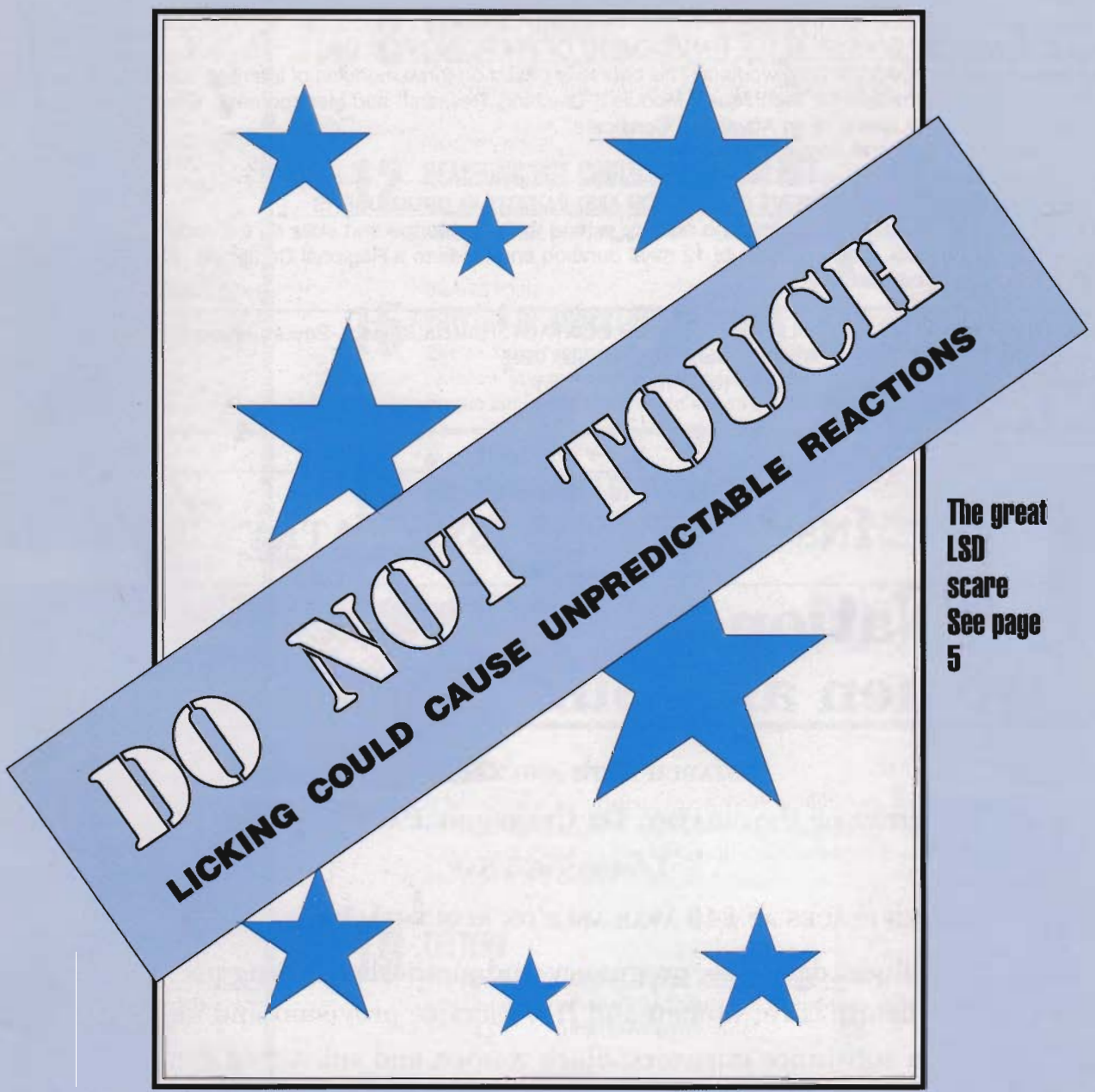
DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN

January/February 1991



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

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

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Focus on drug services

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Despite this technical possibility, Dr Stead says that in the last year no new type of LSD products or high-dose version of an existing type have been seen in the UK, and there is no evidence now nor in the past of LSD being distributed on anything intended to be stuck to the skin.

