

DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN

November/December 1993

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ANNIVERSARY



They want
you to get
your acts
together --
but have
they?
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Across the divides

Discord, disunity, division. Divides between professionals and public, between service providers – even the report *Across the Divide* on building partnerships against drugs has ended up showing how deep those divides are within the Government that commissioned it. Read this issue of *Druglink*, and at least you'll be able to spot some of the fissures.

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PLATFORM DISCORDANT DEFENCE

Alison Chesney argues that the drugs field's disorganised retreat in the face of community care is leaving residential services at the mercy of the market

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Research which is helping to lever feminism out of its '60s time trap. In our last issue she said it was "Time for a Make-Over"; now **Sheila Henderson** outlines the way to a revitalised understanding of gender and drugs.

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Harm reduction education by the people for the people. In Edinburgh a group of clubgoers are effectively educating their peers. **Peter McDermott** and **Willie McBride** were there to support and observe.

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LETTERS Has the author of "Time for a make-over" fallen for establishment propaganda? Regional databases *do* need attributable data. Hepatitis C: uneconomic to screen or unethical not to? Chair of working group responds to *Druglink's* coverage of the **ACMD's** education report.

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LISTINGS Publication. Meetings. Courses. Organisations.



Mobilise drug users to break risk reduction logjam

Theorists and practitioners are turning to community mobilisation strategies to break the logjam in achieving further HIV risk reduction changes in drug users' behaviour. Another pressure point is the spread of recreational drug use to the general youth population. There are simply not enough professionals to go round, it's being argued, so targeting communities rather than individuals is the only realistic option.¹

In what amounts to a manifesto for this approach, an editorial by Tim Rhodes in the October issue of *Addiction* concludes that "prevention research, intervention and debate" must now be diverted to the "application of community change".² In an update to its *AIDS and Drug Misuse* reports due out in November, the Advisory Council on the Misuse of Drugs is expected to back this conclusion.

Good but not good enough

Behind this call is the realisation that strategies aimed at persuading individuals to change and providing them with the means to do so (syringes, condoms, bleach) are not enough to arrest the spread of HIV.

Rhodes is based at the Centre for Research on Drugs and Health Behaviour which houses the UK's leading authorities on syringe exchange. In a book co-authored with Jill Burt, the centre's Director,

Professor Gerry Stimson, observes that "although syringe exchanges have enabled some injectors to change their behaviour ... about 20 per cent of people who use [them] still share syringes".³

Researchers from the same team have tracked behaviour change in a sample of drug injectors between 1989 and 1990.⁴ In 1989, 35 per cent of syringe exchange attenders in London and the south west of England had shared syringes in the last month. A year later the sharing rate was down to 16 per cent. Among non-attenders too, sharing had gone down by 20 per cent. None of those tested on both occasions had become newly infected with HIV.

The results were encouraging, but not encouraging enough. Professor Stimson and his colleagues warn that "residual levels of risk behaviour may still be high enough to facilitate further epidemic spread of HIV infection".

Achieving sexual behaviour change has proved even more difficult. Among a sample of heroin users interviewed in 1991, researchers from the Maudsley Hospital in London have concluded that the "risk of HIV transmission through unprotected sexual behaviour may be at least as great as the risk through injection".⁵

Even if more is needed, there has already been substantial change,

including the beginnings of a shift in the culture of drug use. Burt and Stimson found clear evidence that by at least 1989 the "social etiquette" of drug injecting in London had changed. From seeing the sharing of equipment as normal behaviour, injectors now regarded it as a "lapse" and took steps to avoid it. Most shared only when these measures had broken down.

It is this kind of change which community strategists such as Tim Rhodes hope to achieve by harnessing opinion leaders from the drug using community. Another pay off is that 'peer education' can reach way beyond the minority of drug users in touch with services. Peer educators may be there when drug use actually occurs and when drug agencies are closed.

Using drug users to do *in situ* harm reduction is not without its problems – accountability and evaluation being among them.⁶

Community mobilisation

Mobilising the drug using community to protect its members' health takes the strategy even further, promising a self-generating process of education and empowerment. The model often cited is the collective self-defence of gay men, who created their own organisations in response to the threat of sexually transmitted HIV infection. Among drug users the obstacles to

community mobilisation are recognised to be much greater.

Tim Rhodes points to the lack of shared values and the absence of a cohesive political or social identity among drug users, raising doubts over whether there is a 'drug using community' to mobilise. Peer influence assumes relationships of trust which may be lacking in drug using networks held together more by mutual consumer and trading interests than by mutual respect.

However, across Britain small groups of current drug users are organising themselves or being encouraged into organisation. Drug agencies are acting as seeding points for these structures as well as providing some of the resources needed to keep them running.

In the USA, Australia and Holland, drug user groups are more evident and more vocal than in Britain. There is now enough of a track record in these countries for attempts to be made at a structured theory of achieving subcultural change among drug users.

Samuel Friedman of New York stresses the need for "democratic involvement and openness".⁷ Participants in a drug user organisation must see it as something they "can have a fair say in". To maintain credibility these groups should be clearly seen to defend the drug using scene against its presumed enemies – even if this embarrasses mainstream funders.

Such developments chime well with the Government's emphasis on consumer participation in service planning. However, it is difficult to avoid the feeling that in this area a truly 'empowered' and 'mobilised' consumer community will eventually demand things that government would rather not see provided, and perhaps which some of the services giving birth to these groups would be unhappy to offer.

Farringdon

A fairy story

Once upon a time there were *D-dacs*, hydra-headed creatures created by an *Advisory Group who Misused Drugs*. Supposed to be 'multi-disciplinary', the *D-dacs* had no discipline at all and chased their tails endlessly, often disappearing up their own backsides.

One day a *White Paper* beast appeared, conjured up by powerful magicians to cower, bribe and bamboozle the population to do their bidding, and all the time think they were not. It spoke a new language and proclaimed this as the only true tongue which all were to speak or be shunned, ridiculed and starved, until they too learnt the new ways. Henceforth, it decreed, there would be two tribes where previously there was one, the *Purchasers* and the *Providers*.

Panic ensued. No one, so they said, really knew what would happen. But perhaps the *Chiefs* who rode the *White Paper* knew. Swopping, they captured some multi-disciplinaries from the *D-dacs* and made them *Purchasers*. They fed them *Propaganda* which gave them the power that they craved. Chemicals spurted over their synaptic gaps and mated with protein receptors – some call it *Euphoria*. (Others think *Euphoria* is where *Seekers* go when they have

taken drugs to escape from somewhere called *Reality*.)

The price of this *Euphoria* most were happy to pay: a solemn pledge never to feed any creatures not of their own making. Power and *Euphoria* were theirs, on condition only that they keep them unto themselves and never share. But the *Purchasers* were fallible and human. Brave beyond belief or foolish beyond words, some disobeyed the *Chiefs* and shared their *Euphoria* with the *Seekers*.

To these they dispensed *Harm Reduction* – pills, potions, learning called 'education' and arcane and wonderful tools. This made the *Bringers of the White Paper* very angry. They threatened to take these away from the *Seekers*.

Maybe they will. Or maybe the *Advisory Group who Misused Drugs* will talk to the *Bringers of the White Paper* and tell them that the lesson is simple. If you make too much *Euphoria* available there is a strong chance that someone will abuse it. Often to the detriment of others and the exclusion of all else.

The spirit of Farringdon

Farringdon is not a person but a spirit – the spirit of invective, sarcasm, satire and wit. Send your 400 words to the editor who is sworn to keep your identities secret. Your chance to have your say, and survive.



1. McDermott P. "Editorial." *International Journal on Drug Policy*: 1993, 4(2), p.63.
2. Rhodes T. "Time for community change: what has outreach to offer?" *Addiction*: 1993, 88, p.1317-1320.
3. Burt J. and Stimson G.V. *Drug injectors and HIV risk reduction*. Health Education Authority, 1993.
4. Dolan K. A., Stimson G. V., Donoghoe M. C. *Drug and Alcohol Review*: 1993, 12, p. 133-142.
5. Gossop M., Griffiths P., Powis B., Strang J. "Severity of heroin dependence and HIV risk. I. Sexual Behaviour." *AIDS Care*: 1993, 5(2), p.149-157.
6. Bolton K., Waffling A. "User to user." *Druglink*: 1993, 8(4), p. 34-35.
7. Friedman S. "Going beyond education to mobilising subcultural change." *International Journal on Drug Policy*: 1993, 4(2), p.91-95.

Nearly half 16-year-olds have tried drugs

Research led by Professor Howard Parker at Manchester University continues to document unprecedented levels of drug use among the school-age population of the north west of England.

In 1991 a survey of a representative sample of 776 14-15-year-old pupils from eight schools in Manchester and Merseyside reported that 36 per cent had tried drugs other than alcohol or tobacco.¹

Summary figures released on 8 October show that a year later when most were 16-year-olds, 47 per cent said they had tried drugs. Contact with drugs was the norm – 71 per cent had been in drug offer situations compared to 59 per cent the year before.²

Between a quarter and a third of the sample can, say the researchers, be described as "drug users rather than merely triers". 41 per cent also

drank alcohol on a weekly basis.

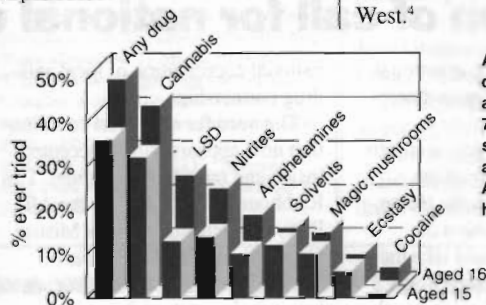
"These young people appear to see themselves as consumers in a psychoactive 'pick'n'mix' sweet shop," says Professor Parker. "starting and staying with alcohol ... but then trying cannabis, 'poppers' and LSD blotters. All these products are within their reach, both literally and financially."

At 16 years of age most of these youngsters were too young to be active in the rave scene. Nevertheless, preliminary data from the same study published suggested that in 1992 a staggering quarter of the sample had tried LSD, 22 per cent nitrites ("poppers"), 16 per cent amphetamines and roughly 1 in 8 had sampled solvents or magic mushrooms. 41 per cent had tried cannabis, 7 per cent ecstasy and 4 per cent cocaine. For all but 2 per cent heroin was still an unknown experience.³

Professor Parker's findings are the hardest evidence available so far to support the contention that Britain is experiencing the greatest upsurge in youth drug use since the '60s. Not surprisingly the research is seen as having policy implications. Some commentators argue that drug use at this level means a 'say no' approach is irrelevant and must be replaced by harm reduction education. There will be others who say it means drug prevention efforts must be redoubled rather than abandoned.

Corresponding research from other parts of the country is generally unavailable. How far these eight schools are representative of national trends is unclear. What research there is does converge to suggest a nationwide rise in the extent and variety of youth drug use, though not to such dramatic levels as in the North West.⁴

1. Measham F., Newcomer R., Parker H. "The post-heroin generation." *Druglink*: 1993, 8(3), p.16-17.
2. University of Manchester. "Alcohol and drug use among North West youth." 8 October 1993.
3. Michael A. *Cutting the lifeline*. Labour Party, May 1993.
4. Ashton M. *Drug misuse in Britain*. 1992. ISDD, 1993.



As 15-year-olds the drug experience of a sample of over 750 North West schoolchildren was already impressive. A year later nearly a half had tried drugs

Minister says nicotine addicts can do it without drugs

Health Minister Brian Mawhinney's proposal to add nicotine patches to the list of drugs unavailable on the NHS will come into effect from 1 November. Previously Nicotine II patches were not prescribable on the NHS but newer products such as Nicorette and Nicabate had escaped the restrictions.

In a statement issued on 12 August, Dr Mawhinney explained that "Nicotine patches do have a role to play in helping some people to stop smoking, but there is no reason why their cost should be met by the NHS. People who can afford to smoke can also afford to buy

products which may help them to stop smoking. It is also worth emphasising that it is estimated that there are around 11 million ex-smokers in this country – and the vast majority of them have given up without pharmacological help."

Regulations to stop NHS doctors prescribing the patches were laid before Parliament on 11 October. The effect is that patients who want the patches will have to pay the full cost of £150 or more for a course of treatment.

Dr Mawhinney is also known to be less than enthusiastic about methadone treatment of opiate addiction. Last April a DoH spokesperson said he wanted particularly to review the use of substitute drugs as he feels "people should not be taking drugs".¹

■ There is as yet no announcement of the "fundamental review" of methadone prescribing and other harm minimisation approaches presaged last April in a leak to the *Daily Telegraph* which almost certainly originated from Dr

Mawhinney. However, the Health Minister's twin concerns with outcomes and prescribing costs were evident in a series of statements issued earlier this year.

In March he announced a "prescribing incentive scheme" to reward GPs who prescribe "economically" by allowing them to spend part of the savings on other forms of care for their patients.²

By June at least three RHAs had taken up Dr Mawhinney's offer. In the Northern region, for example, GPs stand to gain up to £2,500 by cutting their prescribing costs.³

In the first of three speeches on purchasing in the NHS, in April Dr Mawhinney said the "cosy" relationship between health purchasers and providers had to end as the phase of protecting providers from the market gave way to purchaser-driven changes.⁴

Later he stressed the role of targets and outcome measures in purchasing, highlighting the DoH's new Outcomes Clearing House at Leeds University.⁵

1. *Druglink*: 1993, 8(3), p.5.
2. Department of Health. "Prescribing incentive scheme 'will benefit patients', says Dr Brian Mawhinney." *Press Release*: 11 March 1993.
3. *Pharmaceutical Journal*: 5 June 1993, p. 774.
4. Department of Health. "New initiative to improve quality of health." *Press Release*: 29 April 1993.
5. Department of Health. "Dr Mawhinney issues principles for judging success of purchasing." *Press Release*: 3 June 1993.



