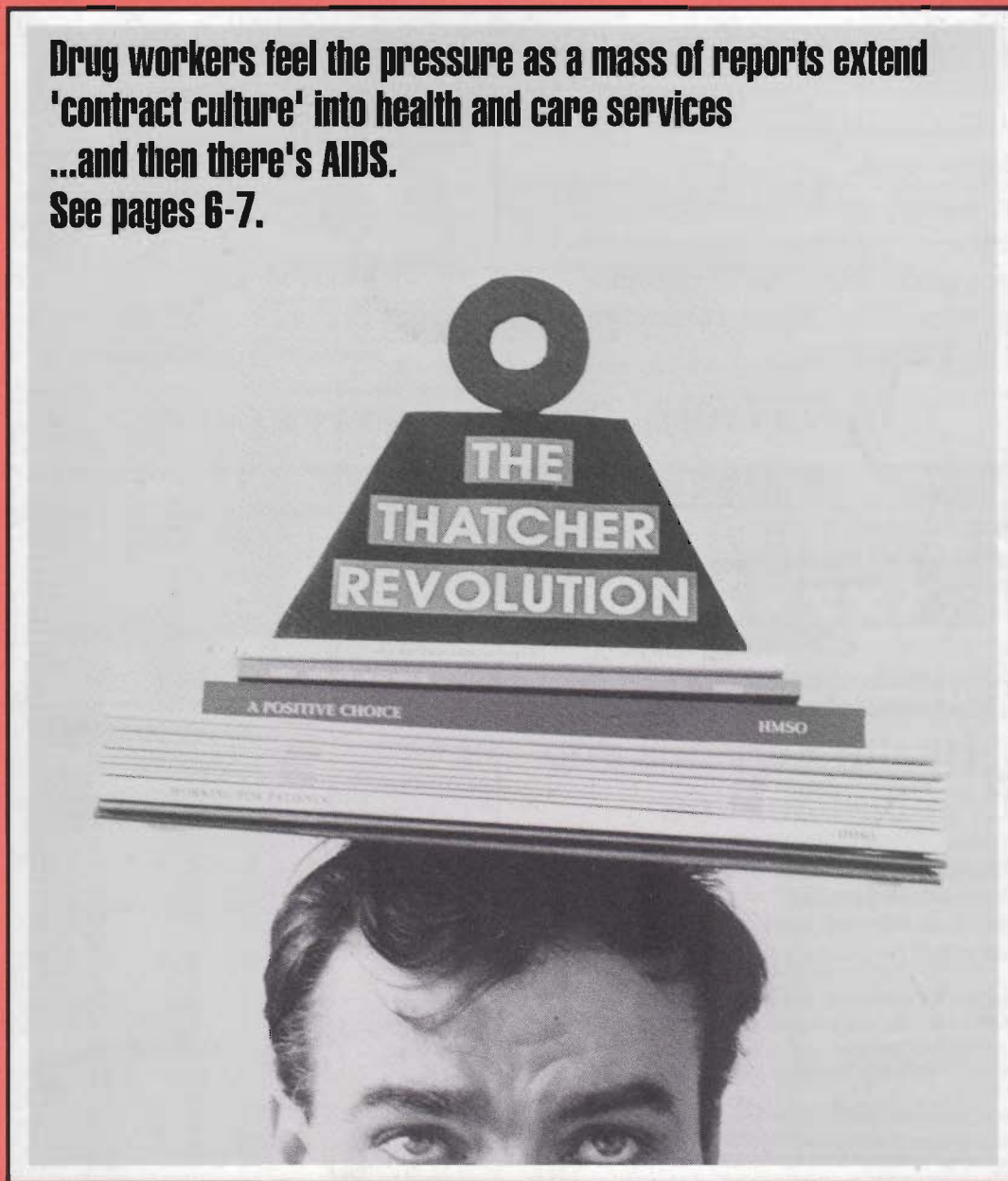


DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN

May/June 1989

Drug workers feel the pressure as a mass of reports extend 'contract culture' into health and care services ...and then there's AIDS.
See pages 6-7.



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DRUGLINK

May/June 1989
Vol 4 issue 3
THE JOURNAL ON DRUG MISUSE IN BRITAIN

DRUGLINK is about 'disapproved' forms of drug use — seen legally, socially and/or medically as 'misuse'. **Druglink** does not aim to cover alcohol and tobacco use. **Druglink** is for specialist and non-specialist workers occupationally, professionally, or academically involved in responding to drug misuse in Britain. **Druglink** aims to inform, promote understanding and encourage debate.

ISDD provides Britain's national library and information service on the misuse of drugs and drug dependence, and conducts related research. **ISDD's** reference library of books, scientific articles, reports and UK press cuttings is unique in Britain and an important international resource. Services to library users include current awareness bulletins, publications and an enquiry service. **ISDD** is an independent charity grant-aided by the Department of health.

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Rundown on the reports

Closest to home is the Advisory Council's second AIDS report — summary on pages 10-12, news report on page 4. But what happened after the first one? See page 5 for how one key drug service sector responded.

The wide world too is changing in ways that cannot be ignored. On pages 6-7 we attempt to introduce the reports in the health, community care and criminal justice fields which could dramatically alter the environment within which drugs work occurs. What nobody can deliver is a definitive statement of what the impact will be — but one tip is to sharpen up your contract negotiating skills.

4 NEWS

We need a full six pages to fit in coverage of the volley of important reports and events now impacting the drugs field (see above). Plus the inside story of the AIDS pack reviewed on page 15 and the final (?) word on syringe hygiene from the Expert Advisory Group on AIDS... and much more.

10 COPING WITH AIDS

Mike Ashton's summary of the second AIDS report from the Advisory Council on the Misuse of Drugs. This time the council tackles how workers should respond to drug users with HIV disease.

12 PLATFORM ► CRIME AND COMPULSORY TREATMENT

A view from America. Leading US researcher **Bruce Johnson** is interviewed for *Druglink*. He says treatment and punishment must be merged in new ways if the drugs-crime cycle is to be broken. That's also the trend in the UK.

14 PRACTICE NOTES ► BEING RESEARCHED

And how to make the most of it. **Robert Power** on the etiquette of the relationship between the researcher and the researched, one fraught with conflict opportunities.

15 REVIEWS

The **Learning about AIDS** training materials from Bristol Polytechnic will help plug your AIDS education gaps — see also the story of their production on page 9. A full-page composite review of what's available for women surveys leaflets from **DAWN**, the **Suffering from Life** video, and **Changing Gear** from the Blenheim Project.

17 LETTERS

Either he's joking or he's crazy seems to be the message of three responses from drugs outreach/detached workers to what Les Kay called his 'modest proposal' to do away with their profession and instead pay drug users a bounty to bring their friends in.

18 LISTINGS ► PUBLICATIONS. COURSES. MEETINGS

Cover photo: thanks to Hugh Dufficy

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Advisory Council report urges planning now for the wave of HIV disease to come

AIDS and Drug Misuse Part 2, the second AIDS report from the Advisory Council on the Misuse of Drugs, deals with the care of drug users with HIV disease — a term coined to cover anyone infected with the virus.

Announcing the report, the Advisory Council stressed the need for planning. Ruth Runciman chaired the working group behind the report. "We have the opportunity to plan for the care of drug misusers with HIV disease while the numbers are relatively low," she said.

David Turner, Director of the Standing Conference on Drug Abuse, also served on the working group. He points out that the interval of several years between HIV infection and becoming ill gives policy makers and services a breathing space to plan how to cope with HIV related illness. He believes learning how to recognise and respond to physical illness indicative of HIV disease is one skill drug services will need to develop.

Working group members do not

believe this stress on the physical entails a return to the 'medical model' of treating drug problems. But the consensus in the working group was that drug services will need to change dramatically to cater for HIV positive clients.

So far HIV training in the drugs field has been mainly one-off information sessions. Dave Turner argues these will not be enough to help workers cope with the emotional shock of dealing with clients likely to die while under their care. Training now, and planning for the further training and support that will be needed when the problem arises, must deal with attitudes and emotions as well as information.

Drug services will also need to develop links with the housing, welfare and medical services involved in caring for infected and ill people. Services may, for example, have given up on their local housing department in the face of unsympathetic attitudes to drug users. But these same departments might react more sympathetically to the physically

ill. Even so, the problems may be enormous. "Imagine", says Gerry Stimson, "arguing with a local council that a junkie with AIDS should go to the top of the housing list."

One simple fact is central to much of what the Advisory Council suggests. This is that a proportion of drug users *not known* to be infected with HIV will nevertheless be infected and infectious, and there is no way of telling who they are.

Summary of the Advisory Council's Report on pages 10-11

Dr Dermot Kennedy of the Infectious Diseases Unit at Ruchill Hospital in Glasgow explains that the first three months after infection are among the most contagious periods in the course of HIV disease. Yet the infection is often undetectable in these first months as antibodies are not yet sufficiently developed to register in the test.

Blanket compulsory testing is in

any event ethically unacceptable and probably practically impossible.

The Advisory Council concludes that services must treat everyone at risk of HIV infection as if they are infected, whether they are known to be or not. This is their main argument against a two-tier treatment system giving priority to drug users known to be infected.

Dr Kennedy reports that some of his patients have expressed disappointment at a negative HIV test. There is a real risk, he believes, that some will seek to become infected to jump queues and gain access to prescribed drugs denied non-infected patients.

But with drug services forced to ration treatment slots, the pressure to prioritise infected clients may be irresistible. The alternative is to deliberately leave people known to be infected on the waiting list along with the rest. Knowingly risking further infection and avoidable deterioration of the client's health in this way may be an unacceptable price to pay for preventing a two-tier response.

New media for the message

200,000 copies of a glossy drugs facts youth magazine distributed through record shops and health departments in Scotland and a beer mat advertising a telephone factline warning about some major drug-related risks — these are two of the products of government-funded regional anti-drugs campaigns underway in three English regional health authorities and in Scotland and Wales.

Each area has received £100,000 to set up locally geared mini-campaigns designed to add a second tier to the national campaign, which is the same across the UK.

The hallmark of the regional campaigns is their innovative range of media to carry anti-drugs or harm-reduction messages. These include TV, cinema, radio, the press, theatre groups touring schools, an 'alternative cabaret' performed in a pub, as well as the more familiar leaflets and posters.

English campaign planners in the South East Thames, Wessex and Trent RHAs have been helped by a consultant seconded

to the Department of Health from a commercial marketing and sales promotion company. For some of the materials she called upon the services of Yellowhammer, the advertising agency behind the latest national campaign.

The campaigns are being evaluated with a view to producing a handbook to guide future campaigns and campaigns elsewhere.

More details of the campaigns and how they were organised in the next issue of *Druglink*.

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HIV fails to galvanise clinics

Many drug dependence treatment centres have not moved to achieve the flexible and responsive service called for in the Advisory Council's first report on AIDS released over a year ago. Far from providing an easy access service attractive to drug users, waiting lists, motivation-testing assessments and reduction-only prescribing are still commonplace.

These are the impressions of drug workers in close day-to-day referral contact with clinics in London and elsewhere. Their statements have been confirmed by questionnaires returned to ISDD by 24 treatment centres throughout Britain.

The problem is not limited to the treatment centres. "In practice we haven't been able to persuade drug services that HIV is the top priority," admits Gerry Stimson, an Advisory Council member involved in both their AIDS reports. But the centres (or 'clinics') are a key resource because in many areas the back-up they provide limits what front-line services can achieve with their clients.

Instead of revamping their procedures, many centres now allow people known to be HIV infected to bypass the restrictions and waiting lists, flying in the face of advice that all clients should be treated as if they were infected. Yet addiction statistics for 1988 show that over 60 per cent of the opiate addicts notified by treatment centres were injecting, a proportion of whom must be infected with the virus whether known to be or not.

In some cases resources are inadequate to the task of cutting waiting lists while treating more patients on longer term prescriptions. One psychiatrist said

his clinic's three-week waiting list would rise to twelve weeks unless more consultant sessions were approved. He feared the service "will go under" due to increasing demands arising from HIV and AIDS.

Another clinic was now more prepared to prescribe long term but found the slots occupied by these patients increased waiting times for new referrals. Such limitations may be forcing clinics to ration resources in favour of those known to be HIV infected.

What Britain lacks, argues Gerry Stimson, is US-style central direction stipulating by what multiplier clinics should increase their caseloads and providing the money needed for this expansion.

The Advisory Council's first AIDS report was itself less than specific about the standards clinics should aim for: hours should be "flexible", waiting time and assessment barriers "minimised", there should be a "prescribing element" in each district service, it was "acceptable" for prescribing to aim at goals short of abstinence.

