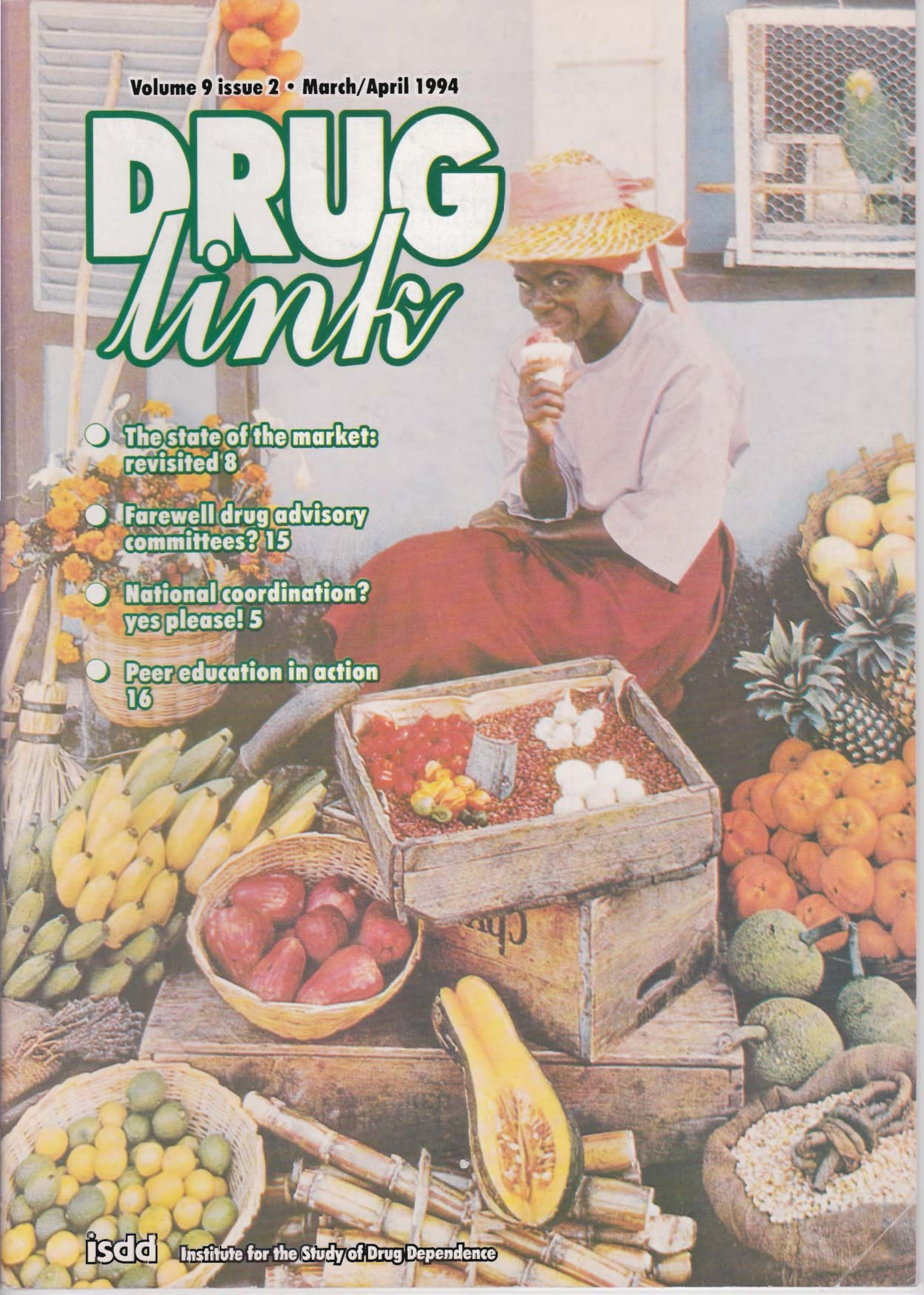
Volume 9 issue 2 • March/April 1994

DRUG links



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isdd Institute for the Study of Drug Dependence

DRUG links

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

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

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MARKET MOVES

Familiar structures are on the way out (RHAs and DACs), others are metamorphosing fast (DHAs, local authorities), new structures are forming (trusts, purchaser coalitions), and the '90s power brokers are getting a grip (health and social care commissioners). Three experts at the heart of these changes give generously of their views and understandings. See pages 8 and 15. Then settle back and take the long view with a historian's cool look at today's 'new' policies (page 12), and witness one of the 'newest' of these policies in action, the nitty gritty of peer education in Birkenhead (page 16).

8 The state of the market: revisited

Two of the best brains in the business bend their neurones to the current market for drug services and what's on the horizon. If you're in the market, you'll want to read **Peter Mason** and **John Marsden**'s analysis of the state of play.

12 AIDS and drug policy: revolution or revision?

Virginia Berridge takes a historian's look at 'modern' harm minimisation policies and finds more echoes from the past than you might have expected.

15 New horizons needed

In his pivotal report to the Department of Health, **Roger Howard** called for drug advisory committees to be replaced by community partnerships. Here he presents the key arguments.

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16 Healthy women

'Peer education' in practice among the drug using prostitutes of Birkenhead. **Janet Hanslope**'s innovative project deservedly won a health education award.

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4 NEWS

In 1993 we asked when the Government was going to get it's act together. The answer may be now – through the new Central Drugs Coordination Unit.

4 COPPERFIELD

Alone and lost somewhere within the serried lanes of the M25, Copperfield needs your help. Please donate 400 words.

7 CONNECTIONS

The self-help network for the drugs field.

18 REVIEWS

The *Just Say Know* drug information comic may be too daring for its own good. All the sleaze of drugs and rock 'n' roll in *Songs They Never Play on the Radio. Drug Injectors and HIV Risk Reduction* offers ways forward in the drive to prevent HIV spread.

19 LETTERS

A male correspondent rails against the "politically correct" while a female writer says men are the problem. ADSA is not "unaccountable" says its chair. Is deliberate ignorance an acceptable response to hepatitis C? Does it have to be a comic to be 'user friendly'?

20 LISTINGS

A nearly double helping of publications, meetings, courses and organisations.

Cover photo: courtesy of Jamaica Tourist Board

Labour offensive on drugs and crime

The tussle between Labour and the Government for the high ground over drugs and crime became open warfare in February. What was a remnant of consensus politics has become a key party political issue in the struggle to persuade the electorate which party will make streets and homes safer from drug-related crime.

Despite the sound and fury, a sharp policy divide is hard to divine. The Government has tacitly acknowledged the lack of a strong national lead by establishing a new policy unit (see opposite) and Labour is vague about how it would reduce drug-related crime, depriving opponents of a clear policy target.

Radical solutions are confined to the political fringes. Neither party will risk appearing soft on drugs or clamping down in ways which might seriously alienate the pot smokers of middle Britain.

Labour's latest onslaught began on 11 February when Shadow Home Secretary Tony Blair issued a report estimating that in value terms half the property crime in England and Wales was committed by addicts to finance drug purchases. The calculations were, he admitted, crude, but gave some support to the assertion that "A law and order policy without a drugs strategy is not a strategy worth the name". The Government's law and order package "doesn't even deal with drug abuse among young people", accused Labour.[1]

Eleven days later Tony Blair released sections of Roger Howard's report on local coordination the day before the DoH's scheduled publication date.[2] Adding insult to injury, Labour documented how key sections of the original draft on the perceived lack of coordination at a national level had been deleted or rewritten. Last November *Druglink* first revealed that potentially embarrassing passages had been altered at the insistence of the Department of Health, which commissioned the report.[3]

Fines plan boomerangs

Meantime the Government failed to win hearts and minds with Home Secretary Michael Howard's plan to raise maximum fines for possessing cannabis. The proposal was in the form of an amendment to the Criminal Justice Bill now going through Parliament, and would also raise fines for other offences involving class B and class C drugs (see panel).

A move which might have been expected to put Labour on the defensive and raise cheers from the Conservative press and law enforcement agencies instead drew fire from those sources. Only the *Daily Mail* (14 February) gave Mr Howard the headline he might have wished for ("Drugs hard man") but its editorial queried "whether he has really thought this one through ... Won't the most likely result be an increase in unpaid fines ... ?"

Most outspoken was the *Daily Sport* (15 February) – "What a dope", "Crackpot", were its verdicts on the Home Secretary and his proposal. "We need a brave, radical rethink about the whole drugs business ... prohibition simply does not work."

The Police Federation said raising the penalty for cannabis possession was "absurd ... Many people who use cannabis simply won't be able to afford the fines and may end up in prison".[4] Magistrates predicted it would have little impact and pronounced themselves unlikely to amend guidelines which recommend a £180 fine for the average cannabis possession offence.[5]

Spokespersons at the Home Office gave mixed messages, suggesting that raising fines from £500 to £2500 would merely be a technical adjustment for inflation since 1977, and that it was designed to show that "drugtaking is not going to be taken lightly".[6]

The Home Office PR people were not helped by news that the Scottish Office's Drugs Task Force was considering recommending a £25 fine for cannabis possession payable by post,[7] though the Scottish Drugs Forum says the task force has not yet agreed to propose the plan.

Proposed new penalties[1]

Max. fines up	from	to
Possessing class B drugs[2]	£500	£2500
Possessing class C drugs	£200	£1000
Trafficking class C drugs[3]	£500	£2500

1. No change is proposed in penalties for class A drugs. Maximum fines for certain other offences involving class C drugs are also to be increased
2. Inc. cannabis and amphetamines.
3. Production, supply, intent to supply.

Labour ducks political fallout

Labour kept their heads down, ducking the political risk of outright opposition to the hike in fines and dismissing Mr Howard's amendment as irrelevant to the main task of reducing crime. Their chosen policy targets are the addicted users of class A drugs (heroin and cocaine) who they believe are responsible for the mass of drug-related crime, rather than recreational cannabis users quietly puffing away at home.

On 22 February when the Government's amendment came before the Standing Committee on the Bill, Labour declined to force a vote. Home Affairs spokesperson, Alun Michael, explained: "It is unlikely to have any significant impact on sentencing. It didn't deserve the satisfaction of them being able to say 'Labour voted against higher penalties'."

Complicating Labour's attempt to maintain its anti-drug credentials is the fact that Tony Banks, one of its best-known backbenchers, plans at the report stage to table an amendment to the Criminal Justice Bill to liberalise the law on cannabis. It is unclear whether this will be to permit medical use only, decriminalisation, legalisation, or a choice of all three.

Last December Mr Banks moved an Early Day Motion calling for a Royal Commission on cannabis control, now signed by 18 other MPs including three Liberal Democrats (David Steel among them). Missing from the list are Tony Blair and other leading Labour frontbenchers.

This January another Early Day Motion from Labour MP Paul Flynn called for a Royal Commission on drug use, attracting 36 signatures. Labour's official line is that there are more pressing issues for Royal Commissions.

1. Labour Party. *Drugs: the need for action*. 1994 and press release from Tony Blair, 11 February 1994.
2. Tony Blair and David Blunkett. *News Release*, 22 February 1994.
3. *Druglink*: 1993, 8(6), p.6.
4. *Sunday Times*: 13 February 1994.
5. *Daily Telegraph*: 15 February 1994.
6. *Daily Telegraph*: 14 February 1994.
7. *Scotsman*: 9 February 1994.

Where is Copperfield?

Our grumpy scribe has yet to find the way to our new offices. Unfamiliar with the territory south of the Thames, they could be wandering anywhere within the M25. Copperfield's misfortune is our gain as we can fit in more of the hard news so abundant in the first months of 1994. Copperfield will be back in May, more bellicose than ever after months in the wilderness.

Who is Copperfield?

It could be you. Each column is by a different contributor. Be wicked – no one will ever know (except the editor). Contributions (400 words) to Mike Ashton at ISDD.

❑ Government is to table a clause in the Criminal Justice Bill now going through Parliament to allow prisoners to be tested for drug use. Also a change to prison rules will make illegal drug use a specific disciplinary offence. Similar measures are expected in Scotland.[1] In 1992 over 2000 prisoners in England and Wales were disciplined for possessing drugs. The provisional figure for 1993 is 1759.[2]

1. Michael Howard. *Hansard*: 3 February 1994, col 875.
2. *Hansard*: 19 January 1994, col. 701.

❑ Analysis of UK solvent related deaths between 1981 and 1990 has revealed that the death rate in the under 18s was significantly higher in Scotland and the north of England than in the rest of the UK and that proportionately four times as many died from the lowest social class as from the highest.[1] The authors link both findings to socioeconomic deprivation. 1 in 10 deaths of 15-year-olds are due to solvent misuse, making it the leading cause of death at this age.

1. Esmail A. *et al*. "Death from volatile substance abuse in those under 18 years ..." *Archives of Diseases in Childhood*: 1993, 69, p.356-360.

❑ Psychiatrists at the Maudsley Hospital in south London say that distress due to opiate withdrawal should be grounds for judging a confession in police custody unreliable and therefore inadmissible under the Police and Criminal Evidence Act.[1] They argue that the short-term need to get out of custody to access drugs to ease withdrawal can incapacitate rational decision-making, meaning that confessions do not meet the common law criterion that the person should be acting autonomously.

1. Davison S.E. and Forshaw D.M. "Retracted confessions: through opiate withdrawal to a new conceptual framework." *Med. Sci. Law*: 1993, 33(4), p.285-290.