The blue stars LSD story has been around for well over ten years. Dr Stead points out that some of the first paper square forms of LSD that appeared in the mid-70s were decorated with Disney characters and suggests it's possible that the scare developed as people mistook these to be intended as transfers or 'tattoos' aimed at children.

Detective Chief Superintendent Derek Todd of the Metropolitan Police suspects that a similar misunderstanding may be happening today.

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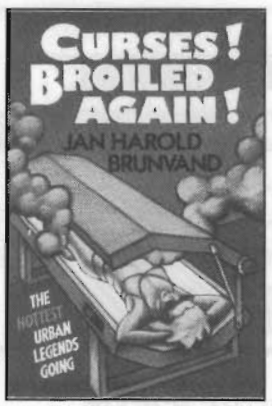

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As in the current scare, recipients were invited to broadcast the warning to their contacts. Then as now the chain letter technique was successful – what started with a single letter delivered to a local police department gathered into a "tempest" which forced Canadian police to issue a press release declaring the warnings a hoax (RCMP, October 1988).

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Law reform group rejects decriminalisation

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The prestigious Justice committee – British section of the International Commission of Jurists – will be considering its working party's report in the next few weeks. Justice's initiative comes when diversion of offenders from custody is a priority in Britain, and when internationally the drug legalisation lobby has gained high-powered supporters.

What the report has to say on these issues could make an important contribution to both debates, with this year's Criminal Justice Bill offering an opportunity to implement any changes.

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But this interpretation of the international legal framework was questioned by the UN itself in the mid-70s. Their lawyers concluded that the convention did not *require* penalisation of personal use – though states could do so if they wished (see below).

Convinced that international agreements did require a cannabis possession offence, the Justice working party will probably recommend cannabis be demoted to class C of the Misuse of Drugs Act.

This would not cut maximum prison terms for the vast majority of offenders who are tried at magistrates' courts, but would reduce maximum fines, by far the more common punishment. If tried before a judge, the maximum penalty would be cut from five years to two.

For some working party members, the crunch implication of this was that cannabis possession would then cease to be an arrestable offence under the Police and Criminal Evidence Act (PACE). Swayed by arguments that this would render the law unenforceable – and rob police of the chance to search for more incriminating evidence – the working party is likely to call for a special provision to retain the power of arrest.

While police may find it useful to be able to arrest what in 1989 totalled over 30,000 people (see this issue of ***Druglink***, p.15), this is where the main drugs field representatives on the working group may part company with the majority. SCODA policy and Release's civil liberties concerns are almost certain to force their directors David Turner and Jane Goodsir to dissent.

Release believes that if implemented the Justice recommendations would not represent a net advance in the legal position of drug users, and may pull out altogether.

On the offence of supplying drugs, the group may call for what many feel is a long overdue distinction between supply for gain and 'social supply' between friends, as when a cannabis joint is passed round. This is likely to be widely supported in the drugs field as meaning users who share drugs will no longer face a theoretical maximum of life imprisonment and the stigma of being a 'trafficker'.

On diversion of drug offenders out of the criminal justice system, the liberally-minded working group is certain to encourage existing developments, but new proposals are unlikely.

Do UN agreements ban cannabis decriminalisation?

In an article in the UN *Bulletin on Narcotics* (Oct/Dec 1977), UN lawyer Alfons Nolls attempted once and for all to clear up the "confusion and misunderstanding" on the possession issue.

Nolls emphasised that "'possession' of drugs *for personal consumption* is not to be considered a 'punishable offence' by a Party to the [Narcotics] Convention... The whole international drug control system envisages in its *penal provisions* the *illicit traffic* in drugs".

As the UN Secretary General admitted in the official commentary, confusion over possession arose because a late redraft of the convention omitted chapter headings.