Clinics can easily convince themselves they are doing all this without getting anywhere near the rethink of service delivery required to transform them into the effective HIV prevention services desired by the council.

Neither did either of the council's reports explicitly revise the prescribing guidelines issued by the DHSS in 1984. These are now widely regarded as a disincentive to flexible prescribing, yet doctors have nothing to replace them as professional backing for taking more risks with their prescribing.

Several of the questionnaires returned to ISDD gave clear evidence of the 'in-principle'

resistance to change noted in the Advisory Council's second AIDS report. After welcoming the advances of "many" services, the council complained that "a number" had made "inadequate" changes, in some cases due to "deeply entrenched attitudes on management of drug misuse by withdrawal".

It was hardly surprising that one clinic was able to claim "almost nil" waiting times in its questionnaire return to ISDD. They "seldom feel prescribing appropriate but occasionally give methadone" and "try to reduce drugs in 10-14 days".

Dave Turner, director of the Standing Conference on Drug Abuse, gives another reason for the slow pace of change in some services. He explains that sudden wholesale changes might do more harm than good to the bulk of existing clients recruited under the previous philosophy.

Doctors in Scotland came in for a restrained tongue-lashing in the Advisory Council's first AIDS report. A year later Dr Kennedy of Glasgow's Infectious Diseases Unit can only say, "We are beginning to persuade them". From his disease-control perspective he is in no doubt that 'cure' is the form of the abstinence goal must give way to 'care' in the form of a willingness to prescribe to continuing users.

Dr Kennedy believes a new breed of public health doctors may be needed to take on this role. Just why can be seen in the response of the psychiatrist running the sole NHS clinic in a major Scottish town. His clinic prescribes diazepam only. Patients who supplement this from the illegal market are discharged after a single warning.

Barriers to treatment still there, say referral agencies

Release is the closest thing to a London-wide referral service for drug users. Its deputy director John Jolly says most of the capital's clinics "operate in a way that precludes drug users using their service". His comment that users are still made to "jump through hoops" to gain a reducing script of oral medication is echoed by London's drug specialist street agencies. Some clinics that have opened the doors have had to close them again, unable to cope with the influx of new patients.

The Community Drug Project is south London's major street agency. Its workers increasingly have to refer clients to private

doctors to sidestep waiting lists of 6-8 weeks or longer at NHS clinics, and to get the kind of longer term prescribing and injectables they believe some of their clients need.

One London project is uniquely placed to know how clinics are treating their patients. To protect their close working relationship with the clinics they prefer not to be named. But the project's head says, "We have seen little sign that any real attempt is being made to increase flexibility or make services more attractive to clients".

The project sent *Druglink* detailed information on seven London clinics and three outside London. To check its

representativeness ISDD sent a questionnaire to 36 treatment centres across Britain. Twenty-four replied of which just half could specify any changes to their basic intake procedures and prescribing regimes in response to the HIV epidemic.

There is little evidence that the rest have in practice made radical priority reversals in line with the need to draw in and keep clients to prevent further HIV spread. A few had made wholesale changes but most responded in terms of a greater "tendency" or "willingness" to prescribe longer term and more flexibly, and "attempts" to cut waiting times.

● A new UK drugs journal is being launched at the end of June by Mersey RHA's Drug Training and Information Centre. The *International Journal on Drug Policy* will replace the *Mersey Drugs Journal* which ceases publication in April. Its aims will be to stimulate cross-national debate about the reform of drug policy, including the legalisation option. More information on 051-709 3511.

● *Addiction Counselling World* will be Britain's first US-style magazine giving 'how to do it' guidance to professionals in addiction treatment featuring articles by 'successful' British practitioners. Its line will be that abstinence and ongoing support is the proper route to recovery but NA and AA's 'twelve steps' approach will not be presented as the only model. Initially it will be free to drug agency subscribers.

● The Advisory Council on the Misuse of Drugs has recommended that buprenorphine (Temgesic) be controlled in class C of the Misuse of Drugs Act under a schedule that would permit its continued medical use on prescription. The Home Office is consulting on the proposal which will be resisted by the manufacturers (Reckitt and Colman) who stand to lose money if their product's claim to be a 'non-addictive painkiller' suffers a further blow.

● Legislation closely modelled on the Drug Trafficking Offences Act now allows courts in England and Wales to seize the proceeds of major non-drugs crime such as robbery or fraud. The Criminal Justice Act 1988 which came into force this April is the latest example of legislative innovations piloted on the back of the emotive drugs issue being extended to other areas.

● In March the US Supreme Court ruled for the first time on the constitutional legitimacy of the government's mandatory drug testing programme. In a decision which could set a precedent for scores of others, it was held that testing an individual without any specific reason to believe they had taken drugs could in some circumstances be reasonable. The cases at issue involved testing train crews after an accident or safety violation, and testing customs officers before they carry guns, deal with classified material, or work on drugs interception.

● From March no authorities will be issued or renewed for commercial slimming clinics to possess or supply amphetamine-like 'slimming drugs' to their clients. The drugs concerned are diethylpropion (Apsiate, Tenuate Dospan), phentermine, and mazindol, which the *British National Formulary* says are "of no real value" in obesity treatment. Slimming clinic patients have approached some drug agencies for help after being supplied these drugs for years with apparently minimal medical supervision.

Home Office Curbs Supply of Controlled Drugs by Slimming Clinics. Home Office News Release, 30 March 1989.

● The Council of the Pharmaceutical Society has published guidelines to pharmacists following recent government encouragement to health and local authorities to set up syringe exchange schemes at pharmacies. The guidelines incorporate the advice issued two years ago. They encourage pharmacists to accept used syringes as well as supply new ones.

Pharmaceutical Journal, 11 February 1989.

● Two drops of naloxone applied to the eyes of opiate dependents cause an increase in pupil size which can be used as a practically 'instant' test of physical dependence, eliminating the need for a time-consuming series of urine tests. The drug opposes the effects of the opiates, creating withdrawal symptoms if ingested, but the eye test causes only minor and transitory discomfort.

Creighton F.J. and Ghodse A.H. Lancet, 8 April 1989, p. 748-750.

● Canadian addiction researchers are challenging the US picture of cocaine as 'instantly' addictive. A review co-authored by a leading academic at Toronto's respected Addiction Research Foundation estimates that 5-10 per cent of cocaine tryers become more frequent users and 10-25 per cent of these lose control and need treatment. The authors believe laboratory research showing animals will self-inject cocaine to the point of death are not applicable to normal human use.

The Journal (of the Addiction Research Foundation), 1 February 1989.

● An AIDS Social History Unit has been established at the London School of Hygiene and Tropical Medicine. Virginia Berridge, author of *Opium and the People*, is the unit's deputy director. It will look into the development and impact of UK AIDS policies as well as researching the historical context of the epidemic. More information on 01-636 8636.

Drug services could be forced to compete for care contracts

Those working with drug users are reeling under a volley of official reports which seem set to introduce quasi-commercial considerations into management and funding processes.

Nothing is certain, but what seems more than likely is that more voluntary and statutory projects will be required to contract specific services to the authorities in competition with each other and with the private sector. In the 1990s, business training in negotiating contracts and undercutting the competition may be essential elements in a drug project's staff programme.

The drugs field is affected by recent reports and government action in the health, social services, and criminal justice fields. These include the reorganisation of the NHS now underway, the Griffiths and Wagner reports on community and residential care, and the Home Office paper on non-custodial punishment.

Perhaps worst of all is the uncertainty. The NHS reorganisation is happening, yet the experts are still unable to predict what the impact will be on particular client groups.

The situation is even worse in respect to the Griffiths and Wagner reports. These are in limbo with a new cabinet committee reopening the whole subject of community care to fresh proposals. The problem is that both reports saw local authorities as the natural organising and funding agencies, but such a move would run counter to wider government policy. With this option cut off there is no clear alternative around which to coordinate the current hotchpotch of services.

Despite the uncertainties, a move towards an open market in care and medical services is a clear trend in the reports and in government policy. The key to unlocking the market is to create a division between the purchase of services and their delivery. In practice this will mean health and local authorities devolving their role as direct care providers to outside agencies.

In the market created by this division, the health and local authorities (and their agents, such as GPs and social workers, or even families) will be the purchasers of services, and a mix of statutory, private and voluntary

organisations will be the suppliers.

Supply of services will increasingly be on a contractual basis. Instead of, for instance, receiving a grant, drug agencies will contract to supply the specified services required by the purchaser for a set fee. In many cases it will be a buyers' market with voluntary projects, self-governing hospitals, NHS and social services units, and private companies all competing to win the contracts and the referrals that go with them.

At recent meetings organised by the Standing Conference on Drug Abuse (SCODA), voluntary drug projects expressed deep concern about how they and their clients will fare in the new order. Looming large were visions of private companies winning exclusive contracts by offering attractively packaged cut-price deals backed by a hard-nosed business approach alien to voluntary and statutory workers.

Where this happened other projects could be starved not just of money but also of referrals, or be forced to compete on the same terms to survive. The net result could be a narrowing of the options open to drug users as 'unsuccessful' projects lose out.

It was also feared that contracts could rob projects of the autonomy that permits the flexible and innovative responses for which the voluntary sector is valued. In the

contract the purchasing authority would usually have the upper hand in stipulating what services it wished to purchase for how many clients.

The pressure will be on to deliver the maximum in quantifiable results for the minimum outlay. For some critics of the voluntary drugs field this would be a welcome injection of accountability, but the dominant reaction in the field is anxiety.

Despite the gloom, the new 'contract culture' does open opportunities for voluntary projects to provide services previously performed 'in-house' by health and local authorities. It also opens opportunities for in-house drug services to become independent agents contracting to the health or local authority of which they were formerly a part (and also to other authorities). Some of these services would see the increased autonomy this could bring as more than adequate compensation for the need to raise revenue on business lines.

Responding to financial pressure some health and local authorities have already extended competitive tendering (mandatory for refuse, catering, building services, etc) to care services in advance of a definitive push from the government. In England, Age Concern for one has responded by establishing a unit to help its local branches negotiate care contracts with local authorities.

Concern over NHS reorganisation

With their medical tag as suffering from a 'chronic relapsing' condition with a high risk of expensive-to-treat infection, it's feared that implementation of the NHS review will leave GPs and hospitals even more reluctant to treat drug users.

This might happen because under the reforms some GPs will have a set budget for their practice and all will have 'indicative' prescribing budgets. Hospitals will be able to apply for self-governing status within the NHS selling services to health authorities at the going rate — the rate needed to provide adequate care for drug users may be more than they wish to pay.

But speaking to the Royal College of Nursing in April Kenneth Clarke, Secretary of State for Health, ridiculed suggestions that the chronically sick will lose out. "I cannot imagine that any self-governing hospital will ever want to

move out of the fastest growing areas of health care which are those for elderly and chronically sick people."

Concerns over the NHS review can at present be no more than speculation. Set against them is the likely continuance of earmarked central funding for drugs/AIDS services which could help make this 'business' a lucrative one for care providers to compete for. Also the government overseeing the reforms has a track record in funding and encouraging drug services that some see as inadequate but most will agree is far in advance of its predecessors.

But even if the drugs/AIDS corner is protected, increasingly drug agencies and their clients will be reliant on other housing, medical and welfare services to provide elements in the required package of care for drug users, especially those infected with HIV.

See opposite for summary of reports

RUNDOWN ON THE REPORTS

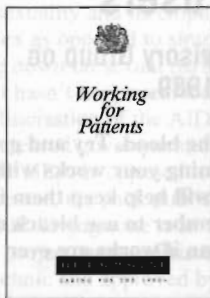
The reports

What they're about

Likely government action

Some implications for drug services

On the NHS. *Working for Patients.* HMSO, 1989 (Cm 555). A government white paper. £8.80. *National Health Service Review Working Papers.* Department of Health. HMSO, 1989.



Restructuring the NHS by creating a market in which the suppliers of health care (private or voluntary health services and NHS hospitals) compete to sell specified services to 'budget holders' (GPs and health authorities) responsible for providing health care. Associated proposals clear the way for competition by increasing the autonomy of the purchasers and suppliers of health care and ensuring their decisions are based on the costs incurred.

Government intends to implement these proposals: only the details are for discussion. By May 1989 it is intended that discussions will be concluded so the necessary legislation can be introduced. Implementation has begun and will continue through 1991. Already over 50 acute hospitals are participating in the process needed to cost their services so they can enter into contracts with GPs, health authorities and other hospitals.

Impossible to predict. Main concerns so far are around drug users' access to medical care. For example, GPs and self-governing hospitals may shy away from taking on drug users because of the budgetary implications. Who's budget will pay for drug users who do not have a GP and/or are self-referred or referred by a voluntary project? Much will depend on whether health authorities define drug problems into the 'core services' that must be provided locally. Contractual arrangements between particular health service providers and GPs/health authorities may limit the range of services open to drug users.