❑ High doses in methadone maintenance can save lives, concludes a follow-up study of 307 heroin addicts admitted to an Australian programme in the 1970s. Patients given up to 120mg of methadone a day were nearly half as likely to leave during the first three years as those given up to 80mg. Additionally, a change in clinic policy from aiming for abstinence to indefinite prescribing reduced risk of leaving by a third. Clinic records showed patients who stayed in the programme were three times less likely to die. The authors say that to minimise the risk of death heroin addicts "should be offered indefinite, high dose methadone maintenance".[1]

1. Caplehorn J.R.M. *et al*. "Retention in methadone maintenance and heroin addicts' risk of death." *Addiction*: 1994, 89, p.203-207.

SCODA members in two minds about admitting statutory agencies

At its AGM in January SCODA members voted to open membership to "all 'not for profit' drug service providers", ending the rule which allowed only organisations from the voluntary sector to be members plus individuals from the statutory or private sectors. The change promises to give England and Wales a more broadly representative voice for the drugs field as the pressure on services mounts after the halcyon days of the '80s Central Funding Initiative.

For years voluntary as well as statutory sector voices have argued that the expansion of statutory services such as community drug teams has weakened SCODA's ability to speak on behalf of the drugs field.

A similar debate took place in 1988 when SCODA's management committee opposed a move to individual membership open equally to the statutory and voluntary sectors, the structure adopted by the Scottish Drugs Forum.

The difference this time was that SCODA's management committee backed the move following a consultation which showed overwhelming support from members. Recently a consultation exercise for the Department of Health, SCODA's major funder, also called for its membership base to be broadened.

Arguing for widening the membership was the fact that the purchaser/provider split meant "We are 'all providers now'". Ironically, the same market reforms led other speakers to see the statutory sector as powerful competitors from which they needed protection. Now more than ever, they argued, SCODA was needed to stand up for the voluntary sector.

Within hours of approving the change, the membership voted to put it on ice until the "position of the residential sector is resolved within SCODA". This unexpected reversal arose out of a call from residential service members for their concerns to be "fully incorporated" into SCODA's work. Gerry Sutton said "bland assurances" from SCODA were not enough to satisfy the threatened residentials. Eddie Killoran of Turning Point argued that widening the membership would further marginalise residential services in SCODA.

The fact that the residential sector's proposal achieved an 18-12 majority – greater than for admitting not-for-profit services – probably reflects sympathy for the plight of residential services and ambivalence over letting in the statutory sector.

The reversal put SCODA in the difficult position of having agreed an important policy change supported by its major funder but which it was now unable to implement until an ill-defined resolution had been achieved. Its management committeee chaired by Jane Goodsir is seeking ways to reassure the residential sector and in the meantime is holding off from widening the membership.

Among the issues they have to deal with is the fear of many in the voluntary sector that the far more numerous statuory providers will "swamp" the voluntary agencies. The structure of the NHS also means that heads of multi-provider units could wield considerable power in SCODA if constituent services were 'whipped' into voting the same way.

Government acts to silence 'no strategy' critics

The promise in the Conservatives' 1987 election manifesto to "ensure that the control of drug misuse is coordinated effectively" moved a step closer to reality this January with the setting up of the Government's new Central Drugs Coordination Unit for England.[1]

The unit is attached to the Privy Council Office and reports to the Lord President of the Council, Tony Newton, who also chairs the Cabinet committee on drug misuse. That committee will continue as the forum for ministers to attempt inter-departmental coordination, an attempt which the Conservative MP Tim Rathbone, who chairs the All Party Parliamentary Drugs Misuse Group, has described as "entirely inadequate".[2]

The committee will now be advised by a unit intended to be free of departmental interest and able to take an impartial overview in developing national strategy. Appointed on 24 January, the unit's director Sue Street says it will conduct an intensive programme of visits to drug services and other agencies between February and April.[3]

Mrs Street's background is in strategic planning rather than drugs and her colleagues drawn from the Home Office and Department of Health are also new to the drugs field. With its own fact finding programme and fresh outlooks, the unit is in a position to move beyond existing departmental policies but is aware that it needs to tread carefully to avoid upsetting ministerial sensibilities.

The aim is to develop a national strategy which the major government departments can all subscribe to. Neither the unit nor Tony Newton can make recalcitrant ministers toe the line or commit the resources of other departments, and any strategy they come up with will need to be endorsed by the Cabinet drugs committee.

Power of persuasion

The unit's first task is to review the Government's drugs strategy last published in 1989. Having devised an improved strategy and stimulated national and local action to implement it, the unit will monitor its progress with value for money high on its agenda.

By this summer Sue Street plans to have an outline strategy agreed and in the second half of the year to consult over what this might mean for local action. Here too the aim is to tread lightly and "build on local arrangements which are working well ... rather than to drive through change for its own sake".

The unit's remit to "devise an effective basis for local coordination" within the national framework goes some way to meet calls for a national agency to underpin proposals for replacing drug advisory committees with drug misuse community partnerships.[4]

Across the Divide, the report which made these recommendations, was published in February with the call for a national body deleted at the insistence of the Department of Health. Its recommendations will be considered by the unit when it comes to consider local action (see this issue of ***Druglink***, p.15).

The unit appears to fall short of former Home Secretary Kenneth Baker's reported ambition to set up a "powerful" new national drugs agency[5] and will not be able to switch resources across departments, for example, by funding NHS treatment efforts through crime prevention money from the Home Office.

But there are hopes that its independence and the backing of key ministers at the Department of Health and the Home Office will lend its recommendations the authority no single department could muster. With his own source of information and a consensual government strategy behind him, Tony Newton will be much better placed to effect the coordination many feel has so far been lacking.

The most notable missing partner in the anti-drugs effort has been the Department for Education, whose withdrawal last year of funding for local authority health/drug education coordinators left a gaping hole in the Government's demand reduction strategy. In February Tim Rathbone once again blasted this decision as a "scandal" (see page 6).[6] Had the unit been in place and working properly, he believes the funding would never have been withdrawn. He admits that no coordinating body can force ministers' hands but argues that "if the coordination of government affairs is better understood across all departments then any department not pulling its weight will have the power of persuasion of other ministers brought to bear on it".

Disunited lobby?

Drugs field leaders too are giving the unit a cautious 'wait and see' welcome. Several have been quick to offer advice in advance of the unit's invitation. Clare Tickell, Phoenix's Chief Executive, is among them. However, she is concerned that a series of drug agencies each advancing their parochial interests to the unit will reinforce the impression of a disunited field unable to coordinate to maximise its lobbying power by agreeing a limited number of key messages.

❑ As Minister for Health it was Tony Newton who in 1988 partially endorsed the radical first conclusion of the first *AIDS and Drug Misuse* report from the Advisory Council on the Misuse of Drugs. His response on behalf of the Government stopped short of accepting the ACMD's view that HIV was a greater threat than drug misuse but did accept that services should aim to "reduce the health risks" associated with drug misuse as an "intermediate goal" on the path to abstinence.[7]

1. Michael Howard. *Hansard*: 16 December 1993.
2. *Druglink*: 1993, *8*(1), p.4.
3. Street S. "CDCU: introduction and remit". Letter, February 1994.
4. *Druglink*: 1993, *8*(6), p.6.
5. *Sunday Times*: 23 February 1992.
6. Rathbone T. Speech to Radical Seminar Programme organised by Yorkshire Health and West Yorkshire Police, Wakefield, 10 February 1994.
7. *Druglink*: 1988, *3*(3).

Funding loss leaves schools doing drug education 'on the side'

A survey of local authorities conducted last autumn by the Local Government Drugs Forum (LGDF) has confirmed the feared loss of drug education capacity after the withdrawal last April of funding from the Department for Education for drug and health education coordinators.[1]

Their report presents a picture of an increasingly 'mend and make do' approach to drug education, with staff doing drug misuse prevention "on the side" supplemented by cheap or free input from wherever schools can get it.

The results have been seized upon by the Labour Party and by Tory MP Tim Rathbone who chairs the All Party Parliamentary Drugs Misuse Group. On 10 February he called the withdrawal of funding a "scandal" and used the LGDF's survey to estimate that "only 17 per cent" of schools now had access to a drug education coordinator, a figure also quoted the following day by Labour in a report on drugs and crime (see report on p.4).

LGDF's survey follows one done in November 1992 which painted a bleak picture of how local authorities were planning to respond to the withdrawal of the funding. Since 1986 the money had supported what last year totalled 135 health or drug education coordinator posts. The coordinators' national group estimates that 75 are left but LGDF's 1993 survey suggests the dilution of drug education input has gone much further than the loss of 60 posts.

From 1986 to 1990 the coordinators' remit was illegal drugs but in 1990 in England and the year before in Wales this was widened to include legal drugs and AIDS.

Now LGDF report that just nine out of the 52 authorities (17 per cent) replying to their survey had at least a half-time post devoted to drug misuse issues. Another 19 had health education staff dealing with drugs as a relatively minor part of their work, leaving nearly half which appeared to have no health/drug education specialist.

Much of the funding for the remaining drug/health education work was short-term, or insecure because it depended on locally managed schools 'buying in' the services of the local authority specialist.

LGDF received responses from just 46 per cent of the authorities they polled. They believe this was fewer than in 1992 because officers previously in post were no longer there to return the questionnaire.

1. LGDF. *Survey on the resourcing of drug misuse prevention activities in education services*, 1993.

DoH trials outcome funding for drug services

'Outcome funding' could become the Government's preferred method for funding drug services if the results of a pilot Department of Health funding exercise show the US approach helps get more results per £. The experiment is part of next year's bidding procedure for the specific grant for local authorities to help them develop voluntary sector services for alcohol and drug misusers.

On 26 January John Bowis, junior minister at the Department of Health, announced a 4 per cent increase in the grant to £2.4 million in 1994/5.[1] As in previous years, at least 30 per cent of each bid must be funded locally. It's thought that about £1.4 million will be needed for continuing projects leaving about £1 million for new initiatives, though the Department of Health did not confirm this estimate.

The accent next year will be on what John Bowis called "creative diversification" into non-residential options.[2] Also new this year is the call for bids which will reduce the impact of drug problems on the community and reduce drug-related crime.

But the major innovation is that the money for new projects will be disbursed according to outcome funding principles. The approach sees the purchaser as an investor seeking the maximum return in terms of benefits for clients rather than funding specific posts or activities.

The DoH circular inviting bids says projects which simply state what will be done are unacceptable.[3] "Targets", "outcomes" and "measurable output" are the new buzzwords. It gives the example of a bid for an outreach project which would fail unless it specified how many contacts were aimed for and the intended outcomes in terms of risk reduction behaviour change or referrals.

Voluntary sector projects receiving outcome funding from the specific grant will be required to submit quarterly monitoring reports to the funding local authority. Grants will be made in two instalments, the second contingent on satisfactory monitoring and the meeting of agreed interim targets.

This exemplifies a key feature of outcome funding – the funder ('investor') doesn't just pay over the money but takes a close interest in how the project is going and whether it is on target. If interim targets are not achieved, the US originators of the approach recommend that investor and provider agree adjustments to get back on target. Withdrawal of funding is the bottom line if outcomes fail to match up. One concern is that an unsympathetic funder could hijack the focus on outcomes to put services on the spot rather than working collaboratively to achieve agreed objectives.

If the Department of Health judge the experiment a success there is little doubt that other central grants will follow suit. With all the bids in, the DoH's first reaction is that services and local authorities have quickly come to grips with the unfamiliar information requirements of the new approach.

Local funders too are looking closely at outcome funding. For the past two years North West Thames RHA has used outcome funding principles for drug and alcohol providers and London social services directors are focusing on outcomes in their thinking on funding residential services. Trent RHA too has been trialing the approach for drug services.

1. Department of Health Press Release 94/38, 26 January 1994.
2. John Bowis speaking at LGDF conference Community Care for Substance Users, London, 26 January 1994.
3. Department of Health Local Authority Circular LAC(94)2, January 1994.
4. Marsden J. *Outcome funding*. NCVO, 1993.

The US connection

Outcome funding was developed by the Rensselaerville Institute in the USA. Two key proponents of the approach in the UK – John Marsden of Turning Point and Peter Mason of the Innovation Group – have recently studied the approach in action in America.

Peter Mason is trained and licensed by the US institute to develop outcome funding in the UK and has been contracted by the Department of Health to help with the outcome funding element of next year's specific grant.

John Marsden is reviewing outcome criteria for the Department of Health. His NCVO study tour to America last summer convinced him that "outcome funding principles and practical materials hold great promise ... for purchasers and providers in the UK."[4]

These two key authorities have co-authored a feature in this issue of ***Druglink*** which deals with outcome funding – see pages 8-11.

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News on the move

As some of you may by now have learnt to your cost, the new phone numbers for SCODA and Alcohol Concern were reversed in our last ISDD column. The real numbers are: SCODA, 071 928 9500; Alcohol Concern, 071 928 7377. ISDD's number is 071 928 1211.

ISDD and SCODA are now established in our new offices. Alcohol Concern joins us in April. The ISDD library is open for business and now has room for twice as many library users, more desks for users to work at, and more accessible stock. If you want to come and visit, give the library staff a ring to arrange a date – we'll be happy to show you round.

New Druglink advisory group

Thanks to all those people who included comments on ***Druglink*** on their subscription renewal forms. Every one is read by the editor and taken to heart.

This feedback from you supplements our regular readership surveys (every two years – expect one this summer) and the work of our newly recruited Druglink Advisory Group, drawn largely at random from the readership.