As you read this I will be facing my first week as Director of ISDD and I am looking forward to it immensely. There's no question that Jasper Woodcock is going to be a hard act to follow – he has an enviable reputation in the drugs field and leaves ISDD firmly established as the UK source of information on drugs.

It is clear that ISDD is already in a position to capitalise on its solid reputation to make even more impact on drug information. Since I don't come from the drugs field, I obviously need to gather a lot of information before I can decide what ISDD should be aiming to look like in five years time.



Anna Bradley, ISDD's new Director

To gather the information, I will be spending a lot of my time talking to staff, finding out more about the people who use our services and those who don't, and getting people to help me second guess the future of drug information needs and likely developments in the not-for-profit world. ISDD's customers and clients are welcome to contribute to this process – either by writing or by phoning on 071 430 1991.

I will be presenting an initial plan to ISDD later this year and we will keep you informed through *Druglink*.

Better access to the ISDD database

The ISDD library database is now available on CD ROM. The database includes details of some 20,000 documents – journals and books in the most recent part of the collection. It gives full bibliographic details and, in most cases an abstract. We hope that libraries and research institutes will buy the CD ROM and so enable drug workers and researchers to search our library database from any country in the world – and just as importantly, from elsewhere in the UK.

Anna Bradley

Report to DoH says 'community partnerships' should replace district drug advisory committees

A report commissioned by the Department of Health on local collaboration to tackle drug misuse has ironically shown how poor collaboration is at national level. At local level it has called for the abolition of regional drug advisory committees and for the district committees to be replaced by more powerful drug misuse community partnerships.

Commissioned in 1992 and delivered in draft by at least last January, Roger Howard's report *Across the Divide: Building Community Partnerships to Tackle Drug Misuse* is at the time of writing (early October) still unpublished. Commentators close to the research have reliably informed *Druglink* that part of the

delay is due to the Department of Health's insistence on a rewrite of the sections dealing with national coordination (see below).

Roger Howard's report follows one from the Local Government Drugs Forum in 1991. Also commissioned by the Department of Health, this exposed the weakness of the drug advisory committee system.¹ While in 1986 a DoH circular had said the committee's proposals should be "regarded as an important input"² into planning mechanisms, many in fact had "inadequate status" and functioned as forums for the sharing of information rather than joint action.

The new report's solution is to replace district drug advisory committees (DACs) with "drug

misuse community partnerships". Unlike their predecessors, these would be "locked into the decision-making structures ... of the participating agencies" in ways which gave them a "clear ability to influence resource allocation decisions".

But the partnerships would be more than just DACs with money. Responding to the new focus on community safety and prevention, the report says the aim would be to reduce drug-related harm to the community as well as to individuals – to "reduce the cost of drug misuse to the local area". Like the Home Office drug prevention teams and the DoH's healthy alliances and healthy cities initiatives, the partnerships would embrace local community organisations and businesses

as well as specialist services.

In this scenario health interests are still key players but no longer necessarily the agenda-setters. Health authorities would be responsible for setting up the partnerships though these would be based on local authority areas. Once in place, the lead agency would be decided locally. Each partnership would have explicit objectives and reports on their work would be submitted annually to the Department of Health.

While the district committees would be firmed up into decision-making bodies, the regional committees would be abolished, a move in line with the diminishing role of the regional health authorities on which they are based.

DoH insists on deletion of call for national drugs agency

In January Howard's draft report incorporated a major section on national action which by June had been dispersed and watered down into a series of non-committal suggestions (see panel). Effectively the consultants argued that national government needed to get its coordination act together if local collaboration was to succeed. The DoH insisted that making recommendations for national action went beyond their brief.

The most far-reaching recommendation – that government should consider setting up a national body to mirror and develop the local partnerships – was deleted. It's believed that the Department of Health was concerned that the recommendation would be 'hijacked' by the Home Office. Rather than risk conceding more of the drug policy initiative to another department, the DoH had the recommendation removed.

Most of the remaining national recommendations were rephrased to make "suggestions" to government about what "could" be done rather than recommendations. The net result – and probably the intended one – is that the Government could

change little or nothing at national level without being seen to ignore its consultants' report.

Roger Howard's report seems to have become a casualty of the ongoing battle between the Home Office and the Department of Health over which would take the lead in a more coordinated drugs strategy. Several schemes put to the Cabinet drugs subcommittee chaired by Tony Newton have foundered on the constituent departments' refusal to countenance reductions in their power and budgets.

The interdepartmental "squabble" surfaced most publicly in April when it was reported that the "strong political will" to create a single drugs office had been stymied by Home Office and Department of Health disagreement over which should take the lead.³ The Treasury too was reported to have an interest in "firmer control" over the £535 million government anti-drugs budget.

The prize being fought over – a new national drugs body – was trailed in February 1992 when the then Home Secretary Kenneth Baker was said to be "drawing up urgent plans" for a powerful new agency.⁴ At that time *Druglink* speculated that any such agency would be likely to be based in the Home Office, the department which has fronted UK drug policy since after the First World War. With 20 local drug prevention teams in place, the Home Office is now in a strong position to argue that it has shown the way forward in the

national coordination of local anti-drug partnerships.

The need for improved coordination now appears widely accepted inside and outside government. Tim Rathbone MP, who chairs the All Party Parliamentary Drugs Misuse Group, spoke last November of "entirely inadequate coordination between departments".⁵

■ In an internal paper which they have used to lobby central government, the Local Government Drugs Forum highlights the fact that the current division of responsibilities for drug misuse prevents money

being switched between different government departments or pooled to achieve coherent national objectives.

Perhaps the clearest example has been the reluctance of the criminal justice sector under the Home Office to fund rehabilitation or treatment services as an alternative to custody or as a crime prevention strategy. Such alternatives may help relieve the pressure on the criminal justice system but there is no mechanism for switching these resources into the Department of Health's treatment efforts.

How the national recommendations changed

The original text has been struck through; the text which replaced it (if any) is italicised. Other text was unchanged.

~~UNDERPINNING LOCAL COOPERATION THROUGH NATIONAL ACTION~~ (heading deleted)

- Central Government ~~should~~ *might* consider ~~setting up a National Partnership Group to provide for the development and implementation of national strategies undertaking a review of national arrangements for coordinating efforts aimed at tackling drug misuse at the local level.~~
- Our research highlights ~~calls~~ *suggestions* ... for central government to provide a clearer, more coordinated strategic lead so as to underpin local collaboration.
- Much expenditure ... takes place outside of specialist drug services. Whether [it] provides value for

money in tackling drug misuse at the local level is ~~unknown unclear~~. A national audit ~~should~~ *could* be undertaken to ascertain what resources are being spent ...

- The availability of targeted resources for tackling drug misuse has been crucial in enabling local cooperation. Such resources ~~should~~ *could* continue to be ~~are seen as necessary~~ as part of a national strategy.
- The way Central Government coordinates the allocation of resources at a national level for tackling drug misuse ~~needs to~~ *could* be reviewed so as to provide a framework within which local collaboration is enabled.
- The NHS Drug Advisory Service's role ~~should~~ *might* be reviewed and developed to enable it to perform an enhanced service at the local level.

1. Baker P. and Runnicles D. *Coordinating drugs services: the role of regional and district drug advisory committees*. London Research Centre and Local Government Drugs Forum, 1991.

2. Baker P. "Disjointed coordination". *Druglink*: 1991, 6(5), p.12-13.

3. *Sunday Telegraph*: 25 April 1993.

4. *Sunday Times*: 23 February 1992

5. *Druglink*: 8(1), p.4.

'Prescribing works' could be moral of a tale of two cities

A report from Sally Haw who in the '80s researched drug use in Glasgow and Edinburgh has highlighted the dramatic differences in recent drug use trends in the two cities.¹ Published in June by Lothian Health, the report says an oral prescribing policy can impact beneficially on patterns of drug use and may lie behind the shift away from injecting in Edinburgh.

Such conclusions are highly controversial in the context of the arguments between pro- and anti-prescribers in the cities. The stakes have been raised by a spate of over 100 deaths over the last two years among drug injectors in Glasgow, where drug-related incidents are now the leading cause of death among young adults.²

Glasgow's HIV and Addictions

Coordinator believes the virtual unavailability of methadone prescribing in Glasgow is one of the root causes of the problem.^{3,4} Some local parents argue that such prescribing as there is (especially of drugs such as temazepam) may lie behind the deaths.⁵ After considerable pressure the Crown Office has agreed to hold a fatal incident inquiry, due to meet for the first time on 1 November.

Virtually all the deaths have been among drug injectors and closely associated with drug injection.⁶ This makes the prevalence of injecting a doubly important public health measure, related not only to the potential for HIV spread but also to sudden death. Sally Haw's report documents the "dramatic" move away from injecting in Edinburgh

while 40 miles away Glasgow's drug users continue to inject at an alarming rate.

In both cities in the mid-80s most problem drug users injected. By the early '90s less than 30 per cent of a sample of Edinburgh drug users had injected in the past year while in Glasgow all the sample had injected in the last two months, nearly 90 per cent at least once a day.

There is little doubt that the reduced injecting rate in Edinburgh has helped halve the extent of HIV infection among the city's drug users. It may also have helped prevent sudden drug-related deaths among problem drug users, which in 1992 numbered just a fifth of Glasgow's total.

While not the whole story, there is some evidence that Edinburgh's move away from injecting is partly due to the city's adoption of an oral prescribing policy in the late '80s. The policy was spearheaded by Dr Judy Greenwood's Community Drug Problem Service (CDPS), which recruited the city's GPs into an accessible network of prescribers.

Now 80 per cent of GP practices in Edinburgh prescribe substitute drugs to addicts and harm-reduction

objectives are widely endorsed. The GPs firmly believe their prescribing helps reduce injecting, a conclusion supported by a study of CDPS's patients which found those being prescribed opioids were much less likely to inject.⁷

In contrast, Glasgow's GPs have taken their lead from specialist services which have been firmly against prescribing.⁸ A survey of south Glasgow's GPs found just 13 out of 77 prepared to undertake methadone maintenance and a large minority unwilling even to prescribe on a reducing basis.⁹

Cultural factors and the extent of the HIV threat in Edinburgh may have played their part in the city's turn away from injecting, but Sally Haw believes her data supports "the view that patterns of drug use can be manipulated through ... a carefully managed oral prescribing policy".

When Glasgow's fatal accident inquiry opens it should help establish whether the lack of a positive prescribing policy there contributed to the deaths, or whether more methadone may simply have added to the pool of potentially lethal chemicals in circulation.

1. Haw S. *Pharmaceutical drugs and illicit drug use in Lothian region*. Edinburgh: Centre for HIV/AIDS and Drug Studies, 1993.

2. Gaba M. "Glasgow inquiries into drug fatalities." *British Medical Journal*: 2 October 1993, p.822.

3. Gruer L. "Death from drug overdose." *Glasgow Herald*: 4 February 1992.

4. "Drug user deaths up tenfold in Glasgow." *Druglink*: 1992, 7(2), p.7.

5. McAlpine J. "Over the sure."

Scotsman: 23 June 1993.

6. *Druglink*, op cit.

7. Griffin S. "Drug misusers in Lothian: changes in injecting habits 1988-90." *Brit. Medical Journal*: 13 March 1993, p.693.

8. Shewan D. "Illegal drug use in Greater Glasgow: a survey of current service responses." *International Journal of Drug Policy*: 1992, p.39-43.

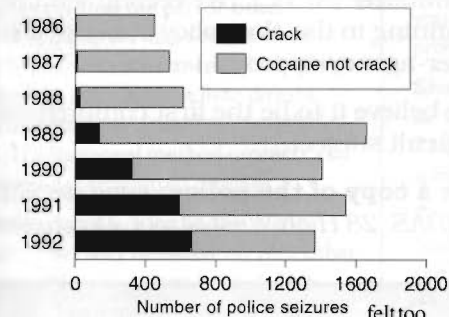
9. Kidd B.A., Radston G.E. "Injecting drug users in Edinburgh." *British Medical Journal*: 22 May 1993, p.1414.

'It's just that I was two years out,' claims US prophet of British crack epidemic

Ex-DEA official Robert Stutman, prophet of crack doom in the UK, maintains that everything he foretold at a UK police conference in April 1989 has come true: "The only problem ... was that I said it would take two years. I should have said four". Four years brings us to now. It is certainly the case that some parts of the UK now host the volatile cocktail of pervasive poverty, lack of legitimate opportunities, crack, high dealing profits, guns, and an imported or home-grown gun culture.

Surveys of police areas by the National Criminal Intelligence Service (NCIS) over the past 12 months reveal how crack has spread beyond London to become a significant element in most inner-city drug scenes. Crack now accounts for roughly half of all police cocaine seizures but, because of the 'cottage industry' nature of the trade, for less than 10 per cent by weight.

Last November NCIS surveyed all 43 UK police forces. Twenty-two said crack was "available" in their areas and eight more said it was "widely" or "increasingly" available. This summer the NCIS followed up



with a survey of these eight forces.

The results hold few surprises with major UK conurbations reporting the widest availability – London (over 70 per cent of crack is seized in the South East), Greater Manchester, the West and East Midlands, and Bristol. Even sedate Cheltenham has its crack producers.

Several forces admit to inadequate intelligence, some relying on reports from local drug workers. A force reporting no crack in its area was corrected by one of its own officers who told the NCIS that it was readily available.

