 1985-6 found that 3 per cent of a random sample of adults in Great Britain were taking sleeping pills or tranquillisers on the day they were interviewed, suggesting there are over one million long-term users in the UK.<sup>1</sup> Usage was twice as common among women and was associated with unemployment, low socio-economic status, and lack of exercise, as well as with physical and mental ill health. A separate study has found that tolerance and withdrawal effects may persist months after chronic users stop benzodiazepines.<sup>2</sup>

1. H. Ashton *et al.* "Tranquillisers: prevalence, predictors and possible consequences." *British Journal of Addiction*; 1989, 84, p.541-546.

2. A. Higgin *et al.* *The natural history of tolerance to the benzodiazepines.* Cambridge University Press, 1988.

■ On 6 July ADFAM will be launching a national telephone helpline for the friends and families of drug users. The service will be available weekdays 10am-4pm with an answerphone outside these hours. Initial costs have been met by British Telecom. The helpline number is 01-823 9313.

■ A report from St George's Hospital Medical School shows that solvent abuse deaths are probably still on the increase. There were 111 deaths in 1987, second only to the 116 in 1985. Fuel gases (mainly lighter fuel) caused more deaths than any other type of solvent. Half the deaths involved 14-17 year olds. The research team expect even more deaths in 1988.

H.R. Anderson *et al.* *Trends in deaths associated with abuse of volatile substances 1971-1987.* St George's Hospital Medical School, April 1989.

■ In July DAWN will be sending a questionnaire to all drug and alcohol agencies in England and Wales as part of a Department of Health funded national survey of services for women with drug and alcohol problems. DAWN (Drugs Alcohol Women Now) aims to identify models of good practice and provide guidelines on developing services for women. A report and directory of services is due to be published in July 1990. More information on 01-700 4653.

# Regional campaigns trial worth the rush say workers

"It was a rush but it was worth it." That seems to be the grassroots verdict on the DoH-funded regional anti-drug campaigns. The thrash to spend £300,000 before the end of March has left drug services with an unprecedented range of strategies through which to advertise themselves and to promote health education messages about drugs.

Half of financial year 1988/9 had already gone before in September Wessex, Trent and South East Thames regional health authorities were invited to bid for £100,000 each for anti-drug campaigns in their areas. Bids were to be in to the Department of Health by the end of December and the money had to be spent before the year ended.

Government ministers were keen to see a locally geared second tier added to the national campaign launched in November, and the pressure filtered down to drugs and health promotion workers in the areas concerned.

Different funding arrangements in Wales allowed them to spend their £100,000 at a more leisurely pace. Scotland received £200,000 for its campaign.

Leicester's experience illustrates the kind of timetable people had to work to in England. In early October a letter from the Department of Health invited Trent region to participate in the campaigns. A month later the region formally contacted Leicester Health Authority asking them to bid for part of the £100,000 on offer.

The bid had to be processed by the regional health authority before going to ministers by early December. That left Leicester's planners less than a month to decide how to spend what ended up as a £42,000 allocation.

Official approval of Leicester's plans came on 14 February with the financial year shutters came down at the end of March. In Wessex and South East Thames the story was the same. "A frightful scramble", said Laura Gamble of Brighton's Drug Advice and Information Service (DAIS).

Blanket local media blitzes helped soak up the money quickly, but the lack of public response in some areas has left workers wondering if it was all worthwhile. Some point out that raising awareness of drug problems is of

little use if the services aren't there to cope with the demand.

The outcome of this first hurried stab at mounting centrally coordinated local campaigns will have long-term consequences. Local campaigns seem set to become a regular feature of the government's strategy. Descriptions and evaluations of 1988/9 campaigns are to be compiled into a handbook to guide planners in the years to come. From the reactions of those involved it seems some positive lessons may emerge.



Strange but true. A sober drugs facts video from Project Icarus, notorious for their *Better Dead*.

Despite the sweat there was general approval of the outcome. The end result was "brilliant", said Lorraine Hewitt of the Stockwell Project. Produced for the campaign, the project's leaflet for injectors carries some of the most explicit harm-reduction advice ever distributed in Britain.

That it passed Department of Health scrutiny confirms reports that local originators of the materials were allowed almost complete freedom, more than many expected. Workers we spoke to reported only two minor and easily reconciled differences with the department's scrutineers.

Harm-reduction was a major theme in Trent and South East Thames. In Leicester a free information pack gives advice for solvent users under the heading, "If you want to be careful how you use, follow the rules."

In the same pack is the *Willy Whizz* cartoon strip. Its messages are about how to use amphetamine without getting badly screwed up rather than about how *not* to use the drug. When first released in Mersey in 1987, controversy over the cartoon led to resignations from health authority and drug committee posts in the region.

In Wessex and Scotland the materials produced for the campaign are more traditionally anti-drug and, in Scotland, anti-sex. Even so Wessex region had Project Icarus — responsible for some classics of shock-horror drug education — produce an uncharacteristically sober drug information video.

What the outcomes from all the regions share is a professional sheen borrowed from commercial marketing practice. Behind much of the innovation in England was Penny Bousfield, seconded to the Department of Health from a commercial marketing and promotions company to help get the campaigns off the ground. This help from the heart of free enterprise Britain received universal praise from the workers *Druglink* contacted.

Notable too was the use of private industry and commercial media to help in the promotions.

Whether all this energy and innovation achieves anything remains to be seen. What we'll certainly have is the experience of new drug education vehicles such as touring theatre groups and alternative pub cabaret. Arguably approaches like these would never have emerged this side of the year 2000 without the pressure cooker methods applied in the months leading up to the end of the last financial year.

■ For its 1989 national drugs campaign due to be launched in November, the government south of the border will jettison past anti-heroin, anti-injecting themes in favour of the broad Scottish pro-health approach. So said the magazine *Media Week* in May.

According to *Media Week*, "Education Minister John Butcher's proposed message was a broad-based health education one of 'stay healthy, stay in control'." A DES spokesman confirmed this was Butcher's line.

If the DES had their way, it seems the new campaign would take a 'do this' rather than a 'don't do that' approach. However the Department of Health, supposedly the source of *Media Week's* story, were unable to confirm it, and it's DoH money that will pay for the campaign.

Clearly a radical rethink of strategy is going on in ministerial circles, probably led by John Butcher whose close relationship with the drug education coordinators may have influenced his thinking.

See pages 10-11 for a description of the campaigns

# Drug education coordinators given extra £2 million to cover alcohol and AIDS

Drug Education Coordinators have doubled their money and changed their names. In parliament on 4 May DES minister John Butcher announced that the original £2 million a year grant will go up to £4 million from 1990/91 and that funding for the coordinators will be guaranteed for at least three years.

A further £3 million in 1990/91 will be provided to fund in-service training for teachers in the same "key areas of health education".

The rub is that the coordinators' remit will be broadened to take in advising and informing schools about alcohol and AIDS on top of their existing drugs work. From being Drug Education Coordinators (DECs) they will now be known as Health Education Coordinators (HECs).

In making his announcement — foreshadowed in *Druglink* in March — Mr Butcher gave a clear

indication that schools-based education would be nudged away from the 'anti-heroin' type message. Instead pupils should, he said, "be taught about the importance of a healthy lifestyle and a healthy body". To help maintain health they would need the skills to resist pressures to misuse drugs and alcohol.

■ In April John Butcher told a parliamentary committee that it was essential to retain personal and social education (PSHE) in the curriculum even though it is not one of the foundation subjects in the new national curriculum.

By early June the minister is thought to have approved an interim report from the National Curriculum Council task group looking into PSHE. The report identified ways drug education could be dealt with in the foundation subjects. Already the specifications for science include

education about alcohol, drugs and smoking. The health education group is advising groups working on history and geography how drugs can be incorporated into these subjects.

Their interim report also said that to prevent gaps in PSHE teaching there would still need to be a separately timetabled health education slot. This will be reassuring news for DECs-cum-HECs concerned about their specialism being diffused across the foundation subjects.

The interim report listed attainment targets in PSHE for children from 5-16 years of age, a less popular move among coordinators who value the less testable skills and attitudes side of drugs teaching.

More on the National Curriculum and drugs on pages 12-13

# Cocaine 'not so addictive', say leading Canadian researchers

A new report on cocaine from Canada's Addiction Research Foundation arguing that the addictive potential of cocaine has been overstated has sparked controversy in the North American drugs field. The claim is that such a conclusion undermines the war against drugs, which in the USA is dominated by the cocaine problem.

Contrary to cocaine's 'instantly addictive' image, the report's authors conclude that just 5-10 per cent of all those who ever try cocaine go on to use weekly, and of these no more than a quarter go through periods of addictive use. Most social-recreational users can, says the review, maintain long periods of low-level cocaine use without escalating to addiction.

The report was briefly mentioned in the last issue of *Druglink* (see p.6) but now ISDD has obtained the full manuscript prior to its publication in *Social Pharmacology*.

Patricia Erickson and Bruce Alexander reviewed animal and clinical studies, population surveys, and samples of users not in treatment. Their review covered use of cocaine hydrochloride powder but not 'crack' — an important distinction since by all accounts cocaine transformed into 'crack' and other smokeable products is far more potently

addictive.

The main conclusions were:

◆ Animal studies where the subject has continuous access to intravenous cocaine bear little relation to normal human patterns of use. Where animals prefer cocaine to food under these circumstances, this can be explained by the appetite-suppressing effect of the drug.

◆ Even in the artificial setting of the laboratory, animals kept in an environment and with a social group similar to their natural state are less likely to compulsively self-administer cocaine than those kept isolated in small cages.

◆ Studies of users in treatment or who contact help lines can be regarded as the tip of the iceberg of all cocaine users. Even so, most of these are multiple drug users, not solely users of cocaine. Also, despite the rapid rise in the numbers using cocaine, the drug was still poorly represented in indices of problematic drug use, such as those gathered by the US Drug Abuse Warning Network.

◆ Community studies contacting users not in treatment and not in prison show that regular users of cocaine demonstrate wide fluctuations in their intensity of use over time and that controlled use is possible. Most of those studied did not present to health

services unless there were medical complications arising from their cocaine use.

◆ Household and high school student surveys carried out in Canada and the USA all demonstrate a significant rise in the numbers who have used cocaine through the 1980s. However, in follow-up studies few had gone on to compulsive use.

Publicity for the report in the February edition of the Addiction Research Foundation's *Journal* resulted in correspondence both attacking and defending the authors' conclusions. In the light of crack, they were accused of sending out an untimely message playing down the dangers of cocaine, undermining the efforts of those engaged in prevention and treatment.

But in the May edition of the *Journal* Peter Cohen of Amsterdam University reported a Dutch study which supported Erickson and Alexander's conclusions. Most of a randomly selected sample of "experienced" cocaine users restricted their use to weekends and 80 per cent practised regular periods of abstinence.

Established researchers Waldorf and Reinman also defended the report as "a useful corrective to... crack hysteria".

## WHO WE ARE

We are not just drug users



■ A former photographer for the Phoenix House drug rehabilitation centre is seeking funding to transform her work into a poster campaign that could for the first time give a voice to drug users themselves. "Moving and eloquent" was *Time Out's* verdict on her work, part of a touring AIDS photo exhibition. Arabella Plouviez can be contacted on 01-708 1887.