Their valuable input has already influenced the look and content of this issue of ***Druglink***. The group serves for a year and is then re-recruited – so towards the end of this year you may invited to join the 1995 group. In the meantime, keep the comments coming – even if they're critical, it's nice to know you care!

VAT on advertisements in Druglink

ISDD is now registered for VAT which in practice for most of our customers means business as usual, but adverts in ***Druglink*** are VAT-able. The new rate card with this issue of ***Druglink*** reflects this change.

With an estimated readership approaching 12,000, adverts in ***Druglink*** are still the best single way of reaching the largest number of your colleagues in the drugs field. We can design and typeset your ad if you wish – a service free to voluntary organisations. Call Véronique on 071 928 1211.

COMPUTERISED PRESCRIBING

I would like to thank all those who responded to our plea for information about computerised prescription writing. I am pleased to say we have a pilot scheme for 20 clients running, and hope to have the rest on soon.

Contact: *Dr P. Parker, Clinical Assistant, Exeter Drugs Project, Dean Clarke House, Southernhay East, Exeter EX1 1PQ, phone 0392 410292*

WANTED: SYRINGE EXCHANGE FORMS AND RESEARCH/POLICY CONTACTS

I am revamping our needle and syringe form – changing what is asked and how it is recorded – and I would like examples of the forms used by other agencies.
I am also researching the effectiveness of the needle and syringe service, and would like to get in touch with others doing similar research.
We are also reviewing our harm reduction policy and would appreciate seeing practice guidelines and policies from other agencies.

Contact: *Sarah Woffindale, Bath Area Drugs Advisory Service (BADAS), 1/2 Bridewell Lane, Bath BA1 -1, phone 0225 469479*

DO YOU HAVE COMPUTERISED DISPENSING AT YOUR DRUG SERVICE?

The pharmacy department at the Maudsley Hospital is considering a computer system to record daily administration and dispensing of methadone and benzodiazepines for 200 clients. Other functions (eg. capacity to hold patient histories, name of GP involved, etc) would be helpful.
I would be grateful for any recommendations from people with experience of such computer systems.

Contact: *Sile O'Connor, DDD Pharmacist, Maudsley Hospital. Denmark Hill, London SE5 8AZ, phone 071 9192336*

TRAINING ON TRANQUILLISERS?

Hillingdon Drug Services is interested in finding out what training is available for people working with benzodiazepine users in Greater London.
Please let us know if you are running courses in subjects such as benzodiazepine withdrawal techniques.

Contact: *David Marshall, Drug Counsellor, Hillingdon Drug Services, 81 High Street, Uxbridge UB8 1JR, phone 0895 250414/5*

SCODA'S NATIONAL DRUG SERVICES LIAISON GROUP

This new group aims to provide a forum for drug services from across the UK to meet and discuss issues of concern, share information and carry out work on particular issues. It replaces the Community Care Link Persons Group which we feel has completed its tasks. The National Drugs Service Liaison Group will aim to be more proactive by helping services to meet the challenges of community care.
Meetings will continue to be chaired by Phil Willan and organised by Beverley Polson of SCODA. They will be held bimonthly at SCODA. Membership will be open to both statutory and non-statutory, residential and non-residential services. Two representatives from each region will be selected, one attending each meeting. Dissemination of information will be via the precis of the minutes being circulated by SCODA with the mailings to the Regional Drug Workers' Forums.

Contact: *Beverley Polson, SCODA, phone 071 928 9500*

SYRINGE EXCHANGE TAKEAWAYS

The biggest problem with a busy syringe exchange is the large quantity of plastic carrier bags needed so that users can tote away the goodies. Our staff recycle bags from home and some users of the exchange bring in their surplus – but it's never enough, particularly since many bags are very thin and 'double-bagging' is needed to disguise the contents.
Does anyone know of a cheap source of the small paper carrier bags used by takeaways?

Contact: *Andrew Fraser, DAIS, 38 West Street, Brighton BN1 2RE, phone 0273 321000*

HELP DRUGLINK PRODUCE A HEPATITIS C MAP OF BRITAIN

We are producing a prevalence map of hepatitis C in British injecting drug users for ***Druglink***. Even if you have only tested six people, we would like to know your results. If you are having difficulty obtaining hepatitis C tests or further investigation treatment for those positive, we would also like to know. The source of this latter information will be treated confidentially, but the results will be aggregated to form a national picture. Please help by completing the questionnaire inserted in this issue of ***Druglink*** and return to us using the FREEPOST address.

Contact: *Roger Holmes and Tom Waller, West Suffolk Drug Advisory Service, using questionnaire with this issue of* ***Druglink***

REVISITED

The state of the market

Take an aerial view of the purchaser-provider landscape. That way it's easier to see where you're going

LAST APRIL's NHS and Community Care Act represented the sharpest change to social care funding and delivery mechanisms for decades – and it seemed drug services and their clients would be its first victims. Fourteen months earlier, one of us had described the likely changes to drug service purchasing arrangements and warned of the turbulence to come.[1] Two years before community care, the NHS internal market initiated a restructuring of the health service which has yet to mature.

In both cases the principal objective was to disengage the purchasing of services from their provision, freeing purchasers (health and social services authorities) to shop for health and social care in a mixed market of statutory providers (NHS trusts, social services units), voluntary organisations and the private sector.

How are providers reacting to the upheaval, and how should they react? The first imperative for providers is not to underestimate the extent of the change. Purchasers' decisions are dramatically challenging established patterns of service buying, emphasising local provision and the reconfiguration of services. The models they promote do not necessarily match those of providers. Shifting control of the delivery system from providers to purchasers will continue to be a major priority for purchasers over the next two years; mid-term, the prospects are for increasingly aggressive buying.

The second imperative for providers is not to back away from change, but to engage with the new powers. We are early in the life cycles of both reforms; their growth can still be influenced. So now is a good time to look back on how they have affected drug services, and forward to some emerging issues likely to shape health and social care markets in the future. Into this pot we also throw some recent thinking about service delivery, which is likely to be equally influential.

Councils rise to challenge

Before the NHS and Community Care Act, for most local authorities planning and purchasing drug services was virgin territory. Almost forgotten now, there was a strong lobby to divert the new community care money to health authorities, with their track record in this area. But local government is rising to the challenge. Some important players were acutely aware that the fate of drug and alcohol services would be seen as the acid test of their fitness for new community care responsibilities – their "Achilles heel", as one social services director recently put it.[2] Spurring them on was the knowledge that drug misuse could become a major political issue for local residents, particularly around community safety.

Even before the act was implemented, the process of formalising funding relationships with local councils ranging from informal service-level agreements to detailed contracts generated heated debate. Early concerns that the system would be too bureaucratic and overburden voluntary sector providers have proved well founded, but goodwill, innovation and flexibility on both sides have prevented what remains an unsuitable system turning into a disaster.

The first shock wave of change has now subsided; so too has the disruption it brought to the accessibility and financing of drug services. However, a fresh wave of change has begun as health and social care markets bed down and new resource allocation and purchasing strategies take hold.

Many residential providers, battered by the about turn on the ringfencing of community care funding, were forced into energetic marketing to survive. Most secured a place for their service in the local purchasing strategy.

Local authorities have now set up their assessment and management arrangements for purchasing packages of care. Free to reconfigure services to meet local needs, where possible they have initiated a definite move from residential to day services.

But political will is no substitute for cash and appropriate systems for its dispersal. Last year's allocation of the grant between authorities severely

by
Peter Mason & John Marsden

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Continuing realignment between purchasers and between purchasers and providers characterises the new markets for health and social care. Purchaser-driven changes in service delivery are likely to accelerate as the focus shifts to service outcomes. Services have shown themselves able to adapt to the new environment but there are concerns that inadequate funding is leading to cost-driven decrease in standards. The future lies in documenting service outcomes and in services collaborating to provide a range of provision for their clients.

DRUG link
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INFORMATION FOR DRUG USERS FROM ISDD

6 DRUG TESTING

Drug testing is most prevalent in the transport and oil industries where random testing of employees is now in place and in some areas of manufacturing. Other sectors such as finance have introduced pre-employment testing even where there is no risk to public safety, on the grounds there should be no risk to profitability or productivity either. Testing exists also at the higher levels of competitive sport and several public schools have said they might begin testing pupils.

Tests are available for alcohol, heroin, amphetamine, cannabis, barbiturates, benzodiazepines (Valium, etc), cocaine, methadone and other drugs. There do not seem to be simple screening tests for hallucinogens such as LSD and magic mushrooms.

What is tested?

Urine The most popular because it is easy to get a sample, quick and relatively cheap to get a result.

Breath Most commonly used for alcohol. Like urine, non-invasive (doesn't involve a medical procedure to get the sample). Cheap and the result is virtually instantaneous.

Blood Requires medical skill, expensive and invasive.

Hair Becoming more popular. Police now hair test prospective recruits. Inexpensive, non invasive. Can reveal use going back a long time. One doctor in America showed that Keats used opium by testing strands of his hair. Alcohol cannot be tested in this way. Said to be virtually evasion proof. Works on hair from any part of the body. The longer your hair, the further back your drug history could be traced.

Are tests accurate?

- Except for the breathalyser for alcohol, urine and other tests cannot show whether performance was impaired by the drug at the time of the test. If your employer routinely tests and you are a regular cannabis smoker, you may have to give it up as the drug is detectable up to a month after use.

- 'False positives' (showing an illegal drug has been taken when it hasn't) are most common when a drug group being tested for is present in small amounts in a legal product, eg, codeine in cold cures breaks down to morphine in the liver. If you are tested, make sure you tell the testers of any medication you are taking.

False positives can also happen if the testing staff are inexperienced or the equipment is contaminated.

- The most common tests can only tell that at some time a drug has been used, not how much.

What are the safeguards?

- 'Chain of custody' conditions should provide a record of the progress of a urine specimen from collection to the reporting of the results. A specially designed kit should be used with space to record declared medication.

- Results should be interpreted by a medical review officer as no test can tell a drug used for legitimate purposes from the same one used illegally.

- The only laboratory test procedure accepted in court is an initial immuno-assay screen confirmed by gas chromatography/mass spectrometry.

- There are no guidelines for testing in the UK. Most reputable laboratories follow US government guidelines. These can allow for very low levels of drugs to be taken into account such as might be found after passive smoking of cannabis.

How long do drugs stay in the body?

Detection times vary with food and fluid intake, metabolic rate, kidney function, amount used and for how long, how it was taken, whether other drugs were taken with it and the sensitivity of the test – see table below.

London Underground advise staff that to guarantee starting work with near zero alcohol levels in the body, no more than seven units should be taken in the previous 24 hours (eg, about three pints) and none in the previous eight hours.

What is the legal situation?

Apart from public transport law (see below) there is no specific UK legislation on drug testing nor any court rulings to go on. So it is impossible to be sure what might stand up in a court of law.

Employment The Transport and Works Act 1992 makes it illegal to be intoxicated or under the influence of drugs if you work on any kind of railway or tramway system where public safety in involved. This includes drivers, guards, signalmen, maintenance staff and their supervisors. In a sense this is an extension of the Road Traffic Act which covers driving on the road.

Nothing in law prevents an employer requiring you to be tested at interview or including testing in a contract of employment. Most job offers are conditional on a satisfactory medical report and this might include testing. If you find this unacceptable, all you can do is not go for the interview or refuse the job.

Refusal to go along with an employer who wants to impose drug testing on existing employees might be seen as disobeying a 'reasonable instruction'; the employer may be within their rights to take disciplinary action. An exception might be medically invasive tests (like blood tests) which require the employee's consent. However, courts might take a dim view of an employer who suddenly announced random drug testing without prior consultations with the workforce.

Education Nothing in law prevents a state or public school introducing drug testing of pupils but no pupil can be tested against their will. In public schools drug testing could be included in the contract between school and parent. If a public school pupil then refused, this might be interpreted as breach of contract and the pupil expelled (or whatever penalty is in the contract).

Sport Sports bodies affiliated to the Sports Council must have a testing procedure. In theory this means that Sunday league football players could be tested if their league is affiliated to the Football Association, which in turn is affiliated to the Sports Council. In practice, testing happens among the sporting elite, where legal challenges have been launched against alleged restraint of trade. At lower levels of sport there would probably be no such defence against a positive test.

Drug detection periods

A rough guide to how long different drugs can be detected in urine after use at dose levels typically taken by drug misusers.

Amphetamine	2-4 days	Cannabis	
Ecstasy	2-4 days	– casual use	2-7 days
Diazepam	1-2 days	– heavy use	up to 30 days
Temazepam	1-2 days	Alcohol	12-24 hours
	(longer after	Heroin	1-2 days
	i.v. use?)	Buprenorphine	2-3 days
Cocaine	12 hrs-3 days	Methadone	2 days
			LSD 2-3 days

 Written by Harry Shapiro with thanks to Dr John Strang, Andrew Fraser of DAIS, Robin Lewis of Bindman & Partners and Stephanie Parkin of JS Pathology Services.

disadvantaged many urban areas because it was based partly on the location of existing residential homes. Some councils calculated that the grant was unlikely to match independent estimates of need and were forced to allocate extra funding.[3]

Such problems are likely to continue until government comes up with a more sophisticated funding formula and allocation model which properly reimburses authorities in areas with a high demand for drug services. The strain on community care funds in some areas ripples through into problems with residential contracts, as purchasers are forced to limit costs and lengths of stay. Another impact is that hard-pressed urban councils may be unenthusiastic about accepting the care responsibility for their transient and homeless populations.