Policing the crack trade is currently a subject of controversy in police circles. After the crack panic of 1989 the Metropolitan Police set up a Crack Intelligence Unit. In line

with a decision to decentralise – but to the dismay of officers who favour a London-wide strategic approach – the unit was replaced in April by crack liaison officers in each area drug squad. Across the country the NCIS found drug squad officers who felt too little was being done to combat crack.

Behind much police concern is the level of the violence associated with the crack trade. The recent spate of fatal shootings using sophisticated and powerful firearms marks a worrying departure in the UK drug scene.

Police intelligence is that much of the traffic is controlled by Jamaican criminals, many of whom have fled the enforcement crackdown in Jamaica. Much of the violence appears related to 'business' rivalry between dealing gangs, including helping themselves at gunpoint to each other's cocaine shipments.

Two hundred Jamaican gunmen are believed to be operating in London alone. Police suggest that only Britain's gun controls stop them

committing more violent offences.

Crack use may also be related to less serious revenue-raising crimes to fund purchases. A police superintendent in charge of the St Paul's area of Bristol recently said local street robberies had doubled in the past year,¹ while a Manchester researcher told *Druglink* that the advent of crack had sent burglaries "through the roof".

■ A recent survey by Release showed that agencies are seeing more (though still relatively few) cocaine and crack using clients, at least a third of whom are white women. Reports are surfacing of cocaine users who have become heroin addicts after using the drug to control the cocaine experience. Many present with an opiate rather than a cocaine problem.

Press allegations in September that Dr John Marks of the Halton drug dependency unit in Cheshire was prescribing crack to "dozens" of his patients have been denied by clinic manager Andy Palombella. Dr Marks was not prescribing crack, but cocaine powder, and then only to a handful of patients. Others were prescribed cocaine in a solution to be taken as a nasal spray.

1. *Sunday Times*: 22 August 1993.



BENZODIAZEPINE WITHDRAWAL

I would like to thank all the people throughout the country who took the time to contact me and forward useful literature related to our benzodiazepine withdrawal project. I now have a wealth of information on what is happening nationwide in relation to benzodiazepine projects.

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



WORKING WITH GPs

Thank you for publishing our call for contacts on drug services and GPs. I had a number of calls and letters as a result – all from individuals and agencies interested in sharing experiences about working with GPs and ideas about good working practice. I also know from other contacts that there is a lot of interest in developing work with GPs so I hope to set up a small seminar on the subject in the autumn. Meanwhile, if there are any other people interested in this work, please get in touch.

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

HEARD OF TRIPPING ON TRILUDAN?

We have recently been made aware of a potential problem involving Triludan (chemical name terfenadine), which is an antihistamine. Although it contains no cyclizine, our source of information claims that, when taken in large quantities with alcohol and a small quantity of amphetamine, it causes profound hallucinatory effects. We would be interested to hear if anybody else has heard of the use of Triludan with these other substances.

Contact: *Mark Barrett, Turning Point, Stanfield House, 4 Stainburn Road, Workington, Cumbria, CA14 4EA, phone 0900 65737*



COMPREHENSIVE POLICY ON 'UNDER-AGE' SYRINGE EXCHANGE NOW AVAILABLE

We now have available copies of the Wessex Syringe Exchange Group's policy for the provision of needle exchange services to young people. Thanks to all the people who responded to our previous entry on the Connections page.

The Syringe Exchange Group is a subgroup of the Wessex Regional Drug Workers Forum and the policy was drawn up by the group with the regional drug problem team. It has been approved by the Dorset Area Child Protection Committee (ACPC). (We recommend that any agency planning to use the policy submits it to their ACPC for inter-agency approval.)

We believe it to be the first comprehensive policy on this difficult subject.

For a copy of the policy: *send an SAE to Andrew Preston, CADAS, 28 High West Street, Dorchester, Dorset DT1 1UP*

COMPUTERISED PRESCRIBING – IN SEARCH OF FP10s

We are trying to computerise our prescribing system. However, our health trust does not seem to be able to get the appropriate stationery for hospital prescriptions to be computerised (FP10s). Has anyone else managed to get these in the appropriate form?

Contact: *Dr Patrick Parker, c/o Exeter Drugs Project, Dean Clarke House, Southernhay East, Exeter EX1 1PQ, phone 0392 410292*

4 DRUGS AND YOU

PART ♀ ONE

Clear and reliable information on how illegal drugs affect women's health is hard to come by. Findings are often based on inadequate information about the women involved or on animal studies. Drugs can affect appetite, weight and appearance, moods and ability to cope with everyday matters. But this factsheet concentrates on how they affect your monthly cycle, and your chances of protecting yourself from pregnancy and sexually transmitted diseases.

Drugs and the monthly cycle

Some women who use drugs find their periods becoming irregular, heavier or lighter – sometimes stopping altogether. In fewer cases, women have experienced spot bleeding after taking the drug.

Why does this happen? Again, there is little information about how drugs affect the hormone system. It is known that heroin has a direct effect on the part of the brain which controls your cycle – which can stop you ovulating and stop your periods. *If your periods stop, that does not necessarily mean you have stopped producing eggs. You can still get pregnant.*

Some drugs affect the cycle because of their other effects on the body. Drugs that dull appetite (such as amphetamines, ecstasy and heroin), that make you more active and lose sleep (such as amphetamines, cocaine and ecstasy), or that increase your body temperature (such as ecstasy), can all affect your weight and general health. This in turn can affect your periods and moods. A well-balanced diet, sleeping well and gentle exercise can help.

The pill and other hormonal contraceptives

There is no evidence that illegal drugs stop the pill (or other hormonal contraceptives) working if they are taken as intended. However, street drugs may be mixed with substances which could have an effect – no one really knows. Also, serious liver disease (which may be associated with alcohol or drug use) can interfere with hormonal contraceptives. No hormonal method protects you from HIV infection and other sexually transmitted diseases.

The pill Taking it regularly can be a problem for people with a serious drug or alcohol problem. They may be better off with other methods (such as Depoprovera or Norplant – see below). This applies even more to the 'mini-pill'. The mini-pill contains only progesterone (rather than progesterone plus oestrogen, as in the more usual 'combined' pill) and has to be taken every day at the same time.

Drugs may make you or your partner more likely to want sex but less likely to use contraceptives. Heroin and other drugs that cause periods to stop may lead to a false sense of security – the assumption that you cannot get pregnant so don't need to take the pill.

Being sick if you are on the pill can make it ineffective. So can forgetting to take it on time – that means within the 12-hour safety margin for the combined pill and more or less bang on time for the mini-pill. On these occasions you will need to use condoms or some other form of protection.

Smoking while on the combined pill has been discouraged for some time as it increases the risk of heart disease.

Depoprovera and Norplant Highly effective contraceptives based on progesterone. Once in place, neither requires the woman to do anything nor cooperation from a sexual partner. Should be considered when taking the pill every day may be unrealistic.

Depoprovera is given by injection every three to four months. It often causes menstrual flows to be lighter or to stop altogether – a harmless side-effect which some women appreciate. It has been linked with irregular bleeding after delivery of a baby. However, this is usually light, will stop, and should not give cause for alarm.

Norplant is placed under the skin of the arm. Protection from pregnancy lasts five years, during which time it can be reversed if the woman wants to have a baby. New and needs special training to apply so not available from all GPs and family planning clinics. Less interference with menstrual cycle than with Depoprovera.

Non-hormonal contraceptives

The coil/IUD Anyone who is sexually active could be at risk of pelvic inflammatory disease (PID) and other sexually transmitted diseases (STDs). If you have a coil, you are at greater risk of PID. Women with HIV infection are generally advised not to use the coil/IUD. It may also make painful periods worse. Otherwise, it is safe and effective, requiring no cooperation from sexual partners. No protection from HIV and other sexually transmitted diseases.

The 'cap'/diaphragm Needs an initial fitting by a trained doctor or nurse and to be used every time. It should always be used with a spermicidal cream. Rapid weight loss (perhaps due to drug use) can mean the cap no longer fits properly, making it less likely to protect you fully from pregnancy. The spermicidal cream offers slight protection from HIV (see below).

Sheath/condom The best protection from HIV infection though far from foolproof. On its own not a reliable form of contraception. Requires cooperation from your sexual partner and care to avoid it splitting.

The female condom Has great potential because it gives women control in protecting themselves and their sexual partners from HIV and other STDs, as well as pregnancy. Free at family planning clinics which stock it. Elsewhere it costs £3.95 for 3.

However, studies differ on how acceptable it is to women. Some of the problems reported include it splitting, slipping out of the vagina, being accidentally pushed in, or the penis accidentally entering the vagina outside the condom. Women have objected to discomfort caused by it rubbing during intercourse, and to the rustling and noisiness of the product and its cold feel.

Spermicides These come in lots of different forms – pessaries, creams, sponges, etc – for use on their own or with caps and condoms. Spermicide (nonoxinol) is thought to be an extra barrier against HIV. It can cause side-effects with high levels of use.

Sponges are particularly popular because so easy to use. They are easy to insert and pull out, require no cooperation from sexual partners, and protection from pregnancy lasts 24 hours. Because of the spermicide they also provide some protection from HIV, but nowhere near as effectively as condoms.

Discordant defence

Poor coordination is leaving rehabs at the mercy of the market

WITHDRAWAL IN OCTOBER 1992 of the plan to ringfence funds for residential care left local authorities and providers the near impossible task of having systems in place for April. Even more difficult was the need to make major financial and policy decisions at short notice, with limited information, and in an atmosphere of near panic. Most local authorities were unprepared, some with no assessment procedures, many with obstructive or inept ones, others having made ill-advised block-purchasing deals which proved untenable in the face of clients' diverse needs and preferences. The first three months were marked by chaos in assessment, impeding clients' access to services. Soon it was clear that the most needy were not making it through the obstacle course.

The response of SCODA and Alcohol Concern received much criticism; it did seem lacking in urgency. ADSA (the Alcohol and Drug Services Alliance) was important in monitoring developments, providing information and a link for smaller providers. However, its lobbying was flawed by the unrepresentative and unaccountable nature of the group and by its failure to coordinate with SCODA at key moments when cohesive public representation was required.

This came to a head in July when the DoH released the report from Goldsmiths' College on the first three months of community care. It recorded significant drops in the resources available to residential services and in staff and bed numbers, but the fact that wholesale closures had been averted allowed the Department of Health to claim all was well.

Days before ADSA had fired off a press release based on its finding that "Over 90% of the agencies ... say their clients are not getting the help they need". It might have had greater impact if saved for a coordinated drugs/alcohol field response to the cosy picture painted by the Department of Health. SCODA and Alcohol Concern did respond to the DoH's statement, mildly warning against assuming Goldsmiths' report "paints the final picture," but they did not contest the official line that, for now at least, the system was holding up. These contradictory messages discredited well-founded concerns about client access and the viability of services.

Goldsmiths' key findings that admissions had dropped by 'just' 27 per cent and that local authorities had set aside £33 million for drug and alcohol clients also went uncontested. Both were soon shown to be perhaps 50 per cent on the wrong side of reality. SCODA and Alcohol Concern failed to spot this, depriving services of crucial ammunition in their attempts to show they were not crying wolf.

Providers too can hardly be said to have stood firm or together. A providers' coalition to match the power of the purchasers is noticeable by its absence. To widespread dismay, some houses plumped early for deregistration as care homes, maximising their residents' rights to

housing benefit. This aids short-term survival but also undermines claims about the specialist nature of drug and alcohol services and their value in improving public health and reducing criminality. By August, 17 per cent of beds had been deregistered. While a few low-care projects can deregister without affecting their services, it is increasingly difficult to agree housing benefit rates which can support the level of supervision drug users need. Services which provide nursing care, care for children, or cater for other specialist needs, do not have the option of deregistering.

The allocation formula resulted in generous community care grants to shire counties, while inner-city boroughs, where drug use is higher, were left hopelessly short. Many local authority purchasers had no choice but to ration care. Early on

"Providers have accepted spending limits: the words 'turkeys' and 'Christmas' spring to mind"

limits were put on lengths of stay and costs. The 12 inner London boroughs agreed to limit charges to £220 and £315 a week for care and nursing homes respectively. This was done without consultation with providers and in the absence of a proper assessment of

costs, outcomes, or quality. It fails to recognise the importance of maintaining a range of provision, where more specialist services, and those catering for complex needs, cost more.

Many providers have capitulated and allowed these limits to be imposed. Some can survive in the short term using subsidies from their parent organisations or reserves, but long term this can only result in reduced levels and standards of care. If providers accept the myth of the buyers' market, we escalate the trend which will force high-care services out of business and result in a reduction in the range of services. The words 'turkeys' and 'Christmas' spring to mind.

Purchasers are looking for cheaper alternatives to residential care and some providers are happy to propose day programmes. Fine, if you can ignore the needs of drug users who are homeless or too chaotic to turn up Monday to Friday. Pity the drug user who gets thrown out of the low-care hostel after five minutes for using drugs and is dropped from the day programme because he missed his 10am assertiveness class!

The Government's agenda seems clear. Loss of drug and alcohol services will cause few electoral ripples; HIV services are likely to be next. The market will do the rationing for them, ably assisted by poorly informed purchasers.

Providers now need to put maintaining an adequate network of drug services above short-term survival. The priority is to press for reallocation of the community care grant to put drug and alcohol monies where demand is greatest.

Better informed purchasing is in the interests of budget-holders, providers and, most of all, service users. We should give purchasers the hard information they need to prioritise budgets, so that drug users in crisis, and those with complex, entrenched problems have the services they need. ■

by

Alison Chesney

The author is the Director of the Cranstoun Projects, a voluntary agency whose projects include five residential services.

Keep your bra and burn your brain?