■ Cannabis was found in the bodies of 2.4 per cent of people killed in road accidents in England and Wales since 1985, a figure which rose to 3.3 per cent among men aged 20-39. The incidence of other "drugs of abuse" was negligible. Benzodiazepines were found in 1.6 per cent of cases, alcohol in a third. The authors conclude that medicines or drugs other than alcohol make a "comparatively modest" contribution to road deaths.

J.T. Everest *et al.* *The incidence of drugs in road accident fatalities in England and Wales.* Transport and Road Research Laboratory, 1988.



■ Among the points made in a report on the Lifeline Project's innovative drugs/AIDS harm reduction comic *Smack in the Eye* is that 'old-timers' on the drugs scene cannot be relied on to educate newcomers in harm-reduction techniques. More in the next issue of *Druglink*.

Mark Gilman. *Comics as a strategy in reducing drug-related harm.* Manchester: Lifeline Project, June 1989.

# Drug advisers quit key AIDS charity

The Terrence Higgins Trust suffered a major blow to its credibility as an across-the-board AIDS agency when in early June leading drug advisers resigned saying, "The needs of drug users cannot be met in such an organisation." But the Trust believes this crisis will prove to be a turning point in the gay-based charity's attempts to extend itself into the mainly heterosexual drug using population.

The six advisers were members of the Trust's Drug Education Group, workers from the drugs field recruited on a volunteer basis to guide the Trust through unfamiliar drugs territory. Their resignations came in the form of an open letter to the Trust's directors (extracts below).

According to one active member who is not resigning, disillusionment with the Trust is practically universal in the group. Martin Donoghoe of the Monitoring Research Group says many members have voted with their feet, the number of regular attenders dwindling from 15-20 two years ago to barely enough to be called a group.

Though fully supporting the six who are quitting, with just two years of what he calls "false promises" behind him, he is not

yet ready to give up all hope of the Trust getting it together on drugs. Another non-resigning member speaks of the group being repeatedly "kicked in the teeth" by the Trust and of it taking years for letters to be answered.

After nearly three years in the group, Radhe Bentley of ADFAM says she and the others resigning have "absolutely no confidence in the Trust" ever producing answers to the needs of drug users.

Their main complaint is that the Trust has acted as if tackling HIV among drug users can be tacked onto its work with homosexuals, rather than dealt with as a priority requiring special strategies.

Ironically they are leaving just as the Trust is establishing a separate drugs team headed by a Drug Services Coordinator with management-level authority.

Until now drugs work has been split up under units to do with education, counselling, information, etc. In future drug users will be the only sub-group of the at risk population to have a unit 'of their own' at the Trust, a move which can be considered an important achievement on the part of the Drug Education Group.

Splitting off drugs work was "not an easy decision" said the Trust. Resolving policy wrangles

such as this has seriously retarded the Trust's drugs work.

Assurances of a better future for drugs work at the Trust did not impress Radhe Bentley. "They've been saying that for three years," was her response. "Their attitude is that anyone can deal with drugs. I wish the Trust would have the nerve to say, 'We are a gay organisation; everything else, forget it.' Then they'd be dealing with the people they're used to."

In a swiftly prepared response to the resignations (extracts below) the Terrence Higgins Trust admitted that adapting to drugs work had been "a painful experience". But the Trust's Press Officer Nick Partridge claimed that prejudice against drug users and homosexual camaraderie off-putting to 'straight' drug users were both things of the past.

With the experienced drugs researcher Betsy Ettore now heading their drugs team, the Trust is firmly looking forward to recreating and expanding its drug work. "In some ways this is a watershed", said Nick Partridge. The Trust's Chief Executive Martin Eede says the drugs budget of £181,000 this financial year is planned to rise to £335,000 next year and to £422,000 in 1991/2.

But the Trust now faces a

situation where HIV positive drug users have established their own support networks and where other AIDS organisations such as London Lighthouse are setting up groups for drug users.

It remains to be seen what place the THT can occupy in this new situation, having lost ground in the years of protracted disputes.

Established as a form of gay self-help organisation, it has clearly been difficult for the Trust to embrace the needs of 'outsiders' such as drug users. More detached observers believe the dispute between the Trust and its advisers over the priority to be given to drugs work has been compounded by differences over styles of work.

Unlike the Trust's other volunteer groups, the drugs group work every day with drugs and AIDS issues in their employment. Attempts to import this professionalism into the Trust have been frustrated by a structure geared to volunteer effort driven by compassion and fellow-feeling rather than to hard-headed service delivery.

Rocketed to prominence by sudden massive government grants such as last year's £400,000, the Trust has, even its friends admit, still to develop the organisation to handle the enormous task before it.

## We quit. Extracts from a letter to the Terrence Higgins Trust from six volunteer drug advisers.

...There is an assumption in the Trust that drug issues can be taken on without any clear thought or strategies and that they are merely part of the baggage of HIV infection ...

There have been ever-diminishing rewards for our efforts... and constant disappointments, not only in matters directly related to improving services for drug users but also, more importantly, in the constant negation of sound drug policies and in the Trust's generally negative attitudes towards drug users ...

Over the past year no new client-related services have been created; no up-to-date health education material has been produced ...; the once thriving support group has apparently been allowed to collapse for a year; and the face-to-face counselling service for drug users has been largely inoperative. Surely these are symptoms of a service in decline rather than of one which places the needs of drug users at the top of the agenda ...

We have never received satisfactory information on how [drugs] moneys have been spent. In our opinion, the Trust's vaunted commitment to drug issues is merely tokenistic ... Surely it is time for [the Trust] to admit that it has failed to build on its promising beginnings in the field of drugs and HIV. The Trust has never learnt how to work effectively with drug users: they meet with mainly two responses — either panic and terror, or misplaced generosity...

All the indications are that the Trust ... will continue to marginalise drug issues. The drug-related staff operate within ever confined circumstances and an already stressful job is made doubly so by what seem to be interminable wranglings over policy and practice. The needs of drug users cannot be met in such an organisation ...

Radhe Bentley, Steve Cranfield, Heidi Gilhooly, Raymond Molloy, Geraldine Mulleady, Michael Read

## A statement from the Terrence Higgins Trust. Past problems admitted but commitment to re-establish and expand its services for drug users.

As we all know, AIDS agencies in the UK and the USA arose from and addressed primarily the concerns of gay men ... However, with increasing numbers of injecting drug users found seropositive (16 per cent of the total number in the UK), AIDS agencies have needed to expand their focus ... In the nine months from April to December 1988, the Trust spent £65,000 (excluding building and general administration costs) on drugs related education and services ... 17.6 per cent of our total direct charitable expenditure ...

This expansion of our work ... has not been an easy process. Rather, it has been a painful experience for the gay community organising around AIDS service provision. For example, recognising the needs of drug users and providing help for this group within a primarily gay context has had to be built positively, as an affirmation of the needs of all those infected with HIV. Sharing the same public stigma (as 'AIDS victims') ... has been the foundation for a real if not natural 'service provision attraction' between gay men and drug users.

[Establishing the] Drug Education Group ... was a move to lessen the gap between the gay community and the drug using community ... it was a sincere attempt to draw drug experts into the Trust's work and to build upon an already established expertise.

While there has been some resistance to this work within and outside of the Trust [it] has been fruitful. Currently the Trust is expanding its commitment to the development of services for drug users concerned about AIDS. By late autumn of this year we hope to have a full drugs team including a Drug Development Officer, Prison Liaison Officer, Drugs Counselling Officer, Drugs Education Officer and a Prisons Resources Officer. Because of this growth we would also like to expand the membership of our Drug Education Group ...

# MOTIVATING CHANGE

DURING OUR TIME in the caring profession we have shared a concern that clients assessed as being 'poorly motivated' or 'unmotivated' have often been rejected from treatment possibilities. Such rejection deserves even greater scrutiny today, when a client may return to behaviour risking not only an overdose and loss of limbs, but also HIV infection. As a result, our work at Northern Road Clinic over the past two years has been aimed at developing a service for a wider range of drug users, regardless of their reason for attending.

Motivated clients often have little or no need of treatment clinics or rehabilitation centres. The challenge is to meet the needs of the 'unmotivated' client. To meet these needs we have employed the motivational interviewing method developed by Miller<sup>1</sup> and by Van Bilson<sup>2</sup>, a method used mainly in America and Holland, initially with problem drinkers and latterly with heroin users. Motivational interviewing has been incorporated into our assessment procedure as well as into individual and group therapy settings with a variety of drug users.

There is a close relationship between our use of motivational interviewing and the low threshold methadone programme described previously in *Druglink*.<sup>3</sup> One point of the programme is to attract clients who would not otherwise attend and who do not come with ready-made motivations for change. Motivational interviewing gives us a constructive way to work with these clients, avoiding the confrontations or demands that would merely drive them back out the door.

Conversely, the methadone programme enables us to require almost daily attendance at the clinic to take the drug. This gives us the chance to identify the emergence of opportunities to intervene as they happen, rather than having to seek to create those opportunities at weekly or fortnightly appointments.

## Attitudes and morals

There is little point in employing motivational interviewing if one starts with the idea that drug use must stop before treatment can begin and

**At Northern Road clinic in Portsmouth, methadone pulls in the clients and 'motivational interviewing' helps nudge them to move away from drugs.**

**Keith Bolton and Robert Watt**

that clients have no power over their addiction. Van Bilson has described the key principles of the approach as:

- ◆ Accepting the client in a complete and unconditional way;

- ◆ The client is a responsible person;
- ◆ The client must be ready for change and not forced into it by the counsellor;
- ◆ The goals and the forms treatment must be negotiated.

Figure 1 shows how Van Bilson has contrasted these and other tenets of his approach with traditional approaches.<sup>4</sup> Non-adherence to principles such as those behind motivational interviewing often leads to a breakdown of relationships with clients who may not return to treatment centres for fear of disapproval from staff.

There are many pitfalls drug counsellors need

**Figure 1. The characteristics of motivational interviewing**

Motivational interviewing	Traditional approach
<b>Individual responsibility</b>	
Emphasis on personal choice regarding future use of heroin.	Emphasis on the disease of addiction which reduces personal choice.
Goal of treatment is negotiated based on data and preferences.	The treatment goal is always total and life-long abstinence.
Controlled heroin use is a possible goal though not optimal for all.	Controlled heroin use is dismissed as impossible.
<b>Internal attribution</b>	
The individual is seen as able to control and choose.	The individual is seen as helpless towards heroin and unable to control his/her own heroin use.
The interviewer focuses on eliciting the client's own statement of concern regarding the heroin use.	The interviewer presents perceived evidence to convince the client of his or her problem.
<b>Denial/telling lies</b>	
Denial and telling lies are seen as an interpersonal behaviour pattern (communication) influenced by the interviewer's behaviour.	Denial and telling lies are seen as a personal trait of the heroin addict/junkie, requiring heavy confrontation by the interviewer.
Lies and denial are met with reflections.	Lies and denial are met with argument/correction.
<b>Labelling</b>	
There is a general de-emphasis on labels. Confessions of being a junkie or being an irresponsible heroin addict are seen as irrelevant.	There is a heavy emphasis on acceptance of the person as a junkie or an addict.
Objective data of impairment are presented in a low-key fashion, not imposing any conclusion on the client.	Objective data of impairment are presented in a confrontational fashion; as proof of a progressive disease and the necessity of complete abstinence.

