

# DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN

March/April 1990

*'We're just like you,  
except we've got a home  
and a job, we're not  
strung out on smack, we  
haven't got a court case  
coming up, and we can  
throw you out if you're  
not nice to us, but  
otherwise...'*

— Drug worker to client

A counter-  
blast against  
a current  
hypocrisy  
or an old-  
timer's  
reactionary  
tirade?  
Decide for  
yourself as  
today's drug  
workers are  
put in the  
dock.  
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# THE BLEACH PROJECT

ARE OFFERING A

**£500**

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to the drug agency that can create the best image/logo to promote the use of bleach as an aid to safer injecting practices.

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Entries should include ideas about colour in the design.

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CLOSING DATE: FRIDAY APRIL 20TH 1990

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**Druglink** is for all specialist and non-specialist workers and researchers involved in the response to drug misuse in Britain.

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**CONTRIBUTIONS:** **Druglink** welcomes letters and other contributions. Send direct or phone Mike Ashton (01-430 1991) to discuss your ideas.

**SUBSCRIPTIONS:** **Druglink** is published every two months. The subscription year is January to December. During the current year subscriptions can start from: January (£15); March (£12.50); May (£10); July (£7.50); September (£5); or November (£2.50). Send a further £15 to continue your subscription through 1991. Cheques payable to **ISDD**.

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ISSN0305-4349

*'We're just like you, except we've got a home and a job, we're not strung out on smack, we haven't got a court case coming up, and we can throw you out if you're not nice to us, but otherwise...'*

— Drug worker to client

## Avenues to enlightenment

"The information base on which policies are formulated is seriously deficient", said Virginia Berridge two years ago in *Druglink*. In this issue *Druglink* shows three ways the data drought is being ended: through a new national database (p.10); through local research/drug work partnerships (p.16); and through clinical research (p.14). But our first article argues that a little bit of knowledge can be dangerously distorted (p.8).

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## Police forces back referral schemes

At least half the police forces in England and Wales will be operating referral schemes within a year, predicts ISDD's Research Unit, though the response from Scotland has been relatively muted. Aberdeen, Avon and Somerset, Durham, and Sussex now boast new drug referral schemes enabling people caught in possession of drugs by the police to be referred to local drug agencies.

Initiated by ISDD and by local police forces and drug agencies, up to six other areas have schemes in the pipeline, including Gwent, Humberside, North Wales and Staffordshire. Similar schemes have been running for some time in Merseyside, Barnstaple and several areas of London.

Cautions are increasingly replacing court appearances for

simple possession — sometimes even of class A drugs in small amounts — and the referral schemes are seen as underpinning this trend. Cautions are especially likely for juvenile offenders.

Schemes vary depending on local arrangements. In some a referral card with agencies' telephone numbers and addresses is given only to drugs offenders; elsewhere, the card is also given to other offenders (for instance,

people arrested for theft or burglary), the assumption being that drugs could be a hidden problem or that people are engaging in acquisitive crime to purchase drugs.

As well as cards being handed out in the police station, it is also possible for officers from the drugs squad to carry the cards around and dispense them 'on the street', or for community liaison officers to hand out referral cards at community centres and other places. ISDD's research unit has funds to pay for the referral cards and to monitor the schemes to make information available on best practice.

**Soon half Britain's police forces may be referring drug users for help, using cards such as this one from Gwent, one of the latest recruits to the scheme.**



## Company markets 'black box' to tranquilliser dependents

Tranquilliser dependents are being offered £130 electrostimulation 'black boxes' by a commercial company whose literature claims the equipment is "one of the few genuine treatment possibilities available to remove problems encountered when withdrawing from tranquillisers".

Experts outside the complementary medicine field believe the company is marketing a treatment of unproven worth to a vulnerable, often isolated group of people.

Equinox International's UK distribution point in Liverpool sells around 20 units a month for addictions treatment.

The company has broken new ground by marketing direct to tranquilliser users rather than through clinics.

Their *Tranquilliser Self-Help Information Pack* encourages self-help groups to incorporate the 'Equinox System' in their work, partly with the promise of a free unit for the group if five members buy their own.

Joan Jerome of Tranx runs Britain's biggest self-help network for tranquilliser users. Last year she was repeatedly contacted by Equinox representatives "pushing", as she puts it, their electrostimulation system. "They were like double glazing salesmen," she says.

Equinox says home treatment can be prescribed on the basis of a questionnaire completed by the

client and sent to Equinox for assessment, particularly useful for agoraphobics who do not want to attend groups.

The company's line is that tranquilliser dependence and withdrawal are biochemical processes produced by taking the drug. Many of their clients will be relieved to be approached as 'tranquilliser victims' rather than as 'neurotics' with deeper personal problems.

This denial of the role of psychological or social problems in tranquilliser dependence worries some mainstream treatment professionals. One of Britain's most experienced tranquilliser dependence counsellors believes as many as a third of people seeking help for tranquilliser dependence have problems which a 'black box' cannot address.

The other two-thirds just need to withdraw gradually with appropriate support, says Diane Hammersley, formerly of Withdraw, an NHS clinical and research project which acquired a considerable reputation for its work with tranquilliser dependency. She too was persistently phoned by Equinox asking her to attend a demonstration of their equipment.

Equinox's Technical Director, Ian Ward-Baskin, says if a client questionnaire reveals a psychiatric condition then they will not be sold the equipment — but this would only happen if there were

clear signs such as prescription of major tranquillisers or antidepressants.

Backing up Equinox's marketing literature is a series of *Equinox Reviews*. These academic-looking papers offer scientific support for the company's work. Dr Andrew Herxheimer, a lecturer in clinical pharmacology and an expert at assessing the validity of treatment evaluations, says the reviews prove "nothing whatsoever".

The controversy leaves potential customers and those who advise them with little to go on. One benchmark is Bethlem Hospital's test of electrostimulation in the treatment of heroin addiction (Equinox's original field), which did not use the Equinox System.<sup>1</sup>

Equinox theorise that the same mechanism — stimulation of endorphin production — lies behind their treatment of both tranquilliser and heroin dependence.

If they're right, this test did not bode well for either group. Reported in the *British Journal of Psychiatry*, the authors concluded that electrostimulation appeared little, if any, better than no treatment at all at suppressing withdrawal symptoms. Whether Equinox's version of the black box would do better remains to be proven.

1. Gossop M. *et al.* "The clinical effectiveness of electrostimulation vs oral methadone in managing opiate withdrawal." *British Journal of Psychiatry*: 1984; 144, p.203-8.

■ A quarter of British men aged 18-35 believe "soft drugs should be legalised", found a Gallup survey conducted last spring. The year before, another Gallup survey found that over a fifth of British university or polytechnic students had used cannabis since becoming a student. By age 22-30, 40 per cent had taken illegal drugs while a student. Use of drugs other than cannabis was at or below four per cent.

■ The new anti-anxiety drug buspirone has "significantly less potential for dependence" than the benzodiazepines, found a carefully controlled study of 51 patients suffering anxiety disorder.<sup>1</sup> Patients were abruptly switched to identical-looking placebos after taking either buspirone or diazepam. There was some rebound anxiety in both groups when placebos were introduced but practically no new withdrawal symptoms appeared after buspirone. However, buspirone takes weeks to become effective and may be less acceptable to patients.

1. Murphy S.M. *et al.* "Comparative assessment of efficacy and withdrawal symptoms after 6 and 12 weeks' treatment with diazepam or buspirone." *British Journal of Psychiatry*: 1989, 154, p.529-534.

■ A health clinic for drug users in London found that over half the injectors tested for HIV after counselling did not return for the test results.<sup>1</sup> A third of the injectors decided not to take the test, and for a third of these the reason given was inability to cope with a positive result.

1. Sonnex C. *et al.* "An appraisal of HIV antibody test counselling of injecting drug users." *AIDS Care*: 1989, 1(3), p.307-311.

■ A study of the Alpha House therapeutic community has concluded that the project's move from traditional confrontational strategies to a more "democratic and permissive" regime significantly improved outcome for residents who stayed longer than four weeks.<sup>1</sup> In each of three periods studied (1971-2, 1974-5, 1981-2), 50 to 60 per cent of Alpha's residents stayed for at least four weeks. Criminal records of around half the residents in the first two periods improved after treatment, but under the new regime in 1981-2 over 80 per cent improved.

1. Norris M. "A follow-up study of drug abusers in a therapeutic community during periods of change." *International Journal of Therapeutic Communities*: 1988, 9(4), p.249-261.

# Cooperate with community punishments or see your clients in prison — dilemma for drug agencies

Servicing the criminal justice system will become a major part of the work of drug agencies. Those not prepared to cooperate risk being sidelined as others take on assessment and supervision roles to help drug users stay out of prison, and to gain access to a slice of the £millions released by cutting the prison population.

These are the implications of the Government's white paper *Crime, Justice and Protecting the Public* published on 6 February. The paper's proposed 'punishments in the community' have been widely publicised. On 7 February Home Office Minister David Mellor told magistrates that among them would be "probation orders with a condition of treatment for drug and alcohol problems".

These orders might be applied to drug dependents convicted of property crime as well as those convicted of drug offences.

Obliging courts to justify custodial sentences will put pressure on them to use such

orders instead of immediate or suspended imprisonment. The new legislation will also allow probation orders to be combined with fines, the most common sentence for drug offences.

Drug agencies will be involved in at least two ways — in assessing offenders before sentence, and in implementing treatment conditions imposed as a condition of a non-custodial sentence.

How big the assessment job might be can be estimated by looking back at 1988. Had the system been in place then, over 4000 drug possession offenders might have been considered for a 'treatment sentence'. This conservative estimate excludes those fined, and those convicted of more serious offences or of non-drug offences. With some of these the total may have been nearer 10,000.

How many are judged candidates for treatment will depend partly on the pre-sentence social inquiry reports which will be required for every case where the

court is considering custody.

The probation service is likely to turn to drug agencies to assess offenders for possible therapeutic programmes and motivation to change, both mandatory elements of the reports. Offering assessment packages to probation could become big business.

The offender's consent will be required before a treatment condition can be made part of a probation order. Nevertheless, drug agencies who go along with the new system will find themselves with clients whose motivation amounts primarily to staying out of prison.

A major role for drug specialists will be educating the probation service and the courts to ensure that drug offenders are not forced to accept unrealistic conditions in order to stay out of prison.

Welcome passages in the white paper acknowledge that young drug dependent offenders in particular may be incapable of the self-control and organisation

needed to fulfil a restrictive non-custodial sentence, such as curfew or regular attendance for treatment.

Where offenders fail to adhere to the court's treatment conditions, then the drug agency will be expected to inform the probation service.

There will be fierce debate in the drugs field over the propriety of cooperating with community-based punishments. Residential agencies are concerned at the prospect of housing residents who feel forced to stay there by the courts. Non-residential services may find a policing role incompatible with a user-friendly persona, identification with the client's interests, and an advocacy role vis a vis the criminal justice system.

Other agencies feel just as strongly that the white paper presents a great opportunity to give more drug users a positive therapeutic experience rather than prison, so long as treatment orders are only imposed where probation would otherwise have been refused.

## Call for radical shift in UK drug policing

Assets confiscated from drug traffickers should fund a new 'problem-oriented' approach to drugs policing in Britain, drawing communities together to tackle the local problems underlying drug use.

These are the conclusions of a report now being considered by top officers in the Metropolitan Police. The report's author is Detective Sergeant Graham Saltmarsh of the Met's Central Drug Squad, who recently visited the USA to witness the drug problems of some of America's poorest neighbourhoods.

In April Britain's chief police officers will hear John Eck of the US Police Executive Research Forum describe the initial results of a federally-funded trial of problem-oriented drug policing in five US cities. Saltmarsh is hoping Eck's presentation will galvanise Britain's police in the same way as DEA agent Stutman did the year before, but in a different direction.

Eck argues that blanket national anti-drug strategies bypass the most disadvantaged groups in US society, who have little to lose from social sanctions and cannot afford to jump the queue for treatment.

He advocates localised approaches tailored to the underlying

causes of drug problems in a particular setting. In one place, these might be poor lighting combined with derelict buildings offering a safe haven for local truants to deal and use, while in a city firm, competitive pressure might lie behind stimulant use.

Together with other local agencies, police would work to identify these factors. The concentration is not on drug use itself but on the problems — violence, theft, illness, intimidation, etc — that it may be posing for residents.