On community care — the Griffiths report. *Community Care: Agenda for Action.* Roy Griffiths. HMSO, 1988. £3.90.



Rationalising the hotchpotch provision of community care (including residential care). Aims to centralise responsibility in the hands of a new minister (who will develop a national plan and approve local plans) and local authority social services department (which will organise local services). Rather than directly providing care, social services would assess need and arrange individualised care packages by purchasing services from the voluntary and private as well as the statutory sectors.

Nobody knows. This report and the Wagner report (see below) will be responded to together. A cabinet committee has been set up to look afresh at the whole issue. Centralising community care in the hands of local authorities is contrary to broader government policy trends and is almost certain to be rejected. All other options are still open. But the idea of voluntary and private organisations contracting care services to whoever holds the purse strings is likely to survive and is already happening in some areas.

A major concern is that coherent reorganisation may not happen. Opportunities to insert community care for drug users into national and local plans may be lost along with the chance to set standards for this care. Indicators of local needs may not be sensitive enough to pick up drug users. Voluntary organisations may have to compete with statutory and private services for care contracts. The outcome has the potential to greatly affect the type of service available locally. Projects may have to prune their services and accept loss of autonomy.

On residential care — the Wagner report. *Residential Care: A Positive Choice.* Report of the Independent Review of Residential Care. HMSO, 1988. £6.50.

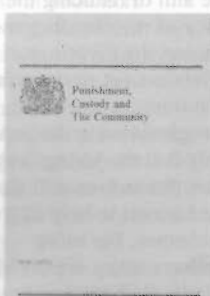


Concentrates on the residential side of community care. Emphasises such care cannot be a 'positive choice' unless the non-residential alternatives are adequate. As in the Griffiths report (see above), the local authority would organise and purchase individualised packages of care on a market including private and voluntary provision. Social workers would be delegated budgets to purchase care for their clients. Most of the report is about the standards that residential care should meet and how these could be set and maintained.

Government will respond to this report along with the Griffiths report. See above for likely general response. The idea of budget holders (whether the social worker, the family, the potential resident, or some new agency) purchasing residential care on a contractual basis from a 'mixed economy' of statutory, private and voluntary provision parallels the NHS review proposals for health care and is likely to be retained.

See above for general implications applicable also to residential care. Added concern is that if non-residential care is not rationalised then residential care will not become a 'positive choice' but the only option in the face of inadequate home-support services. The need for home-based care for HIV positive drug users increases this concern. Wagner's insistence on residents retaining their rights as citizens may conflict with therapeutic practices in some drug rehabs such as restricting access to friends and families, opening mail, etc.

On alternatives to imprisonment. *Punishment, Custody and the Community.* Home Office. HMSO, 1988 (Cm 424). A government green paper.



Aims to reduce courts' recourse to imprisonment by introducing forms of punishment which leave less serious offenders in the community. Some of these already exist (probation, community service, compensation orders), others would need legislative or other action. These include house curfews, electronic tagging, day centres, etc. A new supervision and restriction order may allow courts to sentence offenders to a package of community-based punishment plus rehabilitative programmes.

Consultations on this paper ended 31 January. Steps have already been taken to increase use of existing alternatives to imprisonment. The new proposals are likely to be implemented in some form but the decision over whether to use them will probably still be left up to judges and magistrates, so their practical impact may not be great. Reluctance of the probation service to supervise more restrictive sentences may impede implementation.

Minor drug offenders will be prime candidates for punishment in the community with associated treatment/rehabilitation conditions. If taken up by the courts there could be an increase in court referrals to both residential and non-residential services. Main issue is whether these agencies will be prepared to accept more 'involuntary' referrals. Some risks are that agencies will be seen by clients as part of the punishment system and that agencies will be drawn into 'treating' drug users whose only problem is legal. For more see page 13.

See opposite for commentary

Syringe hygiene controversy now resolved

The Expert Advisory Group on AIDS has finalised its advice on syringe hygiene for drug users. Drug users and those advising them now appear to have a sound and realistic basis on which to develop procedures to minimise the risk of HIV infection if syringes are shared, though not to share is still the priority message.

As anticipated in the last issue of *Druglink*, the note recommends flushing with washing-up liquid or with bleach. The boiling method originally recommended is relegated to footnote status as an ideal but often impractical option that damages many syringes. If boiling works for you, continue with it, is the message, but there is now little encouragement for users to shift to the method.

Parts of the note on points to cover in advice to drug users are reprinted opposite. A separate section on points to cover with drug workers repeats and in places amplifies the advice. It says that washing-up liquid "removes some of the blood in syringes and may have some viricidal effect".

About the bleach method, the advice for drug workers adds that it too will remove some of the blood "and has a viricidal effect". Workers are advised to caution drug users that bleach does not completely sterilise works and should never be reused.

Bleach also loses strength over time and on exposure to heat or light, so, says the note, drug users should be warned against carrying small quantities which may no longer be effective.

This last comment appears aimed at the US-style bleach 'n' teach schemes being introduced into parts of Britain. Although the Public Health Laboratory Service were involved in drawing up the note, experts there say undiluted bleach will last three months without

significant loss of its power to kill HIV. This should not seriously impede the success of schemes based on 'pocket packs' of small bottles of bleach and water.

The full note headed *Cleaning Injecting Equipment* is available

from Trudy Saunders at the Department of Health on 01-407 5522, extension 6035. The updated advice is being incorporated into a new edition of the leaflet, *AIDS: How Drug Users Can Avoid It* published by the Standing Conference on Drug Abuse.

Points to cover in advice to drug users

Excerpts from a note agreed by representatives of the Expert Advisory Group on AIDS and disseminated by the Department of Health, February 1989.

● If you find yourself in a situation where you feel you have got no choice but to share ... use one of these methods of cleaning:

EITHER

Put a generous squirt of washing-up liquid into a cup and add cold water. Draw the liquid right up the needle and into the syringe. Flush it all away (not back into the cup) then draw some more liquid in and flush that away. Then flush the works through with cold water two or three times.

OR

Draw concentrated bleach (like Domestos) from a cup or other container up the needle and into the syringe, and then flush it away (not back into the bleach container). Do this again, and then flush the works through with cold water two or three times.

AT THE VERY LEAST

If you have not got washing-up liquid or bleach handy, then at least flush the works through with cold water three or four times.

● Always try to clean works as soon as possible after they've been used. This makes

it much easier to remove the blood. Try and get in the habit of always cleaning your works with cold water after use. This will help keep them in better condition. But remember to use bleach or washing-up liquid if you can if works are ever shared.

● Boiling is the best and safest method of cleaning, but some syringes collapse when they are boiled, and often you won't be in a position where you can boil works anyway. But if you already boil your works, carry on using this method. The whole works should be taken apart, placed in a pan of boiling water and boiled for five minutes. Boiling for five minutes gives you the best protection from HIV infection. But these makes of syringe have been found to buckle if left in boiling water for five minutes, so don't boil them:

| COMPANY | SYRINGE TRADEMARK/SIZE |
|---------------|-------------------------------|
| Sabre | Sabre (or Gillette) all sizes |
| Sherwood | Monoject 1ml syringe |
| S & N Everett | 10ml |

No tests have been conducted on insulin syringes and until more information is available, they should not be boiled.

Police back referral scheme for drug users' families



One of the referral cards police in two London boroughs are handing to parents of young people found with illegal drugs.

Police forces and independent drugs advice agencies are working together in Merseyside, Barnstaple and London to provide help for parents whose young son or daughter is found in possession of illegal drugs. In these pilot schemes parents called to the police station to be present during cautioning/charging are being given a referral card with the address and phone number of a local drugs advice agency where they can get confidential advice.

These new family referral schemes build upon existing experience in Merseyside, parts of London and elsewhere. In these areas schemes have been set up to refer drug users to advice agencies after being cautioned or charged for minor possession offences.

Now this kind of help is being

extended to young drug users' parents. ISDD is monitoring the pilot schemes with a view to encouraging nationwide adoption of the idea. Nicholas Dorn heads the research team. He explains that "Parents are understandably deeply upset to hear that their son or daughter has been found with illegal drugs."

"It may be the first suggestion of illegal drug use in the family, and also the first involvement with the police. A range of feelings, including shock, shame, anger, and confusion can follow, and the parents will often not know what to do next. This situation is not good for the parents, the child, or the family as a whole."

Police are obliged to call parents to the police station while children under 17 are being cautioned or

charged. Often the parents of older children also become involved. Parents may also be contacted by police if their son or daughter is informally warned for a drugs offence.

The net result is that the problem of what to do next often lands up in the parents' lap. The schemes give them access to support and advice to help them cope better, with the ultimate aim of reducing the frequency of re-offending and encouraging the diversion of young drug offenders out of the criminal justice system.

Although aimed at the parents it's likely that the young drug offenders themselves will also gain increased access to help as a result of the schemes. For more information contact Karim Murji at ISDD on 01-242 1878.

HEA sidesteps veto on AIDS pack

By not publishing it directly, the Health Education Authority has sidestepped Department of Health interference with the important new *Learning About AIDS* training pack (reviewed on page 15).

Those involved in its production believe the government would almost certainly have forced changes in the pack's non-moralistic treatment of homosexuality and its emphasis on safer sex as opposed to simply cutting down on sexual partners.

That hasn't happened. Despite the politicisation of the AIDS issue and increased government control over the HEA as opposed to its predecessor, the pack published by Churchill Livingstone is as written by the project team at Bristol Polytechnic and approved by the project's advisory group, including representatives from SCODA and the Terrence Higgins Trust.

An HEA spokesman said the authority "thoroughly endorsed" the materials and was prepared to stake its professional reputation on their accuracy and approach to AIDS training.

The wrangle over publication meant that although approved by the HEA in June 1988 the materials were not published until March 1989. This delay might have stretched into years had the government attempted to veto the text.

Although the HEA was forced to pull out of publishing the materials, it has been able to fund their

publication and dissemination. Peter Aggleton and his co-workers at Bristol Polytechnic (the pack's authors) have been contracted by the HEA to run workshops across the country to train trainers in the use of the materials. The workshops will draw in trainers from the statutory and the voluntary sectors.

Intervention by the Department of Health led the project's major funders to withdraw from publication. Though both fully endorse the final product, neither AVERT's nor the HEA's logos appear on the pack. AVERT (AIDS Education and Research Trust) put £80,000 into the development of the materials while £50,000 from the HEA underwrote their publication by Churchill Livingstone.

The project was initiated in 1986 when the Health Education Council approached AVERT to fund the development of AIDS training materials which the HEC would publish and disseminate. Just weeks after agreement was reached, the HEC was abolished and reconstituted as the HEA, an integral part of the NHS now directly accountable to the Secretary of State for Health.

The reorganisation meant that the HEA/AVERT partnership was put on ice but AVERT went ahead to fund the project's development, including interim materials published in 1987.

Early in 1988 the HEA agreed to

publish the final materials jointly with AVERT, subject to HEA approval of the text. In June this approval was given in a letter which said the HEA's vice-chairman was "impressed by the quality of the materials".

Days later the trouble began when AVERT learned that the Department of Health had asked to see the materials. In the HEA's words, the department required to "have the opportunity to comment on AIDS materials produced by this authority prior to publication".

Later the department explained it was "responsible for ensuring that material produced as part of the [AIDS and HIV] campaign is consistent with the latest medical and scientific knowledge about AIDS". Neither the HEA nor AVERT were under any illusion that pre-publication scrutiny would mean significant changes being imposed by the government, and not for strictly scientific reasons.

As a result the HEA, AVERT, and the project's advisory group unanimously refused to allow departmental scrutiny.

In July the department responded by ordering the HEA not to publish. To get the materials out, the authority was forced to seek an alternative publisher. Paying Churchill Livingstone to do the job meant the HEA could sidestep government control over the HEA's own publications.

Other convoluted arrangements ensured the HEA could put public

money into the materials' publication and support their dissemination. Over a year ago the HEA put itself into a contractual relationship with AVERT and the authors which would have laid the HEA (and ultimately the Department of Health) open to being sued if it failed to fund and promote the materials as agreed. The result is that the HEA is now able to put its full weight behind getting the pack into use.

HEA and AVERT hope *Learning About AIDS*'s troubled history will not affect its uptake. The major question mark appears to be the important issue of updating the materials in a fast-moving field.

So concerned were AVERT over this and other aspects of the proposed arrangements with Churchill Livingstone that in November 1988 they gave up all copyright claim to the materials and withdrew from the project.