See reference 4 for source.

*Both authors work at the Northern Road Clinic in Portsmouth, the first author as a community psychiatric nurse, the second as a social worker.*

to guard against. Motivational interviewing demands that we do not reinforce labels, whether self-attributed or given to the drug user. Information on the client's situation can be fed back to them in a neutral way, not to force change.

Another pitfall may be the perception of drug users as telling lies and untrustworthy in reporting their own drug use. Confrontational approaches can make this a self-fulfilling prophecy. Denial and lies are often a product of the treatment programme or drug service. For example, if the methadone programme requires abstinence from other drug use, will the client be honest if the consequence is the loss of a prescription?

## Assessing motivation

To assess a client's motivation to change we use the model documented by Prochaska and DiClemente.<sup>5</sup> Six stages of change have been identified (see figure 2).

**Precontemplation** is a stage where clients do not perceive they have a problem but others around them may be disapproving. Often at this stage clients arrive at a drug unit having been sent by the courts, probation office or family, etc. A typical interview may start with, "I've been told to come here by ...".

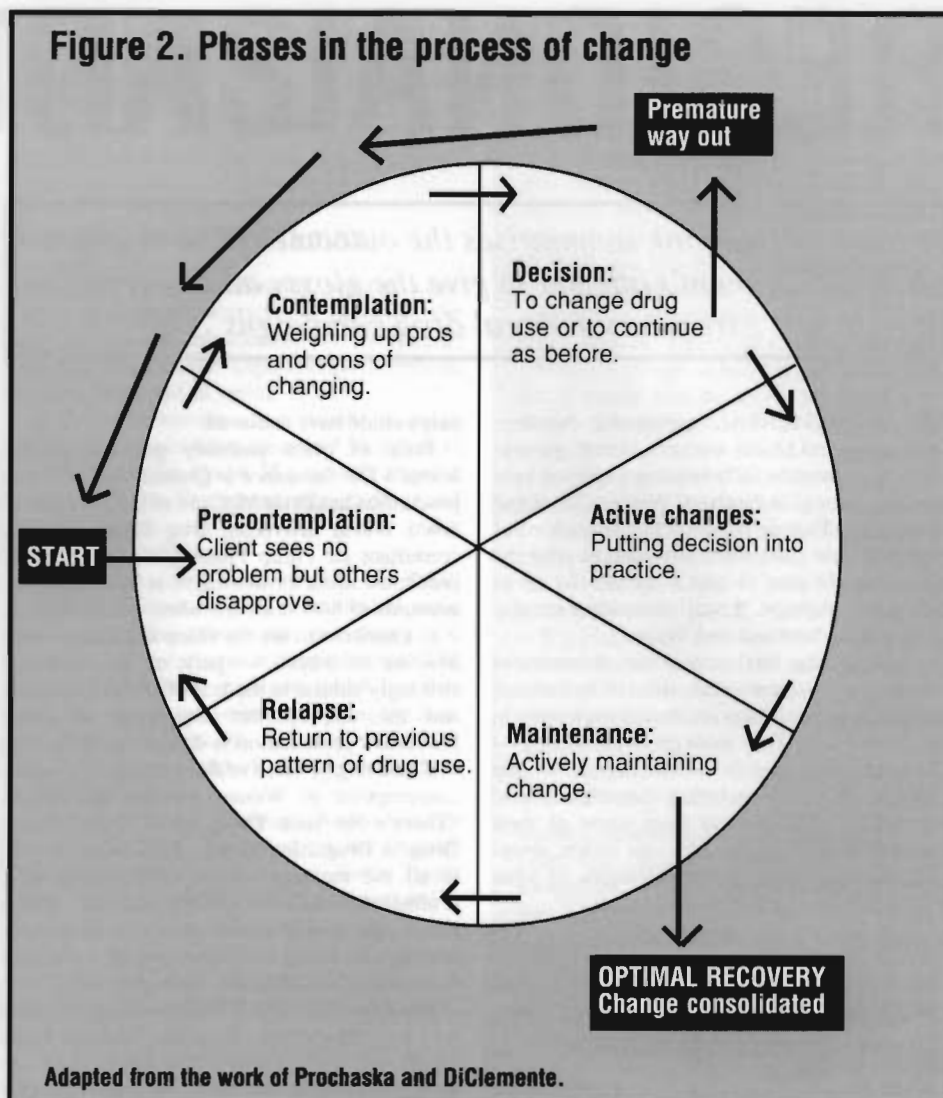
**Contemplation** is the stage where the client is weighing up the pros and cons of their drug use. They may be suffering financial hardship and deteriorating physical health, but on the other hand may see their drug use as helping to cope with life's stresses.

**Decision** is the point where the client decides what to do about their drug use based on the previous stage of contemplation. Clients rarely stay in this stage for long and soon choose either to return to precontemplation, preferring to continue with their previous level of drug use, or, alternatively, to move to 'change'.

**Active change** is the process of the client taking steps to put their decision into effect. To do this they use methods and goals negotiated with programme staff, for example, obtaining clean needles and syringes from our exchange scheme rather than sharing with friends.

**Maintenance** involves the drug worker introducing and encouraging conscious coping strategies to maintain the change already made, using relapse prevention techniques such as those described by Marlatt and Gordon.<sup>6</sup>

These include problem solving skills, strategies to avoid or escape situations where relapse might occur, and cue exposure tactics which deliberately expose the client to these situations and to drug-related stimuli. Cue exposure in a controlled and supportive environment can



enhance the client's confidence in their ability to cope with 'temptation' without losing control.

Once again there are two routes out of this stage. One is to move out of the process of change to optimal recovery. Here change can be maintained with less effort and less need for conscious preoccupation with avoiding relapse. (This model differs from the philosophy 'once an addict always an addict', which assumes people must remain at the maintenance stage for life.) Another way out of this stage is to move to relapse then back to precontemplation.

**Relapse** is the return to the drug use patterns of the pre-change period. The odd drink or drug use episode does not, however, amount to a relapse. Many such setbacks can be dealt with in maintenance and learned from, rather than interpreted as a relapse.

Even if relapse does occur, it should not be seen as a failure. Each revolution through the process of change should be used as a positive learning experience, leading to a greater chance of success the next time around.

## Counselling techniques

Motivation for change arises when the client sees their drugtaking behaviour as incompatible with their view of themselves or their feelings about what they should be like or should be doing. To reduce the resultant discomfort, either the drugtaking behaviour must change, or the client must revise their thinking about themselves. Counselling interventions based on this conflict

(or 'cognitive dissonance') are more likely to succeed in moving the client through the stages in the process of change.

In the precontemplation phase, thinking changes (through mechanisms such as rationalisation and denial) to fit in with the drugtaking. At this stage the first task is to create conflict between the two, for without this there is little chance of lasting change. This may take one session or it may take many months. To create conflict we mainly summarise the client's behaviour and reflect it back to them, to first elicit and then reinforce expressions of self-concern.

Once conflict is created (the contemplation stage) we use positive feedback to raise the client's self-esteem and feeling of being able to control their own life. This may take the form of praise, or of finding and playing back to them the positive achievements in what they may see as negative experiences — a version of finding the 'silver lining'.

'Positive restructuring' of, for instance, a return to drug use for a couple of days in the previous week might highlight the achievement of abstinence on the other days. Such positive feedback encourages the client to end the decision stage with a change in drugtaking behaviour rather than a return to rationalising and denial to reduce conflict.

These counselling techniques are not new to the helping professions,<sup>8</sup> but in the context of the motivational approach they do provide us with a fresh approach to working with those experiencing difficulties with their drug use. ■

1. Miller W.R. "Motivational interviewing with problem drinkers." *Behavioural Psychotherapy*: 1983, 2, p.147-182.

2. Van Bilson H.P.J.G. "Motivational milieu therapy: motivating heroin addicts for change." Paper presented at the Fifteenth International Institute on the Prevention and Treatment of Drug Dependence, 1986.

3. Fleming P. "A low threshold methadone programme." *Druglink*: 1989, 4(2).

4. Van Bilson H.P.J.G. "Heroin addiction: morals revisited." *Journal of Substance Abuse Treatment*: 1986, 3(4), p.279-284.

5. Prochaska J.O. and DiClemente C. *The transtheoretical approach: crossing traditional boundaries of therapies*. Homewood, Illinois: Dow Jones/Irwin, 1984.

6. Marlatt G.A. and Gordon J.R. *Relapse prevention*. London: Guilford Press, 1985, p.128-200.

7. Marlatt and Gordon, op cit, p.41-42.

8. Nelson Jones R. *Human relationship skills*. Cassell Education Ltd, p.163-193.

# REGIONAL ANTI-DRUG

*Druglink summarises the outcome of the government's attempt to give the glossy ad-agency treatment to local drug campaigns*

AN EXPERIMENTAL partnership between local drugs and health workers, central government, and commercial marketing expertise bore fruit this spring. In England, Wessex, Trent and South East Thames regional health authorities unveiled local campaigns designed to pilot the government's plan to add a second tier to its UK-wide campaign. 'Local' campaigns are also being run in Scotland and Wales.

In organising this second tier, government put some of the most vocal critics of its national campaign — local drugs and health workers — in the driving seat. They were given the money — £100,000 per English health region — the freedom and the marketing consultancy and support to implement at least some of their fondest dreams about how to tackle drugs campaigning. Here's some highlights of what they did.

## Trent aims for the cinemagoer

Trent chose to mount a number of independent campaigns organised by different health districts. At £42,000, the largest slice of the region's allocation went to fund Leicester Health Authority's campaign, featuring a 60-second cinema ad being screened in every cinema in Leicester for 30 weeks from 14 April. The aim is to use the techniques of youth-orientated lager ads to encourage cinemagoers to pick up a drug education leaflet available in the cinema. Inside is an explicitly harm-reductionist message on solvents as well as alcohol. Cut-out coupons allow readers to order packs of further information.

Youth-orientated plays are central to the campaigns in North Trent and Nottingham districts. The Channel Theatre Company is taking its *All Fixed Up* production on a five-week tour of schools in North Trent (see S.E. Thames for more on the play). In Nottingham, two productions aimed at different racial groups are playing in youth clubs, accompanied by training days for youth workers to help them deal with the fallout from the plays.

## Wessex goes for the facts

Unlike the other two English regions, Wessex's "Get Drugwise" campaign is centrally coordinated by the region's drug problem team and public affairs department, rather than a collection of separate district campaigns.

'Public affairs' experience showed in the spate of ten press releases describing the campaign, and in advance publicity aimed at encouraging the press to play a positive role as part of the campaign rather than as critical bystanders. It worked — of all the campaigns, Wessex's press coverage was probably the most extensive and consistently sympathetic, giving much broader publicity than the specific cam-

paign could have achieved.

Pride of place probably goes to Project Icarus's *The Substance in Question* video. Their production has Peter McCann of BBC's *Tomorrow's World* delivering drug facts and drug consultant Dr Philip Fleming discussing drug problems, while ex-users give at times glowing accounts of how it all felt when it was new.

It's hard not to see the video as a *Drug Abuse Briefing* on wheels — parts of the script are strikingly similar to the text of ISDD's booklet, and the dispassionate objectivity of Peter McCann's presentation is distinctly ISDD-like.