Police advocating urban renewal and helping to establish strong tenants' groups as a bulwark against the dealers, seems a far cry

**A minor miracle: tenants of St Louis housing blocks scheduled for demolition not only organised to reclaim their neighbourhood from the dealers but also developed this new upmarket estate.**



from current policing approaches.

Community or 'multi-agency' policing in the drugs field often amounts to participation in liaison groups. What could transform these into problem-solving units is access to traffickers' cash confiscated under the Drug Trafficking Offences Act.

So far the Government will only allow this money to help fund expensive international drugs investigations, the remainder being absorbed by the Treasury.

Saltmarsh's report proposes a "compromise" solution to competing claims on the money. After paying basic police costs for a major investigation, remaining

assets would be held on deposit under the control of a board of trustees, who would loan sums to fund suitable local schemes at a very low rate of interest.

The argument is that to implement schemes agencies often need money now which can be repaid in the years to come.

Home Office-funded drug prevention teams to be extended to over 30 localities in the next two years could provide ready-made local groups to identify problems and apply to the fund for money to solve them.

Using traffickers' money to fund urban improvements is the kind of imaginative scheme likely to meet stiff resistance from both sides of the political divide.

At local level a major issue would be reaching agreement on what 'the problem' really is. Police definitions of the problem may well differ from those of groups such as tenants, local authorities, and voluntary bodies.

Sergeant Saltmarsh believes most urban drug policing policies are visibly failing and says there appears to be no alternative other than the one he proposes. Whether chief police officers see it that way may be revealed in their reaction to John Eck.

## Scientific bias scaring pregnant cocaine users into abortions, say researchers

Bias in the publishing of research on cocaine and pregnancy may be leading to unnecessary abortions as women react to publicity about malformed 'crack babies'.

In the late '80s a wave of scientific research has linked cocaine to a range of adverse effects including sudden infant death and neonatal malformation.

But Canadian researchers writing in the *Lancet* say studies which found these effects may have been accepted by academic journals while equally sound studies finding no adverse effects were rejected.<sup>1</sup>

The proceedings of the Society for Pediatric Research gave the researchers a unique opportunity to test for editorial bias. All abstracts submitted to the society's annual meeting are reported whether or not the studies are accepted for publication in the society's journal, *Pediatric Research*.

Between 1980 and 1989, 58 abstracts on cocaine and pregnancy were submitted. Nearly 60

per cent of the 49 studies finding adverse effects were accepted for publication. In contrast, just one of the nine studies finding no adverse effects was published. This high rejection rate could not be explained by poor methodology. On six key methodological issues the negative studies were as good as or better than the studies finding adverse effects.



The authors' experience of counselling mothers-to-be who'd used cocaine leads them to believe that fear of giving birth to a damaged baby had led many women to terminate pregnancy, even if their cocaine use levels had been low.

The most recent review of cocaine and pregnancy studies received by ISDD's library illustrates the difficulty of reaching conclusions in this area. The authors admitted that adverse effects apparently due to cocaine were also "heavily related" to other risk factors such as poor prenatal care, other drug use, malnutrition, and social deprivation.<sup>2</sup>

1. Koren G. *et al.* "Bias against the null hypothesis: the reproductive hazards of cocaine." *Lancet*: 16 December 1989.  
2. Doering P.L. *et al.* "Effects of cocaine on the human fetus: a review of clinical studies." *Annals of Pharmacotherapy*: 1989, 23, p.639-645.

4 Posters like this one from the USA may be leading cocaine users needlessly to abort their pregnancies.

## THT drugs manager quits

The Terrence Higgins Trust is attempting to restore confidence in its drugs work after the premature departure of its drug unit manager, but there must now be serious doubt over whether the trust can fulfill its national remit in developing services for HIV-positive drug users.

Dr Betsy Ettorre planned to stay three years but left within seven months saying the trust had done fine work with gay men but "money for drugs work would be better spent elsewhere".

Dr Ettorre joined the trust last May just as six members of the THT's drug advisory group resigned, declaring the organisation was incapable of effective work with drug users (see *Druglink* July/August 1989). Her reputation within the drugs field was seen as giving the trust a golden opportunity to climb back from this serious blow to its credibility.

Three people have occupied the trust's key drugs post since 1985; Bill Nelles was its first drug education officer, Steve Cranfield acted as caretaker until Betsy Ettorre took over in the new post of Drugs Services Coordinator. Now all three say they would not refer drug users to the THT.

THT's Chief Executive Martin Eede is positive about the future of

the AIDS charity's drugs work. He says drug users will constitute the next wave of HIV disease in Britain and to remain relevant the trust must gear itself to work with them as well as with the gay men who formed the first wave. The trust still plans to put £235,000 into drugs work in 1990/91. In 1989/90 the Department of Health put £450,000 into the THT.

Mr Eede spotlighted the trust's cramped quarters as the main impediment to developing its work with drug users. But Dr Ettorre believes the organisation's board of directors is the source of "structural constraints" strong enough to frustrate her efforts, despite Martin Eede's support.

She argues that the directors share society's stigmatising stereotypes of drug users and that their interventionist management style helped create an organisation unwelcoming for drug users.

Dr Massimo Riccio of Charing Cross Hospital joined the THT's board to give a top level push to drugs work. He supports Martin Eede's contention that the board is not set against drugs work but identified resistance to diverting resources to drugs among the trust's membership.

The trust's three ex-employees agree that the way forward for the

organisation is either to get out of drugs work or to accept a back-room role resourcing drug agencies. But Martin Eede believes direct client work is essential to lend credibility to the trust's education and information work in the drugs field.

Bill Nelles' predominant feeling is sadness at the fate of the work he started at the trust. Direct client work with drug users was introduced as a crisis response at a time when drug agencies had yet to come to grips with HIV. In the mid-'80s, HIV positive drug users had few alternatives, but now drug agencies have developed their HIV work to the point where the trust has been left behind.

Under pressure in 1986 to be seen to move beyond work with homosexual men, he believes the trust tried to extend itself into drugs work to maintain its leading role but was unable to make the structural changes needed to sustain that expansion.

To its credit, the trust moved swiftly to fill its vacant drugs coordinator post. Before the appointee will be Betsy Ettorre's leaving review detailing what she saw as serious management and accountability shortcomings and insurmountable obstacles to effective drugs work.

■ Concern over a "complacent" attitude to syringe hygiene has led a group of drugs/AIDS workers and doctors to establish the Bleach Project with the help of a £2,500 grant from the AIDS charity Fashion Act. Their aim is to remind workers of the continued importance of syringe hygiene despite the advent of needle exchanges. Among the project's founders is Nicola Woodward, coordinator of the Cleveland Street Needle Exchange, one of Britain's busiest.

■ Research at the Maudsley Hospital found that London needle exchange staff were often confused over correct syringe cleaning procedures and rarely discussed syringe hygiene with clients.<sup>1</sup> Not surprisingly, drug users themselves were confused over correct procedures. Few knowingly ignored official recommendations but most were mistaken over what these were. The result was that 70 per cent were using unsafe procedures.

1. Herrod J. *et al.* "Cleaning injecting equipment: a message gone wrong?" *British Medical Journal*: 1989, 299, p.601.

■ A study of heroin users seeking treatment at clinics in Liverpool and Chester found no tendency for heroin smokers to switch to injecting within their first three years of use.<sup>1</sup> The group that saw themselves as 'injectors' on average smoked the drug at least as often as they injected. Both heroin smokers and injectors tended to inject less frequently over the three years while maintaining high levels of smoking.

1. Cousin P. *et al.* "Heroin users' careers and perceptions of drug use: a comparison of smokers and injectors in the Mersey region." *British Journal of Addiction*: 1989, 84, p.1467-1472.

■ One of the few studies allowing an assessment of drug trends over time has found that the proportion of fourth-year secondary schoolchildren in Wolverhampton claiming to personally know someone using solvents or illegal drugs more than doubled (from 15 to 31 per cent) between 1969 and 1989. The proportion themselves offered drugs rose from 5 to 19 per cent. Greater personal contact with drugs was not matched by greater knowledge, with 30 per cent of those who mentioned cannabis saying it can kill, but 55 per cent of those mentioning solvents not listing death as a danger.

1. Wright J.D. *et al.* *British Medical Journal*: 13th January 1990, p.99-103.

# Scottish users 'must pay for syringes'

Pharmacy sales are the mainstay of the HIV prevention strategy in Scotland, but to mount an effective response health boards and pharmacists are being forced to circumvent restrictions imposed by the Scottish Home and Health Department (SHHD).

Unlike in the rest of the UK, Scottish pharmacists are not allowed to supply drug misusers injecting equipment free of charge as part of a health authority funded anti-HIV scheme. SHHD insistence that supply be a normal commercial transaction only softened in July when Scottish Health Minister Michael Forsyth

gave his blessing to an innovative 'deposit' scheme already operating in one Edinburgh pharmacy.

The pharmacist in cooperation with a local drug agency and Lothian Health Board had circumvented SHHD rules by charging drug users £0.50 for their first syringe, but supplying replacements free as long as the misuser returned the used syringe.

One result was that the return rate jumped from the 20 per cent typical of other pharmacies to over 70 per cent. 'Defaulters' who do not bring back their syringe have to pay another £0.50. With new recruits this makes the scheme

"virtually self-financing", says Dr George Bath, Lothian's AIDS coordinator.

The SHHD still prohibits the health board from supplying injecting equipment to the pharmacist free of charge to make up any shortfall in his income, and only approved the scheme on the basis that it was self-financing. Not surprisingly, few other pharmacies run deposit schemes, despite the Lothian scheme's popularity with injectors who see it as a 'good deal'.

Dr Bath sees the deposit scheme as a "glimmer of light" in an otherwise frustrating situation.

Initially there was optimism over the response to an SHHD circular sent out in June 1988 asking health boards to report on pharmacists willing to sell to injectors. 192 had volunteered before the end of the year but by the end of March 1989 the number had dwindled to 145.

With over 1100 community pharmacies in Scotland, this represents just 1 in 8 volunteering to sell and less than 10 per cent to exchange. In England and Wales the corresponding figures may be 3 in 4 and nearly 40 per cent respectively (see below).

The SHHD profess themselves still "satisfied", but Dr Jefferson, Secretary of the Scottish Department of the Royal Pharmaceutical Society, is no longer optimistic. SHHD insistence on supply being a commercial transaction had, he said, deterred many pharmacists.

Last October another request by Scottish pharmacists to be allowed to supply free of charge was turned down on the grounds that they would not have the time to provide adequate counselling along with the syringes.

To many observers the restrictions on syringe supply in Scotland seem incredibly short-sighted, almost forcing health boards to 'launder' either money or syringes to achieve their supply through pharmacies as a publicly-funded public health measure.

Dr Bath is at a loss to explain the SHHD's stance. His guess is that behind it may be the misguided ethic that drug users must be made to pay their own way, whatever the health costs to them and to the rest of the community.

## National survey shows scope for involving pharmacists in anti-HIV drugs work

The first national survey of pharmacists' willingness to participate in anti-HIV work suggests a "considerable degree of goodwill" exists which has so far not been tapped by the authorities.

In late 1988 the Institute of Psychiatry's Addiction Research Unit surveyed 1 in 4 pharmacies in England and Wales. Their Department of Health-funded report published last month found that three-quarters would be prepared to sell needles and syringes to injectors.<sup>1</sup> It also revealed that concern over adverse commercial consequences presents a major obstacle to more widespread

involvement in working with drug misusers.

Just 3 per cent of pharmacies participated in local syringe exchange schemes but over half would do so if one were organised. Nearly 30 per cent were already selling injecting equipment to an estimated 6000 injectors a week. But the potential market (drug misusers seeking to buy equipment) totalled 20,000 over a four-week period, a dramatic indication of the scope for involving pharmacists in the anti-HIV effort.

Over 90 per cent of the respondents agreed that pharmacists had an important role to play in drug misuse and AIDS

prevention, but 70 per cent expected remuneration and almost as many thought the presence of drug misusers would damage their business. Fear of business losses was related to reluctance to sell to injectors.

A major disappointment was that most pharmacies willing to sell to injectors were not prepared to keep a sharps bin for returned syringes and needles. Behind this reluctance may be uncertainty over who would finance the disposal system.

1. Glanz A. et al. *Prevention of AIDS among drug misusers: the role of the high street pharmacy*. Addiction Research Unit, 1990. Available price £3.50 inc from Institute of Psychiatry, ARU, 101 Denmark Hill, London SE5 8AF.