Next year (1994/95) the whole grant will be allocated according to local needs and population. This step in the right direction will relieve the pressure on urban areas, but further adjustment is needed to compensate for the extent of homelessness in each area. The downside is that the change in the allocation formula will leave some authorities which benefited from the previous system facing difficulty in matching funding to demand.

In the coming years a diminishing proportion of community care funding will be earmarked as the Special Transitional Grant. By 1997/98 it will be subsumed within the overall central grant to local authorities. With most central funds being channelled through local purchasers, services will become increasingly reliant on each local authority's ability to carve out a workable community care budget. The adequacy of local government financing and the efficiency and friendliness of local councils will become central concerns, not just for residential, but also for many non-residential services.

Healthy alliances?

As the local authorities' new purchasing role beds down, fluidity and uncertainty characterise the traditional purchasers of drug services, the health authorities. District health authority (DHA) purchasing boundaries have altered in many areas, and new agencies are likely to form from mergers between DHAs and family health service authorities (FHSAs). Coupled with reductions in the number and status of regional health authorities (RHAs), the health funding environment for substance misuse services is by no means stable.

Mergers creating larger purchasing consortia have fractured natural local service purchasing arrangements. These 'super' districts have the resources to look to a range of services – some well outside their areas – and to tender for new services in underprovided sectors. Providers can no longer be sure who their main funding agency is, let alone whether their service will be on its shopping list.

Such mergers are not universally welcomed. In some cases, such as the South East London Health Agency (SELHA), the scale of the centralisation of purchasing power causes concern and seems to mitigate against the emphasis on localism. For now, most districts are happy to be learning about working with their local FHSA partner without entering into grander alliances.

These developments probably mean the end of district-based drug advisory committees as the place where providers have a say in local policy. Uncertain of where they stand across the purchaser-provider split, and unable to shadow changes in purchasing boundaries, these forums seem fatally flawed. As these and other familiar oversight structures, such as the RHAs, are being superseded, how will the market for drug services be coordinated?

One tier up from the RHAs are the Department of Health's policy divisions, able to influence local spending decisions by earmarking grants for specific activities – methadone, syringe distribution, drug misuse, HIV/AIDS. But these divisions, and with them the role of central government grant making, are also under review; their influence is likely to diminish. Many health agencies feel that tying government grants to particular services is out of step with *local* business planning and decision making. Like the local councils, they want to be free to spend their money where they feel it will reap the greatest benefit for their residents.

Under this pressure, the immediate trend is likely to be towards undifferentiated central grants based on the number and nature of the local population. As with social services, the absence of adjustments to reflect homelessness, HIV rates, etc, could mean that the grant does not reflect the local need for substance misuse services. Without a protected pot of money to draw on, services now dependent on earmarked funds may find their local health funders allocate insufficient cash.

As local and health authorities restructure, tentative moves are being made to bring the two together. Joint health and local authority care plans are being considered, designed to link two coterminous purchasers into one larger consortium.

Some local authorities have created 'joint drug focus groups', bridging the

PRESCRIBING: COSTS AND QUALITY

Two important components of the response to drug problems and HIV – methadone programmes and community outreach – are receiving close scrutiny. Both are likely to emerge with renewed impetus but in a different direction. Most instructive in the present context is how the tension between purchaser and provider concerns is playing itself out with respect to methadone prescribing.

Purchasers have been unclear why there is no provider consensus about methadone doses and the benefits of the intervention. The ACMD too has questioned current maintenance programmes, finding that some lack clear structure and purpose meaning drug users become "stuck for a prolonged period at an intermediate goal".[10] They called for structured oral methadone programmes, which have received positive research evaluation internationally, to be piloted in the UK, carefully studied and regulated through protocols and standards.

Costs as much as research will shape the future of methadone maintenance in Britain. Services which allow open-ended self-referral of patients – the ideal for controlling HIV – but are funded by a block contract, find themselves in an economy trap: their funding is finite, yet methadone costs escalate as client volumes and dose levels increase.

This is the dynamic pushing services towards the cheaper US practice of on-site dosing, and towards structured counselling programmes which aim to move clients through a process of change, preventing the costly accretion of long-term patients. Apparently pushed to one side have been the advantages (convenience for the patient and normalisation of their treatment) of allowing selected drug users 'take home' doses dispensed at local pharmacies.

In the UK, user involvement and flexibility will be essential as guidelines are developed. Programmes inappropriately standardised with costs in mind risk losing their patients to the illicit market or the private prescriber.

The general practitioner is also being seen as a way out of the prescribing economy trap, with clinics referring 'stabilised' drug users back to their GP.

health-local government divide to complete a specific planning task over a limited period. Increasingly these will involve probation departments, which are preparing to become more substantial grant makers. It is not clear whether such arrangements will work in the new markets – nor whether the purchasing partners will be able to agree where social care ends, and health care begins.

Providers adapt and survive

Voluntary sector residential providers are now fully into the contract culture. Most have adapted to the new environment. Monitoring by Goldsmiths' College revealed considerable variation across the country in local authority assessment procedures, aggravating services' administrative burdens and financial anxieties.[4] Rather than caving in, agencies have shown a marked resilience and readiness to adapt. Cushioned at first by residents with preserved funding under the old system, many residential projects shortened programme length and budgeted to survive on reduced income.

Services that have adapted successfully have been able to manage costs, communicate their value to purchasers, and implement effective marketing strategies. Others have chosen an alternative destiny and opted out of the community care system by de-registering as care homes. By last September the residential market had undergone considerable restructuring, with the loss of some 400 registered beds (down 16 per cent) due to de-registration and bed losses.[5]

Providers are now being driven through contract specifications to develop guidelines and protocols which explicitly state services to be delivered and quality standards to be met. However, in many areas they are expressing concern that price cutting will see a reduction in standards and quality.

In the longer term, residential providers will maintain their place in the market only through a concerted effort to prove the positive impact of their programmes. As information on the costs and results of residential rehabilitation become more available to purchasers, competition between providers may become fierce. Purchasers may move towards licensing organisations to vet them before they are admitted to the local provider network, with periodic review.

What is missing in all this is independent, expert advice both sides can refer to. One candidate could be the NHS's Drug Advisory Service, which might play the role of assessor, measuring performance against external standards.

Also missing is a strong national lead. A Central Drugs Coordination Unit attached to the Privy Council Office is being developed,[6] but at the moment there is something of a vacuum in national strategy. National bodies are trying to keep communications open, but moves towards coalition and partnership are slow. Vested interest in your own service, or suspicion of it on the part of other services, impedes the sharing of information and the pooling of influence over government. In this policy void, larger agencies are relying on their own business plans as the driving force for developments.

> The challenge for providers is to overcome a competitive and suspicious climate

Without outcome measures or national policy to guide purchasing, *local* has become the chief marketing slogan, with agencies attempting to become preferred providers for their host local authority. The future is likely to be in purchasers selectively contracting with local preferred providers. The alternative spot contract approach – taking each case as it comes and choosing from services across the country – maximises client choice but does not lend itself to developing relationships with purchasers. A close relationship with a local purchaser maximises the security of the service and can provide for development as well as maintaining current provision.

To do the best for clients, services need to do more than simply survive – difficult as that has been. Just as the system needs a strong purchaser side, so it needs providers to be strong in defence of *their* bottom lines. It is imperative for them to stand fast against market pressures to standardise programmes and argue instead for a rich *diversity* of innovative provision.

The challenge for providers will be to overcome a competitive and suspicious climate and build credible networks across the statutory-voluntary divide. Instead of waiting for purchasers to do it for (to) them, ideally providers will come together to hammer out who will do what for which group of clients and to identify unmet need – with the best possible local network as their prime aim, rather than individual service survival. They will then be in a position to present advice which the purchaser(s) will feel is credible enough to integrate into their planning processes.

For this to happen, leadership from the field must not be compromised by self-interest but seen to be exercised in the interests of clients. The alternative is a dog-eat-dog scenario, services doing each other down with survival the prime objective. In some areas this is closer to the current reality.

Among statutory providers there has been a marked reduction in NHS inpatient detoxification and specialist beds, resulting in admission delays. Some purchasers have been quick to use equivocal findings on the effectiveness of these services to justify their cooling interest in funding them. In contrast, community services have flourished. Recently the Advisory Council on the Misuse of Drugs (ACMD) recommended that balance must be restored, with purchasers commissioning both community services and the specialist units needed to back up and complement their work.[7] One of their other major recommendations, for structured methadone maintenance, concerns an area where costs are likely to be important in shaping service delivery (see panel, p.9).

It is not just the purchasers who will be pressuring statutory drug services. The

1. Mason P. "The state of the market." *Druglink*: 1992, 8(1), p. 8-9.
2. Peter Hewitt speaking at the Local Government Drugs Forum conference "Community care for substance misusers", 26 January 1994.
3. Marsden J. *et al. All change after the DSS*. SCODA, Turning Point and Alcohol Concern, 1994.
4. MacGregor S. *et al. Vulnerable services for vulnerable people*. London: Goldsmiths' College, 1993.
5. MacGregor S. *et al*, op cit.
6. Home Office. "New unit to foster partnership in fight against drugs." News Release, 16 December 1993.
7. Advisory Council on the Misuse of Drugs. *AIDS and drug misuse: update*. HMSO, 1993.
8. Mason P. op cit.
9. Williams H. and Webb A. *Outcome funding: a new approach for public sector grantmaking*. Rensselaerville Institute, 1992.
10. Advisory Council on the Misuse of Drugs 1993, op cit.
11. Department of Health. *Specific grant for making payments to voluntary organisations providing services for alcohol and drug misusers*. Local Authority Circular LAC(94)2, 1994.
12. Marsden J. and Killoran E. *Outcome monitoring for drug and alcohol residential care in Greater London*. Turning Point, 1993.
13. Greater London Association of Directors of Social Services. *Memorandum of understanding for a coordinated purchasing strategy for residential drug and alcohol services in Inner London*. London: GLADSS, 1993.
14. Marsden J. and Keaney F. *Matching clients with alcohol or drug problems to optimal treatments*. Centre for Research on Drugs and Health Behaviour, 1994.

Such measures are, of course, only the starting point for a assessment of outcomes as in themselves they cannot determine whether change was due to service intervention

OUTCOME FUNDING IN PRACTICE

For the last two years, Rensselaerville's outcome funding principles and methodology have been piloted by North West Thames RHA for the delivery of HIV and substance misuse services. Now the Department of Health is taking the radical step of applying outcome funding to all new bids under the specific grant for voluntary drug and alcohol services in 1994/95.[11]

"The focus is on outcomes rather than processes", says the DoH circular. "Proposals which state an intention to, for example, run training workshops, carry out liaison functions or outreach to the community will not be acceptable. Clear targets and outcomes must be identified."

Applying this approach to the specific grant may have a profound impact on the future. We are, for example, ideally positioned with the *Health of the Nation* framework to develop more targets in the drug field using outcome funding methods.

In a complementary way, the GLADSS group of social service directors in London has been considering substance misuse treatment outcomes.[12] An agreement between inner London local authorities on a coordinated purchasing strategy stipulates that placements in residential care are based on three-month episodes "pending a further assessment of both individual needs and the success of agreed care plans in meeting desired outcomes".[13]

In the coming year, a project to establish a standardised assessment protocol and outcome monitoring system for residential care is to be piloted among inner London authorities. The protocol serves as a 'front end' to the assessment and is designed to ensure that local authorities purchase a package of care matched to the individual's presenting needs. If successful, this could be repeated after rehabilitation to measure outcomes in terms of the before-after change.[14]

A central outcomes information clearing house to aid both purchaser and provider thinking in this area is looking more and more attractive.

Outcome misuse

The Rensselaerville model is firmly based on partnership between purchaser and provider to achieve results. But a hostile funder could latch on to the model's emphasis on outcomes to put services on the spot – 'Put up or (literally) shut up'. What follows is a short list of some of the concerns most often expressed about outcome funding and responses to these based on experience in the USA and the UK.

Q *Can performance targets be too high?*

A This often happens when the approach is unfamiliar and a track record of achievement has yet to build up. Outcome funding encourages providers to know what they do and enables course corrections to be made to reach targets. It is better to set targets that encourage high achieving than ones which do not require a stretch to reach them.

Q *Does the model lead to 'creaming' – selecting only those easy to treat?*

A Creaming is neither harder nor easier to do under outcome funding, but it is harder to hide. Outcome funding makes explicit through the customer specification who is being helped and who is not. Creaming can be controlled by the investors as they will get what they ask for and buy.

Q *Can purchasers use outcome funding as an excuse to threaten providers with withdrawal of funds?*

A Nothing in the model guarantees this will not happen. However, outcome funding stresses collaboration. A heavy-handed approach benefits nobody, including the purchaser, who will have wasted their investment to date. Purchasers also are judged by results: there is no glory for them in taking back money because results have not been achieved. The point is not to preserve money, but to spend it to create the greatest possible gain. The interdependence this creates between investor and provider is essential for this model to develop in the UK.

provider bodies of which many services are a part have their own agendas. With the application of corporate business plans, many mental health and community trusts are now pursuing an aggressive marketing strategy. Component services may find themselves forced to tender competitively for contracts; some will have to work hard to prevent pressure to reduce the trust's costs affecting their own resources. Those which see the writing on the wall may look outside their trust to form businesslike mergers and partnerships between statutory and voluntary sector agencies.

The big issue: outcomes

Purchasers are increasingly pushing for a demonstrable return on service investment in terms of health gain and improved social functioning. For example, the Greater London Association of Directors of Social Services (GLADSS) has taken the lead in developing a coordinated purchasing strategy for residential care. Their objectives have included the establishment of performance and quality measures.