Confusingly, some of the material for public consumption in Wessex carries the slogan, "There's No Such Thing As A Hard Or Soft Drug. A Drug... Is A Drug... Is A Drug" — not at all the message of the video aimed at a professional audience. "Get Drugwise" book-marks, the worst offenders in this doubletalk strategy, are being distributed in their thousands from public libraries and NHS premises.

For their £100,000, Wessex workers will also get a computerised drug information bank which will, the promise is, "be available to any authorised user in the world who has a suitable computer and a telephone line".

## Scots adopt 'fanzine' methods

Scotland's £200,000 campaign was designed, said Health Minister Michael Forsyth, "to address the issues of AIDS and drug misuse in a way which is relevant to the lifestyles of the majority of young people". From 6 March a series of six full-page ads appeared weekly in tabloid papers, encouraging young readers to pick up their copy of *Scene*, a full-colour magazine, 200,000 copies of which are being given away in John Menzies record shops and through health education departments across Scotland.

The ads also give potted drugs/AIDS facts. The first AIDS 'fact' says, "As far as sex goes, the one sure way to avoid AIDS is to practise chastity before marriage and fidelity within it." The second is hardly more likely to appeal to the young record-buying public: "It's up to us to do something about the spread of AIDS. Like not injecting drugs and not having sex. Or using a condom if you do have sex."

Radio ads attempt to direct listeners to the press ads, promising that there they will find the skills they lack to introduce the subject of a condom into lovemaking and to resist drug offers.

## Wales ponders a video

Funding arrangements in Wales mean they can decide how to spend their £100,000 at leisure. By mid-May they'd plumped for a drama video for 16-21 year olds to be shown in schools and elsewhere from the autumn term onwards.

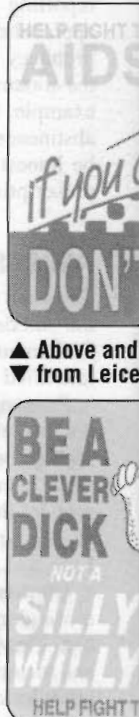
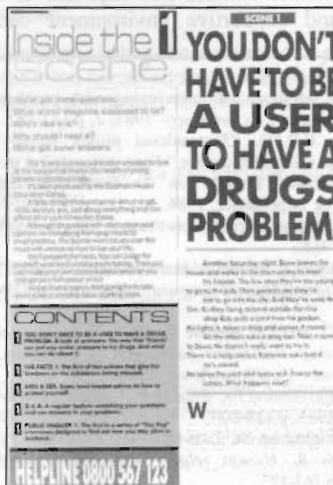


▲ British Telecom donated phonecards for Brighton's youth workers.



▲ A page from the leaflet given away in Leicester's cinemas.

▼ Inside *Scene* young Scottish readers find glossy 'Just Say No' type advice.



▲ Above and ▼ from Leicester

▼ Coca



# CAMPAIGNS



## SPoons AND FLUSHING CUPS

These can also carry viruses so try not to share, but, if you do, **CLEAN THEM TOO.**

## FILTERS

Use a new filter for each person.

## FIXING

Try and use different veins and stick to your arms.

Keep away from sores and arteries.

If you are not sure, we can advise you about cutting the risks from fixing.

## MEDICAL PROBLEMS

If you have abscesses, infections etc. we can help you get medical care.

## DISPOSAL

Used needles are BAD news! We arrange for confidential, safe disposal.

It's helpful if you place the used needle inside the plunger and put it safely inside a coke or beer can, coffee jar etc.

Up-front advice from the Stockwell Project ▲ that passed Department of Health scrutiny.

Poster from Lambeth's Afro-Caribbean Association.

**WHO'S THE CHARLIE NOW!**

**DRUGS AWARENESS PROGRAMME**

- COMMUNITY DRUG PROJECT  
703 0559  
mon-fr 2.00pm - 5.00pm
- ANGEL PROJECT  
226 3013  
mon-fr 2.00pm - 5.00pm
- LAMBETH DRUGLINE  
274 4000 ext.276  
mon-fr 10.00am - 1.00pm
- D.A.P.  
DRUGS AWARENESS PROGRAMME  
328 4851  
mon-fr 11.30am - 12.00pm

## Diversity in S. E. Thames

South East Thames is running separate campaigns in different districts. In Brighton, the Drug Advice and Information Service (DAIS) chose to extend their experimental telephone fact-line first tried in spring 1988.

In the 1989 version a two-minute message dealt with four activities identified by DAIS as high risk areas for the 16-25 year olds targeted by the campaign. These were: mixing drugs and alcohol; unsafe sex; sniffing gases; using unidentified 'pills'.

To get the youngsters ringing in, DAIS bought air-time on the local commercial radio station, dropping their ads in among the station's pop and phone-in programming. The ads raised drug harm questions which listeners were encouraged to resolve by phoning the fact-line. Youth workers in the area were kept informed with the help of phonecards donated by British Telecom.

As part of the campaign organised by Dartford's Druglink advice project, the Channel Theatre Company (also touring North Trent) played its *All Fixed Up* production aimed at 14-18 year olds before audiences in all the area's secondary schools. Their portrayal of a young man's descent into heroin addiction was "excellent, sympathetic and non-moralistic", said Kent's newsletter for drug workers.

On 8 April Dartford's pilot package of cabaret acts with a compere and DJ, all plugging anti-drug and safe sex messages, took place in, of all places, a pub.

Lambeth's Afro-Caribbean Community Association opted to go for the south London cocaine problem with their "Who's The Charlie Now!" poster and leaflet. The leaflet advises on how to overcome cocaine dependency.

The Stockwell Project's leaflet for injectors gives up-front advice on injecting that would have been unthinkable in a government-funded publication before HIV legitimised harm reduction. Beyond its first line — "It's better not to inject, but ..." — the advice is about how to stay healthy if you *are* injecting, not how to stop.

Stockwell Project and Druglink shared a leaflet for GPs offering help in organising joint detoxification programmes, with the GP providing primary health care and drugs, and the drugs project providing the social and psychological support.

Bexley too tried to involve GPs, this time in treating dependence on tranquillisers. A local helpline for tranquilliser users was set up with the help of BBC's Broadcasting Support Services. The helpline was publicised partly through a door-to-door leaflet drop in association with the *Kentish Times*. GPs were approached through a seminar, through information packs sent via family practitioner committees, and by the offer of a free call to the helpline.

See page 5 for how the campaigns were rushed through to beat the 31 March deadline

## Interested?

For more information...

You could wait for the handbook on the English campaigns. No anticipated publication date is available but the last quarter of 1989 is a fair bet. The handbook will include the materials used in the campaigns, the experiences of those using them, and the results of the evaluations. Obviously *Druglink* will list the handbook but it might also be worth phoning our library from September to see if it's arrived.

In the meantime ISDD's library holds a file of many of the materials used in the campaigns in England and Scotland, plus press releases, etc describing the activities. Phone 01-430 1961 to make an appointment.

If a particular campaign has taken your interest, more information may be available from these drugs or health workers, who were involved in the campaigns in their different districts.

## Trent

**South Lincolnshire:** Kate Gorman, Health Promotion Officer, 052 98687.

**Leicester:** Robin Burgess or Tina Barnes, Leicester Community Drug Services, 0533 470200.

**South Derbyshire:** Phil de Silva, South Derbyshire Community Drug Team, 0332 292416.

**Nottingham:** Ira Unell, Mapperley Hospital Drug Dependency Unit, 0602 691300, or Pam Allen, Health Promotion Officer, 0602 481800.

## South East Thames

**General:** Andrew Partington, Press Office, South East Thames RHA, 0424 730073.

**Brighton:** Laura Gamble, DAIS, 0273 21000.

**Dartford:** Druglink drug advice project, 0332 93728. Also Phillip Dart, Channel Theatre Company, 0843 588260.

**Stockwell and Lambeth:** Lorraine Hewitt, Stockwell Project, 01-274 7013. Also the Afro-Caribbean Community Association, 01-326 4651.

**Bexley:** Bexley Health Promotion Unit, 01-300 9701.

## Wessex

Contact:

— Wessex RHA's Public Affairs Department, 0962 63511;

— Dr Philip Fleming (regional consultant in drug treatment) or John East (principal adviser to the region's drug problem team) on 0705 324636;

— Project Icarus, 0705 324248 (their *The Substance in Question* video is available outside Wessex at £34.50).

## Scotland

Contact the Scottish Health Education Group, 031 447 8044.

# FACING UP TO THE NATIONAL CURRICULUM

When the government announced its plans for the new National Curriculum, some saw this as the death knell for drugs education — at the very least, said the specialists, it would be set back ten years. So why all the gloom?

Christine James and Lorraine Lucas

IN RECENT YEARS there has been a strong movement to locate drugs education within personal, social and health education (PSHE), now separately timetabled in many secondary schools. But when the subjects to form the core and foundation of the National Curriculum<sup>1</sup> were announced, PSHE was not among them. The implication drawn was that the government saw this area of work as a low priority.

Despite strong representations, the government has not changed its mind. Instead, health education is one of a number of areas under consideration by a cross-curricular working party whose role is to suggest how they can be accommodated under the new curriculum. The concern is that health education and drugs education with it would be lost to the syllabus by being dispersed across the foundation subjects — a 'subject-based' approach.

Whatever the outcome of the working party — which should be reporting this summer — there is already considerable pessimism. Local authority drug education coordinators provide most of the in-service training for teachers on drugs education. In January ISDD carried out an enquiry to find out what these coordinators thought about a subject-based approach to drugs education.

A questionnaire was sent out asking for

*Christine James is a research officer at ISDD currently working on a cross-curricular guide for teachers on drugs and the National Curriculum for publication in 1990. Lorraine Lucas is a research assistant at ISDD.*

comments on ISDD's *DrugWise Curriculum Guide*, part of the *DrugWise* drugs education pack for use in secondary schools. The guide adopts a subject-based approach, with sections on how to incorporate drug issues into subjects such as maths, history, drama, etc, and how this can be related to the national criteria for GCSE. Our questionnaire sought views on the ideology and practicalities of doing drugs education within subjects. About a third of the coordinators replied. The key points to emerge, based on the 32 replies, are summarised below.

◆ All the coordinators were familiar with a subject-based approach and most had used the relevant part of the *DrugWise Curriculum Guide* with teachers during training or had referred teachers to it. No one mentioned having trained groups of subject teachers.

◆ Coordination was seen as a major problem by nearly everyone. A particular concern was that a subject-based approach would make it difficult to deliver a consistent message. Respondents stressed the need for schools to nominate a 'coordinator' to prevent important issues being lost, to avoid repetition, and to ensure some uniformity of approach.

◆ Many were concerned about testing, on which the National Curriculum places great stress, and felt that it would be inappropriate and/or difficult to test pupils on drugs education. Because it is more difficult to evaluate there were fears that drugs education will not be valued and will be likely to be left out.

◆ Many felt that subject teachers did not possess the necessary skills to take on drugs education — at least, not without considerable

in-service training. Most agreed that subject teachers would be capable of delivering facts but, because teaching styles in subject areas are not sufficiently participative, they would not be able to cope with work around attitudes and skills. Most coordinators consider these aspects of drugs education to be at least as important as the factual elements, so this was thought a serious drawback.