Had they been in control AVERT would have wanted updates sent out with the materials as new information became available. As a commercial publication that now seems unlikely to happen.

Instead it's likely that new editions will be marketed superseding the first edition, depending on how well initial sales go. At the moment the HEA says *Learning about AIDS* is selling "like hot cakes" and heading fast to a reprint.

New form 'caused upturn in addiction statistics'

The 13 per cent increase in newly notified opiate addicts in 1988 has brought an abrupt end to the unprecedented drops of the previous two years. Every relevant statistic in the figures released on 11 April has resumed the upward trend of the last two decades.¹ But more than ever the statistics defy interpretation.

Peter Spurgeon, Chief Inspector of the Home Office Drugs Branch, does not believe the 18 per cent rise in all addicts notified during the year is due to a corresponding increase in addiction.

The main cause, he says, is that doctors are notifying more of the addicts they see. A new notification form was promulgated by the Home Office's Chief Medical Officer (CMO) in September 1987 with copies sent to every doctor in the country.

Added to this publicity is the fact that doctors can now see the

relevance of notification to local AIDS prevention efforts. The form has a new question about whether patients have injected and is coded for each district health authority, permitting local feedback of the data.

Before the new form, notifications were running at about 1000 a month, a figure that jumped 30 per cent to 1300 a month after its introduction.

Between 1987 and 1988 notifications received during the year from GPs rose 25 per cent, presumably partly as a result of the jolt to their memory given by the CMO's communication. In contrast notifications from treatment centres, which can be expected to have been more aware of the need to notify, rose by just 15 per cent.

This comparison is based on the new statistic of all addicts notified during the year (see first line of table), which now includes re-

notifications of addicts in treatment at the start of the year as well as new and former addicts.

What it excludes is addicts thought to be in treatment at the beginning of the year but not notified in the next twelve months. Some of these will simply have been left on the index because doctors do not have to 'de-notify' patients.

This new figure confirms that, in terms of numbers, GPs are the

most important opiate addiction treatment resource in Britain, notifying 60 per cent more addicts than the hospital centres.

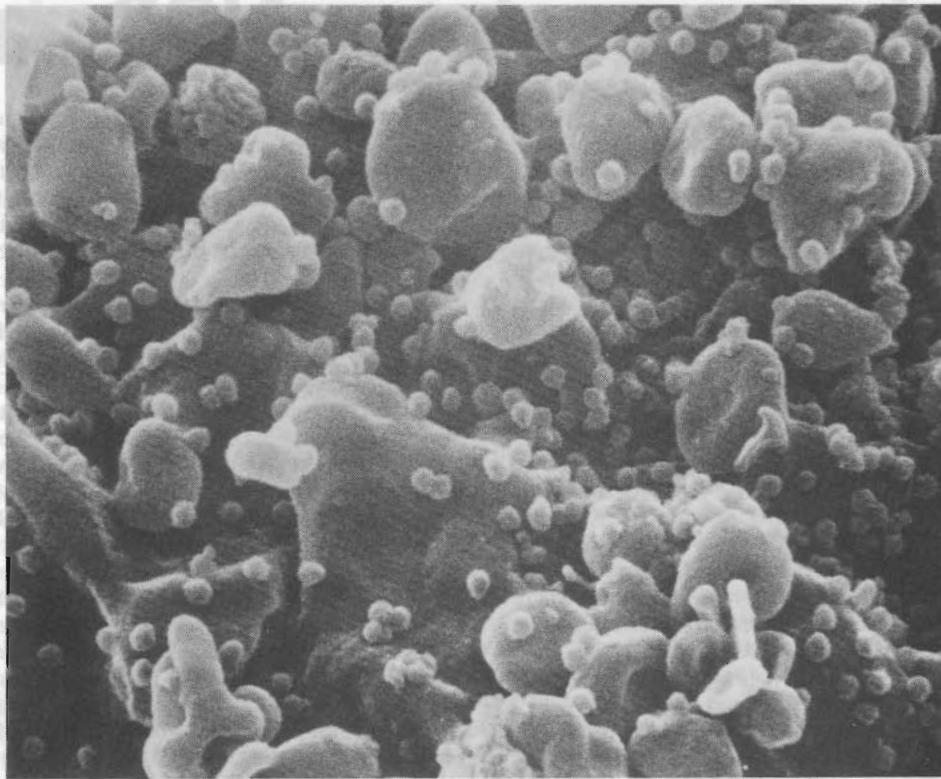
Of those addicts for which the information was given, over two-thirds were said by the doctor to be injecting, a total of 6763 people. This is the first year such information has been collected.

1. Statistics of drug addicts notified to the Home Office, United Kingdom, 1988. Home Office Statistical Bulletin, 11 April 1989.

| | 1988 | 1987 |
|--------------------------------------|-------|-------|
| Addicts notified during the year | 12644 | 10716 |
| Of which: | | |
| - in treatment at 1 Jan ¹ | 3854 | 3023 |
| - newly notified | 5212 | 4593 |
| - formerly notified | 3578 | 3100 |
| Addicts notified by: | | |
| - GPs | 7066 | 5668 |
| - hospitals/treatment centres | 4267 | 3710 |
| - prison medical officers | 1311 | 1338 |

1. And being prescribed notifiable drugs (opiates or cocaine).

The physical reality that's creating a social revolution in drug treatment. At x40000 magnification, myriads of small spherical HIV particles can be seen budding from an infected T-lymphocyte immune cell.



National Biological Standards Board

COPING WITH AIDS

A summary of a report from the Advisory Council on the Misuse of Drugs

IN ITS FIRST report on AIDS and drug misuse the Advisory Council dealt with preventing HIV spread. *AIDS and Drug Misuse Part 2* is about what to do when prevention has failed and services are faced with HIV infected drug users.

At least in theory the first report broke the mould of drug services in Britain by promoting the prevention of a physical disease (AIDS) to top priority, overriding traditional preoccupations with overcoming drug problems and achieving abstinence. Inevitably *AIDS and Drug Misuse Part 2* is a less revolutionary document. But it is also more workmanlike, giving detailed and practical guidance to the range of services likely to be dealing with the expected (in some places, existing) wave of HIV infected drug misusers.

It first points out that drug misusers are the fastest-growing group of people with AIDS in Britain, with as many as 1000 cases expected in England and Wales by the end of 1992 and around 500 new cases in Scotland between 1989 and 1991. Nowhere is excused — all parts of the country must, they say, prepare to cope with increased numbers of ill drug misusers.

The impact of having to deal with HIV

Mike Ashton is the editor of Druglink. AIDS and Drug Misuse Part 2 by the Advisory Council on the Misuse of Drugs (HMSO, 1989) is available from ISDD at £6.70 inc. p&p. Pre-paid orders only, cheques payable to ISDD.

***AIDS and Drug Misuse Part 2* completes the Advisory Council's review of how HIV is transforming the response to drug misuse in Britain. It is essential reading for anyone who is or might be working with HIV infected drug users. It gives an urgent prod to the planners and funders of those services. Some of the main points are summarised here, the full report is available from ISDD.**

Mike Ashton

affected drug users will be felt by services in the AIDS field and by services in the drugs field. These and other services must attract HIV positive misusers early to prevent further HIV spread and to help retard the progress of the disease. They must also be prepared to deal with infected misusers who continue to use drugs and even continue to inject.

Testing and confidentiality

An extended discussion of the pros and cons for drug misusers of being tested for HIV concludes that increased understanding of HIV disease and the availability of treatments may be shifting the balance of advantage towards testing. In any event the council stresses that:

- the person concerned should make the decision; no one else should make it for or require it from him or her;
- no one should make a decision without appropriate information, advice and counselling from someone with the necessary counselling skills and up-to-date knowledge of HIV;
- the decision whether or not to have an HIV antibody test will be determined by individual circumstances.

Confidentiality over HIV status has become a major issue for drug agencies. Complications arise as agencies find themselves increasingly working with medical and welfare services needed to respond to the needs of ill people, but which may have different ideas of what confidentiality means and of its importance.

The council stipulate that the rule that an infected person's serostatus should not be revealed without their informed consent should only be broken in one situation. That's when a specific named contact is at risk of catching the disease and could protect themselves if they knew the client was infected.

Services helping infected drug users are often starting from a lower base than with other infected groups. Under-use of medical and welfare services, social and financial deprivation, poor health, insecure accommodation and estrangement from friends and families, all can put drug misusers at a disadvantage.

Clearly, HIV positive people need regular medical attention. With drug misusers the need could be all the greater as lifestyle, drug use, self-

neglect and other infections transmitted through injecting take their toll on physical health. A regular six-monthly check up by a doctor experienced in HIV is recommended.

Misusers should be counselled against activities which could accelerate progression to AIDS. Those listed are injecting, especially using unsterile equipment and contaminated drugs, exposure to sexually transmitted disease, and re-exposure to HIV by whatever route.

Advice, support and counselling should all be available to infected people, but the council give a blunt reminder that these cannot compensate for cold, hunger and discomfort. For infected drug users adequate housing is both a medical need and, if it takes them out of their drug using environment, an aid to stopping drug use, which could itself benefit health. Local authorities and housing associations should prepare to meet this need, but the council is forced to recognise that in some areas the problems are at present "insurmountable".

'The service offered by specialist drug services is radically altered by the advent of HIV disease'

Heart-rending dilemmas can arise for infected women. Those who planned to have children may be depressed to find this possibility cut off. Others may react with an intensified need for children but will have to face the 25-40 per cent chance that their child will be born infected, with all the practical problems and guilt this can bring. To give these women the support and advice they need, it is even more urgent that services "consciously" seek to attract women and remove barriers (such as child-care problems, fears over children being removed, etc) to their attendance.

HIV infection increases the need to gain access to primary health care through a GP. But many misusers are not in contact with a GP and many GPs are unwilling to take on drug users. The Advisory Council saw the problem as being urgent enough to require the establishment of a working party to look into increasing the involvement of GPs, including offering them money to take on drug misuse treatment.

The role of specialist services

The council's earlier report argued for a re-ordering of priorities away from 'curing' dependence towards preventing HIV spread. Nearly a year later their second AIDS report notes that "a number of [drug] services appear to have made inadequate changes ... some staff ... have deeply entrenched attitudes on management of drug misuse by withdrawal".

As infected drug users become ill, more will approach drug services as a 'friendly' access point for obtaining information and help. Many of these will have no intention of stopping drug use. Rigidity of attitude making abstinence the only goal will, says the council, greatly restrict the help drug services can offer these people.

Making HIV infection a reason for giving priority to treating that individual's drug problem implicitly decreases the priority given to people not known to be HIV positive. In prevention terms this is a mistake, says the council. Priority should be given to clients at high risk of transmitting or contracting HIV, regardless of their known HIV status.

As an "absolute minimum" specialist drug

services should provide advice and information on HIV disease including the transmission of the virus and general health care once infected. Services unable to go beyond this should arrange for other agencies to provide more intensive support for HIV infected clients.

The council is firm that residential drug services should not exclude people known to be HIV infected nor require testing. For the purposes of infection control policies, all residents should be assumed HIV positive. An implication drawn is that stress and ill-health, which may aggravate HIV disease, should be minimised regardless of the resident's known HIV status. No-holds-barred encounter groups and confrontational therapies in some therapeutic communities are among the targets of the council's remarks on stress.

Most existing residential rehabilitation units for drug users are not equipped to meet the requirements of a nursing home for people who are seriously ill or dying. Hence the council's call for at least two specialist houses for drug users or ex-users to go to when they become ill, one drug-free, the other for residents receiving prescribed drugs.

The council's line that prescribing substitute drugs to drug dependent people should not be restricted to those seropositive follows from their insistence that all those at risk must be presumed infected, and from their stress on the need to prevent new cases of infection. Such prescribing should, they repeat, always be aimed at encouraging change to more healthy or less risky behaviour.

If prescribing drugs other than oral methadone (such as injectables or stimulants) could achieve

these ends, then, says the council, it might be justified. But, other than in exceptional circumstances, they doubt if such prescribing would have net benefits.

To cope with the new demands of dealing with large numbers of ill and infectious people, additional earmarked and continuing resources are needed for drug services. Government responded to this call from the council even before their report was published (see last issue of *Druglink*) but the report gives no clue about how much money they were looking for.

Staff in hospitals and HIV counselling clinics will need training in working with drug misusers and to develop two-way referral routes with drug services. In this respect the council sees a clear educational role for specialist drug services, who in turn will need training in HIV and related nursing and medical issues. Close liaison in training and referral and sessional swapping of staff is envisaged.

Avoiding imprisonment

The report makes a bid to marry up the criminal justice and treatment systems in the interests of public health, swimming with the tide of the 1988 Home Office green paper, *Punishment, Custody and the Community*. The council say HIV makes it more important than ever that police refer drug misusers they contact to local drug services and that the courts use treatment alternatives to imprisonment.