Early social and health care contracts tended to focus on the volume of the *service* to be provided.[8] Today, value for money and quality are still important, but service outcomes are uppermost in the minds of government, purchasers and providers. As yet there is no clarity or consensus over the types of outcomes to be expected from substance misuse services nor how these should be measured.

However, developments are under way which will ensure that this issue remains on top of the purchaser-provider agenda. Outcome funding, a new approach for purchasing services using a results-based partnership model developed by the Rensselaerville Institute in the US, has aroused great interest in the UK (see panel).[9] In contrast to traditional grant making, which funds programme activity (inputs), outcome funding shifts purchaser-provider thinking towards customer involvement and the setting of performance targets with milestones to monitor progress towards the target.

This new thinking offers opportunities to simplify development and funding procedures for projects and to sharpen the effectiveness of purchasing strategies. However, there is no gain without pain. Outcome funding requires purchasers to become far more active partners in the design, development and monitoring of services than ever before. Providers will have to be much clearer about what results they can achieve with which clients, and how they can verify those results.

Purchasers and providers ideally see themselves as partners with a mutual interest in achieving desired outcomes. Rather than leaving provider partners to fail, the effective purchaser will have a relationship with services which permits problems to be jointly addressed before they get in the way of meeting targets. How these new relationships mature remains to be seen, but there are encouraging signs that a new era in fostering partnerships for community care may be around the corner.

For More Information

❑ **OUTCOME FUNDING: A NEW APPROACH FOR PUBLIC SECTOR GRANTMAKING.** Williams H. and Webb A. Rensselaerville Institute, 1992. UK edition.
Available from NCVO Publications or The Innovation Group, 31 Totterdown Street, London, SW17 8TB, phone 081 767 6577.

AIDS and drug policy
Revolution or revision?

Are we all the shiny new children of the HIV era – or the inheritors of Victorian values?

AIDS APPEARS TO have caused some radical changes in drug policy in Western Europe, in Australia, and above all in Britain. The general view has been established that the danger of the spread of HIV from drug users into the general population is a greater threat to health than drug use itself. The words and concepts of harm minimisation/reduction are on everyone's lips.

For Britain, some commentators have argued that AIDS changed the direction of drug policy; others have been more cautious.[1,2] In general AIDS has been seen as bringing about a kind of new dawn, a 'new public health' approach integrating drugs into mainstream health policy. The decision to expand needle and syringe exchanges was, said one senior civil servant, of "fundamental importance" – a new departure for drug policy.

But how sharp was the pre- versus post-AIDS division? If you work in a drug agency, how much of what you now do is due to the HIV epidemic? Has drug policy radically changed under the impact of AIDS, or has AIDS simply been used to accelerate existing developments? Do recent changes merely exemplify some long-standing themes and tensions in drug policy?

An analogous issue is the impact of war on social policy. Historians have recently begun to question the view that the Second World War was the only catalyst for radical change, for example in the inauguration of the NHS in Britain.[3] They argue that the wartime national 'consensus' for social change was less than unanimous and that the roots of the NHS can also be found in prewar debates and blueprints for healthcare.

What war did was to enable change to happen more quickly and somewhat differently than might otherwise have been the case. War served to overcome vested interests and opposition to change, but essential continuities with the prewar health service remained.

> AIDS has been seen as bringing about a kind of new dawn

Like war, AIDS evoked a period of political emergency reaction. In Britain this was at its peak from 1986-7 though, in relation to drugs, it spilled over into 1988 with the Government's reaction to the first *AIDS and Drug Misuse* report from the Advisory Council on the Misuse of Drugs (ACMD). There was the creation of an emergency Cabinet committee on AIDS chaired by the Deputy Prime Minister, William Whitelaw; the 'AIDS week' on television in February 1987, when both networks joined with government to broadcast programmes on the wartime model; the Commons emergency debate in November 1986. Many of the actions of central government in this period had a wartime flavour.[4]

by
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The growth of concern over drug-related HIV spread in the mid-80s served to lend political acceptability to and extend pre-existing policy trends towards harm minimisation approaches and away from seeing addiction as a medical disease. Paradoxically this public health concern has brought medical services back towards the centre of Britain's response to drug problems. The coalescence of penal and medical approaches has revived the policy characteristics of previous eras.

Before there was AIDS

The impact of AIDS across many policy areas cannot be understood unless we understand something of their 'prehistory'.[5] What was happening in genito-urinary medicine, for example, or in health education, before AIDS? The immediate prehistory of drug policy clearly shows that harm minimisation was not a new AIDS-specific policy objective.

Throughout the 1980s there was a growing belief in some circles that reducing harm was a more realistic aim than more rigid and medically based ideas of 'treatment', 'cure' and 'abstinence'. The concept received its best-known public expression in the 1984 ACMD report on *Prevention* which abandoned the traditional division into primary, secondary and tertiary prevention in favour of two basic criteria: "(a) reducing the risk of an individual engaging in drug misuse;
(b) reducing the harm associated with drug misuse".[6]

Such ideas were commonplace, too, in the increasingly important voluntary sector. Accompanying them was a tendency to downplay the 'medical model' of addiction as a disease requiring specialist treatment. This change received official sanction in the 1982 ACMD report on *Treatment and Rehabilitation*, with its emphasis on a multidisciplinary

In the '20s Delevingne of the Home Office (left) looked for a ban on long-term prescribing to addicts. Rolleston's committee (right) fought off the challenge and established doctors' right to prescribe

approach based on drug problem teams and drug advisory committees.

The early and mid-80s also saw the formation of a distinct 'policy community' which embodied these ideas. There was a shift from the previous primarily medical community to one more broadly based. This comprised 'revisionist' doctors in drug services, researchers, drug service workers, leaders in the drug voluntary sector and, most crucially, civil servants in the Department of Health who shared their objectives. Differences there were over implementation, but one policy objective – minimisation of harm from drug use – found general support.

But this policy remained difficult to enunciate publicly; it lacked political acceptability. There remained a yawning gap between the 'political' and 'policy community' views of drugs. So pre-AIDS drug policy in the 1980s had a dual face: a 'political' penal policy with a high public and mass media profile, and a much less public 'in-house' health policy based on a rhetoric of de-medicalisation, community services, and harm minimisation.

AIDS, like war and the NHS, lent political feasibility to this 'in-house' policy. A policy which before could be advanced only slowly, as the unspoken underside of penal policy, 'came out' because of AIDS. As a senior medical officer commented:

"AIDS may be the trigger that brings care for drug users into the mainstream for the first time ... The drug world can come 'in from the cold' through AIDS ... it's a golden opportunity to get it right for the first time."[7]

Research by social scientists was an important legitimating factor – a telling comment on the power of the new policy community. Also important was the willingness of Conservative politicians to push for change. In-house policy became a priority for politicians, too.

What emerged was a liberal consensus – harm minimisation and safer sex rather than prohibition or social segregation. One senior Conservative politician saw drug policy post-AIDS as "increased controlled availability at home and stronger prohibition round the edges".[8] Pragmatism was the order of the day.

So far we've looked just at the immediate prehistory of drug policy before AIDS, but reduction of harm, broadly defined, had been a consistent policy theme even before the 1980s.

The history of harm reduction

In the postwar 1920s a hard line emergency response to drug use was at its height. Numbers of addicts were at their lowest ever but the Home Office (inspired by US example and by its new responsibilities under the 1920 Dangerous Drugs Act) saw the solution as prohibition – stamping out addiction via the courts and a penal response. The medical profession defended its role and with it the disease concept of addiction via the Rolleston Committee of 1924-26.[9] For us, what is significant is that committee's justification of maintenance prescribing:

"When ... every effort possible in the circumstances has been made, and made unsuccessfully, to bring the patient to a condition in which he is independent of the drug, it may ... become justifiable in certain cases to order regularly the minimum dose which has been found necessary, either in order to avoid serious withdrawal symptoms, or to keep the patient in a condition in which he can lead a useful life."[10]

This was a framework in which the minimisation of harm to the individual drug user was paramount, albeit also as a means of allowing them to lead a "useful" (ie, economically productive) life. In this Rolleston followed the tradition of the nineteenth century, when the public health rationale for improving the health of the population invariably had an economic justification.

The 1960s provide a more recent example of the durability of harm minimisation in drug policy. Then the arguments more directly encompassed a social dimension. As would happen with HIV in the 1980s, the 'epidemic' – then addiction itself – led to the language of infectious disease, public health and national crisis. The 1965 Brain Report saw addiction as a "socially infectious condition," a disease which "if allowed to spread unchecked, will become a menace to the community".[11]

The report's proposals – notification and (later dropped) compulsory treatment – were classic public health responses. The rationale of the clinics that emerged from the report was harm minimisation – but, in the 1980s, minimisation of harm to society as much as to the individual drug user. Clinic doctors had to prescribe opiates to undercut the black market, but not so much that the overspill supplied the market and new addicts were created. Treatment was of minor importance compared to the minimisation of social harm. Max Glatt, a psychiatrist involved in the debates over the clinics, recalled:

"Most of us were very averse to prescribe what we thought were killer drugs. But in the end when we were asked to man the new addiction centres, the arguments were that if we didn't prescribe, the black market would take over ... But it's quite wrong to say (as people do nowadays) that we thought at the time this was the *treatment* for drug addiction. It was just a kind of first aid ..."[12]

Clearly the reduction of harm as a justification for formal and informal drug controls is not without its immediate and long-term history, dating back as far as the nineteenth century.[13] But there are also more complex tensions in drug policy – a plethora of conflicting, sometimes interconnecting forces.

Complex policy tensions

The classic overarching paradigm in many analyses has been the conflict between penal and medical forms of control. However, there are, and have been, conflicts between *different forms* of medical control, eg, between aiming to cure the individual versus a form of public health approach focused more on community welfare.

Even 'public health' has not been an unchanging concept. The term conjures up visions of nineteenth century battles against disease and poor living conditions. But medical advances, which assigned specific causes for diseases, meant that directly attacking the bacteria rather than an unhealthy environment became the focus of public health.

Social hygiene, with its emphasis on individual responsibility for health, was

the reformulated public health of the early part of this century. The 'new public health' of the 1970s and '80s, emphasising individual lifestyle and prevention, has to some degree revived social hygiene concerns, although there are also strong efforts to broaden the public health paradigm to encompass questions of inequality and social structure.

'*Public* health' thus contains within itself the seeds of an *individually* focused medical approach. The nineteenth century 'public health' focus stimulated by the urban crisis of industrialisation later gave way to individually focused theories of addiction and disease. In the 1960s change was justified on public health grounds – the control of a potentially epidemic disease – but by the '70s this had shifted to an individually focused abstinence-oriented treatment approach. In drugs, as in other health areas, there has always been an implicit tension between prevention and cure.

Historically, the tension between penal and medical approaches has also been more complex than it would appear. Nineteenth century advocates of inebriety as a disease saw treatment as more humane than prison, but for them the 'medical model' was an argument for compulsory incarceration – a prison under *medical* rather than penal control.

Likewise in the 1920s, the Rolleston committee's defence of humanitarian drug treatment applied only to those middle class addicts doctors were likely to treat. Chlorodyne, a working class tipple, was not even in their terms of reference and opiate use in prisons received a distinctly harsher response from the medical experts; compulsory treatment and cold turkey were considered appropriate.

Most important of all, Rolleston did not mark some autonomous medical 'victory'. Maintenance prescribing operated within a system of domestic and international control in which the perspectives of the Home Office, the justice ministry, were dominant. How that balance of forces operated could easily alter over time.[14]

AIDS and its aftermath in British drug policy have displayed these tensions in all their complexity. While nominally 'normalising' drug use via harm minimisation, the 'non-medical' rhetoric of policy post-AIDS has disguised some clear tendencies towards sustained or even increased medical input, and revived some earlier medical arguments.

The impact of AIDS

AIDS has brought doctors back towards the centre of drugs work through the emphasis on prescribing, the focus on the role of the GPs and the new emphasis on the general health of drug users. Whether this is seen as de- or re-medicalisation depends on your perspective.

The need to attract drug users not normally in contact with services, sanctioned by a range of official reports, has served to elevate the notion of 'treatment', which has resumed its place as an unchallengeable 'good'. AIDS also revived some earlier medical arguments around treatment. The debate over prescribing methadone as a 'bait' to attract users into services to prevent HIV spread mirrored the arguments of the '60s, when prescribing was also used to attract addicts to prevent harm to society.

Increasingly, too, voluntary (non-medical) and statutory (medical) services are being brought into closer relationships and the differences between them blurred, a process hastened by the NHS and community care reforms and owing much to more general trends in health policy.

The response to AIDS exemplified the long-standing policy influence of the medical profession. Doctors in the civil service and medical expert advisers were of key importance. Without their support, the 'new departures' in policy could not have been sustained.

The 'public health' paradigm of post-AIDS drug policy contained within it a strong focus on the individual: health education for individuals, and the idea of the drug user as a 'normal' person responsible for their own actions, were key elements. As with past public health responses, the potential exists for a shift to an individualistic medical response.

Differences between penal and medical approaches have also blurred under the impact of AIDS. HIV's potential impact among prison populations has been the impetus behind the introduction of harm reduction into the probation service, of treatment into prisons, and of penal aspects into treatment and rehabilitation.