◆ There were doubts about whether subject teachers would be sufficiently motivated to take on education about drugs. Some felt that while subject teachers may be enthusiastic about their own chosen speciality, they may see 'drugs' as an unwelcome add-on and therefore give such work a low priority.

◆ Overall, most coordinators were strongly in favour of retaining drugs education within PSHE where possible, although some admitted that it may be necessary to adopt a more pragmatic approach in future. There was particular concern that the expertise built up over the last few years among PSHE teachers would be lost if a subject-based approach was introduced.

These initial findings suggest there is little enthusiasm for a subject-based approach to drugs education among the very people who may be responsible for promoting it. Are their fears completely justified? Or is it a case of preferring to stay with what you know, rather than looking for the positive aspects of change? We'll look at the main objections in turn.

**Coordination.** There is no doubt that tackling any issue on a cross-curricular basis requires

## Drug themes in the curriculum

Some ideas on how drug issues might be incorporated into subject-based education. See main text for an example related to English teaching.

**MATHEMATICS. Measuring danger:** measuring alcohol content in terms of standard units, discussing the meaning of degrees of proof; working out if someone would be over the legal limit (to drive) if they consumed a variety of drinks at different times of the day; discussing what constitutes safe drinking.

**ART. Persuasion:** analysing existing persuasive material relating to legal or illegal drugs, eg, cigarette advertising, government anti-injecting campaign. Finding out what devices are used, assessing how successful they are and translating this into personal persuasive projects.

**HISTORY. Drug use in times of stress:** discussion of life and conditions in the trenches in the two world wars and the role that sharing cigarettes played in comradeship and keeping up morale; relating this similar issues in present day situations.

**GEOGRAPHY. Drugs and the economy:** international trade in legal and illegal drugs; for example, for some Third World countries exports of plant-derived drugs to the West are one of the main ways of generating foreign exchange; similarly the West exports alcohol and cigarettes to Third World countries.

**RELIGIOUS EDUCATION. Religion and its contribution to attitudes and behaviour:** comparing the prohibitions of certain drugs in Western (Christian) society with the teachings of Islam, for example in relation to alcohol use; encouraging pupils to form their own opinions about such issues.

**PHYSICAL EDUCATION. Drugs and fitness:** looking at the effect of various drugs on physical activity and ability; discussing the use of stimulants and steroids and their dangers.

These examples are taken from the *DrugWise Curriculum Guide*, part of the *DrugWise* drug education pack for secondary schools.

good coordination. Health educators have seen the concentration of their subject into a single area of the curriculum (PSHE) as a great improvement on the way it was — in some cases still is — carried out in some schools: an uncoordinated hotchpotch of ideas often resulting in repetition, omission and bored pupils. If these pitfalls are to be avoided it will be essential that those responsible for coordination<sup>2</sup> get the recognition, status and financial incentives needed to ensure their success.

**Testing and assessment.** The National Curriculum does greatly stress testing. Each foundation subject will have a set of attainment targets, defined as testable objectives in terms of knowledge, skills, understanding, aptitudes, etc. For example, one attainment target in the science curriculum stipulates that pupils should "know about the risks of alcohol and solvent abuse and how they affect the body processes".

We cannot agree with a respondent from our enquiry who said that he would be very unhappy for a young person to 'fail' simply because he or she did not know about the risks of solvent abuse. Putting aside for the moment the pros and cons of assessment, and its effect on young people, we cannot see the argument for making this area of knowledge a special case immune from testing.

However, reservations about testing may have less to do with information, and more do with the teaching, skills and attitudes, which most coordinators consider so essential. Many attainment targets for the foundation subjects are already skills-based, so assessment techniques will in any event need to be developed in this area. If 'communication skills' and 'assertiveness' are considered important aspects of drugs education, then it ought to be possible to find ways to test for these too.

Attitude-testing is more of a problem, especially if the work focuses on the *pupils'* attitudes. Even if they could be tested accurately, no one would seriously suggest that pupils who had the 'correct' (as defined by drugs educators) attitudes should get more marks than those who did not. However, if we were to shift the focus and look at attitudes from a historical perspective — how our attitudes to various drugs have changed over time — then it would be possible to test for such understandings.

However unpalatable some may find the idea of assessment, drugs educators cannot afford to ignore it. If in the future the 'serious curriculum' is to be that which is testable, then drugs education must rise to this challenge or slip back to second-class status in the syllabus.

**Incompetent teachers?** Whatever the truth of the assertion that subject teachers lack the skills to deal with drugs education, this seems an unhelpful attitude to adopt in the present situation. Shouldn't we perhaps be looking at what subject teachers *can* offer rather than berating them for what they cannot? English teaching provides a concrete example. (See panel for more suggestions.)

In our enquiry someone suggested that they wouldn't like to see pupils set questions such as 'Drugs make you write better poetry — Discuss'. We agree: such an exercise would be unlikely to do much for English or for drugs education — but surely we can do better. Given that English is basically concerned with communication skills — an important element of drugs educa-

tion — a more profitable exercise might go something like this.

Pupils would be asked to read and comprehend various pieces of information on organisations concerned with tobacco, drugs, and alcohol abuse. They would then be asked to write an appeal letter saying which of these should be the beneficiary of a fundraising event and why. Not only would this satisfy the requirements of an English lesson (in terms of comprehension and writing), but it would also give information about help available for drug users and, by the pupils' choice of organisation, raise questions about attitudes to drug users.

Of course, it would be possible for teachers just to concentrate on questions of grammar and style, but we are sure that many teachers, with a little encouragement and support, would be capable of widening the discussion.

**Disinterested teachers?** If subject teachers are to be accused of being narrow-minded because they are reluctant to include drugs within their own field of expertise, might not the same accusation be levied at drugs educators reluctant to acknowledge the contribution other disciplines can make to drugs education?

Obviously attempting to cram drugs into every subject simply for the sake of it is a recipe for disaster and unlikely to enthuse anyone. If subject teachers are to be motivated to take on drug issues then one of two things must happen. Either it must be demonstrated that drug issues are an important aspect of the syllabus, backed up by reference to attainment targets, or teachers must be shown how drug issues can provide grist to the mill for other types of learning — such as in the English example above.

On present information it seems likely that a subject-based approach to drugs education would need to do both.

**What about PSHE?** A subject-based approach to drugs education does not imply PSHE no longer has any role to play. It seems unlikely that PSHE will disappear completely from timetables, especially in schools where it is firmly established. PSHE could still be used to complement 'drugs work' within subjects.

Alternatively, skills could be shared by introducing 'team' or 'pair' teaching, with subject and PSHE specialists working together. For this to succeed all concerned will need to put some effort into repairing the rift which has developed in secondary education between the subject-based curriculum and PSHE, a rift which does not exist in primary education.

NOT EVERYONE is so pessimistic about the future of drugs education under the National Curriculum. For a few, the imminent upheaval has provided the context and the motivation to rethink not only *where* drugs education might take place, but *why* they are doing it. The traditional aim of drugs education in schools — stopping young people experimenting with drugs — needs challenging, not least because there is very little evidence to show that any of the approaches used can achieve this aim. What is needed is to develop broader educational aims and to begin to ask not only 'What can subjects offer drugs education?' but also, 'What can education about drugs do for other areas of the curriculum?' As one drug education coordinator put it, "What we need is more education and less propaganda". ■

1. Encompassed in the Education Reform Act 1988. In addition to religious education, the core and foundation subjects in the curriculum are English, maths, science, technology, history, geography, art, music, physical education, and a modern foreign language. Altogether these are to take up 70 per cent of curriculum time.

2. Many schools already have a nominated health education coordinator. With the advent of the National Curriculum we may see a new breed of teacher whose job will be to oversee not just health education but other cross-curricular issues such as economic awareness.

# WORKING FOR DRUG USERS?

## Drug services and the NHS review

When health services go to market, will caring for drug users become an unmarketable commodity?

Mike Blank

AFTER A YEAR of indecision and dithering the government finally went for broke earlier this year when at the cost of a mere £1 million it launched its plans for reform of the NHS. Its *Working for Patients* white paper is being paraded as a review designed to produce a leaner, fitter NHS which offers shorter waiting lists and greater customer choice.<sup>1</sup>

Yet almost without exception the plans have been greeted with anguish and derision. August bodies such as the British Medical Association are "convinced that many of the proposals would cause serious damage to NHS patient care, lead to a fragmented service and destroy the comprehensive nature of the existing service".<sup>2</sup> The BMA has been joined by the Royal College of Nursing, various royal medical colleges and numerous other institutions which consider the white paper to be a recipe for disaster.

At first the plans were presented as a *fait accompli*. But in the face of the public concern aroused by such determined criticism, the Department of Health has appeared to moderate its line. Although there is no formal consultation exercise underway, there are signs that the department is prepared to compromise on some issues and may now welcome some comments from interested parties. Comments were due to be in by the end of May before the primary legislation begins to be drafted in June or July. But even after this date fine tuning may be possible and how the national legislation is implemented at local level may be influenced by local pressure.

Throughout the papers the words 'drug users' don't make an appearance. But, to be fair, the needs of other small groups of people who use the NHS heavily (for instance, those with chronic conditions such as diabetes) don't get much of a look-in either. We can only attempt to crystal-ball-gaze what the consequences might be for such groups on the basis of the sketchy outline of the overall service so far available.

Mike Blank is manager of the Llanelli Drugs Project. He has worked in the NHS for the past 14 years.

The white paper's primary aim is to introduce market forces into the NHS. The Tory tenet that competition encourages efficiency and a higher quality of service is now being applied to health care — and by 'efficiency', this government means 'cost-effective'.

So before considering the details of the proposals it is important to ask whether cost-effectiveness equals a high quality of service. Caring for drug users is expensive. One of the major requirements is to establish a trusting relationship. This takes time and skill, and in the post-white paper NHS, time will mean money out of somebody's limited budget. With a ceiling on costs it's being suggested that competition between service providers may concentrate on economy in a way that jeopardises quality.<sup>3</sup>

### *Drug users are resistant to packaging and hence a financial risk for all concerned*

According to the psychiatrist Philip Maclean in his recent address to the SCODA AGM,<sup>4</sup> the white paper is essentially about introducing management systems to reduce the waiting lists for 'cold' surgery (ie, non-emergency work which can be done at a convenient time and place) such as hip replacements. Unfortunately, these systems will be applied to other areas within the NHS to which they are clearly inappropriate. You can't process drug users in the way that you process bunion removals.

The fate of chronically ill patients, especially those subject to unpredictable and possibly expensive relapses, is a central concern. In its response to the white paper, even the National Association of Health Authorities, which supports the creation of a health services market, was concerned lest "the emphasis on acute services in the white paper led to a neglect of long-stay and other priority services".

To be specific we need to look at some of the plans in more detail. Eight working papers flesh out the main areas in the white paper. All these papers will impact on the care of drug users, but the ones likely to have most effect deal with hospital services and with general practice.

## Selling treatment to hospitals

Hospital services are dealt with in the working papers on *Self-governing Hospitals* and on *Funding and Contracts for Hospital Services*.

The first of these encourages hospitals and in some cases community units to opt out of health authority management control. Health authorities will contract with these newly independent hospitals to provide set services for their catchment populations.

This could have profound implications for drug users. A health policy analyst has made the point that "services offering clear revenue earning potential will become more attractive ... Providing long-term care for the mentally ill and ... chronically sick may hold less attraction as a source of revenue."<sup>5</sup> Somewhere in the latter category are drug users, resistant to packaging as uniform units susceptible to clear contractual arrangements, and hence a financial risk for all concerned.