## Drug law debate hots up as UK conference approaches

The programme for the British-organised World Ministerial Drugs Summit on 9-11 April will be evenly split between broader demand-reduction issues and the specific "cocaine threat". The cocaine wing of the proceedings will concentrate on supply-reduction strategies.

The outcome is certain to add a further twist to the international war against drugs. Meantime in Liverpool the First International Conference on Harm Reduction organised by Mersey's Drug Information Centre will be seeking to unwind the drugs war and promote safer drug use.

As the conferences approach, legalisation and anti-legalisation groups (including the UK govern-

ment) are likely to be jostling for the eye of the media, creating the potential for the most public debate on drugs policy yet seen in the UK.

Lobbying for the Mersey line will be the newly formed UK Committee for Open Debate on Drugs (CODD). CODD is plotting to ride on the back of the Drugs Summit to put anti-prohibitionist arguments before the world's press and blot the summit's media profile by posing awkward questions about current drug policies.

CODD's line is close to that of the International Anti-Prohibitionist League, an organisation of jurists and academics. Its newsletter is funded via Marco Taradash's European Parliament budget.

Taradash was the first MEP to be elected on an exclusively anti-prohibitionist ticket.

Supported by European Commission money is Europe Against Drugs (EURAD), which considers "all non-medical use of drugs (controlled substances) to be drug abuse". EURAD is committed to "prevent any form of legalisation of drugs". Their UK representative is Joan Keogh of Merseyside's PADA, a grassroots group based on parents of drug users.

EURAD has a strong Nordic influence, but it's Holland's 'normalisation' policy that gave rise to the European Movement for the Normalisation of Drug Policy. Their British section wants drugtaking treated as a normal

activity rather than as a deviance or a disease.

The first of the modern-day anti-prohibition movements was Professor Trebach's Drug Policy Foundation. Despite its US base, the foundation has several European supporters. Trebach's pragmatic line has succeeded in drawing support from right-wing US politicians concerned at the cost of the drugs war as well as from liberals more concerned about civil liberties.

A measure of the success of legalisation movements in at least putting the issue on the agenda is the fact that this year even the UN International Narcotics Control Board felt it had to "emphatically" reject their views.

# HOW NORMAL IS NORMAL?

*A critical analysis of a fashionable stereotype finds false logic and dubious motivation.*

It is mistaken to conclude that today's heroin users are all non-deviant and psychologically 'normal' simply because there are more of them. Continuing social sanctions and disapproval are as likely now as in the past to have negative psychological effects on drug users. The 'normal drug user' stereotype simplifies the drug worker's job and satisfies their need to identify with clients, but does not accord with reality.

**Brian Pearson**

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ONCE UPON A TIME drug users were seen as 'morally weak': not too long ago, they were 'sick'. Nowadays drug workers are more and more prone to proclaim that users are 'normal'. This looks like progress, but is it? We may be witnessing the birth of a new stereotype — one apparently more enlightened than its forebears, but just as likely to lead us astray.

There are two senses in which people talk about normalisation.

◆ The first is the call for 'the normalisation of drug use' as the goal of a programme to change unhelpful public attitudes and their expression in legislation and service delivery. With this I am fully in sympathy.

◆ The second and more dubious sense talks of the 'normal drug user' as the type of client who turns up at services these days. The reference is usually to people with an established heroin habit.

Apostles of this second doctrine hold that heroin users nowadays — as opposed to their predecessors of the '60s and '70s — are 'normal'. They often go on to suggest that attempts to modify users' behaviour, to uncover and work with any accumulated problems, are not only unnecessary, but reactionary. Users' problems are attributed solely to misguided public attitudes and responses, to the 'war on drugs', to prohibitionist fetishes, oppressive legislation, or whatever.

Could we but sweep these away, they imply, drug users would be revealed as fully-functioning members of society. Meanwhile, our best bet is refrain from 'messing about with their heads' and to shield them from the worst effects of social reaction by giving them what they want — a prescription.

Some perfectly respectable strands of thought have been tangled together to produce this ideology. In this article I have tried to unpick a few of the knots.

The hypothesis that as drug use becomes more common, the users will show fewer signs of 'abnormality' is not new.<sup>1</sup> In 1984, Dr John Strang restated it in an influential article (see box). Strang was cautious in the

conclusions he drew from this argument — but not everyone has been so restrained, sometimes using it to back the claim that heroin use is now so widespread that users are 'normal'.

This claim is simply not sustainable. Heroin use, though now much more common, is still highly atypical. We are a long way from having "several hundred thousand" drugtakers in a city of a couple of million. So the process of normalisation cannot yet have gone very far.

Even if there were very many more heroin users, this would not necessarily mean *all* of them were more 'normal' in anything other than a statistical sense. All Strang's hypothesis predicts is that as drug users increase in number they are *in general* likely to become less distinguishable from the rest of the community. But within a given population of drug users, individuals may vary widely in their degree of 'normality', however we define that slippery term.

## The statistical argument

"... as notorious drugs (such as use of heroin) become more widespread in a population the people using them are likely to be more normal (statistically and in other senses) than the abnormal population who presented originally. When a city with a couple of million inhabitants has only one or two dozen heroin users then this group will probably be deviant and abnormal in many ways; but as this behaviour becomes more widespread the abnormal characteristics will become less noticeable. By the time there are several hundred thousand drugtakers in such a city their characteristics would be much more similar to the non-using population."<sup>2</sup>

— John Strang, 1984

## 'War on drugs' argument

Here the two senses of 'normalisation' become well and truly confused. The argument starts with the sensible proposition that most of the problems of drug users stem from social reaction. It goes on to hold that drug users would be fine if only society would get off their backs, then illogically concludes that today's users have remained 'normal' with their psyches in mint condition despite the full onslaught of societal disapproval.

That social attitudes and responses have changed little, and have serious negative social and psychological effects on at least some drug users, is the rationale behind the attempt to normalise drug use. It is less than logical to fulminate against these evil effects while holding that today's drug users have magically resisted them.

If today's users experience very similar social pressures to their predecessors, is it not reasonable to assume this will be reflected in similar behaviour, attitudes and views of themselves? In which case, there seems little reason to suggest the overall psychological profile of drug users has changed dramatically over the years.

The war on drugs argument also ignores the fact that not all drug-related problems can be put down to outside social forces. Normalising drug use would do a great deal to ameliorate heroin users' lives, but it would not eliminate all their problems.

If an example is needed, one is readily to hand. Alcohol is a drug which is thoroughly normalised in Western society and its users are undoubtedly, on the whole, 'normal'. But it gives rise to problems that dwarf those attributed to heroin. Why should the outcome be different if we normalised heroin use? Or the use of amphetamines, or crack? People use mind-altering drugs precisely because they alter minds, and for some this becomes a single-minded pursuit almost regardless of the consequences.

## What kind of 'normal'?

To all of this, the reply might be made that 'normalisers' are simply saying that drug users are much like the rest of the population. However, the rest of us are remarkably diverse. What I am arguing against is the mistaken conclusion drawn from this that drug users are *all the same* and so all want, or need, the same things.

It is this assumption, usually not articulated (for if it were, its absurdity would immediately be apparent) but nevertheless the ideological basis of some services, which turns a sensible point of view into a stereotype. What is being lost is the hard-won recognition that drug users do not

necessarily have much in common except the use of drugs.

This loss leads to an odd kind of stereotyping of drug users — as 'normal' and 'problem free', reminiscent of the excesses of Laingian psychology, which burdened schizophrenics with being the only truly sane members of society.

Drug use is unquestionably more 'normal' in the trivial *demographic* sense — no one disputes that drug users are thicker on the ground. But does it follow that they are more 'normal' in other ways? Since their numbers are greater, drug users may regard themselves as more normal in the *sociological* sense of 'less deviant'; they may see the decision to use heroin as a less dramatic step than their predecessors did.

*'We're just like you, except we've got a home and a job, we're not strung out on smack, we haven't got a court case coming up, and we can throw you out if you're not nice to us, but otherwise...'*

But drug users' views of themselves do not count for much outside their own circles. A deviant activity being more widespread does not guarantee that it will appear any more acceptable or 'normal' to society as a whole. Negative sanctions may even increase in response to the perception of a growing threat to existing norms.

On the other hand, for most people *psychological* normality is by definition desirable. Devotees of the 'normal drug user' doctrine are understandably concerned to defend users from the charge that they are 'abnormal' in this sense. But in quite correctly asserting that drug users are not necessarily pathological to begin with, they retrospectively pathologise former generations. Many heroin users today do not fit the old 'junkie' stereotype, but this was also true of previous generations.

WHAT CAN LEGITIMATELY be deduced from the increased prevalence of heroin use in the '80s?

◆ The drug's greater availability and acceptability among some groups makes it more likely that it will be tried by people with no particular problems, or at least none that differentiate them from most others in their community. Some will enjoy it and continue to use. Some of these will experience problems as a result, if only because of negative social reactions.

◆ But it is also more likely that people who *do* have problems will turn to heroin as a way of coping and that these problems will be aggravated and new ones emerge because of their drug use.

◆ It is reasonable to suggest that those who do develop drug-related problems will disproportionately present to drug services, so that however trouble-free and 'normal' the heroin using population as a whole might be, caseloads will be skewed towards the 'abnormal' end of the spectrum. Workers ideologically convinced that all their customers are 'normal' will be ill-fitted to respond to their needs.

Users are so often seen by the public as being abnormal that there is a real need to redress the balance by presenting more positive and less distorted images of drug users. That many drug users are 'normal' tempts us to assert that all of them are. But fooling ourselves that the world is as we would like it to be, rather than as it is, will get us nowhere.

## Workers' benefits

To see how a useful idea became a stereotype, we need to ask what functions it might serve for drug workers.

One central function of any stereotype is to make life simpler. If we 'know' that all drug users are 'normal' (or 'sick', or 'criminal'), it makes responding to them much easier. We are spared the complications of trying to understand a unique individual from scratch. If that individual happens to conform to the stereotype, he or she may benefit from our intervention; if not, we can always explain the failure in ways that do not challenge our beliefs.

The 'normal drug user' stereotype can also give workers a warm sense of their own worth, in that they alone are perspicacious enough to recognise the truth. It can pander to a romantic need to associate themselves with their clients' lifestyles (the 'street cred' factor), and allow them to mystify the uncomfortable disparity of power between them — 'We're just like you, except we've got a home and a job, we're not strung out on smack, we haven't got a court case coming up, and we can throw you out if you're not nice to us, but otherwise...'

It can also justify giving clients what they say they want, removing the burden of trying to work out what they need. Since users are by definition 'normal', any signs of 'abnormality' do not have to be dealt with in the here and now, but can be discounted as due to misguided and malevolent social responses. About these we can do little, except blame other people — always a satisfying pastime.

In other words, the popularity of the 'normal drug user' stereotype, like that of others in the past, may have less to do with the actual characteristics of users, than with the predilections and comfort of workers themselves. ■

1. Jaffe J.H. "Factors in the etiology of drug use and drug dependence." In: Schechter A. *Rehabilitation aspects of drug dependence*. Cleveland, Ohio: CRC, 1977.

2. Strang J. "Changing the image of the drug taker." *Health and Social Service Journal*: 11, October 1984.

# TOWARDS A NATIONAL DRUG DATABASE

*The North West has pioneered a revolution in drug misuse data. Now the revolution's coming your way. The chief architect explains.*

The Department of Health has instructed RHAs to establish drug misuse databases and recommended they adopt the system developed for the North West. The system's originator explains that it preserves client confidentiality while gathering information on a much wider range of drugs and from a much wider range of services than any previous national system. The self-carboning forms can also be used for agency records.

## Michael Donmall

*The author heads the Drug Research Unit at the University of Manchester which created the Drug Misuse Database being used in the North Western RHA and now recommended for national adoption by the Department of Health.*

THE DEPARTMENT of Health has announced that each regional health authority will be setting up a local drug misuse database modelled on the system developed by the Drug Research Unit in Manchester. On 3 November Health Secretary Baroness Hooper described this as "a very important step forward. If we are to tackle the problem of drug misuse successfully it is essential that we have better information about the pattern of drug misuse and the impact of services".

On the same day a circular was issued requiring each region to implement a drug misuse database by 31 March 1990, and to arrange for a return to be made for at least one district by November 1990.<sup>1</sup>

What does this mean for drug services? What is the information to be used for and by whom? How can we protect the rights of the individual? I will try to describe what the database is and what it is not; what it can, and what it cannot achieve.