These shifts have been part of broader changes in the criminal justice system which have aimed to keep offenders out of prison. The Prison Medical Service is becoming the Prison Health Service; but offenders can now also be 'sentenced' into treatment. The probation service appears to be developing a key 'gatekeeping' role between medical and penal approaches. HIV has emphasised the health aspects of the penal response, but it has also emphasised (as in the nineteenth century, the 1920s and the 1960s) the punitive aspects of the medical.[15]

REFERENCE TO historical precedents was absent from the initial policy debates around AIDS and drug use, despite the long tradition of 'using history' to support particular lines in drug policy.[16] The promotion of existing policy objectives was better served by emphasising their relation to the *new* AIDS situation than to the drug policy past.

But many aspects of policy change did draw on distinct pre-AIDS continuities. War and crisis do lead to change, but long-standing themes also reassert themselves – witness the current revival of the prescribing debate and of forms of 'compulsory treatment'. The complex historical tensions within drug policy have been clearly displayed in the wake of AIDS. Whatever the future of that policy, it will not escape from its history.

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drugs prevention NEWS
Home Office Drugs Prevention Initiative

JOHN DUNWORTH OF LAMBETH DRUGS PREVENTION TEAM REPORTS

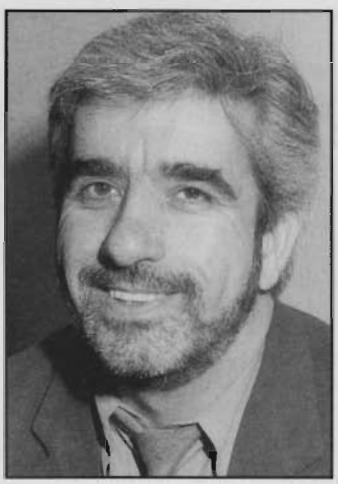
INTEGRATING DRUGS PREVENTION WITHIN COMMUNITY CARE

COMMUNITY care has had a major impact on drug services nationally and, as the changes in legislation have been implemented at local level, the Drugs Prevention Teams have acted as catalysts and conduits for change and have been well placed to innovate and support other players in the field.

As a new department, the DPI has been able to concentrate on the opportunities arising from legislative changes and develop services and resources accordingly.

It can also be argued that the changes in legislation with community care offer a real opportunity for the DPI to be promoted vigorously: its "modus operandi" and indeed its very existence contribute much to the philosophical debate on what is to be done about drugs in the community.

Drug strategies as formulated by health and local authorities, informed by Health of the Nation and Community Care, have had a radical impact on drug service provision and delivery. However, although radical in their approach to service delivery, philosophically the strategies remain conservative, reactive and individualised, requiring drug problems to develop into crises before responses are made.



John Dunworth

Individual drug problems do not develop overnight, but are years in the making and, while developing, drug users are attending schools and colleges, working, living in families and communities. Drug problems in this sense are not confined solely to individuals but become the concern of institutions and communities.

Therefore it would make both financial and philosophical sense to refocus and identify resources "upstream" to develop prevention and early intervention strategies that can address problems before they develop into crises. Traditionally, responses to drugs issues, as expressed socially in the community, are either tackled by law enforcement or by the drug agencies. To ask the police to deal with the multiple complexities of drug problems as experienced by local communities is wholly unrealistic. They certainly have an important role to play, but their part of the partnership is to promote law enforcement and community safety.

Likewise, to ask drug agencies to assist communities and community groups in formulating strategies and plans, while still trying to run an individualised client-based service, is also unrealistic.

Besieged

These polarised options can leave communities feeling besieged and powerless to achieve their own solutions. To help local communities respond to drug issues effectively requires reserves of time and resources which neither the police nor the street agencies can afford.

However if community care is to be effective, successful and potent, then community concerns around drugs have to be listened to and addressed by the drug service purchasers and planners. There needs to be effective arbitration and mediation that can link potential partnerships to create community-based responses.

Community groups and individuals have a crucial role to play in the design and delivery of such services and the models used by the DPI and the work of the teams have started such a process of consultation. Teams have been successful in targeting money and resources in communities to develop initiatives but more importantly have managed to make philosophical leaps which have stretched existing provider services and exploited their expertise, creating imaginative and effective community responses and services. They have also acted as catalysts to form new partnerships with agencies and community groups for whom drugs and the drugs field have till now appeared alien and mysterious. This has been most evident with the work developed with parents, youth services, churches, housing departments and the development of policy for schools, colleges and the workplace.

As the first phase of the experiment is drawing to its conclusion, the DPI has now to consolidate its position and attach itself to the existing purchasers and providers so that drugs prevention and the teams become recognised and valued as an innovative resource with much to offer the overall drugs strategy both locally and nationally.

Drugs Prevention Week II planned for October

GERMANY has set itself the challenge of leading the second Europe-wide Drug Prevention Week, in October. The idea was pioneered in November 1992 when Britain held the presidency of the then European Community. Germany, which will be president of the new European Union, has been working towards a repeat event, which will take place between 15 and 22 October.

The theme of the week will be "Drugs Prevention and the Young", and the DPI will again be taking an active role in the UK in putting the message across. The 20 local teams will be spreading the message in their areas, with health authorities the focus of action.

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New horizons needed

Farewell drug advisory committees and welcome to the community, a new focus for local coordination

LOCAL INTER-AGENCY collaboration in tackling drug misuse needs to shift its focus away from services. That is a primary conclusion of our report *Across the Divide: Building Community Partnerships to Tackle Drug Misuse*, the outcome of a year-long piece of research for the Department of Health.

As more resources for drug misuse services have become available, local efforts at coordination have run into the mud of vested interests and the seeming inertia of large bureaucracies. With change in the air for health, local authority and criminal justice services, many people hope that the new structure of commissioners, purchasers and providers will crystallise relationships, leading to better joint working; but will it?

I fear not – because many people are still locked into a world view where responses to drug misuse are led by the provision of services. New services *are* desperately needed. But, just as public organisations have been slow to recognise a growing problem, many drug agencies have been slow to acknowledge that effective local responses to drug misuse are not just about services for drug misusers.

The key question – why coordinate?

Our research repeatedly took us back to a fundamental question, one rarely answered satisfactorily – 'What is the purpose of [local] collaboration?' The Advisory Council on the Misuse of Drugs has stressed preventive education and reducing drug-related risks as key objectives. Few people now seriously challenge harm minimisation as an objective, allowing it to act as the common ground on which relationships between agencies can be improved. However, there is now a much wider perspective about what constitutes prevention and harm minimisation. This embraces concerns about drug misusers and those at risk of misusing, but also goes beyond these to wider concerns about the wellbeing of the local community.

From this perspective, prevention must be about more than simply information for individuals. The jury is still out on the Home Office drugs prevention teams, but they have moved us beyond health education to a broader perspective on what constitutes preventive activity. In many areas we visited, it was pointed out that collaboration on drug misuse must take account of the economic and social costs to the community. We concluded, therefore, that local collaboration should aim:

- to reduce the harm to individuals *and* the community; and
- to reduce the cost of drug misuse to the locality.

We have enough information to know that today's local drug misuse forums do not embrace the wider concerns of the local community. They have not achieved a balance between developing specialist services, prevention through education, promoting community safety, and ensuring that mainstream services become more responsive to drug misuse issues. Some people believe that new joint commissioning arrangements may be the test bed for better joint working. But joint commissioning retains an emphasis on the purchase of services, whereas tackling drug misuse at a community level relies on shifts in the policies and practices of public bodies.

A new framework needs to be established within which a broad-based response to tackling drug misuse can flourish based on *partnership* between different agencies and acknowledgement of shared responsibility between the key stakeholders, whether public bodies, specialist services or community organisations. We propose that **Drug Misuse Community Partnerships** be established at local level to:

Aim to reduce community as well as individual harm

- monitor and provide information on drug misuse;
- assess the needs of drug misusers and the wider community;
- develop strategies to prevent drug misuse and to reduce the availability of illicit drugs;
- enable and empower individuals and communities to address risks and problems associated with drug use; and
- develop programmes for commissioning specialist services and prevention initiatives involving the wider community.

Policy-shaping role for drug services

What roles should drug services play in this new vision of inter-agency coordination? They will remain key service providers and sources of valuable intelligence on the local drug scene. But they should also be shaping policy. To do this effectively, drug services will need to broaden their own and others' horizons about the range of responses needed. For example, current drug misuse forums rarely involve community or tenants' groups, or (except as a funder) local businesses. And how do drug misuse forums link with other inter-agency groups, such as those dealing with community safety? These are issues which the next generation of drug misuse coordinating groups will have to address.

Coordination is not just a local issue. At national level too, change is in the air. The new Central Drugs Coordination Unit set up under Tony Newton is a welcome recognition of the need for a more coherent approach to national strategy. As at local level, its success will depend on shaping a new agenda, transcending organisational boundaries, and, in particular, gaining clarity about the aims of collaborative effort.

The problem that national and local coordinating efforts share is that tackling drug misuse does not fit easily into the institutions created for the administration of nineteenth and twentieth century social policy. Not only do enhanced efforts have to be made to bring about good collaboration, but we have to set new agendas for collaboration to address. ○

from
Roger Howard

The author is a management consultant and the author of Across the Divide, *a report to the Department of Health on local coordination in tackling drug misuse.*

Healthy women

Drugs/HIV peer education in action among Birkenhead's sex workers

SEX AND DRUGS are focal to HIV spread. Where they come together, concern is bound to be high. Prostitution is one clear overlap point. Women and men working as street prostitutes often also regularly inject drugs. In some areas outreach initiatives have reduced the sharing of injecting equipment in these groups and helped make condom use in commercial sex the norm. However, the risk of HIV transmission remains.[1] More needs to be done.

In Birkenhead, the Wirral Drugs Service tried to go beyond outreach. Our aim was to develop women as 'peer educators' operating among their fellow prostitutes – to motivate and educate them to 'do it themselves'.

Using the women as volunteers did not mean this was a 'cheap' option. Building self-esteem, peer education skills and HIV-related knowledge, were all needed. There was also an essential added ingredient. To want to be involved and to be effective, the women had to *value* what they had to offer. That meant we had to demonstrate – in *how* we did things as well as what we did – that we valued them and were prepared to put resources into their development as peer educators.

This is the story of that experiment, based partly on an independent evaluation commissioned by Mersey Regional Health Authority.[2] The project received further validation when it won a Domestos Health Education Award.[3]

Importantly, we had a long-standing relationship to build on. Women working as prostitutes in Birkenhead have received an evening/late night outreach HIV prevention service since 1989, jointly run by Wirral Health Authority and Wirral Youth Service. About 50-60 women have been contacted, including a core of 20 who work fairly regularly. Our pre-existing presence with the women contributed to the success of the project we embarked on together. The project grew from the women's own practice; coming in 'cold' and trying to 'graft' it on to such a group would be very difficult.

Outreach work was followed up in the day by services dealing with issues ranging from childcare, housing and law to welfare benefits. However, the women recognised that more time needed to be devoted to these recurring issues. How to provide it was the question.

Beyond outreach

We chose to supplement outreach and daytime office-based services with peer education. There were three main reasons:

- it was already happening – the women were familiar and comfortable with it;
- the results could quickly be observed and recorded; and
- it offered to overcome the limitations inherent in outreach work.

Outreach is a successful way of contacting hard to reach women and engaging them in HIV prevention, but, however late, at some point in the evening the work finishes. Women in the target group can carry on the HIV educa-tion process night or day. Continuity in outreach work is dependent on funding, but knowledge once shared among the target group can be shared indefinitely. Women do move in and out of the scene, but discontinuity can be minimised by identifying 'significant', established figures with a track record on the scene.

Together with the women, we decided to apply for funding to enable us to devote time to exploring the issues on which they felt the need for more input. Mersey Regional Health Authority agreed to support our attempt to extend the peer education already taking place.

Meetings of women working as prostitutes and staff from women's services were held to discuss which issues peer education should cover, and how the educational content could be tailored to be acceptable to the funder. What emerged was a project which would recruit peer educators and educate/train them in six weekly four-hour sessions, culminating in a residential weekend away. Each session would cover a different topic and explore peer education itself. Our project proposal seeking a £3000 grant was accepted and in further meetings we worked out the fine details – venue, facilitators, etc.

In the nature of the project there were some unusual expenses. The proposal emphasised the importance of childcare payments. Almost all the women had childcare responsibilities; it would be

by
Janet Hanslope

The author is the Service Development Manager of the Wirral Drugs Service and the coordinator of the project described in the article.

Building on an existing outreach initiative, the Wirral Drugs Service developed an HIV peer education project among drug using women working as prostitutes. Education/training sessions were followed by a residential weekend. An assessment suggested the project successfully engaged the women and that HIV prevention gains would result. Closely involving the women in planning the project and demonstrably valuing their contributions were essential to its success.

unrealistic to expect them to attend without help. In the end, these payments accounted for 20 per cent of the costs.

Our insistence on adopting the women's choice of a 'quality' venue for the weekend residential was no extravagance. Thinking on this went deeper than providing an incentive to attend. Attempting to enhance the women's self-esteem and sense of self-worth was vital to the project. To get people to practice safer sex/safer drug use, they need to believe they are worth protecting; to act as peer educators, they need to feel they have an important message worth sharing. The choice of accommodation showed the women that the health authority and the staff took them and the project seriously.

Enthusiastic response

Attending planning meetings was difficult for many of the women. At this stage no childcare allowance was available and women sometimes attended with their children – not ideal. Tea and sandwiches at lunchtime meetings helped give most mothers a chance to contribute while the children were kept occupied.