The heading left out in the section on penalising possession read "Measures against Illicit Traffickers", implying that *only* possession of drugs in the course of trafficking had to be an offence. (UN, *Commentary on the Single Convention on Narcotic Drugs 1961*, 1973.)

The respected Canadian Le Dain Commission explained in 1972 that while the "prevailing view" is that personal use must be penalised, a closer reading of the convention allows the interpretation that "one may take measures which will have the effect of restricting use to medical and scientific purposes without necessarily making use or simple possession for other purposes a penal offence". (Commission of Inquiry into the Non-Medical Use of Drugs, *Cannabis*, 1972, p.210.)

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This would not cut maximum prison terms for the vast majority of offenders who are tried at magistrates' courts, but would reduce maximum fines, by far the more common punishment. If tried before a judge, the maximum penalty would be cut from five years to two.

For some working party members, the crunch implication of this was that cannabis possession would then cease to be an arrestable offence under the Police and Criminal Evidence Act (PACE). Swayed by arguments that this would render the law unenforceable – and rob police of the chance to search for more incriminating evidence – the working party is likely to call for a special provision to retain the power of arrest.

While police may find it useful to be able to arrest what in 1989 totalled over 30,000 people (see this issue of ***Druglink***, p.15), this is where the main drugs field representatives on the working group may part company with the majority. SCODA policy and Release's civil liberties concerns are almost certain to force their directors David Turner and Jane Goodsir to dissent.

Release believes that if implemented the Justice recommendations would not represent a net advance in the legal position of drug users, and may pull out altogether.

On the offence of supplying drugs, the group may call for what many feel is a long overdue distinction between supply for gain and 'social supply' between friends, as when a cannabis joint is passed round. This is likely to be widely supported in the drugs field as meaning users who share drugs will no longer face a theoretical maximum of life imprisonment and the stigma of being a 'trafficker'.

On diversion of drug offenders out of the criminal justice system, the liberally-minded working group is certain to encourage existing developments, but new proposals are unlikely.

Do UN agreements ban cannabis decriminalisation?

In an article in the UN *Bulletin on Narcotics* (Oct/Dec 1977), UN lawyer Alfons Nolls attempted once and for all to clear up the "confusion and misunderstanding" on the possession issue.

Nolls emphasised that "'possession' of drugs *for personal consumption* is not to be considered a 'punishable offence' by a Party to the [Narcotics] Convention... The whole international drug control system envisages in its *penal provisions* the *illicit traffic* in drugs".

As the UN Secretary General admitted in the official commentary, confusion over possession arose because a late redraft of the convention omitted chapter headings.

The heading left out in the section on penalising possession read "Measures against Illicit Traffickers", implying that *only* possession of drugs in the course of trafficking had to be an offence. (UN, *Commentary on the Single Convention on Narcotic Drugs 1961*, 1973.)

The respected Canadian Le Dain Commission explained in 1972 that while the "prevailing view" is that personal use must be penalised, a closer reading of the convention allows the interpretation that "one may take measures which will have the effect of restricting use to medical and scientific purposes without necessarily making use or simple possession for other purposes a penal offence". (Commission of Inquiry into the Non-Medical Use of Drugs, *Cannabis*, 1972, p.210.)

Readers find Druglink 'balanced and useful'

Nearly a quarter of *Druglink*'s readers responded to last year's readership survey On the two crucial issues, your responses were encouraging. On a 'usefulness scale' of 1 to 5, half scored *Druglink* 4 out of 5 and over a quarter gave it top marks. Well over 80 per cent thought *Druglink*'s editorial line unbiased – and most who thought it biased, thought it biased in the right direction!

***Druglink* scored highly on being easy to read and logically presented but few thought it positively attractive. Being beautiful isn't *Druglink*'s main mission, but we do want improvements on this score – let us know if we succeed in smartening our image.**

Many thanks to all those who responded to our survey, and special thanks to the brave readers who offered their services as contributors.