In making these proposals the council is aware that many drug agencies will not want to take on clients forced into treatment by the courts. Non-residential services in particular are unused to this role. They will have to get used to it, is the council's message. Extra resources will be needed for which, says the council, the Home Office is the obvious source.

'Working with people with HIV disease requires a high level of commitment in the face of great intensity, stress and sadness'

All else failing, drug misusers infected with HIV, whether known to be or not, will end up in prison or become infected there by sharing scarce injecting equipment. Several pages in the report are devoted to a detailed criticism of the isolation of known HIV positive prisoners under viral infectivity restrictions. The denial of work and recreation opportunities this entails is argued to be counterproductive in health terms and unnecessary for the prevention of HIV spreading to other prisoners.

Here as elsewhere the most telling point is that separate treatment of known HIV infected people ignores the probability that many more will be infected, unknown even to themselves. Singling out people known to be HIV positive may give the dangerously reassuring impression that everyone else is free from the virus.

In its last chapter the council's report outlines a formidable array of training needs—formidable not just in terms of updating knowledge in a fast-moving field, but also in terms of equipping workers with the attitudes and emotional resources needed to help people infected with an incurable and usually fatal disease. Workers' attitudes, knowledge, skills and support structures all need to be systematically developed if inappropriate responses and premature burn-out are to be avoided. ■

Planning failures

What AIDS and Drug Misuse Part 2 has to say about planning for the HIV epidemic to come makes depressing reading. Most of Britain is in the fortunate position of AIDS not yet being endemic, but the Advisory Council found little evidence that this interlude is being used to plan for the epidemic to come. They stress that advance planning and adequate funding are needed if services are not to be caught unprepared.

Planners are warned that complacency and denial now will result later in panic measures when the need becomes impossible to ignore. But baseline information on how big the problem is or is likely to become is lacking in most areas, and frequently local AIDS and drugs committees work in isolation from each other.

Among the council's recommendations on planning are the appointment of someone in the health authority and in social services to ensure that the health and community care needs of HIV infected people are met. Continuity of care is stressed and the report suggests a particular worker take on the role of case manager for each client. They would be responsible for seeing that the client's needs are met at each stage of the disease. For drug misusers the case manager might be a member of a community drug team.

A view from America

CRIME AND COMPULSORY TREATMENT

Druglink: We recently had the mayor of Washington on our television screens very worried about a rapid increase in murders in Washington due almost exclusively to underground battles between groups of drug suppliers. Is that really happening?

Bruce Johnson: It's actually happening. Strangely enough, very few crimes committed by drug abusers are the ones people are afraid of. That is, being robbed and then assaulted. 'Innocent' people do not get killed during robberies by heroin or drug abusers.

By far the most important and growing area of violence happens *within* the drug business and drug trade. Probably most homicides connected to drugs now involve a supplier who gives drugs 'on loan' to people who are supposed to sell the drugs and return money to him. Those sellers do not return the right amount of money or otherwise violate some other rule and are 'offed', as they say on the streets, for failure to repay their loans. With the rise in crack distribution there now also seems to be a rise in inter-group battles between drug selling organisations and drug selling groups. Although we do not have much scientific evidence for that, we do have many good police and journalistic reports.

Druglink: Your research into drug use in the early '80s showed there was a vast amount of 'business' going on at street level. Has it changed since then?

Bruce Johnson: For heroin, it's very much the same. There is primarily a freelance relationship between heroin suppliers, users/sellers, and their customers. Each person gets a supply for that day and returns the money to their supplier, but that association may not carry over to the next day.

Interviewed recently for Druglink, one of America's most respected authorities on the workings of the drug market says the division between treating drug dependence and punishing drug offences has to end. In Britain too (see box) the trend is towards treating rather than jailing the drug misusing offender.

Bruce Johnson

With the rise of crack we have seen the development of crack dealing organisations dominated by persons who may take cocaine frequently but are not addicted. Suppliers put large quantities of cocaine and crack on the streets and have developed very systematic recruitment of people who they then tend to keep on as sellers. Crack dealing groups are now well armed and more worried about their competitors — other crack selling organisations like themselves — than they are about the police.

Cocaine selling organisations are now well armed and more worried about their competitors than about the police

Druglink: In the United States at the moment there seems to be great interest in compulsory treatment. Can you say something about why that's emerged and what your views are on it?

Bruce Johnson: This interest is a direct outgrowth of much of the research into the addict's life on the streets and into their progress in treatment and correctional criminal justice settings. A key finding has been the high crime rates and how much economic harm addicts are doing while on the streets, especially in the form of drug selling and distribution. Another major finding is that people tend to reduce their criminality substantially while in treatment but not necessarily after release from prison or after treatment.

Compulsory treatment is probably the most effective way to control the largest number of criminally active heroin users. The jail and prison systems are overloaded with incarcerated

addicts and there's thousands more to go. In 1980 there were roughly half a million people in US jails and prisons. By 1986 that figure had reached three-quarters of a million.

Druglink: How many of those are drug users?

Bruce Johnson: In 1980, 20 per cent or less were heroin or cocaine abusers. Now it is probably running, in the United States as a whole, at just under 50 per cent. In New York, Miami, Los Angeles, Chicago, Detroit, Washington D.C. and several other large cities, 75-80 per cent of those incarcerated are there for drug selling or because of drug-related crimes such as robbery, burglary or shoplifting. Given current trends and policies, by the year 2000 those incarcerated on drug charges alone could easily reach 50 per cent of all US prisoners.

In New York it now costs \$25,000 a year to keep an average offender in prison. I have made projections that the cost will rise to \$50,000 a year by the year 2000. Each new cell we need to build will cost about \$75,000. It's a very expensive proposition. If society were at all cost-conscious, it would realise that for the same amount of money you could place five to ten street heroin abusers in treatment — people who would have received a prison sentence, except for the fact that there are not enough cells for them. If they could be placed under some kind of mandatory non-custodial supervision, it would have an important impact in reducing their criminality — not to zero, but to much lower levels. This could be achieved through a combination of careful controls over their behaviour and keeping them in treatment during their supervision.

Druglink: Are you advocating compulsory treatment?

Bruce Johnson: These are ideas that I and colleagues of mine in New York are trying to promote but, for the most part, the criminal justice system is responding in the usual way. They admit there is a serious problem with heroin and cocaine users but don't know what to do about it, so they tend to ignore it.

Recently in New York City there has been some movement. Jails there are now willing to provide not just methadone detoxification but also to begin heroin addicts on methadone maintenance treatment. On release they are referred into maintenance programmes in the community.

Druglink: Are you saying that you have methadone maintenance in prison?

Bruce Johnson: Yes, but so far only in New York City. This is a new programme that began about a year ago and our office is beginning an evaluation funded by the National Institute on Drug Abuse.

Druglink: Would your research lead you to be in favour of compulsory treatment in the community as well as treatment in prison?

Bruce Johnson: Yes. The current division between criminal justice and voluntary drug treatment doesn't work well. We need to work toward developing a new approach to community supervision that combines something like probation with something like treatment, but in new and ingenious ways. We have got to spend a lot of money and effort in the future trying to figure out how to make it work. That's going to necessitate careful thinking, collaboration between magistrates or judges, probation depart-

Bruce Johnson of Narcotic and Drug Research Inc was the principal author of Taking Care of Business (Lexington, 1985), a report of a US government funded research project into the economics of crime by heroin abusers. A co-author of the book was the late Edward Preble, extracts from whose 1969 paper "Taking Care of Business" were reprinted in Druglink July/August 1988.

ments, treatment officials and community/voluntary drug treatment programmes.

Druglink: What sort of response are you getting from probation officers and drug treatment workers to these ideas?

Bruce Johnson: The ideas are going over better in the prison system at this point than in the probation field. Two of my colleagues in New York are developing a model for a modified therapeutic community in the wards of state prisons. Roughly a year before an offender is to be released or placed on parole, they enter a therapeutic community in such a prison setting. They become involved in a whole new set of expectations, learning how to stand on their own, how to confront life and to prepare themselves for entry into an outside therapeutic community while on parole.

A condition of their parole is frequently that they are to be enrolled in drug treatment after prison. If they violate conditions of parole, then they have to be brought back. It's not clear yet how it's going to work out with people who abscond while in treatment in the community, whether they are going to be returned to prison.

Druglink: What about drug treatment providers, how do they respond to the idea?

Bruce Johnson: Most voluntary programmes believe strongly in the voluntary nature of treatment and that people cannot become absti-

nent or even become appropriate treatment clients unless they really come in with a desire to get better.

But voluntary admission doesn't work very well with clients who are criminally active and not motivated to get 'better'. These are precisely the clients researchers have shown are most likely to drop out, relapse to heroin addiction and return to criminality. The voluntary sector is not very eager to have these kinds of clients so the debate continues about whether they will even accept such court-mandated clients. Many won't, but a few have taken some cases. As almost everywhere, such services are seriously underfunded in relation to the kind of people they have.

Druglink: How do you make sure that treatment options are used as an alternative to prison?

Bruce Johnson: There seems to be one very clear solution to that problem. The easiest, simplest and cheapest solution is to stop expanding the number of prison cells. If prisons don't have any place to put people, they have to make decisions as to who is serious enough to justify those cells.

Druglink: What have been the main lessons that we might learn from the last 20 odd years of drugs/crime research in the States?

Bruce Johnson: The first lesson is how intractable the problem is, how easily drugs can spread and continue in society, and how difficult it is to

interrupt patterns of criminality. I think we must learn much more about how the illegal drug market works. This involves ethnographic research, talking to people who are dealing in drugs, understanding how they do their business and what shape the illicit drug market takes, in order to understand how better to intervene.

The thing that the United Kingdom is doing best is its response to the AIDS crisis. The framework set by the Rolleston Committee in 1926 was that of a public health approach to the drug problem. It has, under various guises, continued down to the current time. This gives you the flexibility to address the AIDS problems without strong moralistic overtones.

Without question, the best example of the power of that flexibility is your response to AIDS. I am just amazed, from an American perspective, to read the reports on AIDS published here since 1985. Your health ministry made a good decision in asking that a systematic evaluation be done of syringe exchange schemes. Very broad outlines were given. Programmes were opened in sites across the country. Within a bare two years those evaluation findings have led to major policy shifts which support syringe exchange schemes. The United Kingdom is miles ahead of the United States in trying to answer these difficult AIDS questions, because the UK's primary response reflects a reliance on public health measures. ■

US experience with compulsion. UK scheme could involve drug agencies

In January 1987 the US National Institute on Drug Abuse (NIDA) sponsored a meeting of researchers to review experience with civil commitment and other forms of compulsory treatment. The aim was to see if compulsory treatment could reduce the spread of HIV.

Presented to the meeting were the results of 25 years of experience with civil commitment in 25 US states, under which addicts, even if not convicted of an offence, may be referred to a period of compulsory treatment in state or federal institutions.

Eighteen states have also enacted Treatment Alternatives to Street Crime (TASC) programmes. TASC identifies potential drug or alcohol treatment clients among accused or convicted non-violent offenders. The aim is to arrange their referral to community-based treatment as an alternative to further criminal proceedings. Failure to adhere to treatment or legal requirements results in the client being ejected back into the criminal justice system.

Based on experience with TASC and civil commitment, the researchers agreed that legal coercion could play a positive role by improving retention in treatment which increases the probability of a successful outcome. As NIDA's summary put it:

"The consensus suggests that, based on the research that indicates that treatment is effective in reducing intravenous drug abuse and that the length of time in treatment is positively related to treatment success, the criminal justice system is important for identification and retention of drug abusers in treatment." Prime targets for compulsory treatment were identified as chronic injecting drug abusers who had committed an offence

and showed the potential to benefit from treatment.

In Britain civil commitment in the form of compulsory detention of addicts during the withdrawal period was proposed by a government advisory committee in 1965 but rejected. There are no treatment facilities run by either national or local government specifically for convicted drug misusers and treatment in prison is practically non-existent, though some outside drug agencies do advise and support drug dependent prisoners.

Neither is there any formal national system for diverting addicts out of the criminal justice system and into treatment on the lines of the US TASC programme. However, a substantial proportion of referrals to residential rehabilitation programmes come via the criminal justice system and some new local initiatives (such as the Southwark arrest referral scheme) are attempting to provide treatment alternatives for arrested drug users.

Implementation of the Home Office consultative paper *Punishment, Custody and the Community* (HMSO, 1988) could dramatically alter this situation. It suggests a number of measures aimed at "reducing the use of imprisonment by introducing a form of punishment which leaves the offender in the community".