The research which is helping to lever feminism out of its '60s time trap

TALKING WITH and being with, the kind of young woman drug user who *doesn't* attend drug services led me in the last issue of *Druglink*¹ to call for a more integrated approach to gender in the drugs field, one in which the roles of femininity and masculinity are taken into account.

The gender issue has been addressed mainly through feminist input into the literature and service provision. Drawing on my own research, I argued that much of this input is now out of sync with everyday life, especially when it comes to today's young drugtakers. In this article I examine the research more closely. Though (perhaps, because) they rarely cross the thresholds of drug services, the young women I spoke to have some important messages for service providers.

Interviews with 30 young women aged from 15 to 25 (see panel for more on methodology) formed the project's core data. Contacted by a range of methods, only three of the 30 had been to a drug service for help and advice. Sixteen had been in the dance and drugs 'scene' for at least two years, five for less than a year.

Two of the women had never experimented with drugs and one had tried ecstasy and amphetamine only once. The rest had all been through periods of weekly use of various permutations of ecstasy, LSD and/or amphetamine ranging from three months to three years. Eight had stopped taking these drugs entirely at the time of interview and seven were using less often. Only one had stopped going to clubs. All but three smoked cigarettes, most since the age of 14 or younger. Most had also drunk alcohol at a similarly young age and moved on to experiment with cannabis within two years.

Within two years of trying cannabis, just over half the sample were taking LSD, ecstasy and amphetamine. For some, a 'sweet shop' approach to drug experimentation – 'I'll try anything once', 'I'll always want to get just that bit more wasted' – clearly hastened their progress.

Were they universally introduced to

illegal drugtaking by the men in their lives? Emphatically not. Roughly half (14) had first accessed drugs through a mixed-sex group of friends. Of the remainder, half had been initiated by other women/girls and half by males (mainly boyfriends).

***"Sixties-style
consciousness-raising
does not appeal to these young
women – they feel they're
already there"***

Their drug use formed an important part of what for them was a highly valued part of their lives. They found it difficult to separate out the elements of the dance/drugs experience – music, drugs, dancing, togetherness – and ascribe to one greater importance. Sounds and body language rather than words were the most common responses to being asked to describe the experience.

Where words were forthcoming, some

by

Sheila Henderson

The author is a Research Associate with the Lifeline Project in Manchester working until recently on the project Young Women, Sexuality and Recreational Drug Use.

Research involving in-depth interviews with young women using drugs in the club scene who do not attend drug services suggests it would be counterproductive and inaccurate to apply unmodified feminist analyses of the '60s and '70s to their lives or to their drug use. Services seeking to establish a fruitful relationship with this group will need to appreciate that, for them, being female does not preclude sexual equality and independence and avoid seeing them solely as victims of male sexual oppression.

gave slightly more weight to the drugs, others said 'music is the drug', and still others spoke of 'dancing on the notes' when on ecstasy. 'Feeling like you belong' and the degree of nonverbal communication possible also figured high on the list of desirable elements. Even the two non-users, who talked ecstatically about the pleasures of the 'scene', emphasised the central role of 'buzzing off' other people's drug use.

Sexuality without sex?

One drug effect was frequently cited as adding to the appeal of the dance club atmosphere for the young women. This was the contribution of drugs to an environment in which 'copping off' – finding someone to have sex with – was not a primary goal either for the women or the men. Although by no means universal, this effect on men's behaviour seemed one of a range of factors (including the women's own drug use) which enhanced the young women's confidence in their physical abilities and in their abilities as actors in a social world.

The dance club setting offered these young women a social space in which to explore a range of sensual and sexualized pleasures, yet one in which pursuing sex or being pursued for sex was downplayed. Lack of active interest in sex often appeared to accompany periods of heavy club-going and 'dance drug' use.

This doesn't mean these women were sexually naive or disinterested. Most felt women should enjoy sex and be able to have casual sex on the same terms as men. Often their sexual activities were curtailed by a concern that promiscuity involved unacceptable risks. AIDS figured so strongly among these that there was a general commitment to using condoms. Four young women volunteered that they had undergone an HIV test despite no obvious risk factors.

New youth cultures constantly recycle elements – styles, music, drugs – from the '60s, but today's young drugtakers operate in a very different social landscape. Among

other changes, jobs (or, the traditional 'career' route for women, eligible men with jobs) no longer grow on trees. Full employment and all the expectations of the future this entails used to be a fact of life for the bright young things of the '60s. You could always get a job if or when you tired of trying to beat the system. 'Opting out' could usually be followed by 'opting in'; the teenage 'phase' ended by the assumption of a job, a home, even a family.

Equality and ambition

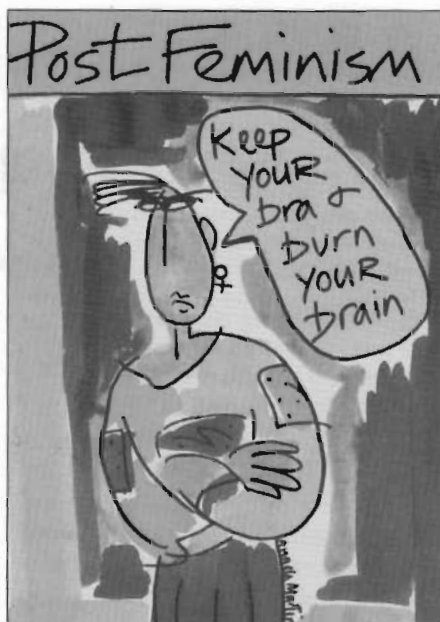
Expectations today are very different. For the first time since the Second World War most parents cannot automatically expect their children to have better opportunities than they had, and most teenagers would find it hard to believe in an ever-improving future. At the same time, the scale and scope of consumer culture have expanded almost beyond recognition, playing an ever-increasing role in defining our lifestyles and aspirations.

Against this gloomy economic backdrop, these young women were surprisingly resilient, confident and assertive, with high aspirations – but not of the traditional kind. Even in their mid-20s, many still lived with friends, on their own or with their parent(s), suggesting that the old female story of romance, marriage and the kitchen sink held

Research methods

This article is based on a two-year research and development project completed in October 1993. Based in Manchester and funded by the North West Regional Health Authority, it focused on the 'dance drug' phenomenon. Three hundred and four young women and 70 young men aged 15-25 living and (typically) 'club-drugging' in the north west of England participated in the research.

The core data was my 30 taped in-depth individual interviews. These were accompanied by a lifestyle questionnaire and covered: drug, clubbing and sex 'careers'; attitudes to sex and AIDS; effects of drug use; and self-concept. Supplementary project data included a small study of ecstasy use (103 subjects), an evaluation of Lifeline's young people's information materials, field notes and participant observation diaries, taped interviews in which key young women interviewed their peers, plus background discussions with six individuals and two groups.



This postcard's message is that abandoning feminist fundamentalism means the return of the bimbo. But for today's young women, 'wearing bras' can go with sexual equality and a far from frazzled brain

limited appeal as *the* option for the future. 'Finding Mr Right' did feature among the dreams and aspirations of some but they all, whether unemployed, working, or in full-time education, often dreamed of achieving personal fulfilment in a range of social spheres.

Among these dreams were a good job – not any job, but one conferring status, responsibility and interest – and foreign holidays/travel – not as a lethargic break from dull routine, but as an opportunity to broaden their horizons and develop as independent adults. Becoming *dependent* – on men, employers, the state, or anything else – was not part of their vision of the future. Their determination to make their own opportunities, and confidence in their abilities to do so and enjoy what the world has to offer, was remarkable.

From a variety of sources, feminist ideas had been incorporated into their daily lives and their ways of thinking and feeling about themselves and about men. Economic decline, which might have been expected only to diminish their sense of power and self-worth, appears if anything to have had the opposite effect. The wasting away of manufacturing and 'male' jobs and the upsurge in 'female' service industry jobs has contributed to a further shake-up in traditional gender roles and behaviours. Even if they wanted to be dependent on a male earner, one might be hard to find.

These shifts in the ideological and economic basis of inequality mean '60s-style consciousness-raising does not appeal to these young women – they feel they're already there, though not in ways all older feminists would recognise or appreciate.

Through feminist spectacles

Perspectives born of the youth cultures of the 1960s need revising in the light of these and other changes. Feminist perspectives are no exception. Although published in 1983, Betty Friedan's very popular book, *The Feminine Mystique*, typified and reinforced the perspectives of '60s feminism.

It described how manufacturers and advertisers in the post-war period tempted the women of the West to want more consumer goods for their homes. By seducing them into believing they could express their femininity and individuality through housework and purchasing consumer goods, this "feminine mystique ... proclaimed full feminine achievement was to be found in being wife and mother". The result was to keep women in a socially dependent position and stop them seeking to determine their own lives and identities.

The key to self-determination or, as Friedan put it, to "growing up", was the women's movement. When in the early days of this movement women burnt their bras, symbolically they were casting off 'repressive' and 'false' consumer identities as well as male prescriptions of womanhood. This critique of consumer capitalism as a repressive force in female life underpinned the view that female drug dependence is a direct result of female social dependence; women were 'sold additions' as a means of keeping them down.²

How would the confident and generally positive young women encountered in my research appear through the spectacles of this brand of feminism?

An extreme application of Friedan's anti-consumerist analysis would conclude that the consumerist dance-drugs phenomenon was merely another version of the 'opium of the people' – young people being lulled into accepting poor social conditions instead of trying to change them.

If the phenomenon were deemed worthy of further analysis at all, this would emphasise features which seemingly support the view that women are oppressed and unable to be their 'real' selves, and that consumer culture is one of the main ways this oppression is maintained. Looming large would be instances of young women being introduced

Some initial guidelines for service providers

Though too early to make specific response recommendations, there are clearly some attitudes/assumptions which would be counterproductive for service providers attempting to reach the kind of young drugtaker I researched, and some others that would at least help to establish channels of communication.

- Don't assume young women on the dance drugs scene are merely taking an escapist route from grinding deprivation and/or one that leads to addiction.
- Understand that for many the fun and the drugs are merged in a positive reality, not an escape from reality.
- Don't automatically assume that their way of being female means they have buckled

under to the male agenda of what women should look/be like, or that these young women are victims/oppressed. Encouraging them to understand themselves in these terms could be counterproductive.

- Appreciate that many of these women see themselves as independent, confident and in control and that they are by no means universally bound into drugs/prostitution/domestic drudgery and damaging relations with men. Question feminist dogma.
- Consumer information rather than counselling or treatment could well be their primary service need.

to drugs and duped by DJs or older boy-friends, or using their looks to get free drugs, free club entry, etc. Seized upon too would be the sexualized images of women on club flyers and flirtatious behaviour on the dance floor.

The seemingly uncritical devotion of some young women to the latest fashions and styles (especially since these incorporate the looks of the '60s and '70s which women's liberation reacted against) would certainly be noted. The hair, the make-up, the skimpy clothes, add up to a feminine look which could suggest these women have also fallen victim to the restricted set of '60s female social options.

From the 'feminine mystique' viewpoint, these young women are slaves both to the fashion industry and to traditional femininity. Nothing's changed, would be the conclusion – youth culture is still merely a means of managing the transition from childhood to motherhood and domesticity. A postcard doing the rounds in recent years, *Post-feminism – keep your bra and burn your brain*, inferring that a review of feminist fundamentalism was tantamount to the return of the bimbo, illustrates this point of view. From this kind of feminist perspective, young dance/drug devotees definitely do seem to be 'burning their brains' and not 'their bras'.

Another example of the gulf between dominant feminist analyses and today's young can be found in the 1984 *Prevention* report from the Advisory Council on the Misuse of Drugs. "The potential contributions to drug prevention of women's consciousness-raising and self-help within the context of the women's movement ... are areas deserving closer study."

It is difficult to imagine how joining consciousness-raising groups could ever have been seen as a form of drug prevention – even more difficult to see it rating higher than Cliff Richard at a rave with the young women I studied.

Such views are an inadequate basis for developing service/policy responses to many of today's young female drug users. The young women in question tend to be averse to feminist fundamentalism and embrace forms of femininity (bras included) which definitely transgress the orthodox feminist norm. It is patronising and alienating to dismiss their energy and sense of independence and adventure as 'false' or transient. The gulf between current drug service provision and the fabric of these young women's lives and needs can only be deepened by such an approach.

Unrepentant consumers

Consumerism is an important aspect of the youth drugtaking phenomenon. Drugs feature, at least in part, as fashion, as part of the leisure and media industries. Taking this seriously, seeing how it shapes the options available to young people, is important. Dismissing or belittling it is bound to create mutual alienation.

Social deprivation remains a major influence on drug use but is not a total explanation, especially of today's 'recreational' use patterns. Even for the most socially deprived, consumer culture defines not only what we lack, but also our dreams and aspirations. Be it the theatre or a video, billboards or TV ads, buying, selling, stealing, desiring or simply watching, the activities and icons of consumer cultures are part of the fabric of everyday life.

Consumerism is not only a major source of personal identity but an arena within which active personal choices are made – for young people, far more real than the worlds of policy and service provision which target them. For us to ignore this would be foolhardy.

The 'dance drug' phenomenon (infinitely bound up in consumerism) has been a significant motor to expansion in drug markets. We now have a mainstream youth culture within which drugtaking is the norm. The drug cultures of the 1960s bequeathed us a legion of professionals whose careers have not suffered greatly due to recreational drug use, but also many regular users of drug services. Today's youth drugtaking boom will also have its casualties – both now and in the longer term. Today's responses could be crucial.

Fashioning a response

How do we ensure that those for whom drugs are a fashion accessory or an adjunct to fun do not progress their drug careers? That living for the weekend does not become living only for drugs? That pill-popping and smoking do not turn into injecting? That young injectors do not take out a 'retirement option' in the shape of a 'legal opiate bubble'?