Keep the feedback coming: the more we know about your needs, the better we can do – so let us know when we do particularly well *and* when we fail. Phone Mike Ashton or in his absence Harry Shapiro or Jan Hodgman, all on 071-430 1991, or write to the editor at ISDD.

Fragmented funding threatens the capital's drug services

Implementation of the NHS part of the NHS and Community Care Act in April will leave voluntary sector drug services in London particularly vulnerable. The purchaser-provider split will place these agencies at the sharp end of the new health market but without a stable cross-London funding body at which to market their services.

Nearly half of all notified addicts are treated in the four Thames regional health authorities while London's 32 boroughs housed nearly 40 per cent of all addicts newly notified in 1989.

Many of the capital's drug services see clients from across the region, but the funding structure fails to match this cross-London caseload. Since abolition of the GLC in 1985, London has failed to institute an alternative pan-Thames body to monitor or plan voluntary services.

Currently London's boroughs cooperate together in the London Boroughs Grants Unit (LBGU), which inherited its grant-aiding role from the GLC. Similarly the four Thames RHAs have acted as a consortium reacting to needs for cross-funding and London-wide facilities.

Both these groupings are politically unstable, depending on the voluntary participation of individual boroughs or RHAs. Failure of one member to pull their financial weight could lead to collapse as the other parties refuse to make up the shortfall or conceivably retreat into solely local funding.

The RHA consortium is uncertain about its future, although government drug funds for 1991/92 will at least be channelled through the regions rather than disbursed directly to districts.

The £2 million community care grant for voluntary drug services will give London's boroughs (and other local authorities) a new role in funding social care costs for drug users. But next year many boroughs will find themselves under financial pressure due to inadequate community charge levels or late/non-payment. How this will affect their willingness to fund residential places for drug users is worrying many analysts.

Health authorities are also under pressure to balance their books before April 1991. Many drug dependency units are now uncovering the hidden costs of prescribing regimes and asking for increased funding from RHAs.

In the foreseeable future, the LBGU will remain the only central funding body for pan-Thames services. Its approximate drugs budget of £850,000 will provide essential core funds for major projects, but competition for funding is fierce among less acknowledged initiatives. Adding to the uncertainty is the fact that budgets have not been confirmed for 1991, with speculation ranging between a 15 per cent cut and a five per cent increase.

■ The plight of the widely respected Kaleidoscope project on London's fringes shows how even projects of acknowledged worth can fall foul of the capital's fragmented funding structure.

Kaleidoscope's funding problems are a direct result of its success. While surrounding hospital drug clinics run office-hour services with waiting lists and an implicit abstinence goal, Kaleidoscope operates from 7am to 11pm providing a prescribing service literally next door to its entertainment and youth club facilities.

This approach resulted in nearly a 40 per cent increase in clients this year, up to 316 per day.

To prevent spillage onto the illicit market, the project requires clients to take their drugs on the premises. The cost per client per day is £1.85 rising to £2 from next April – modest in comparison to pharmacy-based prescribing.

Drawn by Kingston's social and commercial facilities, Kaleidoscope's clients come from across the four Thames regional health authorities. Unable any longer to absorb the costs of treating so many clients, last autumn the project wrote to 18 health authorities asking them to pay for patients from their areas. Apart from the project's home health authority, just one other has so far committed itself to paying. Meantime, Kaleidoscope's income shortfall on the service is mounting at the rate of nearly £16,000 per quarter.

Explaining their refusal to pay, several health authorities say they expect their residents to use their own, often newly established clinics. Some suggest Kaleidoscope refer clients back to their home districts, but the project knows from experience that many will not go or will soon return to the project.

Kaleidoscope is a prime example of a unique and innovative project succeeding in attracting clients from across London and the Thames regions, but financially hamstrung by parochial local funding decisions and unable to turn instead to a stable London-wide funding authority.