To this end, the Government proposes to introduce a new order giving courts the power to place a range of requirements on offenders who would otherwise be sent to jail. Among these are curfews, attendance at day centres, community service, and the controversial scheme enabling offenders to be electronically tagged.

Any of these and more may be applied to drug misusers, especially those who commit other non-drug offences such as burglary. But the

paper also has specific suggestions for the compulsory treatment of alcohol or drug misusers.

"The programme for the offender could also include regular attendance at work, education or training and treatment for misuse of alcohol or drugs ... Although more coordinated and intensified effort is being put into the care of drug misusers who go to prison, the chances of dealing effectively with a drug problem are much greater if the offender can remain in the community and undertakes to cooperate in a sensibly planned programme to help him or her come off drugs. Such a programme would aim, in the first instance, to secure a transition from illegal consumption to a medically supervised regime designed to reduce the harm caused to the individual by drugtaking and would be based on a realistic plan for tackling the addiction in the context of his or her other problems. Monitoring by urine tests by the agency providing the treatment could be part of the regime."

What the green paper doesn't address is how the agencies to receive court referrals can be persuaded to go along with the scheme. Most drug agencies believe voluntary referral is an important step on the road to recovery and are unhappy about accepting compulsory clients. The probation service too is against the green paper's proposals which put them more in the role of a supervisor than a carer. It may be that the extra treatment capacity needed to make wholesale diversion from custody possible can only come through services specially set up by the Home Office.

ISDD

BEING RESEARCHED

And how to make the most of it

I ONCE WORKED as a teacher in a centre for 'disruptive' adolescents. Working with them was physically and emotionally taxing, but the rewards were immense. However, when anyone from outside expressed a research interest in what we were doing, we immediately became suspicious. Who were these people? What were their motives? Would their questioning be insensitive? Would their interviews have a deleterious effect upon emotionally fragile clients? Could we trust them to respect confidentiality? How much extra work would their requirements impose on us?

Underlying these initial reactions was an insecurity about the potential effect of the research upon established work practices and policies. Deeper than this ran the feeling that these people were at best interlopers and at worst parasites. So when I left teaching for research I was acutely aware of the reactions I was liable to face from drug agencies.

Many agencies welcome evaluation, realising its potential as an ally in presenting objective assessments of their work to interested parties such as funders and management committees. But difficulties can still arise in its practical implementation. It is the purpose of this short article to examine the relationship between the agency and the researcher and to show that the dynamics are not inherently oppositional.

Social research at drug agencies tends to fall into three categories: in-house research; routine monitoring; and face-to-face interviews. The potential for conflict between agency and research goals lies in the latter two categories.

Researchers wishing to collect client profile statistics from an agency may need to produce amended or additional forms to be completed, adding to the clerical workload and creating

Guidelines on the mutual etiquette of the relationship between researcher and drug agency. Like good manners everywhere, the aim is to avoid conflict getting in the way of communication.

Robert Power

resentment among agency staff. Clearly what is needed is a unified system of routine monitoring that will standardise data collection, suit the requirements of researcher and agency alike, and lighten the burden of paperwork.

In the North West a monitoring system has been devised to achieve this very end. The simple and easily completed self-carboning single sheets can be used for Home Office notification of addiction as required. The widespread adoption of a system such as this would be valuable

The goodwill of agency workers is essential to the success of a research project

as a means of allowing a regional and nationwide database, and as a way of standardising a minimal dataset for drug agencies and researchers.

Any such dataset must be treated as one indicator of the prevalence and patterns of drug misuse and viewed alongside other established markers.

Most strains emerge when researchers require face-to-face interviews with agency clients (see panel). One cause is the belief that research and agency goals are incompatible: the researcher needs a subject to collect information from; the agency worker is in the business of addressing one or other aspect of the individual's drug problem, and will engage in assessment, counselling, therapy or referral.

But a closer examination reveals that researchers and agency workers both have a valuable role to play in understanding and addressing the issue of drug misuse, particularly in the light of HIV infection and AIDS. In this sense they are

working towards common goals. Yet barriers can form unless steps are taken to facilitate the practical needs of each party.

Both have responsibilities in this respect. The agency should discuss the most appropriate ways of accommodating research without unnecessary disruption to the service. They should be frank and precise about the difficulties posed by any proposed research. Agencies should ask to see the questionnaire and interview schedules so as to iron out any doubts they may have as to the suitability of the interview for their clients. This means setting aside time at the start of the project for staff members to air their views and discuss possible stumbling blocks. Feedback to the researcher will enable them to take account of any comments.

The agency should make clear to the researcher the philosophy which underpins their work and outline how they would prefer the research to be conducted. It may even be appropriate for a 'contract' to be drawn up with the researcher, agreeing details such as timetable, sample size, working procedures and dates for feedback.

Setting aside time early on to lay down the parameters for external research will result in fewer problems as the project unfolds, and should ensure a good working relationship between the parties. Nonetheless, researchers must never underestimate the demands they place on collaborating agencies. They should take steps to see that such demands do not become unreasonable or inappropriate, and that they are handled sensitively. In the final analysis, the researcher is the outsider making demands and should remember that the goodwill and cooperation of agency workers (at all levels) is essential for the smooth running and successful completion of a research project.

It is imperative that researchers liaise with workers at every level of the agency's structure. A project may have been approved at management committee level, but it is crucial that representatives of all staff members are involved at some stage in discussion and negotiation. Researchers should take time to present their project to all those involved, so that reservations can be discussed and resolved. How the research can benefit the agency should be outlined.

The author is a senior research fellow at the Charing Cross and Westminster Medical School of London University researching substance use and AIDS for the REPORT project in the Riverside Health Authority in London. He was formerly with the Drug Indicators Project.

Ways to make the research interview a positive experience

Researchers must be keenly aware of the potentially intrusive nature of their intervention. Much of the information they require is sensitive and extremely personal. It is the researcher's responsibility to ensure sufficient thought is given to the structures, order and wording of questions so as to make the experience of being interviewed as positive as possible for the drug user. Such considerations are rarely, if ever, a priority in drugs research.

This may mean allocating time for the interviewee to talk about issues that bother them and to expound views and histories not directly relevant to the research. Where possible, the researcher should allow time either side of the interview to chat with respondents to put them at their ease and to gain their confidence. Researchers should always reassure respondents that the interview is totally confidential and that nothing

will be relayed back to agency workers.

Where a client finds the interview distressing, it is the researcher's responsibility to do all they can to retrieve the situation and to ensure the agency worker concerned is informed so appropriate action can be taken. In the best of worlds, a contingency plan would be devised, with the researcher knowing who is on call should they be needed.

At the more basic level, consideration should be given to the length of the questionnaire and the time demands that the research makes on both the agency and the respondent. Experience suggests that face-to-face interviews should rarely last more than an hour. Researchers must be prepared to fit the interview into the agency's counselling and administrative timetable, even if this means working outside office hours and at weekends.

Wherever appropriate and possible, agency staff should be co-opted to the research management committee to act as spokespersons for, and conveyors of information to, their agencies.

At the outset it is important for the researchers to familiarise themselves with the ethos and goals of each agency and to be aware of these when dealing with clients and working with staff. It might be that the agency does not take extensive case notes from a client until they have settled into the programme. It would then be inappropriate for the researcher to insist on

in-depth interviews with clients at first agency contact. No two agencies are identical and research methods must be adapted to each individually.

Gaining the respect and goodwill of agency staff is the cornerstone of a successful working relationship. With this in mind, researchers should consider offering their services as volunteers as a way of redressing the balance of demands. Volunteering also has benefits for the researcher. It is likely to cement good relationships with the agency, and provides an opportu-

nity for participant observation. Relationships and contacts made with drug users will prove beneficial for current and future research.

To perpetuate good working relationships, adequate dissemination of the results of the study is essential and should be built into the research timetable. Seminars and workshops could be organised to disseminate findings to an audience that includes participating agencies. The timing and location of such events should maximise the number of agency workers able to attend. At the very least, agencies should receive copies of completed research reports.

An issue seldom discussed in the world of drugs research is the competition between various units for access to agencies and their clients. It is essential that regular forums are held so that all interested parties, most importantly, the agencies themselves, are informed about current developments and projected studies. Experiences and problems could be shared and methods discussed. Such a forum might even generate standards of conduct and codes of practice.

IDEALLY, the agency/researcher relationship should be a symbiotic one where treatment interventions include an inbuilt research component and both parties discuss ways of achieving common aims. In this context, developmental work can evolve in tandem, with research informing the development of treatment options and responding to changing clinical and policy needs. Flexible models of research can be developed that are able to account for changing needs and which can be accommodated alongside more long-term goals. At the end of the day it is in everyone's interest, not least the drug using community, that such links are secured and built upon so that informed and relevant responses are devised to address contemporary issues. ■

REVIEWS

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

This is an excellent package of materials through which educators can begin to address the emotive and often fearful concerns people have about HIV and AIDS.

The Learning about AIDS project piloted its work in the health, education and social services, and the voluntary sector. As a result, the authors chose to use an approach based on a process of clarification — enabling individuals to *clarify* what they already know and feel about HIV and AIDS, and to consider the implications of further factual information for their own lifestyles and behaviour.

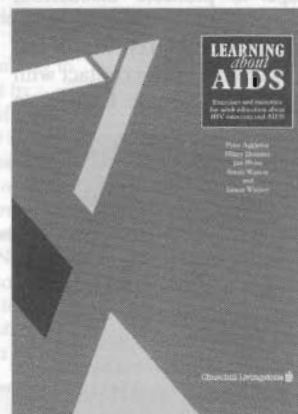
The materials adopt a participatory style, which best enables people's existing feelings and reactions to HIV and AIDS to be articulated and explored. The package is especially useful for drug educators, who have often had to develop HIV course programmes with few sources of reference. It includes a well indexed, easy to read, separately available booklet (*AIDS: Scientific and Social Issues*) as a background text. At strategic points in the exercises, educators are referred to relevant parts of the booklet.

The important equal opportunities issues inherent in education about HIV and AIDS are stressed. Before using the materials, educators are advised to consider their own responses to the issues of racism, sexism, heterosexism and homophobia.

The exercises are the core of the package. Well presented, on easy to photocopy A4 sheets, they cover eight categories. Between the Introduction and the Course Closure exercises, they range across medical and scientific facts, sexuality and safer sex, and injecting drug use. Particularly welcome and important are sections on confidentiality and on understanding individuals' personal and professional lives.

There is an introduction sheet for each category, followed by a careful explanation of each of the exercises under four simple headings: Aims; What You Need; What to Do; Likely Outcome. Given the acknowledged difficulties among drug educators in devising successful materials on sexuality and safer sex, this section of the package is especially useful. It addresses stereotypes about sexual identities and sexual behaviour, sexual language, and how to negotiate safer sex. A humorous card version of TV's *Blind Date* helps participants to examine the ways prospective sexual partners are chosen and how we assess potential HIV risks.

The only areas of HIV education not covered



'An invaluable resource' for drug trainers wishing to develop their HIV and AIDS programmes.

in the pack are death, dying, and loss, as these were outside the project brief. Otherwise it is a comprehensive, well researched set of materials, and an invaluable resource for drug educators seeking to address HIV in their training.

Breda Flaherty

Training Officer, Standing Conference on Drug Abuse

The *Learning about AIDS* materials are available from ISDD at £22 inc. p&p.

See page 9 for how these materials escaped government vetting.

WOMEN AND DRINKING.
WOMEN AND SMOKING.
HEROIN AND OTHER OPIATES.
WOMEN AND STIMULANTS.
WOMEN AND TRANQUILLISERS.

All the above leaflets written and published by DAWN, £0.25 per copy, free to individual women with s.a.e.

CHANGING GEAR. Blenheim Project, 1988. 28 pages. £0.75.

WOMEN AND DEPENDENCY. Edited by Devora Wolfson and Jayne Murray. DAWN, 1986. 100 pages. £2.50.

SUFFERING FROM LIFE. North West Regional Drug Training Unit, 1987. Video. £21 inc. p&p.