These important questions are yet to be adequately addressed, but there are some obvious initial guidelines – dos and don'ts for service providers (see panel). Most of all, it is important to realise that young women are as much a part of the dance drugs phenomenon as their male peers. Viewing them *only* as victims of consumerism, men's power, social deprivation, etc, could be a damaging response – it is often far from what goes on in their heads, their hopes and aspirations, the positive choices they make. Viewing young men as representative of young people as a whole, as all jack-the-lads or male oppressors, is equally inadequate – but research in this area is even less evident.

'Keeping your bra' does not necessarily mean 'burning your brain'. ■

1. Henderson S. "Time for a make-over." *Druglink*: 1993, 8(5), p.14-16.
2. Kilbourne J. "The spirit of the Czar: selling addictions to women." In: Roth P. ed. *Alcohol and drugs are women's issues too! A review of the issues*. US NIDA, 1986.
3. Gilman M. "No more junkie heroes?" *Druglink*: 1992, 7(3), p.16.

Crew 2000: peer coalition in action

*Local knowledge, local skills, local people – the way forward
for harm reduction education?*

THE ENORMOUS SPREAD of dance-related drug phenomena took many British drug services unawares.¹ Agencies were slow to come up with a meaningful response to what appeared to be largely non-problematic drug use. In Edinburgh too, services were caught unawares and workers found themselves short of information on the drugs and on the dynamics of this new drug scene.

In several ways the club-dance scene is a risk-laden situation. Many of those involved are young, new to drugtaking, and know little about the drugs they use. Lothian Health Board's grant of £5000 to the Edinburgh and Lothian Drug Advisory Group gave workers with an interest in the issue the chance to explore a new, creative response – a coalition of local young people active in the club scene, supported but not led by drug workers.

Why a peer coalition?

Experience of responding to the ecstasy culture elsewhere taught us some valuable lessons:²

- the number of young people using drugs today far outstrips the capacities of a traditional outreach model;
- most have already made the decision to continue to use drugs and will not stop because authority tells them to;
- these are sophisticated consumers; unless the information presented to them is credible, they will reject it;
- they are more likely to embrace health education messages congruent with their own attitudes and values.

Drug information campaigns may not prevent initiation into drug use, but they may help slow transitions to heavier or more hazardous use.³ We felt that the best way to achieve this goal was to use the existing informal information networks – a peer education strategy.

Our work was based on principles drawn from the founding fathers of harm reduction, combined with theories of educational empowerment.⁴ In *The Drugtakers*, Jock

Young argued that to minimise drug-related harm we should foster the emergence of health-enhancing values and norms in drugtaking subcultures.⁵ This needed to be done through "positive propaganda" about drugs, as horror stories fail to mesh with the experiences of drug users and are rejected.

Young said that only the subculture of drugtaking has the authority to control its members. "[To] control an activity ... you must base your measures on facts and these facts must come from sources that are valued by the person that you wish to influence ... information aimed at controlling drug use must be phrased in terms of the values of the subculture, not in terms of the values of the outside world."

Our groupwork model was based on the Clinton Peer AIDS Education Coalition in New York – a coalition of professionals and homeless young men and women. Most of the latter are HIV positive and involved in sex work to buy crack cocaine.⁶ Working as peer educators in their own communities had raised their self-esteem and helped

by

**Peter McDermott &
Willie McBride**

Peter McDermott is the editor of the International Journal on Drug Policy and acts as consultant to Crew 2000. Willie McBride is a worker at the North Edinburgh Drug Advice Centre and was involved from the start in Crew 2000's development.

In Edinburgh, drug users and local young people together-with drug workers have formed a coalition to inform their peer group about drugs and have focused initially on the local club scene. Their experience of the use of temazepam by clubgoers led to the production of a leaflet targeted on this issue. Such coalitions are a way of reaching the large number of people using drugs which professional outreach initiatives do not have the resources and/or skills to reach.

them stabilise their lives. They began to recognise that they can do work of immense value, work which most of the paid professionals could not do. Seeing themselves as having a valuable role in society was a refreshing change from feeling totally marginalised.

The structure of this group is central to its success. All members have equal status. Worker input is voluntary and unpaid and decisions are made democratically. Workers pass on their skills and expertise rather than exploiting volunteers by letting them do for nothing the work that paid professionals are unwilling or unable to do.

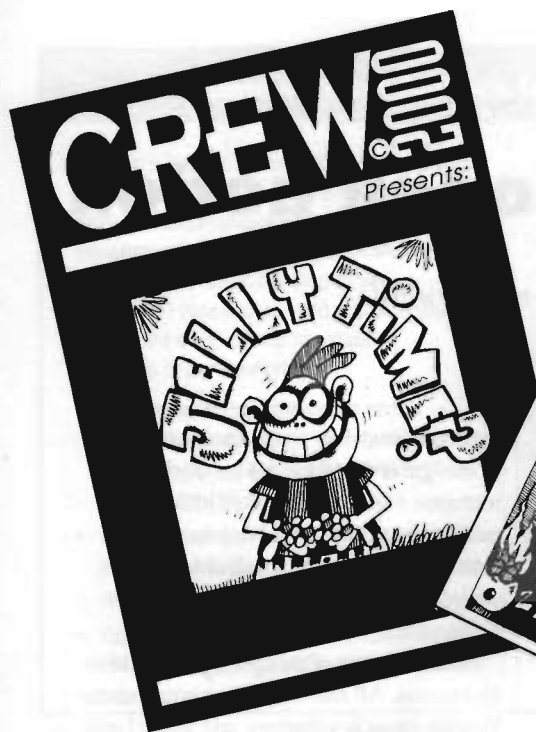
Forming Crew 2000

"Crew 2000" became the name of the peer education group set up in Edinburgh, based on what we'd seen in New York. Initially, recruitment was through friendship networks. The 20 or so young people who became involved were probably a fairly typical sample of clubgoers, including clerks, students, artists, designers, DJs and the unemployed. Such a coalition embraces a much wider range of skills than would normally be available to professional drug workers.

Motives for becoming involved with the project varied. Most volunteers said they'd simply recognised the need for it. All had friends with what they believed were drug-related problems, but none felt that either they or their friends would take such problems to a drug service. Drug workers were felt to be too distant from the lives and concerns of young people in the drug scene.

After getting to know each other, the group began to tease out an agenda. At first, the process was slow. Much time was spent discussing our experiences of drugs, finding common points of reference, identifying our motives and our aspirations – invaluable for forming the trusting relationship needed for such work.

From our first meeting it was clear there was a pressing need to get some drug information out as quickly as possible.



What are JELLIES?
Jellies (which are Temazepam) are one type of a drug collectively called Benzodiazepines (Downers). They are also known as "eggs", "stones" and sometimes "ratty balls" in the "rooms" and in the clubs. Other drugs in the same class are Valium (Valium), Nitrazepam (Nitrazepam) and Librium.

What are the effects of DOWNERS?
The main effects of these drugs are a reduction in anxiety, relaxation of muscular tension and a desire to sleep.

What are the dangers of DOWNERS?
Benzodiazepines can cause dependence if taken over a period of time. When users stop taking the drug they can experience withdrawal symptoms.

There can include insomnia (sleeplessness), anxiety or panic attacks, loss of appetite, nausea, tremors and hallucinations. Abrupt withdrawal from high doses can cause epileptic type fits and mental confusion.

Overdose is possible after taking high doses, but it is much more likely if Downers are mixed with alcohol or with an Opiate drug like Methadone (Methadone) or Dihydrocodeine (DHC) (DHC). People are also at risk of choking on their vomit if they are sick. There have already been 10 deaths in Lothian and elsewhere, a number of deaths through mixing "Jellies" and alcohol (other drugs). HEAVY SCENES!!! Don't do these drugs on your own and don't leave someone who is well "Jellied" on their own.

Some people take Temazepam by intravenous injection. This is a highly dangerous practice. Some people take Temazepam by intravenous injection. This is a highly dangerous practice. Some people take Temazepam by intravenous injection. This is a highly dangerous practice.

Temazepam is now produced in gelatine capsules. Hence the name "Jellies". Surprised? Surprised! These are dissolved by some users for injection. However, once in the blood stream they can re-solidify, leading to thrombosis, abscesses and possibly gangrene - SERIOUS SHIT!!! If you must use Temazepam the best way to reduce these risks is to always take Temazepam and other Downers by mouth.

What is the law on DOWNERS?
Benzodiazepines are prescription only medicines and Class C controlled under the Misuse of Drugs Act. This means they can be possessed in medicinal (original) form without a prescription, but it is an offence to possess them prepared for injection or to supply them to others.

Maximum penalty for possession, if not in medicinal form - 2 years.
Maximum penalty for supply - 5 years.

The cover and a couple of pages from *Jellytime?* Three pages of cartoons based on the distinctive local humour are followed by information on temazepam – a drug causing serious problems in the Lothian area.

We agreed to spend some of the budget on buying leaflets already available in England, despite reservations about their applicability to Scotland. Members identified venues frequented by our target population. The leaflets were divided up between the members each of whom serviced a number of locations, changing the leaflets fortnightly – a strategy also used to distribute Crew 2000's own leaflet, *Jellytime?*

Our second initiative was a club 'condom run' over Christmas 1992 aimed at raising awareness and building credibility on the club scene. Knowing that disinhibited young people are at risk of practising unsafe sex, crew members visited clubs, handing out condoms and leaflets and giving advice on safer sex. Crew 2000 also works with the media to reach a wider audience. The innovative nature of the project and the topical nature of the problem gives us a high local news value, one we continue to exploit to the full.

Jellytime?

Clubgoers in Crew 2000 denied there was a gulf between the so-called 'club drugs' and drugs being used on the estates. Beside the staple stimulant/hallucinogen drug diet of ravers everywhere, in Scotland they also use 'downers' – particularly the benzodiazepine sleeping pill, temazepam – and they use them at the club, not just to 'come down' afterwards.

The usual dance drugs had been tackled using materials produced elsewhere, so it was decided that our first major project would be to tackle the local issue of temazepam ('jellies') on the club scene, using a *Peanut Pete* style leaflet reflecting the region's distinctive humour and culture.

Brainstorming sessions involving the whole group eventually came up with ideas and themes that a sub-group turned into the narrative used in the leaflet. Points that could not be covered in the cartoon were covered in a text section.

The group's commitment to the project is typified by the fact that the cartoonist, a bank worker, took four days off work to complete his drawings in time. *Jellytime?* was ready just two weeks after conception and can stand comparison with the best of professionally produced leaflets. Over 1000 have been sold to drug agencies outside Lothian and a further 500 have been requested by the Lothian Education Authority for schools.

Before distributing the leaflet, group members surveyed 180 young people to assess their knowledge and use of benzodiazepines. A follow-up questionnaire will evaluate the impact of the leaflet.

Reports that crack cocaine had become more available in the region led group members to research the impact of the drug on individuals and communities. Beside desk research, three members visited Merseyside to talk to workers and ex-users. Their conclusion was that harm reduction advice was problematic with crack cocaine – perhaps the only viable approach was to prevent use. They also knew that an information campaign *before* the drug was widely available could stimulate demand, so the group decided to do nothing for now but to carefully monitor developments.

Crew 2000 now has charitable status and is seeking further funding and premises.

Peer coalitions work

In our opinion, Crew 2000 has been an unqualified success. The extent of this success was validated when two volunteers from the Crew attended the Fourth International Conference on the Reduction of Drug Related Harm earlier this year. Interest in their work and in the *Jellytime?* leaflet was high. During one of the plenaries, it was stated (not by someone directly involved!) that Crew 2000 had been the most interesting and radical initiative featured at the

1. Gilman M. "Beyond opiates." *Druglink*: 1991, 6 (6), p.16-18.
2. McDermott P. et al. "Responding to recreational drug use". *Druglink*: 1992, 7 (1), p.12-13.
3. Dorn N. et al. *Drug prevention: a review of the English language literature*. ISDD, 1992.
4. Friere P. *Pedagogy of the oppressed*. London: Penguin, 1972.
5. Young J. *The Drugtakers*. London: Paladin, 1972.
6. Springer E. "Reaching the unreachable. Streetwork with homeless youths". Paper presented at the 10th International AIDS Conference, Amsterdam, 1992.

conference. Funding is being sought to replicate the Edinburgh initiative in other areas.

Working in this manner is not without its problems. Workers involved in a peer coalition must be sensitive to the needs, ambitions and desires of the group as a whole. Untold damage can be caused by workers pursuing their own personal or professional agendas. Therefore, workers getting involved in similar projects should have a clear idea of the purpose of the group.

Some workers have criticised Crew 2000 for being elitist and inaccessible to their clients. But a core principle of this type of work is to enable those *able* to control their own drug use to pass those skills on to others. Somebody attending a drug agency because of problems controlling their own use may have little to teach others. Working with these problem drug users requires a different type of peer group, with different aims and objectives.

Also, it is not enough for group members to be committed to the aims of such a project. Whether workers or volunteers, they must have something to contribute, and be mature and motivated enough to take on a task and see it through. Otherwise the group runs the risk of becoming a talking shop for a clique, and achieves nothing. It is also vital to avoid financial exploitation of group members, a point to bear in mind when seeking revenue funding for such work.

Peer coalitions can challenge the power differential between workers and drug users and radically alter the nature of drugs work – but working in this way requires a commitment to change on the part of workers and managers. Drug workers must be prepared to stop seeing themselves as the 'experts', and begin to see themselves as facilitators, with as much to learn as to teach. In this new order their role is to help drug users define and implement their own agendas, rather than those of the worker, the agency or the funder. Hopefully all sides will come to recognise that all these interests are the same. ■

FOR MORE INFORMATION

■ CONTACT CREW 2000, PO Box 2000, Edinburgh EH2 4RV, or phone Willie McBride on 031 332 2314.