Steve Sampson, Peter Mason and Mike Ashton

■ **A World Health Organisation consultation on *Sociocultural Factors in Drug Abuse* (WHO, 1990) has noted that social and economic deprivation is widely associated with drug use. Even in relatively rich Switzerland, illicit drug use is associated with downward social mobility while in Poland the entire increase in drug use in the 1980s is said to be due to the increase in users of manual worker origins.[1] The report concludes that "economic recession... may have important consequences for levels of drug use".**

■ Final guidelines on the use of the £2 million community care grant for alcohol and drug misuse services stipulate that local authorities must not use it to replace existing funding or as top-up funding to hostels.[1] As feared, grants will only be made for projects where the local authority is funding 30 per cent of the costs from its own general resources. Many authorities may be unwilling or unable to do so without cutting services elsewhere. Bids are to be in by the end of January.

1. *Community Care in the Next Decade and Beyond*. HMSO, 1990.

■ **Nearly 90 per cent of Britain's young adults believe "use of hard drugs such as heroin" is morally wrong and 60 per cent also condemn cannabis use. Heroin use topped the moral condemnation list in the MORI survey of over 1000 18–34-year-olds across Britain.[1]**

1. ***Readers Digest*: October 1990.**

■ Evidence is mounting of the effectiveness of methadone prescribing. US government-funded research in New York found methadone protected against HIV infection but only if dosage was adequate (60mg+) and the addict stayed in treatment.[1] A US Institute of Medicine panel reported that the "benefits of treatment far outweigh the costs" and that – in adequate doses – methadone maintenance retains clients and cuts illicit drug use and criminality.[2] In Sweden major improvements in death rate were found among maintained addicts both during and after treatment, but rates returned to street addict levels among patients expelled for violating treatment rules.[3]

1. *Narcotics Demand Reduction Digest*: October 1990.
2. *ADAMHA News*. March/April 1990.
3. Gronbladh L., *et al. Acta. Psychiatr.*

Drugs bill could force service cutbacks

Health service managers are struggling to find ways to meet the increasing bill for dispensing methadone as drug services react to government pressure to attract more drug users. Freeing up methadone prescribing is one key way to bring in more opiate dependents, but it could backfire if the costs force services to cut back.

Across the country, improved cost accounting in preparation for the health market reforms has brought to light the previously hidden prescribing bill. A change in Drug Tariff regulations in December (see box) will help ease the burden, but health authorities newly sensitised to the cost implications of clinical decisions will still be unwilling to raid general budgets to buy drugs for drug misusers.

The most dramatic example of how success in attracting clients can lead to financial crisis occurred recently in Merseyside. Halton Health Authority houses the Widnes drug dependency unit headed by Dr John Marks, well known for his belief in maintenance prescribing, including injectable and smokable heroin. Clients from surrounding authorities were attracted to the unit, most from the Wirral, which locally has only a short-term detoxification service.

Merseyside Drug Council alone referred over 100 Wirral clients to Halton's unit, with the receiving health authority at first footing the bill. But as the numbers mounted, Halton Health Authority wrote to Wirral and other authorities asking them to pay the drug bill for patients from their areas: Wirral refused.

Halton responded by closing the unit to new patients from outside its area unless the patient's home health authority agreed to pay. Some patients have already been turned away.

But the panic really started when Merseyside Drug Council were told that the drug dependency unit would close from December 1 because the money had run out.

This message was later contradicted by the health authority, but faced with this insecurity Wirral is setting up its own prescribing service. What will happen from 1 April, when theoretically money should follow patients from health authority to health authority is as yet unclear.

In London, health authorities in the North West Thames region have to foot a methadone bill totalling £600,000, but the total government drug misuse funding allocation for the region amounts to just £458,000. The implication is that districts must dip into their general budgets to meet the costs.

Regional drug services manager Peter Mason explains that there just isn't enough money to go round. His region's drugs grant is allocated on the same basis as the DoH allocates to regions – in proportion to the number of 15–34-year-olds. This leaves districts which house major drug dependency units short of cash, but diverting resources from other districts would mean local service closures at a time when the pressure is on to increase accessibility.