> We had to show we valued what they had to offer

Encouraging women to attend the training sessions was not a problem; restricting the numbers was. The selection was done very much by the women who had attended the planning meetings. They had clear criteria for who should/should not be invited. Women who were chaotic in their personal lives or in their drug use (mainly involving alcohol or benzodiazepines) were excluded.

From the outset there was a real sense of investment in and commitment to the project. Restricting the group to just 10 meant some enthusiasts were left out, for a time creating tension.

We worked through the six weekly sessions, learning as we went. The first dealt with the law relating to prostitution. We thought about starting with 'ice-breakers' and setting ground rules, and wondered whether to identify a facilitator to direct and progress the discussion. All were decided against. The main concern was not to patronise the participants but to create a feeling of togetherness. By the close of the first session, it seemed we were doing just that.

The main problem throughout was the perceived hostility of the health promotion staff whose unit hosted the sessions. The fact that the unit's no-smoking policy clashed with several of the women's lifestyles – and that neither were prepared to abandon their principles – was a regular source of conflict.

Positive feedback

Evaluation was integral to the project but, because we were dealing with volunteers with busy personal lives, it had to be non-intrusive. After each weekly session participants were asked for their comments which were noted along with those of the staff. At the weekend residential, HIV-related knowledge was tested in a quiz and the women's feelings about the previous six sessions were explored and noted. The funder received the final project evaluation report in May 1993.[4]

At the weekend away, discussion of where the group went from here led to the idea of each member keeping a weekly diary noting when they had shared information gained on the course. These are being fed back to help evaluate the longer term impact. An initial impression is that these "indigenous' workers feel more comfortable about dealing with safer sex issues than would be expected of paid drug workers.

Some of the sessions were welcomed more than others (see panel) but what of the overall impact? The evaluation indicated that the women had developed camaraderie and friendship over the six-week period. Sessions were enjoyed and looked forward to – one woman stayed up all night so as not to oversleep. Participants showed considerable knowledge and understanding of HIV prevention and were keen to continue to act as a group to promote their own welfare.

In the final report, the evaluator concludes: "The project has proved to be an even greater success than was hoped. Not only has it achieved its objective of providing knowledge and awareness of HIV prevention to a small number of women, who can use this knowledge to educate their peers, it has also provided the women with the confidence to act as a group." ❍

THE PEER EDUCATION CURRICULUM

Six afternoon sessions drawing in outside experts, and a weekend away to reflect and consolidate, were the core educational inputs. The sessions were organised once a week between 12.30 and 5.00pm. Topics in each session were:

❶ **The law relating to prostitutes:** addressed by a solicitor and a barrister. A good start showing the value of responding to the women's own experiences.

❷ **Safer injecting/safer sex:** facilitated by staff from Wirral Drugs Service. Safer sex elements received particularly well.

Relaxation and aromatherapy: provided free by two Body Shop staff and greatly enjoyed.

❸ **English Collective of Prostitutes:** two women from the collective helped generate lots of informative discussion.

❹ **Careers:** alternative legitimate opportunities. Doubts expressed about whether 'going legit' was realistic for unstable drug users or those with a criminal record – and whether straight work could generate enough income.

STD clinic: addressed by a clinic worker, this lively session led to the clinic arranging a special session for the group.

❺ **Control and restraint:** how to avoid and get out of trouble. The outside contributor was the only man to have attended the sessions. 'It was great' was the women's reaction.

❻ **Tricks of the trade:** led by a worker from the Scottish Prostitutes Education Project. Again she showed the value of responding to the women's own experiences. Informal, lively, one of the best sessions said the women.

Residential weekend: a day was devoted to assessing the impact of the programme, discussing the future of the group, and peer education; the rest of the time was spent on leisure activities.

FOR MORE INFORMATION

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❑ **AN ASSESSMENT OF THE HEALTHY WOMEN'S PROJECT.** G. Eaton. A report to Mersey Regional Health Authority, May 1993. The evaluation report on the Healthy Women's Project.
Available from Janet Hanslope – see above.

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Not just another comic – but is it too daring for its own good?

JUST SAY KNOW: A DRUG INFORMATION COMIC. Tower Hamlets Community Drug Team & Joint Productions, 1993. £3.

Yet another play on the 'Just Say No' slogan, this *Just Say Know* employs the comic format to convey factual information about drugs to young people. Many of us think comics now rival posters as the most overused 'right on' way of getting health information over to youngsters without actually telling them. Despite the overworked medium and the outdated title (will today's young drug users remember Zammo and his *Grange Hill* pals rehearsing ways to 'say no' to heroin?), this comic really is extremely good.

Based on research with young people in workshop sessions, it aims to fill a gap in the drug information market, which it says "is still primarily targeted at older opiate users". In contrast, *Just Say Know*'s targets are younger recreational users.

Because of what he has seen in the media, in anti-drug ads, and, of course, been told at school, the central character is convinced that drugs kill all who use them. Distraught on learning that his older sister is recreationally using ecstasy and LSD, he runs away. Without actually seeming to take anything, he then embarks on a strange trip in which he is told the 'real' story behind drugs, including the Opium Wars and US racist cocaine scares. During his re-education he meets Sherlock Holmes and attends a Beatles concert.

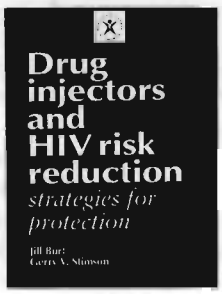
Just Say Know's information content is factual, balanced, and matter-of-fact. This is its strength, and possibly its weakness. The publisher recommends a 14 years+ teenage readership but this comic could be read and understood at an earlier age, say 11-14, when such information is badly needed. Many youngsters will be prevented from reading it by adults who see it as condoning, even promoting, drugs. The odd swear word will not help to get it accepted by those who need to promote it.

Supplementing the comic strip there is a considerable amount of information designed to inform, advise and help reduce risk. Although meant for use in Tower Hamlets, this booklet's application in other areas should not be ruled out.

Ian Clements

Health education consultant

Just Say Know *is available from APA, 37-39 Great Guildford Street, London SE1 0ES, phone 071 620 1919.*



Research pointing the way to the future of HIV prevention

DRUG INJECTORS AND HIV RISK REDUCTION: STRATEGIES FOR PROTECTION. Jill Burt and Gerry Stimson. Health Education Authority, 1993. £7.99.

This small book is based on research carried out in late 1988 and early 1989 in Brighton and London, where researchers interviewed injecting drug users and a number of professionals. The objectives were to explore what injecting drug users know about HIV transmission, document their associated risk behaviours, and then to identify the obstacles to further risk reduction.

Burt and Stimson acknowledge that meeting *Health of the Nation* targets will mean improving prevention strategies to influence more of those practising high risk injecting and sexual behaviour. The key to making progress is, they argue, a better understanding of the dynamics of behavioural change. Despite the relative success of syringe exchanges, about 20 per cent of attenders still share equipment and many more have unprotected sexual intercourse.

In my view less credibly, they also claim prevention strategies have helped change the 'social etiquette' of drug injecting. Sharing injecting equipment is now seen as unusual, whereas up to the mid-1980s drug users saw it as normal behaviour. Even pre-HIV, I don't believe it ever was the norm to share injecting equipment – it happened out of necessity, not because it was considered 'OK'. A false vision of past injecting norms could lead us to overestimate how far these have been changed by prevention policies.

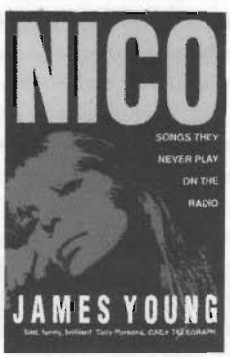
The most significant, but not surprising, conclusions are that drug users do change high-risk behaviours (although often to reduce rather than eliminate risk) and that they respond to health information by actively incorporating (or rejecting) it into their lives, not as passive recipients.

This last point has important implications for prevention. The power relationship between professionals and drug users will need to change for meaningful dialogue to take place. Talking of 'treating' drug users implies someone being passively treated. This does not describe a partnership of professional and drug user working together towards common goals.

Andy Malinowski

Coordinator, Druglink, Swindon

Drug Injectors and HIV Risk Reduction *is available from HEA, Hamilton House, Mabledon Place, London WC1H 9TX.*



Drugs and rock'n'roll with all the sleaze and the reality

SONGS THEY NEVER PLAY ON THE RADIO: NICO, THE LAST BOHEMIAN. James Young. Arrow, 1993. £5.99.

There is a band from the West Midlands called Pop Will Eat Itself. So will the drugs field if it doesn't stop this interminable bickering. Time and again models designed by thoughtful and compassionate colleagues to elucidate this complex business of drug using mysteriously turn into cudgels with which one faction can wage war on another. Many of the arguments – between harm reduction and prevention, prescribing and abstinence, etc – take place in splendid isolation of the subject matter: drug users.

For a change, here is a book about drug users set within the context of the real lives they live. *Songs They Never Play...* is bursting, brimful with drug users. Drug users who do more with their time than use drugs and fill in research questionnaires. They play music, travel, quote poetry, have sex. Not that these are typical drug users – but I'm not sure there are many of those anyway. In Young's admirable, graphic, witty and very sleazy chronicle of the last years of the former Velvet Underground diva, everybody gets a look in. Recreational use rubs shoulders with dependency, abstinence shares works with prescribing.

In the process all our prim little models are defiled and defaced with a certain seedy glee. Witness the following passage:

J.C. Clarke (quizzically): "I didn't know if I don't prefer the brown stuff or the white." (Measures a double dose.)

Echo: "Generally speakin', as a regular tipple, I'm more in favour of the brown ... it's warmer some'ow."

J.C. Clarke: "I know, there's more of a softer glow about the Eye-ranian stuff, it lingers that much longer ... with the China White, on the other 'and, it's 'arder – I must say I sometimes feel chastened by its astringency."

All drug workers should be made to debate the relative merits of substances with connoisseurs of this calibre.

Songs They Never Play... is chock-full of characters and events. The tedium of drug using and touring weigh down on every chapter. I'd have liked more pictures and was puzzled by the patchy use of pseudonyms: but these are minor criticisms of a very good book.

Rowdy Yates

Coordinator, Drugs Training Unit, University of Stirling

Men are the problem

Dear Editor,
The cartoon on the cover of the September/October 1993 issue of ***Druglink*** is offensive. It portrays both women as grotesque and ugly, with no style or dignity.

Why lay into women's differences this way? It would be more realistic to focus on the first hurdle to women wanting to use the drug services – the field is controlled by men.[1] Another [US] study showed that half the women in treatment had been propositioned by male staff. When they refused to comply reprisal resulted. We should initially focus on these problems, rather than on the different ways women present their identities.

Louise Clarke
Newham Drugs Advice Project, London

1. Quoted in: Ettore E. *Women and substance use*. Macmillan, 1992, p. 81.

'Politically correct' blinkers

Dear Editor,
I endorse the editor's response (last issue, p. 19) to the negative feedback over the 'Fiona' cartoon.

I am increasingly depressed by the growth of an inquisitorial scrutiny of images and text lest they contain heresies which could be denounced as 'sexist', 'racist' or 'homophobic'. Raising awareness of these important issues has mutated into a self-perpetuating industry of censorship and attempted thought control.

The 'politically correct' should look beyond the immediate image or careless word to the contextual background.

Hugh Jobber
Regional Development Manager, Problem Drug Use, West Midlands Health.

Cartoonist 'arrogant'

Dear Editor,
In the last issue of ***Druglink***, Mike Linnell failed to answer any of the criticisms of his cartoon choosing to treat the subject in an arrogant and flippant manner.

We speak for many of our colleagues, both male and female, in saying that we welcome constructive criticism and debate but question cheap humour. The cartoon and Mike Linnell's reply were just that.

Declan Burke
HIV/Drugs Counsellor
Joe Sheppard
Coordinator
Stockport Community Drug Team, Stockport

Men are the hurdle to women using services

'Rehab' disrespectful

Dear Editor,
The term 'rehab' is disrespectful both of those who need residential services and of those services – a dreary, complacent, stigmatising tag, conjuring images of prison halfway houses.

It seems to reflect the service user's poor self-esteem and the all too willing complicity in this by others. There is a sense of only deserving low grade treatment that can be described by an ugly, truncated, throwaway term.

Giving services which do such important work the dignity and status they are due is a way of showing those who need those services that they are worthy and deserving of the best.

Nick Barton
Director, Clouds House, Wiltshire

'Trepidation' in Glasgow

Dear Editor,
With reference to your news report in the November/December 1993 issue of ***Druglink***, the Glasgow Association of Family Support Groups recognises that there is a place for harm reduction but only if the prescribing programme is carefully monitored. Previous experiences of harm reduction prescribing programmes in Glasgow have not been particularly edifying. People are entitled to choices; methadone, though possibly the cheapest option, is not the only one.

The cogent point in Sally Haw's report is that oral prescribing should be "carefully managed". With hope mingled with trepidation we await the opening of the drug problem service in Glasgow.

Jim Harrigan
Chairperson, Glasgow Association of Family Support Groups

Booklets can be 'user friendly'

Dear Editor,
Crew 2000's review of *The Methadone Handbook* in the November/December ***Druglink*** raised a general point about presenting information to drug users.

Can only comics be 'user friendly'? *Smack in the Eye* does what it does very well, but comics can't do everything or suit everyone.

The Methadone Handbook has over 4000 words and hundreds of facts. *Smack in the Eye* usually conveys one or two (crucial) messages per side of A4: in this format, *The Methadone Handbook* would have needed volumes of paper.