The North West's Drug Misuse Database grew out of research funded by the DHSS to evaluate the introduction of community initiatives into drug services in the region.<sup>2</sup> Its practical utility in providing agencies with detailed, anonymous information led to its permanent establishment by the North Western Regional Health Authority and also to support from the Department of Health to adapt the system for use in the other regions of England.

Especially in a field afforded considerable media attention, lack of good information often results in the spread of misinformation. What can we say about the drugs misuse problem in our local community and the users presenting to services? For example, what proportion of the using population is known to be injecting?

Basic questions such as this must be asked by all agencies to improve the targeting of local and national services. The information base on which such questions are answered is often inadequate; we have relied on the development of local projects to inform planners and politicians at every level about a subject high on the

agenda of every caring agency since the beginning of the decade.

The official picture of drug misuse in this country is largely informed by two sets of annual statistics:

— Department of Health drug misuse statistics which report regionally on admissions to mental illness hospitals with drug related diagnoses; and

— Home Office statistics on the misuse of drugs which report by police force area on notifications of addiction made by doctors and on figures relating to police activity.

Neither is particularly useful for answering questions relating to trends in known drug users or the utility of services — both essential for planning. Very few drug misusers are admitted to hospital, while notification is required only of doctors (from whom compliance is often poor) and covers only the opiates and cocaine.

Neither of these figures can give a detailed local picture and both are restricted to the work of doctors. Figures relating to drug offences and seizures are dependent to a considerable extent on enforcement policy and deployment and contribute little to health service planning.<sup>3</sup>

## The new database

The Drug Misuse Database overcomes many of the problems of existing statistics by providing a means of routinely monitoring the numbers and profiles of individuals who attend a range of services with a wide range of drug-related problems.

The Drug Data Pack to be made available to each region provides everything needed to set up a basic version of the database operated in the North West. It provides guidelines on implementation, templates for the data collection sheets, detailed notes on coding and avoiding double-counting, and, of course, the software package itself with an operating manual — everything except the hardware and the local will — these must be provided by the end-user.

IN CONFIDENCE: Please read notes on the back

**NORTH WEST DRUG MISUSE DATABASE**

**and NOTIFICATION OF DRUG ADDICTION**

Health Authority Code: P  
Home Office Code: P  
For Database use only  
Ref:

**NORTH WEST DRUG MISUSE DATABASE**

**and NOTIFICATION OF DRUG ADDICTION**

Health Authority Code: P  
Home Office Code: P  
For Database use only  
Ref:

Drugs Act, 1971

Drugs Act, 1971

Ref: 01-273 2213

Date in: \_\_\_\_\_  
If problem of any kind, the notification part of the form should only be filled in if the patient is on the MARS and Ball Point Pen.

Last Name: \_\_\_\_\_  
Alias or Maiden Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Male  Female   
Postcode: \_\_\_\_\_  
Ethnic Group: \_\_\_\_\_

How long unemployed? \_\_\_\_\_  
Probation  Family/Friend   
Other specify \_\_\_\_\_  
on the Misuse of Drugs Act 1971? Yes  No

**prescribed or not (if drug free list significant prior use)**

HOW OFTEN (times per week/month)	HOW MUCH (quantity or cost per session)	ROUTE	DURATION (of this drug episode)	AGE OF 1st USE

No  If yes, how long? \_\_\_\_\_ (See notes)  
Ever injected? Yes  No   
Ever shared? Yes  No

Planned OP treatment  Planned IP treatment  Further appointment   
Where drugs specify \_\_\_\_\_  
Is this a reducing dose? Yes  No  Don't know

Outpatient  Hospital inpatient  Police Surgeon   
Date Seen: \_\_\_\_\_

Drug Research Unit (University of Manchester) 061 275 0544 985-9 M

IN CONFIDENCE: Please read notes on the back

**NORTH WEST DRUG MISUSE DATABASE**

**and NOTIFICATION OF DRUG ADDICTION**

Health Authority Code: P  
Home Office Code: P  
For Database use only  
Ref:

Please complete a form for every patient whom you attend, who has a drug problem of any kind. The notification part of the form should only be sent to the Home Office if the person is notified. Please use BLOCK LETTERS and Ball Point Pen.

**Details of Patient**  
First Name(s): \_\_\_\_\_ Last Name: \_\_\_\_\_  
Alias or Maiden Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male  Female   
Postcode: \_\_\_\_\_ NHS No: \_\_\_\_\_  
Ethnic Group: \_\_\_\_\_

**Employment:** Present or last occupation: \_\_\_\_\_  
Employed  Unemployed  How long unemployed? \_\_\_\_\_  
**Referral From:** Self  GP  Probation  Family/Friend   
Psychiatrist  Drug Team  Other specify \_\_\_\_\_

**Drug Profile Past Month: include each drug used, prescribed or not (if drug free list significant prior use)**

DRUG NAME	PRESCRIBED OR NOT (Yes/No/Both)	HOW OFTEN (times per day/week/month)	HOW MUCH (quantity or cost per session)	ROUTE	DURATION (of this drug episode)	AGE OF 1st USE
MAIN DRUG						
DRUG 2						
DRUG 3						
DRUG 4						
DRUG 5 (alcohol)						

Is person drug free? Yes  No  If yes, how long? \_\_\_\_\_ (See notes)  
Injected in past month? Yes  No  Ever injected? Yes  No   
Shared needles/syringe in past month? Yes  No  Ever shared? Yes  No

**Action Planned**  
Plan at onset: Nil action  Planned OP treatment  Planned IP treatment  Further appointment   
Referred on \_\_\_\_\_ specify where \_\_\_\_\_  
Liaison with \_\_\_\_\_ specify who/where \_\_\_\_\_  
**Prescribing plan:** Nil  Non-opiate drugs  specify \_\_\_\_\_  
Methadone DTF  or other forms, specify \_\_\_\_\_  
Other opiates  specify \_\_\_\_\_  
Anticipated duration of prescribing \_\_\_\_\_ Is this a reducing dose? Yes  No  Don't know

**Details of Reporting Doctor**  
Name: \_\_\_\_\_  
Patient seen in/out by: General Practice  Hospital Outpatient  Hospital Inpatient  Police Surgeon   
Prison Med. Service  Other, specify \_\_\_\_\_  
Treatment Centre/Hospital/Practice: Name/Address \_\_\_\_\_  
Postcode \_\_\_\_\_ Tel: \_\_\_\_\_ Date Seen: \_\_\_\_\_

► This is your copy to retain  
Drug Research Unit (University of Manchester) 061 275 0544 985-9 M

**NORTH WEST DRUG MISUSE DATABASE**

Local Monitoring of Problem Drug Use  
If Client new to this agency? Yes  No  For Database use only: Ref: \_\_\_\_\_  
Type of Contact: Letter  Telephone  Face to face   
Appointment: Made? Yes  No  Date in: \_\_\_\_\_  
Attended? Yes  No

**Details of Client**  
First Name(s): \_\_\_\_\_ Last Name: \_\_\_\_\_  
Maiden Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male  Female   
Postcode: \_\_\_\_\_ Tel: \_\_\_\_\_  
Area of Town: \_\_\_\_\_ Ethnic Group: \_\_\_\_\_

**Employment:** Present or last occupation: \_\_\_\_\_  
Employed  Unemployed  How long unemployed? \_\_\_\_\_  
**Referral From:** Self  GP/Psychiatrist (specify) \_\_\_\_\_ Probation  Family/Friend (specify) \_\_\_\_\_  
Drug/Clinic, specify: \_\_\_\_\_ Other, specify: \_\_\_\_\_  
**Living With:** Drug user(s)  Non-drug user(s)  Parents/Partner (specify) \_\_\_\_\_ Living alone   
**Dependant Children:** None  Number with client: \_\_\_\_\_ No living elsewhere  Number in care: \_\_\_\_\_  
**Drug Related/Contact (in past 12 months):** None  GP  Psychiatrist  Probation   
A.S.E.  Social Services  Vol. drug agency  Private Doctor   
Drug Team/Clinic, specify: \_\_\_\_\_ Other, specify: \_\_\_\_\_

**Housing:** Please summarise \_\_\_\_\_  
**Current Legal Situation:** Please summarise \_\_\_\_\_

**Drug Profile Past Month: include each drug used, prescribed or not (if drug free list significant prior use)**

DRUG NAME	PRESCRIBED OR NOT (Yes/No/Both)	HOW OFTEN (times per day/week/month)	HOW MUCH (quantity or cost per session)	ROUTE	DURATION (of this drug episode)	AGE OF 1st USE
MAIN DRUG						
DRUG 2						
DRUG 3						
DRUG 4						
DRUG 5 (alcohol)						

Is person drug free? Yes  No  If yes, how long? \_\_\_\_\_ (See notes)  
Injected in past month? Yes  No  Ever injected? Yes  No   
Shared needles/syringe in past month? Yes  No  Ever shared? Yes  No

**Action Planned**  
Plan at onset: No action/information  Further appointment  No further action   
Referred on \_\_\_\_\_ specify where \_\_\_\_\_  
Liaison with \_\_\_\_\_ specify agency \_\_\_\_\_  
Prescribed detox.  Non-presc. detox.  Other presc.   
**Prescriber:** GP  Drug Team doctor  Psychiatrist  Other \_\_\_\_\_

**Details of reporting agency**  
Your name: \_\_\_\_\_ (print) \_\_\_\_\_ Job Title: \_\_\_\_\_  
Agency: Name & Address \_\_\_\_\_  
Tel: \_\_\_\_\_ Date of Contact: \_\_\_\_\_

► This is your copy to retain  
Drug Research Unit (University of Manchester) 061 275 0544 985-9 M

▲ The North West's database form for doctors with sheet two to be used for notification to the Home Office (only for opiate or cocaine addiction) and sheet three to be sent to the RHA's database. Note how some of the information on the top copy (for the doctor's records) is blacked out on the other two forms.

◀ The version of the form for non-medical agencies also includes an undercopy (not shown) to be sent to the RHA database which blacks out name and address. Social information on the client replaces some of the medical information on the doctors' form.

The database operates at several different levels. It is as much for service providers as it is for service planners, because one of its most important functions is to feed information back to the agencies themselves. It also satisfies the Department of Health's central requirements and the Home Office notification procedure, minimising the amount of form filling required.

Its main characteristics are that:

- the records are anonymous as far as the drug user is concerned;
- it applies equally to non-medical and medical agencies;
- it covers most drugs, not just the opiates and cocaine;
- it allows for local agency feedback of a comprehensive dataset;
- it allows Home Office notification where appropriate.

## How it works

All medical and non-medical agencies are supplied with one of two alternative sets of database forms — one for medical agencies, one for non-medical (see illustration on page 11).

The three-part medical form consists of:

- a top page to be kept by the agency for use as a summary for patient or client notes;
- second page for Home Office notification if appropriate; and
- a third page which generates data for the database.

Only the top copy is written on. The undercopies are self-carboning, but selectively eliminate data that is confidential or irrelevant. Thus the Home Office page excludes information not required under the Misuse of Drugs Act, while to achieve anonymity the database page includes all the information except name and address. The pages are colour-coded for ease of use and reply-paid envelopes are supplied to encourage returns.

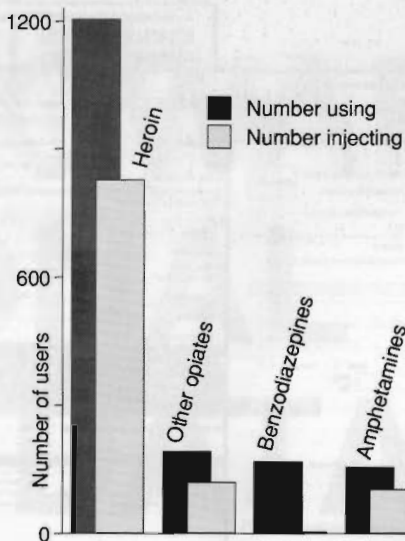
The non-medical database form is similar but consists of just two pages — one

## Training and support

Initial training courses for regional managers and database operators have already been held and will be repeated if necessary. The North Western RHA is offering a package of follow-up support including: copies of the region's database software and manual; a newsletter; visits by experts to help set up local systems; coordinating meetings; help in accommodating local modifications to database forms.