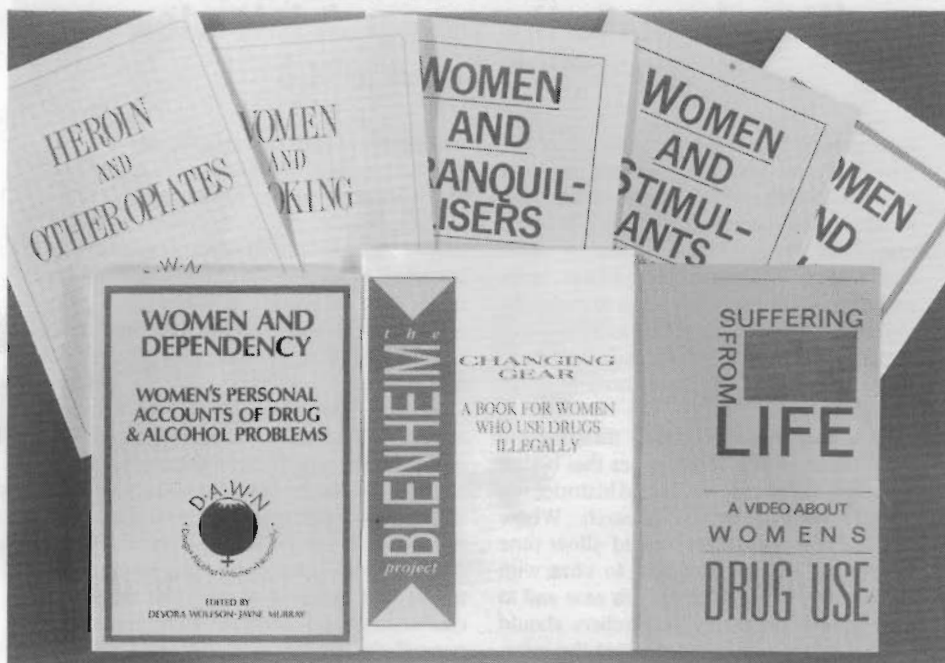
The scarcity of literature and teaching information relating to women and dependency (with the exception of tranquilliser use) simply mirrors the 'state of the art' as far as agencies and practice are concerned. The drugs field is no different from any other area of life—women are still viewed as a low priority! So thank goodness we at least have these resources.

To review these materials I sought comment from the three organisations involved in their production and also from drug workers and drug educators, both women and men. The result is a summary of my own and other workers' opinions.

The leaflets from DAWN, each covering a particular group of substances, are visually striking and use bold type setting to highlight the important information they contain. They target the general public as well as drug users and workers. Information on the effects of specific substances, risk during pregnancy, effects on menstruation and other health risks are included. Mention is also made of the stereotypical images presented of women who use heroin, alcohol, stimulants and other drugs drawing the reader's attention to the problems women encounter counteracting society's moralistic view of women drug users.

These leaflets can be given to drug users, used in women's groups to promote discussion, offered as handouts on training courses, or as general information leaflets on, say, health fair stalls or following initial telephone contact with women. I and most of the people I spoke to

WHAT IS THERE FOR WOMEN? An experienced drugs trainer surveys some of the options.



considered them very helpful, although one worker thought they were too expensive to distribute free to large numbers of women.

Changing Gear is "a book for women who use drugs illegally". This well written, informative booklet should be compulsory reading for everyone working with women drug users to equip them with some basic facts about how opiates, depressants, stimulants, hallucinogens and cannabis affect contraception, pregnancy and health. It can be used by workers either as an information booklet to give to women or as a means of promoting discussion in groups or in one-to-one contact.

Changing Gear has drawn together both the facts and the discrepancies in the information and research available, and, although its size may at first glance make women resistant to reading it, some workers I spoke to were very positive about how well it had been received, particularly by long-term drug users. Clearly if an activity is central to their lives most people will be prepared to work through what is after all just a 28-page booklet.

Women and Dependency—another, but this time book-size publication from DAWN—contains a series of women's personal accounts of their drug and alcohol problems along with some factual information about substances. It states that "women's dependence, both economical and emotional, is reinforced through society's structure", and goes on to give examples of how society works against women taking control of their own lives.

This book is up front about its feminist view of why women should have to be dependent in the first place—a political approach that may be unpalatable for some workers and users alike. However, these arguments must be heard to balance the existing dependency models which are all too often disease-based and/or male-determined. The personal accounts may again cause discomfort because of the editors' attempt to compensate for the omission of black and gay women in the rest of the literature.

Women and Dependency is particularly useful as an educational source for workers wanting to consider these arguments, and could be used with women drug users who could gain comfort from reading or hearing about other

women's problems.

The video pack *Suffering from Life* includes a copy of *Women and Dependency*. The video describes itself as being about "Women's roles in society and how that affects our drug use". Images of women drug users and how these are held by the medical profession are described. Social workers' attitudes towards women drug users as parents are examined as is the need for agencies generally to be better equipped to cater for women and their children.

Criticisms of the video are that women drug users are not interviewed, just workers; that the production quality is poor; that, as with *Women and Dependency*, the politics may not suit everyone; and that the 'talking heads' format might be boring—certainly true in the case of a group of women drug users from Glasgow. My feeling was that the producers had done a reasonable job given the restricted resources available to them.

Despite the criticisms, I believe *Suffering from Life* is useful for working with general groups of women and others in the community to initiate discussion, and as part of an educational event. Useful tutors' notes are attached and, after all, it is the only one of its kind.

With the expansion of services for women I hope there will soon be more examples of useful literature on women and dependency. What is particularly needed are health leaflets which are either free or very cheap for non-funded or under-funded agencies. These should not rely totally on the written word. Cartoons and graphics could illustrate information about the effects of drugs on menstrual cycles and during pregnancy, on methods of contraception, and on women's bodies generally.

"Women learn to suffer quietly", says David Brandon in *Suffering from Life*. It feels like women in the drugs field have been shouting for many years about our needs, and it's about time we were heard!

Vicky Patterson
 Training Organiser, Drugs Training Project,
 University of Stirling, Scotland.
Women and Dependency was separately reviewed in *Druglink* November/December 1987, page 18.

Where to get them

DAWN publications are available from DAWN, Omnibus Workspace, 39-41 North Road, London N7 9DP, phone 01-700 4653. Their leaflet range is in the process of being updated and revised. *Women and Smoking* and *Heroin and Other Opiates* are already available in new editions. Updated and revised versions of *Women and Drinking* and *Women and Tranquillisers* should be available by April. *Women and Stimulants* is temporarily out of print.

Also available from DAWN is a booklet on HIV and AIDS for women who use drugs and publications about alcohol and drug dependence problems among black women—phone 01-700 4653 for a full list.

Changing Gear and *Suffering from Life* are available from ISDD at £0.95 and £21 respectively, inc. p&p.

'Cost effective' incentives scheme attacked

Paying for contacts might encourage injecting, argue outreach workers

Paying drug users to bring their injecting friends back to the drug service may be more cost effective than employing outreach workers, argued James Les Kay in *Druglink's* first issue of 1989. Three groups of drugs workers with experience of detached work respond to the suggestion.

'Contempt' for plan to 'bribe' drug users

Dear Editor,

Les Kay's article in *Druglink* (January/February 1989) shows a lack of understanding of detached (as opposed to outreach) work. It has also highlighted Kay's increasing belief in the primacy of providing some financial inducement as an incentive for doing anything.

If Les truly wants to change the course of drug services he should be campaigning to make drugs (injectable or not) available on demand to whoever wants them. Such a policy would probably eliminate the need for street agencies overnight, empty the prisons of people convicted under the Misuse of Drugs Act, and take an enormous amount of pressure off the

police and Customs and Excise. Added to this would be a dramatic reduction in the spread of HIV. This too would be hard to evaluate but it would certainly be more cost effective than our current system.

We have never been sure of Les's position when it comes to drug use, whether he generally thinks it is a good idea or not. But his naive attempt to belittle a style of work in which many people have invested a good deal of time and effort to make contact with people at risk should be treated with the contempt it deserves.

The author is not a detached or outreach worker — perhaps he should stick to writing on subjects he knows about. He would have been much better employed in trying to get detached workers to identify their training needs, thereby making their work more effective and helping them to feel supported.

Andy Fox, Ken Blair, Fiona MacNeill, Sally Cairns

The Bridge Project, Ayr

Security problems underrated

Dear Editor,

In reply to the article in the January/February edition of *Druglink* on the cost effectiveness of outreach work, we agree that outreach work is not a cheap service — although funders may think that employing someone to take a service to the target group obviates the need to provide much in the way of a back-up service to clients and support to the worker.

Outreach is definitely flavour of the month and a lot of outreach services have been set up or proposed in response to money being made available, not necessarily in response to an identified need which might be appropriately met through detached work.

There are, however, some points we would like clarified. Much of our work is with young chaotic drug users who do not inject. Doing away with outreach workers in favour of cash incentives to drug injectors would mean non-injectors actually losing a service presently extended to them.

We can also envisage security problems with providing cash to callers at the agency:

— how would it be established whether they were drug injectors?

— would they have to display injection sites?

— would there be a danger that some

callers would inject to obtain cash? — would the payment be a one off? — if users were given money on an ongoing basis it would be a disincentive to stop injecting; — would the provision of cash incentives affect clients' benefits?

At a community drug team we know clients can claim back fares spent travelling to the agency. Some call at the agency purely to claim (often greatly inflated) fares and heated arguments between them and counsellors are not unusual.

We too are interested in working as effectively as we can. The three of us employed as outreach drugs workers in Birmingham have constructed a hierarchy of objectives which makes clear our objectives and exactly how we aim to achieve them.

We have identified performance indicators and the means of evaluating them. The model provides us with direction and a method of measuring our effectiveness. It helps funders and colleagues appreciate the nature of our work. We would be happy to send a copy to anyone interested.

Andy McWilliam, Jon Bashford, Conrad Spencer

Turning Point Birmingham Outreach Team

Hungerford Drugs Project

Mark Lee

Tempting the poor to start injecting

Dear Editor,

The following points have been made by a group of detached drug workers in Strathclyde about the article by James Les Kay on 'outreach' work in *Druglink* January/February 1989. They are not in order of priority.

The author cites the "well-established tradition" of paying drug users in research. This "tradition" has been questioned not only by workers in the field but also by other researchers. The problem here (probably one of many) is, are we enticing users to comment, or are we enticing particular comments?

Why should we provide drug users with 'clean money' to inject 'dirty drugs'? Are we providing an incentive for relatively poor young people (students, etc) to begin using? This is particularly a concern if we follow the advice that fees of up to £100 per contact may be justified. Moreover, just offering users money would not increase their access to needle collection and disposal schemes. In our area these are scarce, have restricted hours, and may be several bus rides away for many users.

The 'incentives' method is presented by Les Kay as a straightforward, simplistic solution, yet time and time again we hear drug trainers/educators saying there are no easy answers. It is simplistic to suggest that just enticing people into needle exchanges to hear a message on safer injection techniques will do any good. Surely we should be considering *who* is giving the message and *why*. *When* and *where* this message is delivered are equally important.

There is a real risk that talking to most of the people attracted by incentives will be a waste of time. They will be coming in just to get the money. They will not be interested in talking about the problems of homelessness, unemployment, poverty, rootlessness, etc, which often need to be dealt with first. Nor will many be in the crisis situations that can provide the motivation to change.

Detached work is not *solely* about bringing people into contact with

services. Other work is undertaken actually out there on the streets and in the homes, in places which suit — not only drug users — but all users of presently centralised services. Relationship-building is an important part of this 'other work'.

The author's solution to the problem of reaching injectors is very depersonalising — caught up totally in quantity as opposed to quality. We wonder how parents of young drug users would respond to this method. They, after all, have to deal with most of the drug-induced states which drug users can get into.

It's true that as long as you are giving out money, people will return to the service. But what happens when the money runs out — as it so often does in this climate of governmental 'pruning' of welfare services? Who will these agency 'employees' turn to, particularly with no contract of employment?

Inevitably some malevolent character will be checking out the routes to and from the new money-giving centres — the routes not only of drug users, but also those of the 'purse-string holder' as they make their way to and from the bank. Someone *will* get injured or killed. So much for cutting down on crime!

These are the main points discussed by the detached drugs workers. I can add to them the ignorance of detached working methods displayed in the article. We would be prepared to send the author a few of the voluminous works on the subject, should he be interested.

Graham Walkinshaw, on behalf of a group of detached drugs workers in Strathclyde

Detached Drugs Project, Social Work Department, Strathclyde Regional Council

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

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PUBLICATIONS

Therapy

■ **HEROIN AID.** Bradford: Bridge Project, 1989. 16 pages. Booklet. £0.90.

Updated self-help guide to getting off and staying off heroin.
Available from the *Bridge Project*, Equity Chambers, 40 Piccadilly, Bradford BD1 3NN.

■ **SERVICES FOR DRUG USERS: THE PROCEEDINGS OF A ONE-DAY SEMINAR ...** Colin Brown *et al.*, eds. Portsmouth: PSI and SSRU, 1988. 48 pages. Report. £2.95.

Discussion of drug services in Hampshire.
Available from *Social Services and Intelligence Unit*, Mildam, Burnaby Road, Portsmouth PO1 3AS.