■ JELLYTIME? Crew 2000, 1993. £3 for 10, £25 for 100.

Advice for drug users on temazepam. Available from address above.

Crew 2000 volunteers



A view from the Crew

Two Crew 2000 volunteers describe how they got involved and why

It was a Monday night in October 1992. We were listening to music and playing indoor football at our local youth centre when a drug worker called Willie came in to give us a meeting (or some may have called it a lecture) about the drug ecstasy and other so-called 'dance scene' drugs. Some people found it boring and didn't care, others thought it was interesting. Willie told us all about the problems of the drugs and was astonished at how much some of us knew about them, things that he didn't even know.

At the end of the meeting a few of us were asked if we would like to come along to meet with a group of others about our age to pool some of our information. This group was called Crew 2000 but it was just starting off. We went along because a lot of workers, some of our friends, and ourselves, were concerned about the lack of information going out to people who take dance-scene drugs – ecstasy, speed, acid, hash, and downers.

The meeting included clubgoers, club DJs, and a few drug workers. At first there was a lot being thrown in by everybody. Main topics were dance drugs and the discussions gradually moved on to other drugs also around the dance scene such as Valium and temazepam. These were being widely used after the use of dance drugs for 'coming down'. There was a strong agreement in the group that for some people who could not afford to pay £15 for a tablet, downers were a cheap and readily available hit.

The result of this discussion was the production of Crew 2000's own and first leaflet, *Jellytime?*, which was knocked out in about two weeks. So around four weeks into really talking about the production of the leaflet, we were sitting surrounded by 10,000 *Jellytime?* leaflets filled with information on

temazepam ('jellies') and other downers.

Before distributing the leaflets we decided to talk to people on the streets and maybe they could answer a questionnaire on drugs and drug use. That would give us an idea of the level of knowledge among young people. After all, that was what we wanted to know – whether there really was cause for concern. The responses were very interesting. People were truthful, and there was a high percentage of temazepam users.

Jellytime? started to hit the streets fast and the response was good and still is. We are looking forward to talking again with people and trying to find these truthful people who have hopefully read *Jellytime?*, and find out if they now know certain facts they didn't know before. Any progress is good progress.

The leaflet got a lot of praise at the International Conference on the Reduction of Drug Related Harm this year in Rotterdam which two members of the Crew were able to attend. This was a very large compliment to be paid.

We now thought that a launch event of some kind was needed. Somewhere we could have a party with DJs playing and lots of information on drugs available. Somewhere to meet clubgoers and get involved with putting something back into the scene. So Crew 2000 presented "The Event", hosted by The Vaults in Edinburgh on 25 June. It was a great night with guest DJs and a great crowd.

Now we are looking forward to hearing from the public and also looking for support by way of premises, sponsorships, and communications equipment, as we now have charitable status. Look out for further material by us, because you'll be hearing a lot more in the future.

DR and TC on behalf of Crew 2000



E for Ecstasy is a positive take on the drug the media loves to hate

E FOR ECSTASY. Nicholas Saunders, 1993. £7.95.

This book is a curious example of the entrepreneurship of the '90s. The author wrote *Alternative London* in the 1970s, now runs a large and successful business in Neal's Yard in London, and felt inspired to produce a book to offset what he sees as the establishment misinformation campaign on ecstasy. The book was privately published by the author and has an individual, quirky feel to it.

Its central contention is that ecstasy has probably resulted in far more good than harm. Yet, says Saunders, excessive attention has been paid to the possible dangers and there is virtually no literature guiding potential users to the positive aspects of an 'E' experience. His discussion of the consumption of hallucinogens in pursuit of enlightenment has a decidedly *déjà vu* feeling about it. Clearly the false dawn of instant enlightenment continues to beckon us, but I can't help feeling that the contribution of mind-altering drugs to modern culture is, at the least, debatable.

Nevertheless this is a readable book with a wealth of up-to-date information. Many drug workers will find it extremely useful as a key source of references and information on ecstasy. It could also be edited down to a concise

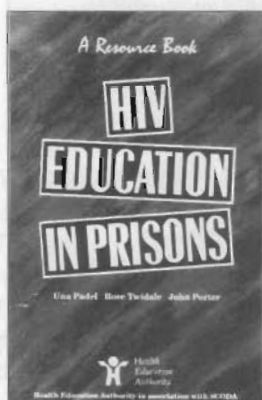
overview for users, covering in particular the law, first time use, effects, what ecstasy is, and where it comes from.

Readers should be cautious about accepting all the information at face value. The author is justified in criticising some of the negative media coverage of ecstasy. However, he errs towards a positive interpretation of the available information in a manner reminiscent of (on the other side) the more clumsy scaremongering voices. He does embarrassing things, such as publishing the results of a survey which he admits are meaningless. Users were asked how taking ecstasy had changed their lives; clearly the desired response was that ecstasy had helped them live richer, more productive lives.

The author feels that he benefited from taking ecstasy and wishes to share this experience with others, but I doubt whether his preoccupations will resonate with many of the young users or potential users of today. Overall, this book harks back to a sentimental '60s flower-child generation, far removed from today's tough, mass rave-dancing culture.

Michael Farrell

Senior Lecturer, National Addiction Centre, London
E for Ecstasy is available through bookshops or from N. Saunders, 14 Neal's Yard, London WC2H 9DP, £9 inc. p&p.



How to get into prison and work with prison staff on HIV/drugs issues

HIV EDUCATION IN PRISONS: A RESOURCE BOOK. Una Padel et al. Health Education Authority and SCODA, 1992. £12.99.

The HIV/AIDS and Drug Misusing Offenders Project was based at SCODA and funded by the HEA. This book is the culmination of three years' hard work by the three co-authors from SCODA. Aimed at those working in prisons or in drug/HIV agencies who may get involved in prison education, it begins by explaining the background to the project and then identifies the objectives of HIV education in prisons. This book will be invaluable for non-prison workers in explaining how to negotiate with prison training departments, how to evaluate training needs, and how to assess the effectiveness of courses. Step by step it explains what a statutory or voluntary agency will encounter when first working with prisons, and what can be realistically expected on both sides.

It deals with how to assess the training needs of prison staff and the educational needs of the inmate population and goes on to provide the tools for prison staff to become inmate educators. More importantly, it gives prison officers the knowledge they need to develop a training model for

their own establishment and to run training sessions for other prison staff. The training exercises in the book have been tried out by the project and the initial teaching problems have been resolved. Many can be cribbed complete or adapted by trainers.

Among the appendices is a directory of prisons and young offender institutions with their corresponding district health authorities, regional health authorities and HIV prevention coordinators. Finally, you will find lists of useful organisations – many with long experience of working in prisons – suggestions on updating information, and a glossary of terms and abbreviations.

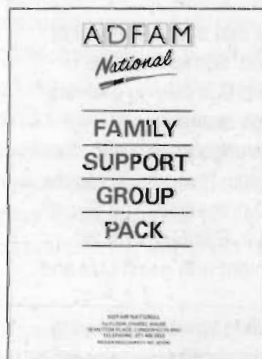
The only let down is the binding, which is cheap and could disintegrate under heavy use. So, gold star to the writers for their good work, and no marks to the printers for the shoddy binding.

James Wilson

Formerly Drugs and Prisons Officer, Terrence Higgins Trust

Sadly James Wilson died before this review could be published. Our condolences to his family and colleagues.

A version of this review was first published in CCETSW's *Training and Working with HIV* newsletter.



A much needed guide for parents – but is it too comprehensive?

FAMILY SUPPORT GROUP PACK. ADFAM National, 1992. £2.50.

ADFAM'S *Family Support Group Pack* has been put together to help those parents/partners and families having a problem with drug abuse in their midst – people who have, I feel, been sadly neglected over the years.

My initial reaction was favourable. The pack goes into great depth about the things anyone wishing to set up a group would want to know about – all the problems and queries, the advantages and disadvantages.

Later I began to wonder how some parents would feel after reading the pack. A lot of thought and work have obviously been put into it, but it could put some parents off setting up a group precisely because so much information is given and the task is dealt with in such depth. For example, there are eleven points about choosing a venue for meetings; I wondered whether PADA would be here today if we had followed this guide – probably still looking for a venue!

Dealing with conflicts in a group, handling difficult members, and listening skills are attributes many parents

would feel they did not possess. It would be a great pity if parents reading this pack then felt this meant they did not have the expertise to run a support group. Most parents, I have found, learn these skills from experience as they go along. PADA has produced its own booklet which I feel is far less formal and more helpful as a beginners' guide. As the group becomes more confident, it could progress to the more formal pack that ADFAM offers.

I am delighted to see that ADFAM offers free training to any voluntary group as long as they cover their own expenses. I hope parents will take up this offer.

This pack is certainly worth buying, perhaps most of all by people who have already set up a group and want to progress further. It would also be excellent material for probation officers, GPs, social workers and other professionals who may simply want to help parents to start up a support group.

Joan Keogh

Chairperson, Wirral Parents Against Drug Abuse (PADA)
The Family Support Group Pack is available from ADFAM National, 1st Floor, Chapel House, 18 Hatton Place, London EC1N 8ND, phone 071 405 3923



The DoH targets parents with this free video pack – and it's not at all bad

DRUGS: A FAMILY MATTER. Department of Health, 1992.

Tony Robinson, its presenter, states this video's main aim at the start: to answer parents' questions about young people's use of drugs, offering a realistic view of the facts in order to dislodge the myths. Another aim, alluded to in the title, is to offset the view that drug misuse is wholly the 'fault' and the concern of the young person involved. In line with this, the video explores family relationships as a potential source of support but also includes them among the sources of tension that can encourage drug misuse.

The first part of the video deals with information on individual substances and later looks at reasons for drug misuse and at parental responses. Legal implications are raised from the angles of both users and parents.

The drug information content includes pictures of the substances and highlights risks, but little about general effects. In its discussion of the possible signs of drug misuse, it reminds viewers that adolescent moods and moods due to substance use can be very similar, so parents shouldn't jump to conclusions. Two Department of Health booklets back up the clear but brief information in the video. The major focus is on solvents and cannabis, with shorter sections on other commonly used substances. Here the fickleness of fashions in drugs has overtaken the resource, with ecstasy attracting a briefer mention than current concern might have warranted.

This section conveys a balanced and non-sensational attitude leading into a later section on parenting where the sense of balance is maintained. Parents are encouraged to be alert and aware of what's going on in their children's lives while responding calmly to suspected drug use. The focus is on the importance of *communication*, aiming to enable the young person to talk about what's happening for them, and parents to talk *with* the young person about the

implications.

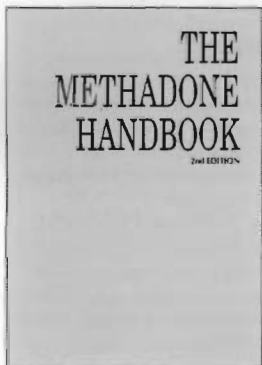
Drugs: a Family Matter would be suitable for showing to parents who say just what the parents in the video say – "I don't know anything," "I'd be scared to death if ..." – people new to the subject and worried. Its structure offers many handy hooks on which to hang discussions and to offer/explore more information – lots of potential discussion material and starting points for exploring parental responses and the implications for family relationships.

The Department of Health has aimed this video at parents' groups. Its accompanying material says group leaders would need no experience in facilitating such groups. They would, however, need to be open to the flexible attitude of the resource and receptive to its aims and messages. In terms of skills, they would need to feel comfortable in enabling discussions and 'chairing' the meeting, drawing things out of the group and feeding in where necessary. Also they would need the maturity and skills to enable the group to work with the feelings inevitably raised by this topic. TACADE's supporting material gives clear, practical guidance to support the group leader. It suggests a very workable programme to follow and provides notes on the ideas behind it. There is a comfortable amount of supporting material – enough to make group discussion possible, without overloading a new group leader.

Videos, especially in the ever-changing drugs field, have a finite shelf life. By themselves, they can be of limited and questionable value as well as expensive. As a trigger to informed discussion they can, however, be very useful. Used properly, *Drugs: a Family Matter* will provide a useful starting point for parents.

Joanna Morgan

*Training and Development Officer, ADFAM National
Drugs: a Family Matter is being distributed by the Department of Health mainly via parent teacher associations*



New edition, new cartoons, more information, lower price – has it hit the mark?

THE METHADONE HANDBOOK. 2nd edition. Andrew Preston. Andrew Preston and Community Alcohol and Drugs Advisory Service, Dorchester, 1993. £0.70.

The second edition of *The Methadone Handbook* is now available, at the reduced price of 70p per issue, with discounts on bulk orders, bringing it more into the affordable range. The first edition was variously described as "hugely successful," "very disappointing" and "essential reading". Given that the booklet is intended to be used by drug workers (particularly, perhaps, prescribers) to hand on to drug users, it seemed appropriate to do a "group review", pulling in opinions from all these quarters. Accordingly we involved drug users and workers (Crew 2000) and a doctor from a statutory drug service involved in methadone prescribing. An added bonus is that we can give a perspective from the other end of the UK on a booklet from the deep south of England.

Andrew Preston's aim remains unchanged: to provide "basic information" to those about to start or already on a methadone prescription. There is the proviso that it is mainly about oral methadone; the user is referred to their doctor or drug worker for information on injectables. The author also suggests it be used for reference and that it is no substitute for personal information and advice from a drug worker.

Its information content is certainly up on the first edition. There is more on side-effects and withdrawals, including a section on dental care, useful information on the law and driving, and a section on being in custody. Unfortunately, the "seven-day detox" mentioned is unlikely to be on offer in most Scottish prisons.