It's also envisaged that a database user group will be formed to discuss issues and recommend improvements.

Details from Michael Donmall on 061 798 0544.



**How use of some drugs looked in the North West in 1987. Much more information can easily be extracted from the database.**

for agency notes and one for the database. Sections of the form specific to medical matters (prescribing action, etc) are replaced here by social data such as legal status, contact with other agencies and number of dependent children. In the North West the non-medical system is used by statutory and non-statutory agencies including the Lifeline Project, local therapeutic communities and all 20 community drug teams; the medical system is used by all doctors in the region.

The 'front end' of the Drug Data Pack provides a straightforward means of entering data into a sophisticated 'relational' database structure. The software automatically adds new treatment episodes to the user's file. Most double-counting is avoided by reference to a person's initials, date of birth and sex, but the database operator is automatically alerted to close matches in case they are, in fact, the same person.

Information can be retrieved through pre-programmed summary tables covering age/sex, employment and main drug and total drug profile, including percentages known to be injecting and average ages. These retrievals can be made for selected districts or agencies between any chosen dates. The operator is 'menu-led' through these procedures. Used with the manual, the process is straightforward even for inexperienced computer users.

The database can also be interrogated using other commercially available packages such as dBase, FoxBase or SPSS, depending on local needs and expertise. Its full potential is realised with this method, but the basic package will give more than enough information for most purposes.

At set-up, the database manager/mentor is able to customise the system by inserting their own region's district and agency names and by determining passwords that allow different levels of access.

Thus it may be desirable to allow one person to edit and/or retrieve data from the system, while another may be given access only to 'display' mode.

Version 1.0 of the software does not allow regions or agencies to add their own data categories, but upgrades being developed will allow this, increasing local flexibility.

Experience in the North West and in the East Sussex pilot scheme has shown that a considerable investment in both time and effort is initially required to make the system known to agencies and to fully explain how it works.

Because of this it is suggested that the databases should be introduced in two phases. Phase one will involve all doctors and all 'specialist' drug services, statutory or non-statutory. Phase two, not envisaged to start until next summer, will involve other 'generic' services such as probation and social services.

The Department of Health has also suggested that regions should start by implementing the system in at least one district rather than attempting to involve the whole region from the start.

## Confidentiality

Two important points should be made about confidentiality. Firstly, the full names and addresses of drug users are not sent to the database, so there can be no question of identification. Secondly, the computer system can be well protected by passwords, making it very difficult for an unauthorised person to gain access. In any case, the personal information stored in the database is not half so sensitive as that routinely kept by any GP or community drug team. Registration with the Data Protection Registrar protects both the individuals represented in the database and those operating the system.

It may also be useful to set up a local steering group, with representation from contributing agencies, to discuss the use of retrieved data. However, our experience over more than three years has been that any initial ethical concern is completely allayed by the genuinely anonymous nature of the user data that is stored and fed back.

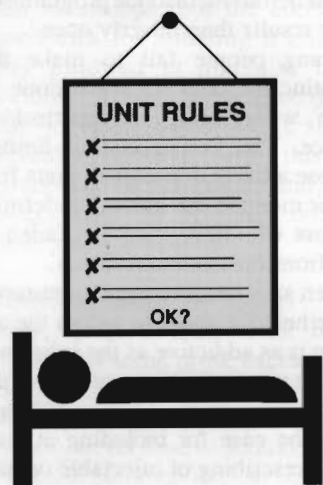
IT IS IMPORTANT for service providers and planners to be aware that, for evaluation purposes, the database can describe only a part of the total drug-related work done by drug teams, agencies or doctors. Non-client work such as liaison, training, etc, will need to be assessed by other means. However, the database can provide a major part of the routine monitoring for an agency.

Also the database should not be thought of as portraying the total picture of the extent and nature of problem drug use 'out there', but as a window into that picture — a piece or two of the total jigsaw. ■

1. Department of Health. Health Circular HC(89)30.  
 2. Donmall M. et al. *The introduction of community-based services for drug misusers: impact and outcome in the North West, 1982-1986*. A report to the Department of Health, 1989.  
 3. *Druglink*: 1989, 4(6), p.5.

# Nursing by rote

*Despite the rhetoric, is it still fit in or get out in Britain's inpatient drug units?*



ADVENT OF HIV and AIDS has led NHS community services to become more flexible, but what is the drug user faced with when they consider admission to an inpatient drug treatment unit?

It seems most units impose strict 'contracts' and discharge patients if they engage on the ward in the very problem they've been admitted for. While some wards are locked, others are proud of their openness. However, doors may be locked by rules as much as by locks. Random urine-testing is common, as is dismissal for programme 'non-compliance'. Even recreational alcohol use is usually an offence punishable by disciplinary discharge.

It adds up to treatment only for people at the end of their using career (essentially, ex-users) who are prepared to suspend some of their basic human rights to become drug free. Inpatient rest and recuperation is not available except by lying about one's intentions and motivations. Small wonder that most users leave

early. They are, after all, only displaying the same behaviours that made them successful survivors in the hostile environment outside.

Tough rules are a manifestation of the abstinence philosophy of such units. That they persist shows how little cross-fertilisation there has been between community and NHS inpatient services. The problem we face is how relevant such an approach is, not only post-HIV but also in the new social and political environment of the '90s.

It has been recognised that young users who chase heroin are a rather different group from older clients. Is it appropriate to treat this group in units which employ a psychotherapeutic method developed for older users?

HIV adds a separate ethical component to our review of treatment practices. For example, an in-patient unit which discharges someone for using on the ward and sends them back into an environment where HIV infection is a major possibility, is in marked contrast to another part of the same system providing a free needle exchange to help prevent such infection.

Inpatient units are generally staffed mainly by psychiatric nurses, and it is these workers who need to look most closely at their practice. Most nurses outside these units now work in a problem-orientated manner using individually tailored treatment plans. In contrast, nursing care in NHS drug units tends to be a highly structured, group-orientated affair with lengthy admissions to facilitate 'personal growth' into a drug-free lifestyle. Programmes are designed around a concept of the 'user', not the real

individual, and people are expected to fit in. Such programmes are likely to be appropriate for an increasingly small percentage of users and have little to offer the adolescent 'chaser', those diagnosed HIV positive, or someone with AIDS.

One option would be to change NHS inpatient services so they admit clients for a wide range of purposes (detox only, rest and recuperation, maintenance, long-term rehabilitation) using treatment programmes designed around the individual — the system one would find in almost any other hospital ward. Alternatively, the units could stay as they are, accepting a more specialised role and allowing others to meet the needs of people who do not fit in. However, inpatient units would then risk becoming an increasingly marginalised arm of drug treatment services.

If these units did become more responsive to users' needs, should they be managed by psychiatric services? Would psychiatric nurses be prepared to staff units with a high degree of detox only or stabilisation admissions? Perhaps agen-

cies run by ex-users or 'recovering addicts' would be more appropriate? General-hospital trained nurses may be better equipped to nurse users with AIDS or who have other general health problems, and who at the same time seek help for their drug use.

The changes required of NHS inpatient services do not just revolve around the 'prescribing debate'. For example, strict house rules may originate from an abstinence philosophy, but they also suggest a 'one track' approach to treatment in general.

The way forward lies in casting aside the shackles of standardised admissions procedures and treatment programmes and substituting individually tailored admissions of varying lengths for varying purposes. Users should be able to determine their needs and negotiate personalised objectives with staff. What must emerge is a recognition that people seek inpatient care for a wide variety of reasons, together with a commitment to provide facilities flexible enough to meet the user's needs, whatever stage they are at.

This is not to suggest a drug free-for-all, but a recognition, for example, that lapses during an inpatient stay may be a constructive therapeutic experience and should not automatically lead to discharge.

THE COMING OF HIV has added to our existing drug services; it has not yet caused us to look sufficiently hard at what we already do. It is now time to take into account not only the new needs of the post-HIV generation user, but the old needs we were not prepared to see. ■

*Drug units are only for people ready to suspend basic human rights to become drug free*

**David Richards**

*The author is a nurse behaviour therapist and a research worker at the Institute of Psychiatry in London.*

# NEW TREATMENTS FOR OPIATE DEPENDENCE

*Oral methadone orthodoxy  
may be blinding us to  
effective alternative  
treatments for the opiate  
addict.*

For some opiate addicts the usual oral methadone regimes are inappropriate or ineffective. Alternative regimes are available. Injectable methadone ampoules can now be labelled to help prevent diversion. Long-acting substitutes for methadone and drugs that block the effects of opiates can improve treatment compliance and prevent relapse. New combinations of drugs can achieve safe opiate withdrawal in 4-5 days.

**Colin Brewer**

*The author is a psychiatrist and the Medical Director of the Stapleford Centre, a private addiction treatment clinic offering outpatient and inpatient services.*

CONVENTIONAL WISDOM in Britain is that the medical treatment of opiate addiction is largely limited to the amelioration of withdrawal symptoms and the prescribing of methadone. Conventional wisdom is wrong, mainly because it appears to ignore a lot of recent medical research.

Even in the use of methadone there have been developments, while in the field of rapid and comfortable opiate withdrawal, that overworked cliché 'breakthrough' is for once appropriate. This paper will summarise the main developments of the past decade in opiate addiction treatment.

Before doing so, it is important to realise that many drug users improve once they recognise they have a problem and symbolise that by seeking help. The placebo effect of any intervention is much stronger than most people realise and all of us in the healing and helping business are walking placebos, whatever else we may be.

Economy and respect for the patient dictate that, before giving help, we ask ourselves: how do I know that this patient/client wouldn't do just as well without my proposed intervention? Only objective, controlled trials can enable us to be reasonably confident that what we do is of real rather than symbolic value. Unless otherwise stated, the studies referenced in this paper concern controlled clinical trials.

## **New ways with methadone**

Oral methadone is the commonest — often, the only — medical response to opiate dependence, but anxiety about diversion to the black market means doses are often inadequate and sometimes derisory. This anxiety is understandable but largely unnecessary. More treatment units could dispense methadone daily to be taken under supervision at the clinic, especially at the start of treatment. Alternatively, the prescription can include a request to the pharmacist to witness the patient swallowing the methadone on the premises. Many pharmacists are willing to do this.

Long-term US follow-up studies sug-

gest methadone is very effective in reducing heroin use and stabilising lifestyles but, as with all drugs, adequate dosage is essential. Generous methadone programmes give better results than miserly ones.<sup>1</sup>

Too many people fail to make the crucial distinction between methadone as an aid to withdrawal, and methadone maintenance. The former is time-limited and for those aiming to become opiate free in weeks or months; the latter is indefinite and for those who have tried and failed to withdraw from opiates many times.

However, oral methadone programmes are of little help for those to whom the act of injection is as addictive as the substance injected. The recent AIDS reports from the Advisory Council on the Misuse of Drugs recognised the case for including at least short-term prescribing of injectable opiates among the range of treatment options.

Several drug dependency units prescribe injectable opiates for some of their patients, sometimes for many years, and a few prescribe them relatively freely. Understandably, most of these units tend not to publicise the fact. In the age of AIDS, there is a case for more openness about this important issue, though consensus is no more likely than with other controversial medical issues, such as abortion. The Advisory Council's suggestion that injectable prescribing should be "exceptional" does not reflect prescribing practices at some major drug dependency units; it was almost certainly a compromise to avoid a split in the committee.

As with oral methadone, the initial aim of prescribing injectables is to encourage and enable patients to lead a healthier, more stable and less criminal lifestyle. One then tries to wean them on to oral or opiate-free programmes.

The recent introduction of larger 35mg/3.5ml and 50mg/5ml methadone ampoules on a named patient basis will considerably reduce the cost of injectable methadone (to about £1.50-£3 per day on a private prescription). Being able to prescribe a larger dose in a single ampoule will reduce

the number of ampoules dispensed, permitting them to be individually labelled to make their source easily traceable. This should help minimise the increased risk of diversion on to the illicit market which is an important disadvantage of injectable programmes.

### Long-acting 'methadone'

Laevo alpha acetyl methadole (LAAM) is a long-acting analogue of methadone used in some US and Dutch methadone maintenance and withdrawal programmes for over 10 years. It has not yet been used in Britain, though interested researchers could probably obtain it from US or Dutch sources. Its main advantage is that it only needs to be taken every two or three days. It also avoids the withdrawal symptoms experienced with daily methadone doses by some people who rapidly metabolise the drug.