If self-governing hospitals do opt out of treating dependence, this can only result in a lower uptake of services by drug users reluctant to travel at a time when it is vital that as many users as possible get in touch with drug agencies. In addition, pressure on remaining drug dependency units to be cost-effective (ie, reduce waiting lists and see more users) may result in 'revolving door' methods of care as they attempt to shoe-horn drug users into a contractual framework. This last point applies also to hospitals that stay under health authority management, as these too will provide services along contractual lines to their own authority and to any other authority they can sell to.

## Will more GPs just say no?

Working papers three and four deal respectively with "practice budgets" and "indicative prescribing budgets" for GPs. The practice budgets plan is the one which has received the greatest publicity and which causes most worry to providers of services to drug users, whether in the voluntary or statutory sectors.

Basically it will allow larger GP practices (11,000 patients or more) to take control of their own budgets including allocations for the drugs they prescribe and the hospital services they

refer patients to. Government has been quick to reassure both GPs and the public that no practice will be allowed to run out of money, but the suspicion remains that your doctor will be examining you with one eye and the bank statement with the other. This suspicion is reinforced when one takes in to account the fact that GPs will be able to plough back a proportion of any underspend in to their practices. So for the first time in modern NHS history a doctor's relationship with his patient will have financial as well as medical implications.

GPs who are budget holders will contract for hospital services in much the same way as health authorities, though with less clout. How many will stipulate dependency treatment in the contract, and how many of these will be in a position to assess the quality of the treatment on offer? In a field where there is no agreement over what constitutes good or bad care, might GPs simply choose on the basis of how big a slice it will take out of their budget?

Many drug agencies have spent the last few years diligently building up relationships with local GP practices, particularly where local hospital services are sparse or non-existent. Despite the government's protestations to the contrary, it seems possible that GPs with their own budgets will be increasingly reluctant to take on or treat people with drug problems.

Introduction of indicative prescribing budgets may spread this reluctance across GPs as a whole. The problem seems particularly acute when we consider prescribing injectables to those unable to stop injecting.

Methadone ampoules at £0.53 a time are not cheap. That means an average cost per patient per week of perhaps £15, or £750 a year. Doubtless the doctor's family practitioner committee will encourage them to swop the patient to oral methadone (10p for an equivalent strength swig) at the earliest opportunity, whether they're ready for it or not. This would only result in users increasing their illicit injecting behaviour, with potentially disastrous results vis-a-vis AIDS.

Talking of AIDS, drug users who are HIV positive or who require treatment for ARC or AIDS aren't cheap either. The thought of GPs becoming increasingly reluctant to take on drug users is worrying drug agencies in both the voluntary and the statutory sectors.

Any further restrictions on GPs' rights to prescribe as they see fit may see an increasing reluctance to be led by the users' needs rather than to follow the needs of the budget. Some GPs, for instance, are prepared to prescribe Palfium or other types of opiate where methadone is not an option — will they still be able to do so?

The relevant working paper says yes: "The scheme will be structured in such a way that patients will always get the drugs they need. It will take full account of the fact that some patients and groups of patients, eg, elderly people, diabetics, patients on home dialysis, need a greater volume of drugs than others."

All well and good, except that in the same paragraph it says: "Some prescribing is wasteful or unnecessarily expensive. The objective of the new arrangements is to place downward pressure on expenditure on drugs in order to eliminate waste." Is prescribing an 'expensive' drug to a drug user in order to assist him or her to avoid AIDS a waste?

## Opportunities

The above examples highlight some of the concerns workers and users of drug services must have about the NHS restructuring. Yet, despite the potential disasters, there are also potential opportunities for services for drug users.

Health authorities will be slimmed down to managing boards purchasing the most cost effective care they can find for their resident populations. They will be responsible for providing a "comprehensive range of services". Crucially, these are to include certain "core" services which must be available locally. Mechanisms will be set up to prevent self-governing hospitals opting out of providing these services if they are the only feasible suppliers.

The white paper does not exactly define what it means by 'core services' — these are to be decided by each health authority depending on local circumstances. But among the categories within which core services would fall are "public health, community-based services and other hospital services which need to be provided on a local basis, either as matter of policy ... or on grounds of practicability".

There is no doubt that the government still sees the provision of services for people with drug problems as a high priority. This is the first government in modern times to take the problem of drug misuse seriously and to pump significant amounts of money into both the statutory and voluntary sectors.

Given this it is highly unlikely that it will take the politically damaging step of allowing funding to be reduced or withdrawn. Drug

services are likely to continue to be protected by earmarked funding and by instructions to regional health authorities such as that issued in 1986 which stipulated that every health district should have advice and counselling services and access to a hospital-based consultant.<sup>6</sup>

The opportunity exists for drug agencies to persuade the government at a national level and health authorities at local level to include drug services as part of the core services and to take account of drug users' care and prescribing needs in setting GPs' budgets. Indeed it is vital that they do so. For drug services to be reduced to providing a peripheral service within the NHS, fighting with other services for the residue of money not allocated to core services, can only result in poorly funded services losing clients. The result could be an increase in HIV as users are forced back on to the streets through lack of help or the need to travel long distances.

Government isn't automatically going to stipulate that drug services need to become part of the core services and some health authorities most definitely don't like the idea of providing services for drug users at all. Government and health authorities must be informed of the need for the proper provision of services for drug users, but time is running out. National organisations such as SCODA and the Advisory Council on the Misuse of Drugs must lobby the Department of Health and lobby it hard in order to ensure drugs are in the core services.

At a local level we have to be certain that every contract provides for the appropriate care of users — and that means quality of care which isn't just tied to expenditure but also takes account of the very special needs of our client group.

In drugs work the voluntary sector and the statutory sector are inextricably interlinked. The NHS white paper will affect all of us and it is up to all of us to ensure that the health authorities and the government continue to provide adequate services for drug users. There is a great potential for harm in this white paper, but there may be a potential for good — at least for our clients. ■

## Further information

◆ For the official line consult the white paper itself: *Working for Patients*, CM555, HMSO, 1989. £8.80.

And for (a little) more detail, the working papers, all published by HMSO in 1989:

1. *Self-governing Hospitals*, £2.80.
2. *Funding and Contracts for Hospital Services*, £2.80.
3. *Practice Budgets for General Medical Practitioners*, £2.80.
4. *Indicative Prescribing Budgets for General Medical Practitioners*, £2.20.
5. *Capital Charges*, £2.60.
6. *Medical Audit*, £1.90.
7. *NHS Consultants: Appointments, Contracts and Distinction Awards*, £1.90.
8. *Implications for Family Practitioner Committees*, £1.90.

The full set of eight working papers are £8. All these documents are available from HMSO. Prices inc. p&p.

◆ For the potential impact on drug services, see the papers prepared for the AGM of the Standing Conference on Drug Abuse (31

March-2 April 1989). One paper outlined the government's plans and a second listed the questions these raise for drug services. See also the report of the AGM's discussions on the white paper in the *SCODA Newsletter*, May/June 1989. Contact SCODA's Policy Officer Rosemary Morle on 01-831 3595.

◆ On the implications of statutory bodies contracting out services to voluntary agencies, contact the National Council for Voluntary Organisations who have helped set up a working group on contracting out. This group produces a bulletin for voluntary projects — order from Nazma Hallim, NCVO, 26 Bedford Square, London WC1B 3HV, phone 01-636 4066.

◆ ISDD's library holds a file including the NHS white paper and associated working papers plus responses to these from the BMA, National Association of Health Authorities, etc, and comments in the medical press — phone 01-430 1991.

1. UK government. *Working for Patients*. HMSO, January 1989.

2. BMA. *Special report on the government's white paper Working for Patients*. BMA, 1989.

3. Ray Robinson. "Self-governing hospitals." *British Medical Journal*, 25 March 1989, p.437-9.

4. Dr Philip Maclean. Speech to SCODA AGM, 1 April 1989.

5. Ray Robinson. "New health care market." *British Medical Journal*, 18 February 1989, p.819-821.

6. DHSS. Health Authority Circular HC(86)3, February 1986.

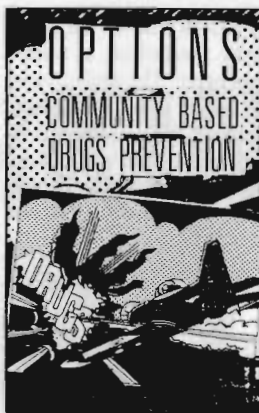
**OPTIONS: COMMUNITY-BASED DRUGS PREVENTION.** Manchester: North West Regional Drug Training Unit, 1988. Video. £46 inc. p&p, or £7 inc. p&p to hire/preview.

Despite the higher profile and acceptability of secondary prevention as a result of HIV/AIDS, it is still essential when developing a community-based campaign to make certain that everyone involved understands both the basic concepts and the objectives of harm minimisation approaches.

The video *Options* from the North West Regional Drug Training Unit, despite its curiously misleading title, has a useful role to play in allaying the anxieties of cautious policy makers who view harm minimisation as a radical step which could stir controversy by accepting or condoning drug use.

The video is a powerful tool of persuasion. I wish it had been available two years ago when we were cajoling our management committee towards harm minimisation. It develops compelling and logical arguments for both the validity of and scope for harm minimisation by means of cameo performances from a galaxy of drug specialist glitterati.

The strong initial stance taken could possibly alienate some cautious potential allies, as it is rather dismissive of primary prevention strategies. Surely it is politic to introduce secondary prevention harm minimisation strategies as complementary to primary initiatives rather than as a competitor? There is no dichotomy in primary and secondary preventive strategies existing in parallel, and certainly no mileage in hard knocking tactics at what should be a compatible rather than a competitive approach.



A video from Manchester to help win the local argument over harm minimisation — but will it export to the prosperous south?

The video suggests that if parents can handle teenage alcohol misuse in a family environment, then they should be equally able — with the appropriate knowledge — to handle youthful heroin use. Certainly, knowledge will help parents cope better, but for many families it is the illegality and deviant image of heroin which gives rise to the situation where they can't handle it in the family environment. Short of legalising heroin use, or downgrading it to the status of alcohol, parental reaction to heroin use is always going to be extreme and emotive.

The video becomes potentially contentious when it starts establishing a relationship between drug use and unemployment, suggesting job and entrepreneurial opportunities as a form of harm minimisation. Coming from a south-coast town where low unemployment is combined with the fourth highest level of addiction notification in England, I can see this short section making some southern viewers

reject the overall message of the video.

It makes me uneasy to hear workers talking about becoming 'advocates' for our client group. Surely it is more appropriate for us to encourage the client group to become, through users' unions or whatever, their own advocates, rather than for drug workers to assume the perhaps unwanted or misguided role as their spokespersons?

Despite these minor carps, the video is a superb promotional tool for harm minimisation to use with the undecided or uncommitted professional. But for those already dedicated to harm minimisation, the video has little to offer. If it is also intended for this market, how much more useful it would have been to have had some examples of 'good practice' from the North West, an innovation leader in the field of harm minimisation.