We had some criticisms regarding gaps in the information. "What is Methadone?" was tackled fairly

comprehensively, but the booklet failed to comment on the mythology surrounding this drug, eg. that it is a safe panacea. Similarly, it stopped short of addressing the abuses of methadone – in particular, the favoured combinations with drugs such as cyclizine or benzodiazepines. Finally, it failed to advise on the pattern of consumption necessary to normalise the wake/sleep cycle.

Although criticised in the first edition, the format remains substantially unaltered for the second edition. This now comes in 'methadone green' with cartoons that, while more attractive, were perceived as unfunny by the Crew. Its looks and language were both felt to be bland: safe, inoffensive – and potentially boring for the drug user. Awarded the Plain English Campaign's Crystal Mark, it still includes phrases like "chloroform water ... has no psychoactive effect". This booklet seems a genuine attempt by a drug worker to get it right, but perhaps one done with little reference to the end user in the production process.

Much time and energy have clearly been spent on this booklet but it typifies the safe approach of many drug information publications. Crew 2000 felt that although it was informative and quite comprehensive, it missed the mark as regards being 'user friendly', and in this respect did not compare favourably with, for example, *Smack in the Eye*. Despite these reservations, the two drug workers on the review team felt that on balance the booklet had much to recommend it to their respective agencies.

Crew 2000, Willie McBride and Fiona Jamieson

*Crew 2000 is a coalition of ravers/drug workers in Lothian (see feature starting page 13); Willie McBride works in a community drugs project in Edinburgh; Fiona Jamieson is a psychiatrist with the Community Drug Problems Service in Lothian
The Methadone Handbook is available from ISDD*

Hepatitis C: uneconomic to screen or unethical not to?

Hepatitis C screening/treatment 'uneconomic'

Dear Editor,

In the May/June edition of *Druglink* Tom Waller and Roger Holmes seemed to argue for diagnostic screening for hepatitis C within the drug using population.¹ Among other requisites for successful screening are:²

– an accepted treatment for the disease;
– that the cost should be economically balanced in relation to possible expenditure on medical care as a whole.

Hepatitis C does not fit these criteria and the costs of diagnosis and treatment together are astronomically large.

The basic cost of a serological test for hepatitis C is £5 per negative test and an average of £35 per positive test, as positives need to be confirmed by further tests. Assuming that a district health authority has, say, 500 injectors all of whom are tested and (conservatively) that half are antibody positive, then testing alone will cost £10,000.

Treating these 250 anti-HCV positive clients with alpha-interferon would be even more expensive. Pooled results from recent random controlled trials of interferon alpha in chronic non-A non-B hepatitis³ show that liver enzyme concentrations return to normal in just 2.6 per cent of the untreated groups but 41.5 per cent of patients receiving a dose of 3Mu three times a week for six months. Unfortunately, half of those who benefited from the treatment relapsed when it was stopped.

Returning to our fictional health

authority, if we assume that the 250 anti-HCV positive individuals are treated with alpha-interferon, the cost would be £60 per week per patient, totalling £390,000 over six months.

Only 52 of these patients will have a sustainable beneficial result, meaning that for every £390,000 spent only £81,120 worth of benefits will be accrued. These costs are the minimum as they are based purely on the crude laboratory cost of a test and the cost of the drug, excluding staff and other costs.

Hepatitis C is not solely a problem among intravenous drug users but also among haemophiliacs, renal dialysis patients and immigrants to inner city areas. Applying Holmes and Waller's arguments to these groups would make the cost even more astronomical.

One study showed that 43 per cent of drug users testing positive for hepatitis C were also HIV positive.⁴ This has important implications, as the symptom-free stage of HIV infection is shorter than with hepatitis C. Many of this 43 per cent will become ill from HIV before they experience the complications of hepatitis C. Any treatment they had been given for hepatitis C may be seen as inappropriate.

Another study found that after seven years 12 per cent of a cohort of drug users in treatment had died and 43 per cent were still attending drug clinics.⁵ This has an equally important bearing on the economics of alpha-interferon treatment in drug users. It means that a proportion of people given this treatment will either die from other

causes or be unwell anyway due to their continued drug misuse.

In the light of the above figures it would be naive to believe that alpha-interferon therapy would be acceptable to today's health service ideals of priorities and rationing. Equally one may wonder why hepatitis C should change injecting practices when the threats of hepatitis B and HIV have been looming for some years.

H.M. Perry and D. Wright

Registrar and Consultant in Public Health Medicine/Consultant in Communicable Disease Control, West Glamorgan Health Authorities

1. Waller T and Holmes R. "Hepatitis C: time to wake up." *Druglink*: 1993, 8(3), p.7-9.
2. Wilson J. *et al.* "Principles and practice of screening for disease." Geneva: WHO, 1968.
3. Lau J.Y.N. *et al.* "Managing chronic hepatitis C virus infection." *British Medical Journal*: 1993, 306, p.469-470.
4. Roggendorf M. *et al.* "Antibodies to hepatitis C virus." *Lancet*: 1989, 2(8658), p.324-325.
5. Stimson G.V. *et al.* "Seven year follow-up of heroin addicts: drug use and outcome." *British Medical Journal*: 1979, 1, p.1190-1192.

'Unethical' not to offer hepatitis C test

Dear Editor,

As the authors of the *Druglink* article they refer to, we are grateful to Drs Perry and Wright (see letter above) for entering the debate on this important subject. We are indeed arguing for diagnostic screening for hepatitis C. Perry and Wright cite a WHO paper on the criteria for mounting a diagnostic screening programme. Eight of these criteria obviously apply to hepatitis C and the remaining two, highlighted in their letter, become more applicable if one thinks of treatment as any measure that will improve prognosis.

Leaving interferon aside, behaviour change, especially reducing alcohol consumption, can reduce morbidity, as alcohol is a known promoter of cirrhosis and liver cancer in those with hepatitis C. Many of our clients have moderated their behaviour to protect themselves or to prevent the spread of the virus to their friends, spouses, etc. Our expenditure on needle exchange has increased from £2042 in 1990/1 to £9600 in 1992/3. Concern about hepatitis C was a major factor in this change.

Perry and Wright suggest that high levels of HIV co-infection among drug users may make treating their hepatitis C infection "inappropriate". Since January 1992 we have tested 131 injecting drug users for hepatitis C, hepatitis B, and HIV. Only one was positive for HIV and none had evidence of current or chronic hepatitis B infection. However, 77 were confirmed positive for hepatitis C.

People have a right to know if they are positive so they can institute behaviour change to protect themselves and others. Untested, they will probably remain symptom-free unless or until they

go into irreversible liver failure. It is unethical not to offer a hepatitis C test.

Anyone who volunteers a history of sharing injection equipment and later develop serious liver disease will have an overwhelming case for suing health authorities which did not offer them a test for hepatitis C.

We contest the figures used by Perry and Wright to estimate the cost-effectiveness of alpha-interferon. If clients who test positive for hepatitis C are investigated by liver biopsy, experience shows that only about 10 per cent need immediate treatment.

Thus if all Perry and Wright's fictional 500 injectors are tested at a cost of £10,000 and half of these test positive, about 25 would be selected for alpha-interferon treatment. The cost would be £39,000 (not £390,000) over six months. Five of these clients should have a sustainable beneficial result and (hopefully) have been spared intractable liver failure. The cost per individual successfully treated would be £7800. Given the cost of treating liver failure, this appears to be cost-effective.

All screening programmes should be thoroughly evaluated. Given the apparent scale of the hepatitis C problem in this country, and the potential cost implications, we hope funds will be found to do this as a matter of urgency.

Tom Waller and Roger Holmes

General practitioner and Clinical Director, West Suffolk Drug Advisory Service

Support for hepatitis C screening

Dear Editor,

Tom Waller and Roger Holmes in their article on hepatitis C (*Druglink*: May/June 1993) draw attention to the increasing incidence of the virus in the drug using population.

In South Glamorgan, where there is a very low incidence of HIV positivity among injecting drug users, we find a high incidence of hepatitis C infection.

A recent article in the *British Medical Journal* states that patient education is important.¹ Treatment is successful in only a minority of cases so prevention is essential.

It is our responsibility to counsel our clients on the mode of transmission of the virus. Knowledge of an HIV negative status may make clients believe they do not pose a health risk to their partners. For this reason alone, it is essential that hepatitis C screening is made available to all drug users who agree to be tested.

Potential treatment costs are very high but this is also true for HIV disease. Is it morally acceptable not to screen for the condition on the grounds of the potential cost of the treatment?

Morfydd Keen

Consultant psychiatrist, South Glamorgan Community Drug Team

1. Lau J.Y.N. *et al.* "Managing chronic hepatitis C virus infection." *British Medical Journal*: 1993, 306, p.469-470.

Pilot teams highlighted social deprivation

Dear Editor,

The July/August issue of *Druglink* reported that an article on the work of a Home Office drugs prevention team was withdrawn by the author, a former team member, after a warning that action could be taken against them under the Official Secrets Act. The article reported that social and economic conditions were the principal concerns of local communities rather than drug misuse.

Such a suggestion is neither new nor surprising. From 1988 to 1990 NACRO ran two Home Office-funded pilot projects in Birmingham and Bristol which were the forerunners of the present drugs prevention teams, a report on which has been publicly available for some time.¹

The pilot teams also encountered local communities concerned about these issues. In the report it was made quite clear that drug misuse prevention was taking place against a background of social deprivation. Neither the Home Office representatives nor the national and local advisory committees which supported their work were under any illusions about the realities of life in the areas involved.

This did not invalidate the work of the projects, much of which was about tackling the job, training, educational, accommodation and leisure needs of these communities as part of the context

in which drug misuse was likely to occur.

Some local workers were initially wary of such initiatives, feeling that perhaps resources were going to drug misuse prevention which could have been used elsewhere. In general, however, the teams were eventually welcomed as people who could work alongside others to address what were very often interlinked concerns.

The report put forward a model for drug misuse prevention which favoured community-based initiatives so that the different strands of community need could be addressed in a holistic manner.

Obviously we have not been able to read the article to which you refer, a matter of regret in itself. I hope it does not, as *Druglink*'s comments suggest, pose an either/or alternative between addressing drug misuse and other problems. To do so would be to run the risk of an oversimplistic analysis, accompanied by a response which might result in some local communities being denied even the limited options available.

Iain Crow

Centre for Criminological and Legal Research, University of Sheffield

1. *Community-based drug misuse prevention. A report on the work of NACRO's Drug Misuse Prevention Unit, 1988-1990.* NACRO, 1991.

Personal identifiers 'essential' for regional databases

No requirement to give personal details

Dear Editor,

The recent *Druglink* article on the regional drug misuse databases (September/October 1993, p.8-9) argues that the recording of drug users' initials and dates of birth leads to an infringement of human rights and is unnecessary for meeting the aims of the initiative.

Collection of attributable data (initials and dates of birth) does not, I believe, remove the rights of drug users to a confidential service since drug users do not have to participate to receive the services they require.

Most of the database managers I know readily acknowledge that it is not always appropriate for drug service staff to ask for this sort of information, especially on a client's first visit. It is accepted, therefore, that there will always be some drug users in contact with services who decide not to give their initials and dates of birth, or who are not asked.

To protect the rights of drug users who do give attributable data, the Welsh Drug Misuse Database (and probably all others) is registered under the 1984 Data Protection Act. This makes it virtually impossible for the police or any other organisation to have access to data with initials and dates of birth.

In Wales further reassurance has been given by a Welsh Office circular which states that data stored on the database would not be used for identification purposes. It is essential that the system never fails on this issue if it is to continue. I believe all database managers are well aware of this.

The crucial question is whether it is

worth collecting attributable data if this means reducing the sample of the drug user population we are trying to describe and monitor. In Wales most drug users in contact with services are willing to release this information and presumably have confidence in agency and regional database staff. Around 80 per cent of forms contain clients' initials and dates of birth. The remaining 20 per cent are analysed separately, mainly to provide more complete feedback to participating agencies. The database has not led to a reduction in agency caseload.

Without attributable data one can only talk about events. This would not be adequate for meeting the aims of the Department of Health. For example, a non-attributable system would not be able to monitor trends in the percentages of amphetamine users (new cases) who inject.

An attributable system is essential for providing valuable epidemiological data and planning drug services.

Sue McGuirk

Health information analyst, Manager of the Welsh Drug Misuse Database

Planners, funders and clients need attributable data

Dear Editor,

With regard to the article on regional databases in September/October's issue of *Druglink*, at the Possil Drug Project in Glasgow we have been operating an attributable database for several years. Over the past two-and-a-half years we have been using a form which is processed in the project and sent on to the Scottish Drug Misuse Database. All

major drug projects in Glasgow are cooperating with this system.

For us this system has proved invaluable as it provides the basis for quarterly surveys and for an annual statistical report which is incorporated in our annual report. This provides a feedback mechanism, whereby changes in the drug profile, routes of administration and the social characteristics of new and ongoing clients can be analysed and fed back to team members.

The accuracy and veracity of this data is reinforced by the fact that it refers to unique individual clients. By using this system we can, for example, distinguish clients who have been with the agency before from those new to the agency. We can also analyse differences between mainstream and outreach client work, and focus on any differences in the drug use trends these workers encounter. This can only be achieved by using identifier details such as dates of birth and initials.

Concern about confidentiality is legitimate but two important points should be borne in mind.

Firstly, by the time clients present to a drug project the vast majority will have been entered onto a host of databases (social services, DSS, police) which contain much more extensive identifier information than the drug misuse databases.

Possibly for this reason, we have found no reluctance on the part of clients to assist with information gathering. After all, the information is not going to be used to the detriment of the client.