At least 50 per cent of methadone patients find LAAM as good as or better than methadone, but the correct medical procedures for initiating it must be carefully followed to minimise the risk of overdose. It takes up to three days for the drug to reach blood levels sufficient to prevent withdrawal. During this time, daily monitoring is essential and additional opiates may be required on a rapidly diminishing schedule.

### Dealing with alcohol

Many opiate abusers drink little or no alcohol but some drink excessively. Alcohol taken in excess is highly toxic, while smoking or even injecting 'clean' opiates is virtually never fatal to addicts. Alcohol and opiates in combination can be lethal, while

alcohol abuse can make it difficult to stabilise methadone dosage.

If counselling and exhortation fail, the alcohol problem can easily be solved in most cases by making the continued prescribing of methadone conditional on patients agreeing to take Antabuse (disulfiram) under supervision two or three times a week.<sup>3</sup> Since most methadone patients value their methadone more than their alcohol, they will usually agree to this stipulation. Supervised Antabuse has been shown in several controlled trials to improve considerably the effectiveness of conventional alcoholism treatment.<sup>4,5</sup>

Antabuse causes an unpleasant, incapacitating and occasionally dangerous reaction if alcohol is consumed — but it is very much less dangerous than persistent alcohol abuse and has no significant interactions with methadone or other opiates or with other commonly abused drugs.

### Narcotic antagonists

Drugs known as 'narcotic antagonists' counter the effects of heroin and other opiates. People taking the antagonist naltrexone, which has been available in Britain since 1985, can take several grams of heroin without feeling any effect. This chemical blockade protects those who have withdrawn from heroin from the many temptations to resume its use, especially on impulse. Naltrexone aids the development of drug-free behaviour patterns and makes it more likely that they will persist for long enough to become established.<sup>6</sup>

As with Antabuse, supervision of the medication by a third party is crucial, and the tablets should be dissolved in water and drunk to minimise the opportunities for evasion. Family members are often the most appropriate 'supervisors'; since they should generally be involved in treatment anyway, this demands little extra effort. Probation officers, friends, counsellors and workmates can also be involved in the supervisory process.

In the USA, naltrexone has given good results in a group normally thought of as having a poor prognosis — addicted prisoners on work-release schemes.<sup>7</sup> I believe it should also be offered to those in residential programmes who continue to use opiates — naltrexone is more constructive and humane than expulsion.

Experience with Antabuse indicates that the process of supervision tends to strengthen the therapeutic relationship and that less counselling is required, mainly because the relapse rate is reduced.<sup>8</sup> A long-acting depot injection of naltrexone is being developed which will obviously improve compliance with treatment. However, even the currently available oral naltrexone need only be given every two or three days.

Naltrexone is unlikely to help those who are socially isolated and/or rootless. Neither will it find much application among true polydrug abusers, as opposed to those

who sometimes use and abuse other drugs but are primarily opiate abusers.

### Clonidine detoxification

Clonidine relieves, but does not abolish, opiate withdrawal symptoms. Instead of or in combination with methadone, it has a place, but does not really cut the withdrawal period. Many addicts relapse during withdrawal because they get fed up with feeling below par for days or weeks on end. With clonidine alone, dropout rates tend to be higher than with methadone.

Clonidine's advantages include the fact that it has no abuse potential and its use is not followed by withdrawal symptoms. Clonidine can lower blood pressure, but most drug abusers are young with healthy cardiovascular systems and tolerate low blood pressure without danger.

If clonidine is stopped abruptly, people with already significantly raised blood pressure may suffer further increases as a 'rebound' effect. Apart from such cases, in my view clonidine can safely be used in outpatient withdrawal.

Combining clonidine with naltrexone and benzodiazepines is a major advance in withdrawal techniques.<sup>9</sup> Given on its own, naltrexone precipitates withdrawal symptoms in opiate addicts within five minutes of swallowing it. This is unpleasant, but not

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### *In rapid withdrawal, that overworked cliché 'breakthrough' is for once appropriate*

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dangerous. However, if clonidine and benzodiazepines are given beforehand, this withdrawal is usually adequately controlled; if the benzodiazepine doses are generous, most patients have no recollection of the worst of the symptoms.<sup>10</sup> For those with jobs, return to work within four or five days is the rule. Using this method, withdrawal from methadone takes no longer than from heroin.

A high-tech variant is to use the short-acting (and rather expensive) narcotic antagonist naloxone by intravenous drip while the patient is given a brief general anaesthetic.<sup>11</sup> These techniques appear to be safe as well as humane.

MANY ABUSERS neither want nor need medical treatments, but nobody should be denied access to a range of treatments including medical ones, especially if the non-medical kind are proving inadequate. Patients have a right to objective evidence about the effectiveness (and, in the private sector at least, the cost-effectiveness) of the various treatment options. Health professionals have a duty to provide it, which means they must be familiar with the scientific literature, though there is nothing to prevent others in the treatment industry familiarising themselves with it too. ■

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# MAKING RESEARCH PART OF DRUG WORK

*How the evaluators can become part of a drug agency's development, not just its observers.*

An example is given of close cooperation between researchers evaluating a drug team and the team itself. Regular, speedy feedback of research findings helped the team refine its objectives and methods. Research surveys and outreach studies doubled as publicity/referral points for the service. Even without research staff, agencies can draw on research techniques to inform their work.

**Robert Power**  
**Sara Jones**  
**Annette Dale**  
**Paul Turnbull**

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AN EARLIER *Druglink* article outlined the ways drug agencies could best benefit from research and pointed to the value of developing a symbiotic relationship between researchers and service providers.<sup>1</sup> This follow-up article will illustrate this model using the case of the Riverside Evaluation Project's (REPORT) ongoing evaluation of the Community Alcohol, Drug and HIV Team operating in London's Riverside District Health Authority. In so doing we will present an example of interactive research in progress and will draw out the implications for the agency/researcher relationship.

To develop this style of operating, the first phase of our research has entailed working closely alongside the team, feeding back information as rapidly as possible, helping the new team to firm up appropriate aims, objectives and working methods.

This phase of cooperative work has been enlightening and beneficial both to the team and to REPORT. A research culture has been developed through mutual understanding, sensitivity and respect for each other's role. The evaluators have augmented the information available to the team to aid the evolution of its aims and objectives, without presuming that they should determine these. The team has been amenable to many of the suggestions from the researchers, even when these have been critical, primarily because an atmosphere of mutual respect has been nurtured through close and communicative working practices.

To understate the case, not every agency will have funds for research. Nonetheless, the example of Riverside's work highlights the advantages of building a research component into service development, both in terms of satisfying managers and funders, and in refining the agency's aims and objectives.

Gone are the days when research was seen as a burden on the functioning of agencies. The 'new realism' dictates the need for research — many funders now insist that evaluation is costed into agen-

cies' requests for new project monies. Agencies may wish to involve local researchers in preparing such bids and, where necessary, in making the case for a research component.

Nevertheless, many of the issues discussed below can be taken on board by any agency, whatever its existing level of research expertise.

## Outreach ambassadors

One of REPORT's researchers regularly accompanied team members on outreach work. This had several functions. In practical terms it meant that the team member had the companion necessary for street work. It enabled the researcher to assess the team's outreach work, to meet its clients, and to contact drug users not in touch with established services.

Researchers also conducted outreach work outside the team's orbit to extend the networks of drug users contacted. In this case an 'action research' approach was adopted with researchers giving drug users leaflets about the community team and, if appropriate, referring them to a team member.

This was very much a two-way process, with team workers providing contacts they felt were appropriate for research purposes and for gaining access to new groups of users.

The researchers also acted as ambassadors for the service by answering queries about its work, operational policy and referral system. Relevant points from these outreach sessions were fed back at the team's development meetings. A paper presented to the team outlined models of outreach work found effective both in this country and in the USA, along with specific comments made by drug users during outreach work in Riverside. These comments included areas and locations drug users felt would benefit from outreach input; also many users believed that using drug users or ex-users from the local area would enhance the team's impact.

It was also possible for the outreach researchers to report back on new drug trends and patterns that might require a rethink of the service's target groups and aims and objectives. The obvious contemporary example is that of cocaine and crack, with researchers reporting activity at a number of locations.

The distinction between 'action research' and the agency's outreach work on the streets is blurred, with many overlapping activities. In the absence of research personnel, outreach workers themselves can collect information on drug trends and patterns, new locations and drug dealing/using arenas, merely by additional informal and sensitive questioning of contacts. This information can be fed back to the agency and influence aims, objectives and strategies.

Obviously, an ambassadorial and publicity function is inherent in the role of agency outreach workers, and in this sense too there is a convergence with action research techniques.

## Direct feedback

Researchers conducted face-to-face interviews with a range of people in contact with the service from drug users to health visitors, some of whom were identified by the community team. The purpose was to aid the team in developing its aims and objectives by feeding back opinions on and demands for its current and future role from a variety of sources.

A number of professionals were eager for the team to carve itself a specific niche rather than duplicate the general counselling role fulfilled by other services in the area, and for the individual skills of staff members to be used to the maximum. For instance, a number felt that the team's doctor would be well placed to offer home-detoxification for relevant referrals.

Drug users, on the other hand, emphasised outreach work and opening outside normal office hours. At the regular weekly meeting all such information could rapidly be fed back to the team.

In the absence of research personnel it would, of course, be extremely difficult for agency workers to interview clients about

1. Power R. "Being researched: and how to make the most of it." *Druglink*: 1989, 4(3), p.14-15.

The full report of the study of which this article describes the methodological approach is now available. *The Riverside Community Alcohol, Drug and HIV Team: an Evaluation of Year One* is available for £7 inc. from the Centre for Research on Drugs and Health Behaviour, 86 Fulham High Street, London SW6 3LF, phone 01-846 6565.

## Engaging GPs

Following a seminar held by the team when their work was described to invited local GPs, the researchers conducted a survey of all GPs in the area to gauge demand for the team's services. Leaflets on the service were included in the mailing, the exercise having a dual function. On the one hand, the team was being publicised and, on the other, valuable research information was being collected. The names and addresses of GPs who expressed a wish to work with the service were passed on to the team and comments fed back.

This survey was conducted through the post, using a stamped addressed envelope to encourage returns. After a fortnight, those who had not yet responded were reminded by phone. The costs of such a survey are moderate, the main outlay being on stamps and phone calls. However, the returns can be most valuable, leading to beneficial contacts with enthusiastic local GPs.

their opinions of the services offered. Problems arise around confidentiality, clash of roles, and objectivity. For a variety of reasons, ranging from the personal relationship with the worker to the drug user wanting to be seen to be positive about the service, the client is unlikely to present a frank and honest appraisal.

However, some limited research around non-controversial issues is still possible, such as how clients feel the service could expand its activities or which areas might best benefit from outreach initiatives.

Such restrictions do not apply to agency staff 'researching' professionals. Agencies should consider routinely contacting as wide a range of professionals as possible when setting up a new initiative. This often takes place informally, but it would be beneficial to formalise the process by interviewing a representative sample or by sending out postal questionnaires in much the same way as we did for the community team. Issues relevant to the new service would be addressed, such as how the respondents would like the service to develop and in which ways they would wish to undertake cooperative work. In Riverside we mounted a particular effort to contact GPs (see box above).

A key problem facing any service is how to record referrals and caseloads. In consultation with Riverside's community team, the North West's monitoring forms were adopted to serve as both a practice and a research instrument.

Team workers used the form as a casenote summary that could also be used to record telephone referrals, even if these

were not followed up or were referred elsewhere. This meant that 'hidden clients' were not excluded when caseloads were totalled, ensuring that most of the team's contacts with drug users could be recorded and monitored — invaluable when it comes to funding applications and accountability to management committees.

The minimal database derived from the forms also had a clear research function in that it enabled the researchers to monitor the actual caseload against the target client groups stated in the team's aims and objectives (for more on the North West's database see pages 10-12).

## Advancing the dialogue

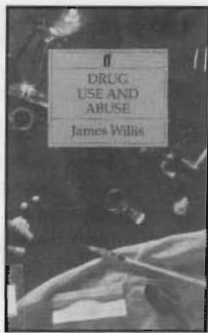
We are *not* suggesting that agency workers should or could replace researchers (or, in the case of action research, vice versa). But, even with limited resources, current practices (such as the emphasis on outreach work) mean many agencies could adopt a number of strategies employed by researchers and achieve short-term returns in the form of information on client groups and drug trends and patterns.