Planning and researching *The Methadone Handbook* (which *did* extensively involve clients) I found good research[1] and evidence that most people with prescribed methadone:
– didn't have good, comprehensive, information about it;
– were eager to learn as much as possible; and
– were willing to read and able to retain lengthy written information.

This isn't surprising: by definition, opiates are central to the lives of most people with a script and clients often want to know everything about them.

Opiate users with a methadone script are often in a different drug using group to Crew 2000, one with information needs that cannot be met by a comic. For many, *The Methadone Handbook* format *is* 'user friendly'.

Andrew Preston
Community Psychiatric Nurse, CADAS, Dorchester

1. Roberts D.K. *The role of the pharmacist in the treatment and detoxification of opiate addicts*. Unpublished, 1992.

ADSA defended

Dear Editor,
Alison Chesney says (***Druglink***, Nov./Dec. 1993, p. 9) the Alcohol and Drug Services Alliance (ADSA) was "unrepresentative and unaccountable" and failed to coordinate with SCODA at key moments. In fact, ADSA was formed at the request of the 1992 SCODA annual general meeting. Steering committee members were chosen by SCODA's Residential Services Forum because they *did* represent the range of residential drug and alcohol services.

As for "unaccountable", regular and extensive mailings have been sent to all residential drug services. Reports were presented to SCODA's Residential Services Forum detailing ADSA's work and asking for feedback. Coordination with SCODA and Alcohol Concern was accomplished by regular communication and by the fact that David Turner (of SCODA) and Eric Appleby (of Alcohol Concern) were members of the steering committee.

ADSA highlighted the difficulties facing residential services and their clients. It raised funds for a monitoring exercise by C.V. Services which provided a crucial focal point for drug agencies and social services.

Ms Chesney says ADSA "fired off" the findings of this exercise days before the Department of Health (DoH) released the Goldsmiths' report, causing its findings to go undisputed, apart from a mild warning. This we dispute. ADSA never intended the press release to be a response to the DoH, but an independent report. The DoH figures were shown to be completely wrong only due to the work of John Reading of C.V. Services and Mike Ashton of ***Druglink***.

The ADSA steering committee carried out all this work voluntarily while under the same pressures to prepare their agencies for community care as everybody else. Our concern throughout was the needs of our client group. We are confident that our work and actions were both appropriate and extremely valuable.

Anne Hooper
Chair, ADSA Steering Group

Ignorance no response to hepatitis C

Dear Editor,
Contrary to Perry and Wright's implication in their letter (***Druglink***, November/December 1993, p.18), drug users have changed their injecting behaviour in the face of HIV. In West Suffolk hepatitis C is motivating further reductions in risk behaviour before HIV becomes prevalent. Why not elsewhere?

Perry and Wright assume that a typical health authority will have about 500 intravenous users and that at least 50 per cent of these will be hepatitis C positive. Mid Glamorgan Health Authority neighbours that of Drs Perry and Wright. Here injecting drug use is probably at least twice as prevalent, but the prevalence of hepatitis C appears to be lower (33 per cent).

Drs Perry and Wright ignore three other high risk groups. Recovered ex-injectors, for whom sharing was normal practice, may have a high prevalence. Up to 25 per cent of long-term sexual partners,[1] and possibly 30 per cent of children born to infected women, will also carry the virus. The problem may be far larger than they suggest. It would be unwise to plan responses using their methods of estimation.

Ignorant of their status, those positive for hepatitis C, their partners and their children will act as bridges to the non drug-injecting population. Some will die before terminal liver disease develops, as Perry and Wright suggest, but the vast majority will not.

Experts consulted for the August 1993 *Drug and Therapeutics Bulletin* generally recommended treatment with interferon alpha. Drs Perry and Wright suggest this is uneconomic, but if it prevents the need for one week's inpatient care during later liver failure, it will have paid for itself.

Public health and communicable disease control services would probably have no place at all in Perry and Wright's vision of the health service, for which they appear to advocate ignorance of health needs as a matter of policy. They fail to generalise the principles of epidemic control employed for HIV to the threat posed by hepatitis C.

As public awareness grows, drug users and others will want to know their hepatitis C status. Given the prevention opportunities this might allow, and the reduction of anxiety in those testing negative, we can see no argument against testing with consent.

Andrew McBride
Consultant Psychiatrist
William B Clee
General Practitioner
Mid Glamorgan Health Authority

1. Peano GM *et al.* "Heterosexual transmission of hepatitis C virus in family groups without risk factors." *British Medical Journal*: 1992, 305, p.1473-1474.

PUBLICATIONS

Service development

❑ **PROGRAM DEVELOPMENT FOR COMMUNITY AIDS OUTREACH.** Rebecca Ashery *ed.* 1992.
❑ **THE INDIGENOUS LEADER OUTREACH MODEL. INTERVENTION MANUAL.** Wayne Wiebel. 1993.
US National Institute on Drug Abuse. Reports.
US government reports on outreach approaches recommended in recent ACMD report.
Available for reference/copying (copyright waived) in ISDD's library or from US Government Printing Office, Superintendent of Documents, Mail Stop: SSOP, Washington, DC 20402-9328.

❑ **DEVELOPING PEER COUNSELLING SKILLS.**
❑ **USING PEER COUNSELLING SKILLS.** Maggie Phillips and Joan Sturkie. Cambridge: Daniels Publishing, 1994. Photocopy-free resources. **£38 each.**
For use with students aged 14+.
Available from Daniels Publishing, 38 Cambridge Place, Cambridge CB2 1NS, phone 0223 467144.

❑ **INNOVATIVE APPROACHES IN THE TREATMENT OF DRUG ABUSE. PROGRAM MODELS AND STRATEGIES.** James A. Inciardi *et al, eds.* Greenwood Press, 1993. Book.
US book of readings based on government-funded research.
Available through bookshops.

❑ **JOURNAL OF MAINTENANCE IN THE ADDICTIONS.**
❑ **JOURNAL OF MINISTRY IN ADDICTION AND RECOVERY.** Haworth Press, 1994. Journals.
New US journals.
Available from The Haworth Press, Inc., 10 Alice Street, Binghamton, New York 13904-1580, USA.

❑ **GUIDELINES FOR WORKING WITH YOUNG PEOPLE.** East Anglian Drug Workers Forum, 1993. **£3.**
Available from SCODA, phone 071 928 9500.

❑ **RURAL DRUGS & ALCOHOL SERVICES: CURRENT STRATEGIES.** Dieter Kessel and Andrew McBride, *eds.* Mid Glamorgan Drugs Advisory Committee, 1994. Conference report.
Contact Health Promotion, Hensol Hospital, Pontyclun, Mid Glamorgan CF7 8YS.

❑ **DRUGS AND OFFENDING.** The Council on Addiction for Northamptonshire, 1993. Pack with video, leaflets, etc. **£69 inc. VAT.**
A resource pack for work with offenders who use drugs.
Available from Council on Addiction, Spring House, 51 Spring Gardens, Northampton NN1 1LX, phone 0604 233227.

Women

❑ **YOUNG WOMEN, SEXUALITY AND RECREATIONAL DRUG USE.** Sheila Henderson. Lifeline Project, 1993. Research report.
Contact The Lifeline Project, Globe House, Southall Street, Manchester M3 1LG, phone 061 834 7160.

❑ **POSITIVELY WOMEN: LIVING WITH AIDS.** Sheba Feminist Press, 1993. Book. **£9.99.**
The stories of British women with HIV.
Available through bookshops.

❑ **WOMEN AND CRACK-COCAINE.** James A. Inciardi *et al.* Macmillan, 1993. 197 pages. Book.
Based on research interviews with US crack users.
Available through bookshops.

❑ **DRUG & ALCOHOL WOMEN'S SERVICES DIRECTORY 1993.** D.A.W.N., 1993.
Contact DAWN, 30-31 Great Sutton Street, London EC1V 0DX, phone 071 253 6221.

Drug facts

❑ **DRUG ABUSE BRIEFING. 5th edition.** ISDD, 1994. Booklet. **£3.**
Now with full-colour illustrations.
Available from ISDD.

❑ **SUBSTANCE MISUSE.** Leicestershire Health Authority Health Education Video Unit, 1993. Video. **£75+VAT.**
Drug facts video for general viewing.
Available from Leicestershire Health Authority, Health Education Video Unit, Clinical Sciences Building, Leicester Royal Infirmary, PO Box 65, Leicester LE2 7LX, phone 0533 550461.

❑ **UPPERS, DOWNERS, ALL ROUNDERS. 2nd edition.** Darryl Inaba and William Cohen. Daniels Publishing, 1994. Photocopy-free resource. **£10.**
Illustrated drug facts reference book for generic professionals.
Available from Daniels Publishing, 38 Cambridge Place, Cambridge CB2 1NS, phone 0223 467144.

❑ **DRUGS AND THE HUMAN BODY WITH IMPLICATIONS FOR SOCIETY. FOURTH EDITION.** Ken Liska. Macmillan, 1993. Book.
US reference text.
Available through bookshops.

For young people

❑ **DRUGS AND SOLVENTS: A YOUNG PERSON'S GUIDE.**
❑ **DRUGS AND SOLVENTS: THINGS YOU SHOULD KNOW.**
Department of Health, 1993. Booklets. Free.
For children aged 8-12 and 13-18 respectively.
Available from BAPS, Health Publications Unit, DSS Distribution Centre, Heywood Stores, Manchester Road, Heywood, Lancs, OL10 2PZ, phone 0800 555 777.

❑ **THE ESSENCE.** Bristol: BREAD youth project, 1993. Boardgame. **£20.00.**
Board game for young people on HIV, sexual health, and drugs.
Available from BREAD youth project, 84 Colston Street, Bristol BS1 5BB, phone 0272 230458.

❑ **GORDON GOODSENSE.** Rugby Community Drug Team. Rugby NHS Trust, 1993. Series of leaflets. **£7.25 for 50.**
Drug fact leaflets featuring cartoon characters.
Available from Rugby NHS Trust, The Orchard Centre for Community Health, Lower Hillmorton Road, Rugby CV21 3SR, phone 0788 555100.

❑ **TAKE NOTICE.** Newcastle Drugs Prevention Team, 1993. Factsheets.
Pocket-sized drug facts cards.
Contact Drugs Prevention Team, Blackfriars Court, Dispensary Lane, Newcastle upon Tyne NE1 4XB, phone 091 233 1972.

Client handouts

❑ **THE METHADONE HANDBOOK. 2nd edition.** Andrew Preston. Andrew Preston and Community Alcohol and Drugs Advisory Service, Dorchester, 1993. **£0.70.**
❑ **THE REHAB HANDBOOK.** Andrew Preston and Andy Malinowski. Andrew Preston, 1993. **£1.10.** Booklets.
Available from ISDD.

❑ **KNOW YOUR RIGHTS.** Alison Chesney. SCODA, 1994. Booklet. **£0.60.**
Community care system for people considering residential rehabilitation.
Available from SCODA, Waterbridge House, 32-36 Loman Street, London SE1 0EE.

❑ **TRAVELLERS GUIDE TO DRUG AND NEEDLE EXCHANGE SERVICES IN WESSEX AND SOUTH WEST.** Wessex Syringe Exchange Group and the South West RDPT, 1993. Booklet with UK maps.
Available from NACRO South West Drug Training Service, phone 0225 336766.

❑ **D.F. HOUSE COMICS 1.** Birmingham: Church Road, 1993. Comic. **£1.**
By professional cartoonist and residents of a drug rehabilitation project on rehab life.
Available from DF House Comics, 10 Church Road, Birmingham B15 3SR, phone 021 454 1407.

Epidemiology

❑ **ANABOLIC STEROID USE IN GREAT BRITAIN: AN EXPLORATORY INVESTIGATION.** Pirkko Korkia and Gerry Stimson. The Centre for Research on Drugs and Health Behaviour, 1993. Research report. **£20.**
Available from The Centre for Research on Drugs and Health Behaviour, 200 Seagrave Road, London SW6 1RQ.

❑ **DRUG USAGE AND DRUG PREVENTION.** Maria Leitner *et al.* HMSO, 1993. Research report. **£18.**
Home Office household surveys of four urban areas on drug use and attitudes.
Available through bookshops or HMSO.

Other

❑ **DRUGS AND SOLVENTS: YOU AND YOUR CHILD.**
❑ **DRUGS: A PARENT'S GUIDE.**
❑ **SOLVENTS: A PARENT'S GUIDE.**
❑ **DRUG AND SOLVENT MISUSE: A BASIC BRIEFING.**
Department of Health, 1993. Booklets. Free.
For parents.
Available from BAPS, Health Publications Unit, DSS Distribution Centre, Heywood Stores, Manchester Road, Heywood, Lancs, OL10 2PZ, phone 0800 555 777.

❑ **DRUGS AND CRIME.** Welsh Committee on Drug Misuse. Welsh Office, 1993. Report.
Contact Welsh Office, Cathays Park, Cardiff CF1 3NQ.

❑ **AIDS AND CONTEMPORARY HISTORY.** Virginia Berridge and Philip Strong, *eds.* Cambridge University Press, 1993. Book.
UK anthology including recent history of drugs and AIDS.
Available through bookshops.

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- ☎ ON TRAINING: phone Dave Hicks, chair Drug Trainers' Forum, on 091 230 1300.

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- Ethnic minorities and drug services

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- Discrimination against drug users
- Drug education cuts

May

- Youth drug use at record levels
- Helping under-age drug users

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- Drug users as outreach volunteers
- Tapping into community resources

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