■ **QUITTING COCAINE: THE STRUGGLE AGAINST IMPULSE.** Howard J. Shaffer and Stephanie B. Jones. Lexington, Mass.: Lexington Books, 1989. xxii, 199 pages. Book. £24.

An overview of cocaine abuse and its treatment based on first-hand accounts of natural recovery.
Available from bookshops.

■ **BENZODIAZEPINES AND THERAPEUTIC COUNSELLING: REPORT FROM A WHO COLLABORATIVE STUDY.** World Health Organization *ed.* Berlin [etc]: Springer-Verlag, 1988. vii, 135 pages. Book. £32.25.

Report of a cross-cultural study.
Available through bookshops.

HIV disease

■ **AIDS AND DRUG MISUSE PART 2.** Advisory Council on the Misuse of Drugs. HMSO, 1989. 98 pages. Report. £6.30.

On how to help HIV infected drug users.
Available from ISDD at £6.70 inc. p&p.

■ **AIDS IN LOTHIAN: EVERYONE'S CONCERN.** 1988. Lothian Health Board, 1989.

Development and extent of HIV infection in Edinburgh and district and responses to it up to 31.3.88.
Available from *HIV/AIDS Team*, Lothian Health Board, 11 Drumsheugh Gardens, Edinburgh EH3 7QQ, phone 031 225 1341.

■ **A REPORT ON THE DEVELOPMENT AND OPERATION OF A SYRINGE EXCHANGE SCHEME BASED AT THE COMMUNITY DRUG PROJECT.** Frances Aston and Stephen Tippell. London: CDP, 1989. 22 pages. Report. £2.50.

The scheme is notable for reaching high risk users and a syringe return rate well over 100 per cent.

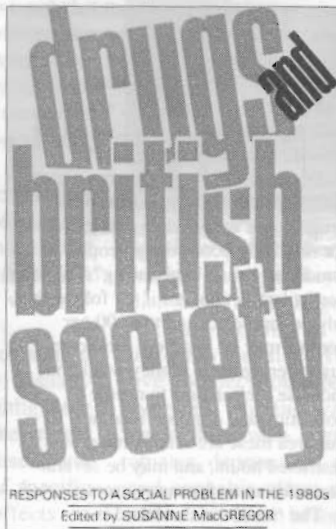
Available from CDP, 30 Manor Place, London SE17 3BB.

■ **HIV AND DRUG USE: THE INVISIBLE NATIONAL DISASTER.** Citizen Action Aids Policy Unit. London: the Unit, 1989. 28 pages. Booklet.

Recommendations for government policy.
Available from the Unit, 53 Queen Anne Street, London W1M 0LJ.

Policy

■ **DRUGS AND BRITISH SOCIETY.** Susanne MacGregor *ed.* Routledge, 1989. 224 pages. Book. £9.95.
Readings on drug policy in the '80s.
Available through bookshops.



■ **DRUG ABUSE: OPPOSING VIEWPOINTS.** Julie S. Bach *ed.* Minnesota: Greenhaven Press, 1988. 212 pages. Book.

Reprints of papers taking opposing views on the USA's 'war on drugs'.
Available through bookshops.

Other

■ **DRINK AND DRUGS AT WORK: THE CONSUMING PROBLEM.** Fred Dickenson. London: Institute of Personnel Management, 1988. vi, 133 pages. Book. £7.50.

A practical guide for personnel managers on how to establish workplace policies.
Available through bookshops.

■ **DRUG EDUCATION IN SCHOOLS: AN EVALUATION OF THE 'DOUBLE TAKE' VIDEO PACKAGE.** Christine Eiser and J. Richard Eiser. New York [etc]: Springer-Verlag, 1988. viii, 156 pages. Book. £15.25.

Research report on how teachers used the package and reactions of pupils.
Available through bookshops.

COURSES

■ **BENZODIAZEPINE WITHDRAWAL WORKSHOPS.** 11-12 May, London; 29-30 June, Edinburgh; autumn dates in York, Exeter and Cardiff; 1989. £96.

Based on the approach to withdrawal from tranquilisers/sleeping pills developed by the WITHDRAW Project.

Details from *Withdraw Workshops*, 515A Bristol Road, Birmingham B29 6AU, phone 021 471 3626.

■ **BASIC COURSE ON WORKING WITH DRUG RELATED PROBLEMS.** Cooperative Training Services. 15-16 May, 19-20 October, 1989. London. £60 statutory agencies; £20 voluntary; free to Home Office funded voluntary agencies.

For workers not in drug specialist agencies and for those new to the drugs field.

Details from CTS, c/o NACRO, 169 Clapham Road, London SW9 0PU.

■ **ALTERNATIVE HEALTH.** 26 May, 30 June, 1989. Manchester. Series of half-day seminars. £5 per seminar for local workers; others £10.

■ **HIV COUNSELLING.** September 1989. £30 for local workers; others £60.
North West Regional Drug Training Unit.

Details from *Training Administrator*, NWRDTU, Kenyon House, Prestwich Hospital, Manchester M25 7BL, phone 061 798 0919.

■ **PSHE, ALCOHOL, DRUGS AND THE NATIONAL CURRICULUM.** 20-22 June.

■ **HEALTH EDUCATION IN THE PRIMARY SCHOOL.** 23-24 May.
■ **METHODS AND RESOURCES IN PSHE.** 16-18 May.

TACADE. 1989, Midlands.
Details from TACADE, 3rd Floor, Furness House, Trafford Road, Salford M5 2XJ, phone 061-848 0351.

■ **DRUGS AWARENESS COURSE.** 3-4 July. £90+VAT.

■ **TRAINING DRUG TRAINERS.** 5-7 July. £130+VAT.
Network ADA. 1989, Stafford.

The first is a multi-disciplinary introductory course.
Details from *Network ADA*, Freepost, Bury, Lancs. BL9 5YZ, phone 070682 8963.

■ **MOTIVATIONAL INTERVIEWING.**

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

■ **DRUGS AND ALCOHOL STUDY COURSE.** Leeds Addiction Unit. 28 September-30 November 1989,

Leeds. £55.

In-depth training for experienced/qualified workers.

Details from *Gillian Tober*, 40 Clarendon Road, Leeds LS2 9PJ, phone 0532 456617.

MEETINGS

■ **AIDS AND HIV: THE CHALLENGE FOR BRITISH DRUG SERVICES.** Institute of Psychiatry. 5.30pm, 25 May 1989, London. Free. No booking required.

A lecture from the Director of the group evaluating syringe exchanges.
At the *Wolfson Lecture Theatre*, Institute of Psychiatry, Denmark Hill, London SE5.

■ **AIDS: INFLUENCES TOWARDS CHANGES IN DRUG PREVENTION AND TREATMENT POLICIES.** Centre for Substance Abuse Policy Studies, Hatfield Polytechnic, 23-25 June 1989. Hertford.

International conference.
Details from *Stuart Ware*, Conference Organiser, Hatfield Polytechnic, Balls Park, Hertford, SG13 8QF, phone Hertford 558451.

■ **MAINTENANCE PRESCRIBING USA/UK/HOLLAND.** International Journal on Drug Policy. 30 June, London; 3 July, Manchester; 5 July, Bristol; 6 July, Edinburgh. London £50, others £40.

Seminar tour featuring the director of Amsterdam's drug research and the director of a large New York maintenance programme.
Details from *Int. J. Drug Policy*, 10 Maryland Street, Liverpool L1 9BX.

■ **YORKSHIRE ANNUAL DRUGS FORUM.** Yorkshire Regional Addictions Group. 19-21 July 1989, Ripon. Fees on application.

For drug workers in Yorkshire but some places available for other workers.
Details from *Mike Farrar* (0422 58191) or *Simon Polley* (0274 547272).

■ **DRUGS AND ALCOHOL IN THE WORKPLACE.** Network ADA. Dates in October 1989 in Edinburgh, Manchester and London. £50 London, £40 others, plus VAT, other rates for commercial and volunteer groups. Series of seminars.
Details from *Network ADA*, Freepost, Bury, Lancs. BL9 5YZ, phone 070682 8963.

FOR MORE INFORMATION ...

- ❖ On the publications listed here: phone ISDD's library on 01-430 1993.
- ❖ On more new publications and articles: order *Drug Abstracts Monthly* — £16 p.a. from ISDD, phone 01-430 1961.
- ❖ On a particular topic: phone ISDD's information service on 01-430 1993 and gain access to the world's finest drug misuse library.
- ❖ On training: for courses not listed here and for information on training in general, phone Breda Flaherty, Training Officer at the Standing Conference on Drug Abuse (SCODA), on 01-831 3595.

DRUGS AND SOCIETY NEW READINGS

DRINKING AND CASUALTIES

ACCIDENTS, POISONINGS AND VIOLENCE IN AN INTERNATIONAL PERSPECTIVE

Norman Giesbrecht, Addiction Research Foundation, Toronto

With Rene Gonzalez, Marcus Grant, Esa Osterberg, Robin Room, Irving Rootman and Leland Toule

Norman Giesbrecht assesses the information on 'drinking casualties' – and looks at how this information can be used to develop preventive policies and programmes.

September 1989: 448pp
Hb: 0-415-00128-5: £30.00

DRUGS AND BRITISH SOCIETY

RESPONSES TO A SOCIAL PROBLEM IN THE 1980s

Edited by **Susanne MacGregor**, Birkbeck College, University of London

Provides up-to-date information on the drugs problem in Britain based on the most recent research and experience. The contributors, all experts in the addiction field, take a social perspective to examine drugs and drug taking.

February 1989: 208pp
Hb: 0-415-03064-1: £29.95
Pb: 0-415-01752-1: £9.95



RELAPSE AND ADDICTIVE BEHAVIOUR

Michael Gossop, Drug Dependence Unit, Bethlam Royal Hospital, Kent

Leading international researchers in the addiction field examine the available evidence about why people find it so hard to escape their addictive behaviour.

July 1989: 314pp
Hb: 0-415-02354-8: £25.00

TREATING DRUG ABUSERS

Edited by **Gerald Bennett**, East Dorset Community Drug Team

A practical and accessible guide to the psychological understanding of drug taking and related new approaches to treatment.

June 1989: 192pp
Hb: 0-415-02039-5: £25.00



For further information and a Sociology Catalogue please contact:
Judith Sherry, Routledge,
11 New Fetter Lane,
London EC4P 4EE

NEW CURRENT AWARENESS BULLETINS FROM ISDD'S LIBRARY

Europe's leading drugs library is launching two new publications this spring

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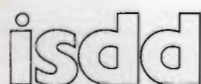
AIDS AND DRUG MISUSE BULLETIN

For all those working in the AIDS/HIV field

£16 per annum

These quarterly bulletins will contain updates on all the latest worldwide research and UK press coverage relevant to their fields.

Order now or contact ISDD's library on 01-430 1961 for further information.



1 Hatton Place
London EC1N 8ND

The **Bucks Council on Alcohol and Drugs** is presently assessing how it presents itself to female drug users.

The Council is seeking to establish the extent of female use of illicit drugs in the area and to ascertain what type of service will be most useful.

Any agency or organisation with relevant experience, thoughts, ideas is asked to contact:

Sue Germain
Bucks Council on Alcohol & Drugs
South Home
Tindal Road
Aylesbury
Bucks.
HP20 1EU
Telephone: Aylesbury (0296) 25329

DRUGLINK in 1988

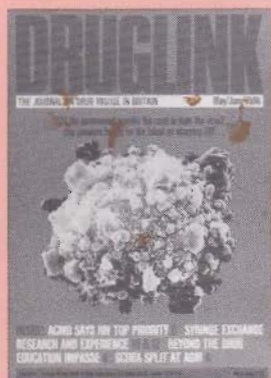
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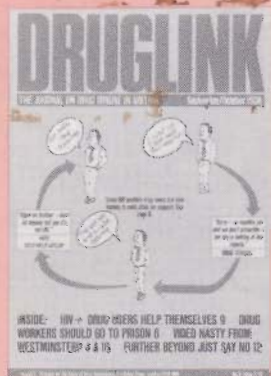
1 Rise and fall of family support groups
Organising Britain's drug research
Educating the police

Heroin lifestyles from mum to macho man
How AIDS is changing rehab. programmes
The special problems of lorazepam **2**



3 Beyond 'just say no' drug education
Practice in syringe exchanges
The release of *AIDS and Drug Misuse Part 1*

'Taking Care of Business': a Living Classic
Wrapping dealers up in the anti-AIDS drive
Failings of syringe hygiene advice **4**



5 HIV+ drug users forced to help themselves
Working with prisoners
Debate continues over drug education

Drug education through popular culture
The Drug Trafficking Offences Act in practice
Inequalities in drugs/AIDS funding **6**



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