Without additional resources and personnel, the ambitions of such a project must be modest. It is unlikely that any in-depth data analysis would be possible, if only because few agencies have the necessary computer equipment, let alone someone with time to enter the data. It would therefore be advantageous to plug into an established monitoring system, where all the technical and analytical components are organised by a central authority.

Nevertheless, agencies can collect limited and manageable data to assist them in developing their objectives and in plotting shifting patterns and trends of drug use in their areas. In practice it would be important for one senior worker at an agency to have coordination and development of research as part of their job description.

A number of forums already exist where researchers and agency workers could come together to discuss collaboration and common strategies. To date these forums have primarily been in the context of outreach work, such as the day workshops held at the Mersey Drug Training and Information Centre and several outreach discussion groups in London. Local meetings could be held where information was pooled by contributing agencies, broadening the picture of drug patterns and trends.

WE DO NOT deny the special talents and specific goals that separate research from agency-based work with clients, nor the essential place of long-term, rigorous academic research. However, we emphasise that, in an area of tight resourcing, it is timely and valuable for skills to be shared and for a dialogue to be opened which will lead to further collaboration between drug researchers and drug workers. ■



**DRUG USE AND ABUSE.** James Willis. London: Faber & Faber, 1989. 115 pages. £3.99.

**ADDICTION: SUBSTANCE ABUSE AND DEPENDENCY.** Norman Imlah. Wilmslow: Sigma, 1989. 182 pages. £14.95.

**DRUGS AND ADDICTIVE BEHAVIOUR. A GUIDE TO TREATMENT.** Hamid Ghodse. Oxford: Blackwell Scientific, 1989. 328 pages. £16.95.

The relationship between psychiatry and addiction has long been uneasy. Like partners on a blind date who find they have little in common, most psychiatrists do not think addiction has much to do with mental illness while drug users cannot understand why they are seeing a psychiatrist.

Nevertheless an active minority of psychiatrists not only established the main drug treatment clinics, but also continue to influence national policies. The authors of these books are experienced clinicians and, taken together, their views are a good reflection of current psychiatric approaches to drug problems.

In *Drug Use and Abuse*, James Willis presents a wide-ranging summary of drug use in a readable and lively style. Its greatest emphasis is on the cultural and historical aspects; in particular, on how society should respond. While his perspectives here are sound, in common with many other authors he draws on exotic behaviours from abroad, overlooking the diversity in drugtaking practices in Britain.

More contentiously, Willis makes partisan statements unsupported by evidence, such as that "Women now smoke and drink more alcohol than formerly, and this may well be due to their wish to achieve a spurious parity with men", and "Muslims are practically invulnerable to alcoholism". He also argues that drawing drug users into treatment with liberal prescribing policies may reduce criminal behaviour. However, the relationship between crime and drug use is more complex than Willis suggests and his solutions do not carry much conviction. In short, this book is not recommended.

Norman Imlah's *Addiction* is described as a comprehensive review of substance misuse for the public and for professionals in this field: it cannot be recommended for either. The author clearly has considerable experience, but over-reliance on personal views leads to a book that is idiosyncratic, at times ill-informed, and out of touch with current thinking. Drug and alcohol users are described throughout in highly stereotyped terms: "the first rule is that all people who are addicted are deceitful during their addiction"; "all who seek treatment come with inadequacies in their make-up".

Similarly, with drinking problems he states: "it is an absolute maxim that every alcoholic will play down the extent of their drinking", and describes "the drinker or the addict as a glib deceiver with loss of insight". A chapter on personality and substance misuse employs categories of personality disorder of doubtful validity, while on treatment he ignores the newer psychological therapies, and seems to advocate long-term amphetamine prescribing without mentioning the dangers. The lay reader seeking an introductory text would do better with *Drug Scenes* published by Gaskell (1987).<sup>1</sup>

By contrast, in *Drugs and Addictive Behaviour* Hamid Ghodse has produced a comprehensive, practical and scholarly guide to assessment and treatment. The book's twin strengths are its wealth of factual information, combined with elegant analysis of the issues. This is the best of the texts currently available, and may unhesitatingly be recommended to all with an interest in this field.

The book opens with a summary of current psychiatric views followed by a useful account of the development of the British response and the structure

of treatment facilities. In the chapter on drug effects, newer agents such as crack and designer drugs are particularly well covered.

It is, however, in the chapters on assessment and treatment that this book succeeds where so many others have failed. Here, the words 'multidisciplinary team' have real meaning in that Ghodse emphasises the importance of nursing, social work, and psychological assessments. Treatment is particularly well described and not solely in the medical setting. Controversial issues such as maintenance and prescribing injectables are thoughtfully presented in such a way as to be of practical help.

There is a fine chapter on special problems such as the pregnant addict, the child at risk, the doctor-addict, and drug users in other medical settings, such as the GP's surgery and casualty departments. The book concludes with a clear examination of the issues involved in prevention and control which draw on the author's national and international experience.

Shortcomings result largely from the wooliness of current psychiatric thinking on some key issues. For example, Ghodse describes the contribution of personality to drug use in general terms which reveal the poverty of our understanding. One of the strongest indictments of psychiatry is that it is still unable to describe the personalities of its clients in a valid and systematic way, without falling back on the stereotyped and grotesque labels in international classifications. Terms such as 'anancastic' and 'hysterical' do not do justice to the personality problems of our clients.

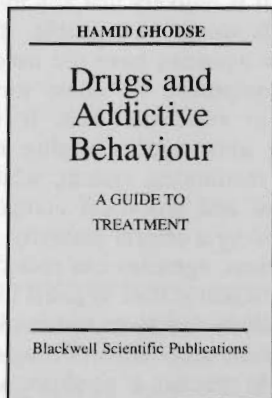
At the heart of our attempts to understand addictive behaviour lies a second and more fundamental matter — the position of free will in an addicted individual. This is not considered in these books and receives only scant attention elsewhere. Current psychiatric opinion places addictive behaviours firmly within the realms of mental phenomena and suggests that continued drug use arises from a compulsion cued by internal or external stimuli. This compulsion sits uncomfortably alongside the view that drug users are rational beings with free will, capable at any time of changing their behaviour.

Addiction awaits its great categoriser who will reclassify our mass of information about drug and alcohol use into a more coherent and palatable whole. Perhaps someone will write a book about it...

Andrew Johns

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1. Available from ISDD, £6.50 inc. p&p.



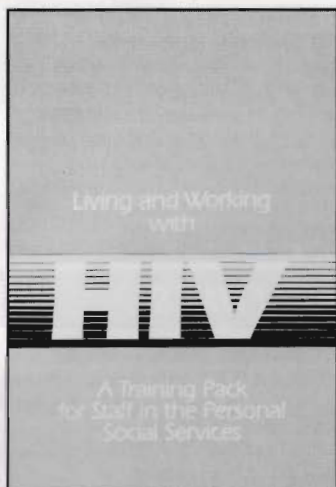
Three British psychiatric heavyweights have recently authored books summarising their extensive experience. What do their works reveal about the state of psychiatric thinking on drug problems?

## CALLING ALL DRUGS RESEARCHERS

*Drug Questions* is the register which lists and describes research projects on matters related to illegal drugs, solvents and HIV. It is produced by ISDD with financial assistance from government departments and research councils. It aims for comprehensive coverage of all relevant UK research, but to meet this goal we need researchers to let us know what they are doing!

*Drug Questions* issue 5 is being compiled now. If you are involved in research you think should be listed and want others to hear about it — then please contact us.

Complete the simple form in this issue of *Druglink* and return to DQ 5, ISDD, 1 Hatton Place, London EC1N 8ND, or phone 01-242 1878 — just ask for *Drug Questions*.



An HIV training pack that takes drugs seriously with papers of interest to drug workers as well as trainers.

**LIVING AND WORKING WITH HIV. A TRAINING PACK FOR STAFF IN THE PERSONAL SOCIAL SERVICES.** Various authors/editors. Central Council for the Education and Training of Social Workers (CCETSW), 1990. £20.

A well-informed, practice-based discussion paper on the *Training Needs of Staff Working with Drug Users* is a startling find in any HIV training pack. More startling still to find this paper produced under the auspices of CCETSW, the social services training body, and available as a separate document at only £1.

CCETSW's pack at last places the training needs of drug workers firmly into the mainstream of social service training provision. Drug workers and trainers, struggling fruitlessly over the years to put drug training on the agenda of the health and social services, may rightly feel it's about time.

The pack is in six parts — *Training Guidance*, a *Training Resources Directory*, plus four discussion papers. The discussion papers are excellent, offering accessible information worth reading by any interested drugs/HIV workers, as well as by trainers. Drawn from 13 participatory workshops held nationally, they are realistic, based in existing good practice, and filled with useable recommendations.

*Issues for Clients and Workers from Black and Ethnic Minority Communities* is particularly welcome, as trainers have often failed to challenge appropriately the racist stereotyping which surrounds HIV. In this paper the overt racism of 'AIDS came from Africa' myths is confronted, and trainers are reminded to confront hidden racial sexual stereotypes and prejudice against black and ethnic minority people with HIV/AIDS. The paper is available in seven languages.

*Training Guidance for Staff in the Personal Social Services*, the pack's main booklet, is extremely comprehensive. Its training matrix looks complicated but is worth the time, dividing training\* for three key staff groups into four areas of training need (see figure). The booklet presents training ideas relevant to each 'cell' of the matrix, with examples to keep the trainer focused on workplace utility.

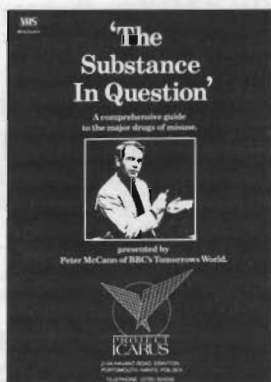
At only £20 for the whole, and each part also available separately, *Living and Working with HIV* is a good investment for HIV training providers. If nothing else, drug trainers could usefully keep to hand a copy of *Training Needs of Staff Working with Drug Users*. Its clear advice on the best approaches to training, and the issues for managers, offers excellent back-up to any trainer seeking to negotiate drugs/HIV training with reluctant staff or managers — those who, even now, remain unconvinced of the need.

**Breda Flaherty**

*Training Officer, Standing Conference on Drug Abuse (SCODA)*

*Living and Working with HIV is available from CCETSW, Derbyshire House, St Chad's Street, London WC1H 8AD, phone 01-278 2455.*

Areas of training need	Key staff groups		
	Field	Residential	Day care
Information			
Attitudes			
Skills			
Organisational			



Like an 'animated *Drug Abuse Briefing*' (ISDD's drugs fact booklet), says our reviewer of this Project Icarus video.

**THE SUBSTANCE IN QUESTION.** Portsmouth: Project Icarus, 1989. Video plus six posters. Hire £14.95, purchase £34.50.

Project Icarus's new video was produced as part of Wessex's Drugwise campaign funded last year by the Department of Health. It aims to provide factual information about, as presenter Peter McCann puts it, "the major illegal drugs at large in our society". It does not deal with caffeine, alcohol and tobacco, even for comparative purposes. More importantly, in terms of public concern, neither does it deal with solvents.

Its stated aim is an honourable one: "to provide the kind of knowledge all too often neglected in the debate about drugs". The format is simple enough — introductory comments followed by detailed discussion of each type of drug. Peter McCann handles the factual information, Dr Philip Fleming comments on the relative dangers of each drug, while users and ex-users describe their experiences.

Herein lies the major drawback of the video. Users and ex-users are shown on screen in a number of formats. Some talk straight to camera about past use, one is seen in shadow describing her use of ecstasy, and some very odd extracts look as if they have been edited in from 1960s or '70s footage. The makers of the video have gone yet again for including 'real users' to lend interest and credibility, but putting drug users on screen, even with their permission, must ultimately be exploitative — a view stated in SCODA's policy statement of 1985:

"The potential harm to our customers of participating 'on camera' in television and video programmes far outweighs any possible benefits... drug workers should not facilitate the use of their customers in this way and actively discourage journalists and film makers from pursuing this tactic."

Most of the information is clearly and concisely presented. It includes ecstasy and crack, so it's pretty

up to date, though in parts a little suspect: the statement that crack "seems to be more addictive than any other drug we know" seems doubtful. There are useful sections on temazepam and temgesic, though it was surprising to learn that temgesic is 20 to 40 times more powerful than morphine on a "dose by dose basis".