Secondly, the authors of the article adduce the nightmarish spectacle of drug misuse database information being

linked up to the Home Office addicts' register and possibly to police files, employers' files, health files, etc. But there is no Orwellian Big Brother computer system in operation. All these systems run in parallel, with little or no linkage.

Even if there was a glimmer of potential for linkage to happen, what would it profit the operators of drug misuse databases to let it? If word got out that information was being passed to police and other agencies, clients and drug workers would cease to cooperate. The whole basis of information gathering, painstakingly built up over the past years, would collapse overnight.

All of us - drug workers, researchers, database administrators - are working in a field where sources of information are diverse and fragmented. Estimates of numbers of drug users and the types of drugs they take fluctuate wildly. Probably in no other field is policy implemented and funds allocated on the basis of so little reliable information.

This situation cannot continue indefinitely. Drug agencies increasingly have to show 'value for money'. As a beginning, one way to show this is to document the numbers of people coming into services. For planning and building up good sources of information at agency, local, regional and national levels, and to justify continued funding, it is essential that we have reliable data collection systems incorporating attributable details.

In the long run, if good, clear information leads to better services, it benefits the people those services are supposed to cater for: the clients.

Alex Meikle

Researcher, Possil Drug Project, Glasgow

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

ACMD education report: no return to 'shock' tactics

Dear Editor,

In the news column of your October issue it is alleged that the recent ACMD report reflects a "deep division of opinion" and an "unresolved clash in the working group". Members of ACMD working groups usually accept a collegiate type of confidentiality and do not discuss with the press the debates which lead up to an agreed report. I will not therefore seek to refute your assertions by reference to who said what. The insinuation that the ACMD has abandoned its previous opposition to tactics of "shock or scare" will, though, be found to be false on any reading of the report itself.

Griffith Edwards

Chairman, ACMD Working Group on Prevention

Unfair to blame feminists for service failures

Dear Editor,

In response to the "Frivolity, fun ... and feminism" and the cartoon on the cover of the same issue (*Druglink*, Sept/Oct 1993, p.14-16), I wholeheartedly agree that service provision for women - or any client group - should be 'user-led', ie, designed to meet the needs of female clients rather than female workers or statutory structures.

However, to place the blame for the failure of services to do this on the shoulders of women workers, especially those who identify themselves as feminists, is incredibly unfair. What little development of provision for women there is has largely depended on the efforts of women workers (and drug users) who have been prepared to stick their necks out and fight for it.

It is unfashionable to be a feminist at the moment; it is also unfashionable to be a trade unionist, a socialist, a social worker or a member of any other group

which might pose a threat to the establishment. This view is one which is largely fostered by the Tory press and which many middle class liberals are (sadly) falling for.

As for the misogynist cartoon on the front cover which grossly stereotypes and insults female workers and service users - I didn't find it funny. But then, we feminists (lesbians, black people, etc, etc) aren't known for our sense of humour ...

Frankly I don't give a damn.

Janet Mantle

Senior Health Promotion Officer (HIV), South Manchester Health Authority

Not an attack on women workers

Dear Editor,

In response to the charges laid against my article by Ms Mantle, I would like to express regret that it should have been construed as an attack on women workers.

It was by no means my intention to place the blame for poor services for

women drug users on their shoulders, merely to provoke a much-needed broadening of the parameters of debate.

Happily, the women drug workers who have given me feedback on the article so far not only did not share Ms Mantle's view, but welcomed a public statement of private discontents.

My commitment to ensuring that gender issues receive due attention and are addressed by a broad audience is not (and has not been) limited to an article in *Druglink*. Those interested in pursuing the debate constructively might like to know that, together with Lifeline and colleagues from the Mersey Drug Training Unit and the Glasgow Women's Reproductive Health Service, I am working towards a conference which looks (in a refreshing and entertaining way) at the role played by (both) genders in drug use. It will be held in Manchester on January 7th 1994.

Sheila Henderson

Research Associate with the Lifeline Project, Manchester

See page 10

PUBLICATIONS

HIV/AIDS

■ **STAYING SAFE: HIV AND DRUG USE.** Sarah Layzell. SCODA, 1993. Booklet. £6.50.

Advice/information for drug services. Available from SCODA, 1 Hatton Place, London EC1N8ND, phone 071 430 2341.

■ **DRUG INJECTORS AND HIV RISK PREVENTION: STRATEGIES FOR PROTECTION.** Jill Burt and Gerry V. Stimson. Health Education Authority, 1993. Book. £7.99. Available from HEA, Hamilton House, Mableton Place, London WC1H 9TX, phone 071 413 1977.

Treatment/services

■ **TREATMENT OPTIONS IN ADDICTION: MEDICAL MANAGEMENT OF ALCOHOL & OPIATE ABUSE.** Colin Brewer ed. Royal College of Psychiatrists/Gaskell, 1993. Book. £7.50. Available through bookshops.

■ **STANDARD SETTING IN AUDIT.** Hugh Dufficy and Kim Hager. SCODA, 1993. Booklet. £4.50/£3.50 SCODA members. Available from SCODA, 1 Hatton Place, London EC1N8ND, phone 071 430 2341.

■ **CHANGING PRACTICE: MOVING ON FROM BENZODIAZEPINES.** Mental Health Media Council, 1993. Video. £20 voluntary groups/£35 statutory. On the needs of people withdrawing from prescribed benzodiazepines. Available from Mental Health Media Council, 380 Harrow Road, London W9 2HU, phone 071 286 2346.

Harm reduction

■ **THE LADS GO MAD IN AMSTERDAM.** £0.80, quantity discounts. 10% p&p.
 ■ **SMACK IN THE EYE ISSUE 9.** £1, quantity discounts. Lifeline Project, 1993. Comics. The first is advice to would-be Amsterdam sex/drugs tourists. Available through Lifeline Project, 101-103 Oldham Street, Manchester M4 1LW, phone 061 839 2054.

■ **POSITIVE XPRESSION.** Swansea Drugs Project, 1993. Various products. Pen, key fob, postcards etc with drug information for club-goers. Sample pack from Swansea Drugs Project, 8 Calvert Terrace, Swansea, West Glamorgan, phone 0792 472002.

■ **STEROID INJECTING.** West Glamorgan Health Authority, 1993. Leaflet. £100 for 500. Harm reduction advice. Available from Dr H.M. Perry, Dept. of Public Health Medicine, West Glamorgan H.A., 36 Orchard Street, Swansea SA1 5AQ, phone 0792 458066.

■ **WHOOPIA DAISY.** Mersey Drug Training and Information Centre, 1993. Various products. Flyers, stickers, matchboxes, carrier bags etc with harm reduction messages aimed at club-goers. Contact MDTIC, 9 Slater St., Liverpool L1 4BW, phone 051 709 3511.



Education

■ **SOLVENTS, DRUGS AND YOUNG PEOPLE - A CROSS-CURRICULAR APPROACH.** Richard Ives and Barbara Wyvill. Daniels Publishing, 1993. Photocopy-free resource.
 ■ **UNDERSTANDING DRUGS.** 2nd edition. Daniels Publishing, 1993. Photocopy-free resource.
 ■ **SUBSTANCE MISUSE-VIDEO.** Leicestershire Health Authority, 1993. Video. £88. For educators inside and outside school. Available from Daniels Publishing, 38 Cambridge Place, Cambridge CB2 1NS, phone 0223 467144.

Other

■ **FACING THE CHALLENGE.** Pauline Sturges. London Drug Policy Forum, 1993. Conference report. Local authorities' role in drug treatment and prevention. Copies from London Drug Policy Forum, Town Clerk's Office, PO Box 270, Guildhall, London EC2P 2EJ, phone 071 603 3030 ext. 3084.

■ **RACE CULTURE AND SUBSTANCE PROBLEMS.** Larry Harrison ed. University of Hull, 1993. Book of conference papers. Available through bookshops.

MEETINGS

■ **DRUG USE AND THE COMMUNITY.** Scottish Drugs Forum. 15-16 November 1993, Glasgow. Details from SDF, 5 Oswald Street, Glasgow G1 4QR, phone 041 221 1175.

■ **NATIONAL PARENTS AND DRUGS CONFERENCE.** Department of Health. 23 November 1993, London. For parents active in their community. Details from David Crewe Associates, 101 Judd Street, London WC1H 9NE, phone 071 387 2221.

■ **EFFECTS OF COMMUNITY CARE ON SERVICES FOR WOMEN.** DAWN. 6 December 1993, London. Details from Seonaid Wright, DAWN, c/o GLAAS, 30-31 Great Sutton Street, London EC1V 0DX, phone 071 253 6221.

■ **GENDER AND DRUG USE.** North West Regional Drug Training Unit. 7 January 1994, Manchester. Details from NWRDTU, Globe House, Manchester M3 1LG, phone 061 834 7160.

COURSES

■ **FIVE-DAY COUNSELLING.** Various dates to December 1993.
 ■ **ADVANCED MANAGEMENT OF HIV INFECTION/AIDS IN THE COMMUNITY.** 24-25 November 1993.
 ■ **MOTIVATIONAL INTERVIEWING.** Stages I & II (2x5 days). Various dates. Starting 17 January 1994. £300 per week.
 ■ **SEXUALITY AND SEXUAL HEALTH.** 23-27 March 1994, 24-28 October 1994. £300. National AIDS Counselling Training Unit, London. Details of these and other courses from NACTU, St. Charles Hosp., Exmoor St., London W10 6DZ, phone 081 968 8514.

■ **SELLING YOUR SERVICE.** 23 Nov. 1993; 10 May 1994. £85+VAT.
 ■ **HEPATITIS.** 25 November 1993. £20+VAT.
 ■ **OUTREACH.** 7-8 December 1993; 12-13 April 1994.
 ■ **DRUGS, PREGNANCY, PERIODS AND THE PILL.** 1 February 1994.
 ■ **CHILDREN, DRUGS AND THE LAW.** 22 March 1994.

■ **WORKING WITH PARENTS OF YOUNG DRUG USERS.** 17-18 May 1994. Mersey Drug Training and Information Centre, Liverpool. Details of these and other courses from MDTIC, 9 Slater Street, Liverpool L1 4BW, phone 051 709 3511.

■ **QUALITY ASSURANCE.** 23 November-14 December 1993 (four half days).
 ■ **A SOLUTIONS-FOCUSED APPROACH.** 25-26 November 1993. £65.
 ■ **ADVANCED COURSE IN THE MANAGEMENT OF SUBSTANCE MISUSE.** January-September 1994 (2 days per week). Leeds Addiction Unit, Leeds. Details of these and other courses from Leeds Addiction Unit, 19 Springfield Mount, Leeds LS2 9NG, phone 0532 316935.

■ **MEASURING LOCAL SUBSTANCE USE & PROBLEMS.** YARTIC. 13 December 1993, York. Details from Geoff Hardman, Centre for Health Economics, University of York, phone 0904 433662.

■ **DIPLOMA IN DRUG DEPENDENCE.** Maudsley/Regional Drug Training Unit. 24 weeks from 10 January 1994, London. Details of this and other courses from Drug Training Unit, National Addiction Centre, 4 Windsor Walk, London SE5 8AF, phone 071 703 0269.

■ **THE CHILDRENS ACT.** 13 January 1994.
 ■ **DETOXIFICATION IN THE COMMUNITY.** 17-18 January 1994.
 ■ **DRUG MISUSE AND THE CRIMINAL JUSTICE ACT 1991.** 17-18 January 1994.
 ■ **WORKING WITHIN THE CRIMINAL JUSTICE SYSTEM.** 1-2 February 1994.
 ■ **LEGAL IMPLICATIONS OF DRUG WORK.** 10 March 1994. NACRO South West Drug Training Service. All courses in Exeter, Bristol or Taunton. Details of these and other courses from NACRO, South West Drugs Training Service, 29A Southgate, Bath BA1 1TP, phone 0225 336766.

■ **TRAINING THE TRAINERS.** Drugs Training Project, Stirling University. 23-25 March and 19-20 May 1994, Stirling. £250 residential. For drug workers who wish to develop training skills. Details of these and other courses from Drugs Training Project, Pathfoot Building, Stirling University, Stirling FK9 4LA, phone 0786 467732.

■ **PERSONAL SKILLS TRAINING FOR CDUNSELLORS.** Aquarius. 16-20 May 1994. Evesham. Details from Aquarius, 6th Floor, The White House, 111 New Street, Birmingham B2 4EU, phone 021 632 4721.

ORGANISATIONS

■ **TRUST FOR INFORMATION AND PREVENTION.** Volunteer befrienders and other support/information for parents of drug users. Contact Dr Stuart Ware, TRIP, Wheathampstead Education Centre, Butterfield Road, Wheathampstead AL4 8PY, phone 0582 830344.

■ **THE POSITIVE PLACE.** For people living with HIV/AIDS in the community. Provides computer bulletin board information service on HIV/AIDS. Contact The Positive Place, Office 115, Regent House, 291 Kirkdale, London SE26 4QE, phone 081 778 0838. Bulletin board on 081 695 6113.

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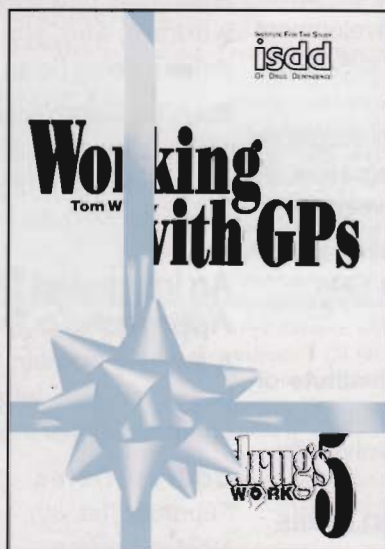
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