The pack includes brief but adequate trainer's notes and a short article from Mark Gilman of the North West Regional Drug Training Unit. He states: "Harm minimisation messages and advice have to come from a user-friendly and non-judgmental agency that accepts drug use as a normal activity that may lead to problems but is not itself pathological behaviour" — on reflection, a statement with which my agency can strongly associate itself.

**Andrew Fraser**

*Director of DAIS (Drug Advice and Information Service), a 'street agency' and part of Brighton Health Authority. The unit's policy and practice endorses harm minimisation objectives.*

*Options* is available from NWRDTU, Kenyon Ward, Prestwich Hospital, Manchester M25 7BL, phone 061 798 0919.

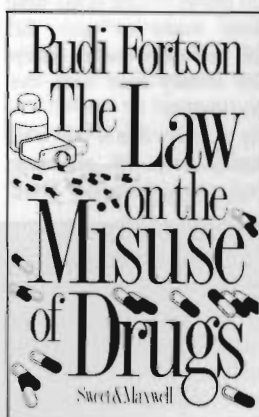
**THE LAW ON THE MISUSE OF DRUGS.** Rudi Fortson. London: Sweet and Maxwell, 1988. xxv, 303 pages. £27.

The law on drugs is constantly changing. Some changes result from well publicised legislation, but many more come about through decisions in the courts, the rescheduling of drugs, and other minor adjustments. Every couple of years a new book appears on drugs law, updating lists of scheduled drugs and reproducing excerpts from the legislation, duly amended. The principal use of such books are as works of reference. Only the truly committed would plough through from cover to cover.

I use drugs law books as travelling companions — to look up obscure drug classification issues during meetings or training courses. But the books are rarely opened during sessions because people I talk to are usually more concerned with *how* the law operates rather than *what* the law is.

When dealing with a person facing criminal proceedings, drugs law is often one legal issue among many others that need to be taken into account. Consideration of pure drugs law issues may be very important when planning services and lobbying, and the need for information on the subject should not be minimised. But for those of us in day-to-day contact with drugs offenders, drugs law needs to be set in a wider criminal law context.

Rudi Fortson's book is much more interesting than most previous books on drugs law. Inevitably, much of the book is given over to excerpts from the legislation, but there is a good commentary and, most significantly, practical



Is there any point in drug agencies buying expensive books on drug law? An expert opinion on the latest example of the genre.

examples and excerpts from legal judgments giving some insight into the reasoning of the courts when dealing with drugs cases.

*The Law on the Misuse of Drugs* outlines principles of drug control and classification and deals very fully with the import and export of controlled drugs before moving on to possession, supply and conspiracy, enforcement (powers of police and customs officers) and the Drug Trafficking Offences Act.

This book is written by a barrister. Its aim is to meet the needs of criminal law practitioners concerned with presenting the prosecution or defence of a drugs case at court. It would also be very useful for police officers who are gathering information for prosecution. It assumes a good knowledge of court procedure, understandably dealing only with those special features of drugs law distinguishable from other procedures in other areas of criminal law.

For the lay person, this is a considerable disadvantage. For example, the book deals with the offence of past possession of drugs in a few lines, and with possession with intent to supply drugs at rather greater length, outlining the necessary evidential 'ingredients' of the offences.

The significance of alleged verbal admissions by defendants on such charges cannot be underestimated. As a result, trials involving these charges are often bitterly contested. But the problems posed by verbal admissions are not mentioned on the assumption that the book's readers will understand the status of such evidence.

Unfortunately, the section on drugs sentencing is so brief that it is not particularly helpful, dealing with many different drugs offences in a few sentences each. There is very little on the law relating to the administration of illegal drugs to another person, an area in which there have been a number of worrying cases recently in which drugs offences have been presented as woundings, assaults, even manslaughter.

*The Law on the Misuse of Drugs* will be very useful to those concerned with large numbers of people contesting drugs charges who want to argue points at court. It will be of less practical use to staff in most drugs counselling and welfare work. If recent changes in drugs law and practice are anything to go by, the book will have a limited shelf-life. At £27 for 300 pages it's useful, but expensive.

**Jane Goodsir**

*Director, Release Legal and Emergency Services.*

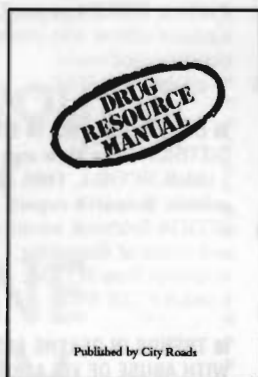
**DRUG RESOURCE MANUAL.** Third edition. City Roads. London: City Roads, 1988. 39 pages. £3.50 inc. p&p.

The third edition of the *Drug Resource Manual* from City Roads is now available for all those who yearn for a simple, concise guide to help them work with drug users. Its message is, "You Can Cope". But will it help those not working in drug specialist services to cope? I have often complained of the wordiness and inaccessibility of some of the books about drug use and working with drug users. So a 'manual', with its promise of conciseness and clarity, would appear to be a sensible way to tackle the subject. Does this manual deliver the goods?

It makes a brave attempt. Sections on working with drug users, commonly used drugs and their effects, and on drug specialist agencies are supplemented with appendices on the Misuse of Drugs Act, GPs, drug users and the law, avoiding overdoses, and further reading. But if the manual's "You Can Cope" message is to be received and acted upon, readers must feel it provides enough information.

While pointing out the inaccuracy and futility of stereotypes, the manual somehow manages to reinforce the assumption that all drug use is necessarily problematic. More fundamentally, it does not do enough to recognise the difficulties those not working in drug specialist agencies can have in actually assessing whether someone is using drugs at all, let alone what role drugs play in their lives.

It is no accident that drugs training courses are often full of people who want 'signs and symptoms'. Outside of drug specialist agencies (where declared drug use is the ticket into the services on offer) people often have to struggle



This manual is unique in attempting to give non-specialists a concise guide to working with drug users — how well does it do?

with rumour, suspicion and symptom-spotting — a situation demeaning to the drug user and frustrating to the worker. Nor does the manual say enough about reducing risks to health, particularly those posed by unsafe injecting and sexual activity.

Yet there is much that is useful. The sections on rehabilitation are heavily weighted towards specialist residential rehabilitation, but do provide a useful overview of what's on offer. They also highlight important issues for referrers, such as their own attitudes to the rehabs, and the rehabs' responses to gender, race, women and children, couples and sexuality. The section on "Drugs and their Effects" is valuable, although ISDD's *Drug Abuse Briefing* does it better.

What is said about drug specialist agencies could be helpful, but lacks information on how they could resource and support others working with drug users so as to avoid unnecessary referrals to specialist services. This is of real importance where specialist services are scarce, and when all drug agencies have had to review

their practice in the light of HIV/AIDS and build closer links with other services.

The list of regional contacts seems a waste of space — many are local agencies who may not be equipped to offer advice on services across a wide geographical area. The space would have been better used recommending SCODA's *Drug Problems: Where to Get Help*.

There are other resources — training packs and videos, leaflets, books — that aim to help people work with drug users: how does the *Drug Resource Manual* rate against the competition?

The manual is clearly more extensive than any leaflet, so comparisons there are unhelpful. It is not a training resource, so that leaves us with books — in particular, two of those most recently published, Annas Dixon's *Dealing with Drugs* and Griffiths and Pearson's *Working with Drug Users*. Whilst praising City Roads's intention to produce a concise manual, I would still recommend Griffiths and Pearson's book as a resource that is reasonably up to date, not too long, and provides sufficient information to really enable people to 'cope' with drug users.

My overriding impression of the manual is that it tries to incorporate too much, but does not give enough detail on more general practical issues that must be addressed when working with drug users. And it does not do enough to highlight the sorts of skills that will be of use. Although I could imagine drawing on certain sections within training courses, its usefulness is severely limited.

Lynne Milburn

Director, North West Regional Drug Training Unit.

The Drug Resource Manual is available from ISDD.

LETTERS

No way to run services for drug users

Dear Editor,  
In the January/February issue of *Druglink* I argued that employing outreach workers may not be the most effective way of spending new money on drug services. I suggested that a cost efficient alternative might be to pay drug users a 'bounty' for bringing in their drug using friends. In the May/June edition I was soundly thrashed by outreach workers — not too many surprises there!

Interestingly, none of my critics said that an incentive scheme would fail to bring new people in. Andy Fox thought it would attract as many as 500. If he's right, then it would be the most successful UK drug service ever in breaking into the 'hidden layers of the iceberg'. I don't know yet whether it would be possible to use this new point of contact with clients to develop constructive relationships. I think it's worth a try.

This approach certainly has at least as much chance of being effective as the outreach workers being appointed in many parts of the country. Some have been appointed purely because it's a surefire way to get extra funding. In one case the funders insisted on creating outreach posts even when the local specialists argued against it. In others outreach workers have been appointed with no job description — just an instruction to go out and find some

drug users. This is not a sensible way to allocate limited resources.

Happily, there are exceptions. The Turning Point outreach workers who replied to my article offered to send out their conceptual model. This identifies a hierarchy of objectives for outreach and sets performance indicators which will allow a thorough evaluation of their work. It deserves much wider circulation.

The real point of importance here is that of measurement of impact and efficiency. If outreach is to be a valuable contribution to our field then it should be able to demonstrate its impact. Of course, we can say the same for other aspects of drug services.

Our field has grown by chasing pots of money made available by politicians anxious to be seen to be doing something about drugs. Outreach is just the latest in a long line of fads and 'flavours of the month'. Few have been adequately evaluated and even fewer have demonstrated their value.

We cannot continue to operate like this. Comparatively speaking, we now have a great deal of money coming into the field. If we don't take a lead in establishing clear and measurable objectives, performance indicators and criteria of cost efficiency, we will lose the money just as quickly — it will serve us right.

James Les Kay

Save paper  
Use Druglink's new  
**PHONE-A-LETTER**  
Service  
Dial 01-430 1991

Needlesticks in exchanges not 'inevitable'

Dear Editor,  
Following your report on needlestick injuries in needle exchanges (March/April 1989, p.6), I write to clarify the view of the Lifeline Project on this issue.

We believe that such injuries are inevitable *only if adequate procedures are not established and adhered to by all staff.*

On reflection, the past few years have seen many organisations deliberately downgrading the health risk implications of needle exchange work in order to emphasise the ordinariness

of the transaction and to counter the 'AIDS scare'.

Whilst in the circumstances this attitude was probably both understandable and appropriate, experience now shows that it needs to be modified in order to strike a balance which preserves both the dignity of the customer and the health and safety of staff.

If adequate guidelines are formulated and adhered to *at all times* we believe that needlesticks need not occur. We have formulated guidelines for staff and managers which we are happy to supply on request.

Our feeling is that normal needlestick policies in force in most hospitals rarely meet the particular needs of staff and customers of needle exchanges.

Rowdy Yates

Director, Lifeline Project Limited, Manchester, phone 061-848 7227

Letters should normally be less than 500 words in length and may be abridged at the editor's discretion. Letters criticising previous articles may be sent to the original author so they can reply in the same issue of Druglink.

## PUBLICATIONS

## Therapy/Services

## ■ TREATING DRUG ABUSERS.

Gerald Bennet, ed. Routledge, 1989. 201 pages. £25. Book. Essential reading on drug treatment and counselling practice by practitioners from UK and Netherlands. Prochaska and DiClemente's processes of change model is a central theme. Available through bookshops or from ISDD at £25.70 inc. p&p.