But on the whole the video does a reasonable job of explaining drugs and their effects. In that way it's a kind of animated *Drug Abuse Briefing* (ISDD). The material is similar to that in the video *Drugs — Information for Parents* (NWRDTU), excluding alcohol, tobacco, caffeine and solvents, but including ecstasy, temgesic and temazepam and aimed at a wider audience. The general tone is balanced and rational.

Occasionally, however, muddle creeps in, most obviously at the end when the presenter states that "Many people who use drugs come to no harm", and moments later that drugs "may not necessarily kill, but they can and they do take your life away". Earlier it had been stressed that drug use was *potentially* problematic: why, then, the need for such an emotive and inaccurate parting shot?

*The Substance in Question* comes packaged with posters from Wessex's campaign. Guidance on how the video should best be used for educational/training purposes would have been much more useful. Videos such as this should be backed up with exercises and written material if the information is to be accurately retained by viewers.

Despite my reservations, *The Substance in Question* could have been a useful addition to the range of information materials available. However, its use of drug users on camera means that I won't be using it.

**Lynne Milburn**

*Coordinator, North West Regional Drug Training Unit*

*The Substance in Question is available from Project Icarus, 214A Havant Road, Portsmouth PO6 2EH, phone 0705 324248.*

## PUBLICATIONS

## Therapy

■ **ADDICTION: SUBSTANCE ABUSE AND DEPENDENCY.** Norman Imlah. Wilmslow: Sigma, 1989. 182 pages. Book. £14.95.

By an experienced UK psychiatrist. (See review.) Available through bookshops.

■ **WORKING WITH STIMULANT USERS.** SCODA, 1990. 22 pages. Conference report. £2.

Practical guidance for drug advice or treatment workers. Available from SCODA, 1 Hatton Place, London EC1N 8ND, phone 01-430 2341.

## Cocaine/crack

■ **COCAINE AND CRACK.** ISDD, 1989. 14 pages. Booklet. £0.95.

In ISDD's Drug Notes series. Available from ISDD.



■ **CRACK. FREEBASE COCAINE.** Release Publications Ltd, 1989. Leaflet. Prices from £0.20 each for up to 9 copies to £0.10 for 501+.

Basic facts for general public. Available from Release, 169 Commercial Street, London E1 6BW, phone 01-377 5905.

## Education

■ **DRUG EDUCATION IN THE PRIMARY SCHODL.** Norma White. Cumbrian Education Authority, 1989. Video. £13.

Available from Norma White, Health Education Coordinator, Furness Teachers' Centre, Dowdales School, Dalton-in-Furness, Cumbria LA15 8AH, phone 0229 62988 (cheques payable to Cumbria County Council).

■ **THINK! INFORM! DECIDE!** Vivienne Evans et al. TACADE, 1989. Education Resource Pack. Includes 65 cards. £11.95.

■ **TAKING DRUGS OR TAKING PART.** Mike Ward and Bill Rice. TACADE, 1989. 52 pages. Teaching pack. £9.95. The first is meant to add drug content to the Skills for Adolescence programme. The second is about drug use in sport. Available from TACADE, 1 Hulme Place, The Crescent, Salford, M5 4QA, phone 061 745 8925.

■ **GET DRUGWISE.** Wessex Regional Health Authority, 1989. Report. Documents the DoH funded regional drug campaign in Wessex. Available from Wessex RHA.

## HIV/AIDS

■ **HIV/AIDS COUNSELLING TRAINER'S PACK.** Martin Williams and Paul Lockley. Scottish Health Education Group, 1990. £95.

Mega double-video pack for trainers with drug worker as a co-author. (To be reviewed). Available from SHEG, Woodburn House, Canaan Lane, Edinburgh EH10 4SG, phone 031 447 8044.

■ **LIVING AND WORKING WITH HIV. A TRAINING PACK FOR STAFF IN THE PERSONAL SOCIAL SERVICES.** CCETSW, 1990. £20.

Includes drug users as one of its major themes. (See review.) Available from CCETSW, Derbyshire House, St Chad's Street, London WC1H 8AD, phone 01-278 2455.

■ **AIDS: WORKING WITH YOUNG PEOPLE.** Peter Aggleton et al. AVERT, 1990. £14.95. Teaching pack. For teachers, youth workers, etc, from the same stable as the respected Learning About AIDS materials. Available from AVERT, PO Box 91, Horsham, West Sussex, RH13 7YR.

■ **PREVENTION OF AIDS AMONG DRUG USERS: THE ROLE OF THE HIGH STREET PHARMACY.** Alan Glanz et al. Addiction Research Unit, 1990. 28 pages. Research report. £3.50. First national picture of pharmacists' willingness to run syringe exchanges, etc.

Available from Institute of Psychiatry, Addiction Research Unit, 101 Denmark Hill, London SE5 8AF, phone 01-703 5411.

## Other

■ **DISEASING OF AMERICA: ADDICTION TREATMENT OUT OF CONTROL.** Stanton Peele. Lexington, 1989. 321 pages. Book. £15.50.

Influential US psychologist challenges the 'disease' model of addiction. Available through bookshops.

■ **TRANQUILLISER INDEPENDENCE.** Cosmo Hallstrom. London: Charing Cross Hospital, 1989. Audio-cassette. £5.95 (Proceeds to research funds). Self-help cassette with general information and guidance on relaxation techniques.

Available from Charing Cross Hospital (Dr Hallstrom), Fulham Palace Road, London W6 8RF.

■ **SCODA RESPONSE TO THE WHITE PAPER ON COMMUNITY CARE AND TO THE NHS AND COMMUNITY CARE BILL.** SCODA, 1990. 12 pages, mimeo. Booklet.

Voluntary drug agencies respond to the NHS and community care reorganisations. Available from SCODA, 1 Hatton Place, London EC1N 8ND, phone 01-430 2341.

## COURSES

■ **HEALTHCARE AND SAFER INJECTING.** 18-20 April 1990, Rochdale. £65/95.

■ **MOTIVATIONAL INTERVIEWING FOR ADDICTIVE BEHAVIOURS.** 30 April-1 May 1990, Manchester. £105.

■ **DEATH, DYING AND BEREAVEMENT.** 17-18 May 1990, Manchester. £60/90.

■ **SEXUALITY AND SEXUAL ABUSE — THE DRUG WORKER'S RESPONSE?** 11-12 June 1990, Manchester. North West Regional Drug Training Unit.

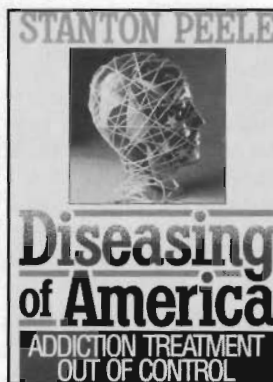
A selection of NWRDTU courses for drug workers. Details from NWRDTU, Kenyon Ward, Prestwich Hospital, Bury New Road, Manchester M25 7BL, phone 061 798 0919.

■ **MANAGEMENT OF PROBLEM DRUG USE.** Part-time course over 15 sessions starting in May 1990 and again in September, London.

■ **CERTIFICATE IN DRUG DEPENDENCE.** 22 week full time course starting June 1990, London.

S.E. Thames Regional Drug Training Unit/Bethlem Royal and Maudsley Hospitals School of Nursing. Details from Hussein Rassool, Regional Drug Training Unit, 11 Windsor Walk, London SE5 8BB, phone 01-703 0269.

■ **MANAGING DRUGS AND HIV OUTREACH WORK.** Mersey Drug Training and Information Centre. 18-20 May 1990, Preston. £185. Weekend residential course for outreach programme managers. Details from MDTIC, 10 Maryland Street, Liverpool L1 9BX, phone 051 709 3511.



■ **AN INTRODUCTION TO WORKING WITH DRUG USERS.** Cooperative Training Services. 7-8 June; 13-14 September; 1990. £70 plus VAT: reductions for voluntary organisations.

For non-specialist workers and those new to specialist drugs work. Details from Pam Pryce, NACRO, on 01-582 6500.

■ **MANAGING BENZODIAZEPINE WITHDRAWAL.** Healthskills Consultants/Withdrawal Workshops. 2-3 April, Birmingham; 11 June, Bristol; 25-26 June, Bristol; 1990. Two-day basic workshops and one-day more advanced workshops. Details from Healthskills Consultants, 515A Bristol Road, Birmingham B29 6AU, phone 021 471 3626.

## MEETINGS

■ **SUBSTANCE ABUSE — WHOSE PROBLEM IS IT?** Association of Nurses in Substance Abuse (ANSA). 2-4 April 1990, Chester College. Annual national conference of specialist drug dependency nurses. Details from Carolyn Steele, Cheshire DTIC, Theatre Court, London Road, Northwich, Cheshire, CW9 5HB, phone 0606 49055.

■ **DRUGS AND AIDS IN PRISON.** 2 April 1990, London. Meeting for agencies working in prisons to discuss methods of working and swap experiences. Contact Mike Trace, Parole Release Scheme, 148-150 Penwith Road, London SW18 4QB, phone 01-877 1414.

■ **FIRST INTERNATIONAL CONFERENCE ON HARM REDUCTION: THE THEORY AND PRACTICE OF SAFER DRUG USE.** Mersey Drug Training and Information Centre. 9-12 April 1990, Liverpool. Details from Mersey Drug Training and Information Centre, 10 Maryland Street, Liverpool L1 9BX, phone 051 709 3511.

■ **FIRST RUSKIN DRUG CONFERENCE.** Ruskin College and ISDD. 6-7 September 1990, Oxford. Workshops on health and welfare, criminal justice and education for drug agency workers. Details from Dept. of Applied Social Studies, Ruskin College, Dunstan Hall, Dunstan Road, Headington, Oxford.

## ORGANISATIONS

■ **TACADE**  
New address 1 Hulme Place, The Crescent, Salford M5 4QA, phone 061 745 8925.

■ **CENTRE FOR RESEARCH ON DRUGS AND HEALTH BEHAVIOUR, CHARING CROSS AND WESTMINSTER MEDICAL SCHOOL.**  
New research centre headed by Gerry Stimson incorporating the Monitoring Research Group and REPORT. 86 Fulham High Street, London SW6 3LF, phone 01-846 6565.

## 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.

# RUSKIN DRUG CONFERENCE

IN ASSOCIATION WITH  
**ISDD**

&

**THE OXFORD REGIONAL  
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6/7th SEPTEMBER, 1990

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The Role of the Voluntary Sector  
Training for Social Workers, Planners  
and Managers.**

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order form, phone or write to:  
The Information Section,  
CCETSW,  
Derbyshire House,  
St. Chad's Street,  
London WC1H 8AD,  
phone 01-278 2455 ext. 394.**



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**Friday, 18th May -  
Sunday, 20th May 1990.**

**Stokes Hall, Leyland, Preston.  
£185.00 plus VAT.**

For further information contact:  
Mersey Drug Training and Information Centre,  
10 Maryland Street, Liverpool, L1 9BX.  
Tel: 051-709 3511

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IN SUBSTANCE ABUSE**

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**SUBSTANCE ABUSE—  
WHOSE PROBLEM IS IT?**

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£95 ANSA members	} residential including all meals and accommodation
£100 non-members	
£26 per day attender	} non-residential, including lunch and coffee breaks
£54 3-day attender	

**SPEAKERS WILL INCLUDE:**

Mrs Jean Faugier: Manchester Polytechnic; National Coordinator, ANSA  
Mr David Turner: Director, SCODA  
Ms Geraldine Nolan: Coordinator, DAWN  
Mr Mike Hindson: Assistant Chief Probation Officer, Greater Manchester

**Further details: Carolyn Steele, CDTIC, Suite B,  
Theatre Court, Northwich, Cheshire, CW9 5HB,  
phone: 0606 49055**

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TRAINING  
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The emphasis throughout is on active participation, using varied methods from small group tasks to practical problem-solving. Drugs are interpreted broadly to include alcohol and solvents.

On completion of the course, participants will be equipped to set up and run a multi-disciplinary drugs training programme in their own area.

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**Venue:** The Cinque Ports Country House Hotel, Hastings.

**Cost:** £325 to include 70-page step-by-step training manual.

**Contact:** Angela Haines,  
Course Administrator,  
Hastings Drug Dependency Clinic,  
St Helens Hospital, Frederick Road,  
Hastings, East Sussex TN35 5AH.  
Phone: 0424 720088  
Fax: 0424 754263