## ■ STUDY OF HELP-SEEKING AND SERVICE UTILISATION BY PROBLEM DRUGTAKERS. Drug Indicators Project. ISDD, 1989. Research report. £4.

Important study commissioned by government as a basis for guidance on how to attract drug users into services. Available from ISDD.

## ■ DRUGS RESPONSE MANUAL.

Wessex Regional Health Authority, 1989. 70 pages. For non-specialists in the Wessex region. Drug facts, law, first aid, local services, etc. Available from Wessex RHA, Highcroft, Romsey Road, Winchester, Hampshire SO22 5DH.

## ■ HOW TO COMBAT ALCOHOLISM AND ADDICTION. Robert Lefever. London: Promis Books, 1988. viii, 129 pages. Book. £7.95.

Handbook based on experience at the PROMIS Recovery Centre, which uses the Minnesota Model. Available through bookshops.

## ■ ADFAM NEWS. ADFAM.

Newsletter from the national charity representing parents and families of drug users. Published three times a year. Available from ADFAM, 82 Old Brompton Road, London SW7 3LQ, phone 01-823 9313.

## ■ MIDLANDS DRUG WORKER. Turning Point. Quarterly newsletter. £5.

For drug workers in the Midlands region. Contact Kit Leck, Turning Point, 2nd Floor, 1 Copthall House, Station Square, Coventry CV1 2FZ, phone 0203 633222.

## HIV disease

## ■ AIDS, AGENCIES AND DRUG ABUSE: THE EDINBURGH EXPERIENCE. Jackie McRae. Norwich: University of East Anglia, 1989. 40 pages. £3.50. Report.

Study of the response of Edinburgh's drug services to HIV/AIDS. Based on interviews with workers. Available from Social Work Monographs, University of East Anglia, Norwich NR4 7TJ

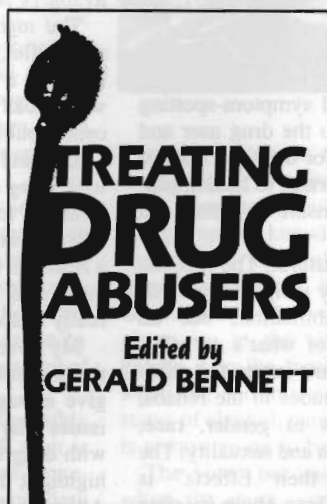
## ■ AIDS. PSYCHOLOGICAL AND SOCIO-MEDICAL ASPECTS OF AIDS/HIV.

Oxford: Carfax Publishing Co. Academic Journal. 3 issues a year. New journal with UK editors dealing with non-medical aspects of HIV/AIDS work.

Available from Carfax Publishing Co., PO Box 25, Abingdon OX14 3UE.

## ■ LEARNING ABOUT AIDS. EXERCISES AND MATERIALS FOR ADULT EDUCATION ABOUT HIV INFECTION AND AIDS. Peter Aggleton et al. Churchill Livingstone, 1989. Training pack. £19.95.

A significant advance in AIDS training materials — see review in last issue. Available from ISDD, £22 inc. p&p.



## Education

## ■ LIFE EDUCATION RESOURCES.

Life Education Centres, various dates. Series of booklets and posters plus audio tape. Materials for educating 5-13 year olds. Catalogue from Life Education Centres, 260 Archway Road, London N6 5BS, phone 01-341 5902.

## ■ HEALTH EDUCATION IN NORTHUMBERLAND: DRUG EDUCATION GUIDELINES.

Northumberland Education Dept., 1989. 40 pages mimeo. Report. Detailed guidelines written for education workers in Northumberland. Available from Morpeth Teachers' Centre, Newgate Street, Morpeth NE61 1BU, phone 0670 513926.

## Drug facts

## ■ THE SUBSTANCE IN QUESTION.

Portsmouth: Project Icarus, 1989. Video plus six posters. Hire £14.95, purchase £34.50. The video is a balanced presentation of drug facts and drug problems produced as part of Wessex's regional anti-drugs campaign — see this issue pages 10-11 for background. Available from Project Icarus, 214A Havant Road, Portsmouth PO6 2EH, phone 0705 324248.

■ TRANQUILLISERS: ISDD DRUG NOTES 7. Malcolm Lader and Harry Shapiro. ISDD, 1989. Leaflet. £0.75. Basic facts and discussion of the issues. Available from ISDD.

## Other

■ THE USER'S GUIDE TO SAFER DRUG USE. London: Community Drugs

Project, 1989. 14 pages. Leaflet. £0.50.

Updated edition with information on cleaning used works. Available from ISDD.

## ■ DRUG PROBLEMS IN EDINBURGH DISTRICT. Sally Haw and David Liddell. SCODA, 1989. 124 pages mimeo. Research report. £5.

SCODA fieldwork survey of the pattern and extent of drugtaking. Available from SCODA, 1 Hatton Place, London EC1N 8ND.

## ■ TRENDS IN DEATHS ASSOCIATED WITH ABUSE OF VOLATILE SUBSTANCES 1971-1987. H.R.

Anderson et al. London: St. George's Hospital Medical School, 1989. 12 pages. Report. Latest in a series of annual reports. Contact Kate Bloor, St. George's Hospital Medical School, Department of Clinical Epidemiology and Social Medicine, Cranmer Terrace, London SW17 0RE.

## ■ DRUG RESEARCH IN EUROPE.

Virginia Berridge. ISDD, 1989. 27 pages. Report. £8. Overview and recommendations. Available from ISDD.

## TRAINING

## ■ INSTITUTE ON DRUGS, CRIME AND JUSTICE. American University, USA.

16-26 July, London; 26 July-5 August, Liverpool; 1989. £25 per day or £100 per week, reductions for charities. Comparative seminar on drug control policy in UK, USA and Holland. Details from Dr. Cindy Fazey, Centre for Urban Studies, University of Liverpool, PO Box 147, Liverpool L69 3BX.

## ■ PAYING PUNTERS INSTEAD OF OUTREACH WORKERS. Mersey Regional Drug Training Centre.

17 July 1989, Liverpool. Free to local workers, others £15. On the controversial idea of using drug users to bring their contacts to services. Details from Mersey Regional Drug Training Centre, 10 Maryland Street, L'pool L1 9BX, phone 051 709 3511.

## ■ MOTIVATIONAL INTERVIEWING.

East Dorset Community Drug Team. 9-11 August 1989, Bournemouth. £95 non-residential. Practical skills training by the Dutch practitioner Henk van Bilsen. Course details from Gerald Bennett, East Dorset CDT, phone 0202 37003; applications to EDDAAS, 28 Lansdowne Road, Bournemouth, phone 0202 28718.

## ■ BENZODIAZEPINE WITHDRAWAL WORKSHOPS. Withdraw Workshops.

7-8 September, York; 2-3 October, Exeter; 9-10 November, Cardiff; 1989. £96.

Based on the approach to withdrawal from tranquillisers/sleeping pills developed by the WITHDRAW Project. Details from Withdraw Workshops, 515A Bristol Road, Birmingham B29 6AU, phone 021 471 3626.

■ DRUGS AND ALCOHOL IN THE WORKPLACE. Dates in October 1989 in Edinburgh, Manchester and London.

■ DRUG USERS IN PRISON. Dates in November 1989 in Edinburgh, Manchester, Dublin, Bristol and London. Network ADA. Two series of seminars featuring US speakers. Details and fees from Network ADA, Freeport, Bury, Lancs. BL9 5YZ, phone 070682 8963.

■ ONE YEAR CERTIFICATE COURSE IN ADDICTIVE BEHAVIOUR FOR GPs. Department of Addictive Behaviour, St. George's Hospital Medical School, London. 3 October 1989-12 June 1990.

One afternoon per week. Priority to GPs in SW Thames RHA. Details from David Monk, Dept. of Addictive Behaviour, St George's Hospital, Clare House, Blackshaw Road, London SW17 0QT, phone 01-672 9944.

■ BASIC COURSE ON WORKING WITH DRUG RELATED PROBLEMS. Cooperative Training Services. 19-20 October 1989, London. £60 statutory agencies; £20 voluntary; free to Home Office funded voluntary agencies.

For workers not in drug specialist agencies and for those new to the field. Details from CTS, c/o NACRO, 169 Clapham Road, London SW9 0PU.

## MEETINGS

■ DRUG DEPENDENCE: CLINICAL PHENOMENA AND BASIC MECHANISMS. Institute of Psychiatry. 11-14 July 1989.

Psychiatric conference with international speakers. Details from Institute of Psychiatry, DeCrespigny Park, London SE5 8AF, phone 01-703 5411.

■ EUROPEAN FORUM FOR PREVENTION AND TREATMENT OF DRUG DEPENDENCE. Polish Society for Prevention of Drug Abuse. 18-21 September 1989, Warsaw. Registration \$150.

Conference with simultaneous translation into English. Contact ISDD's library for more information, phone 01-430 1993.

## FOR MORE INFORMATION ...

- ☞ ON THE PUBLICATIONS LISTED HERE: phone ISDD on 01-430 1993.
- ☞ ON MORE NEW PUBLICATIONS AND ARTICLES: order *Drug Abstracts Monthly* — £16 p.a. from ISDD, phone 01-430 1961.
- ☞ ON A PARTICULAR TOPIC: phone ISDD's library on 01-430 1993.
- ☞ ON TRAINING: phone Breda Flaherty, Training Officer at the Standing Conference on Drug Abuse (SCODA), on 01-831 3595.

# Support-groups forming for **FRONTLINE Drugs/HIV Workers**

For more information  
please contact:

(Acting) Drugs Counselling Officer,  
Terrence Higgins Trust,  
52-54 Grays Inn Road,  
London WC1N 3XX  
or phone  
01-831 0330 ext. 316.

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Further details from: Dr. C. Fazey,  
Centre for Urban Studies, University of Liverpool,  
4 Cambridge Street, Liverpool, L69 3BX,  
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Enquiries will be welcomed by Frank Ryan, Psychologist for the Drug Advisory Service, on (0206) 852271 ext 8941.

An information package is available from Michelle Appleby, Senior Personnel Officer, Severalls Hospital, Boxted Road, Colchester, Essex, CO4 5HG or telephone the 24-hour answering service on (0206) 852271 ext 8633.



**NORTH EAST ESSEX HEALTH**  
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# Added to ISDD's 1989 publications catalogue



## **Treating Drug Abusers**

Edited by Gerald Bennett. Routledge, 1989. Hbk. £25.70.  
A unique practical compilation of UK treatment and counselling approaches.



## **AIDS and Drug Misuse Part 2**

Advisory Council on the Misuse of Drugs.  
HMSO, 1989. £6.70.



## **Study of Help-seeking and Service Utilisation by Problem Drugtakers**

Drug Indicators Project. ISDD, 1989. £4.  
A research basis for the vital task of attracting clients into drug services.



## **Learning about AIDS**

Peter Aggleton *et al.*  
Churchill Livingstone, 1989. £22.  
A major advance in AIDS materials for trainers.



## **Tranquillisers. ISDD Drug Notes 7**

ISDD, 1989. £0.75.  
Latest in ISDD's basic drug facts booklets that also deals with the issues involved in tranquilliser prescribing and the treatment of dependence.



## **Drug Research in Europe**

Virginia Berridge. ISDD, 1989. £8.  
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