Dispensing costs cut

From 1 December 1990 methadone mixture (1mg per ml) was moved to a category of the Drug Tariff which assumes the pharmacist is using a ready-made product rather than making the mixture up from powder. This means pharmacists no longer receive the making-up fee of £1.10 per dispense which constituted around a third of the total prescribing bill.

The bad news is that the price of the drug has increased 20 per cent from £4.72 to £5.66 for 500ml.

The change in tariff was apparently made because pharmacists were finding it difficult to obtain methadone powder, but it will also help cut the costs of prescribing services for drug users. Unlike the powder, methadone mixture is now not in short supply, manufacturers having geared up to the increased demand which in recent years forced the Home Office for the first time to license imports.

North West region faces £1 million methadone costs

North Western Regional Health Authority around Manchester has the country's best developed network of community drug teams as the basis for its prescribing services. The region's drug advisory committee is now telling districts that prescribing to drug users is not just permitted but encouraged as a way of stemming HIV spread.

But harm-minimisation prescribing means longer term prescribing in higher doses to more people. The North West is not renowned for particularly liberal prescribing, but even there the region's drug bill could soon reach £1 million.

The region is giving each of its 20 districts £5000 to help pay for the prescribing, but the real bill could easily be ten times as much.

Phil Willan, North Western RHA's Development Liaison Officer, explains that improved accounting procedures will mean districts will soon become aware of the cost implications of following regional and government advice on prescribing.

Already two have reacted to the new cost information by putting a financial ceiling on methadone costs – potentially forcing practitioners to take "clinical decisions based on resource limitations". Other areas of the health service face similar problems, but Phil Willan believes limiting treatment slots in this area could lead to the increased human and financial costs of more AIDS sufferers.

Despite the relatively small sums involved, there is a widespread unwillingness in health districts to supplement drugs money with general funding.

The issue will soon come to a head when districts follow regional advice to employ clinical assistants attached to community drug teams. North Western RHA is making this move to improve access to prescribing services by sidestepping the general unwillingness of community GPs to treat drug users.

But the result will be that the prescribing costs will then fall directly on already hard-pressed district health authorities rather than on the family health service authorities (FHSAs) which fund general practice prescribing.

Districts will probably seek to supplement their £5000 from the region by using AIDS money, but unless they also use their general budgets the chances are that each will be tens of thousands of pounds short.

Regional officials are concerned that clients encouraged to attend the new services could be "set up to fail" as financial restrictions force the doctors to prematurely tail off their prescribing. Another equally undesirable option would be for districts to cut staff to pay for drugs, offering a stripped down service giving users drugs but little else. In HIV prevention terms, the consequences could be disastrous.

Although changes in Drug Tariff regulations will help, the region is still urgently looking for ways round the problem. Dispensing drugs from drug service premises or hospital pharmacies would cut costs between 30-50 per cent, but bring in their wake security and staffing problems.

Phil Willan's favoured solution is to shift the bill on to FHSAs. His justification is that if more GPs had followed government advice and prescribed to drug users, then the FHSAs would now be picking up the tab.

GPs' reluctance to do so is forcing the region's health authorities to employ some as clinical assistants to offer the service most refuse to provide from their surgeries. If FHSAs allowed them to use their standard surgery prescription forms then the FHSA would – as government intended, Phil Willan argues – pay the bill.

Persuading FHSAs of the logic of this argument could be hard going. Health service reforms will mean GPs' prescribing costs if not explicitly cash limited now have to be justified if over budget. There may no longer be an unlimited pot from which to pay for GP prescribing.

Syringe exchange: has it worked?

The government's evaluators deliver their verdict

It is too early to reliably assess the impact of syringe exchange on HIV levels, but the strategy can be evaluated against other measures. It has been successfully established, reached previously unreached clients, and reduced syringe-sharing due to shortage of syringes. However, most injectors are still not in touch with any drug service and other strategies must be developed (such as bleach programmes) to minimise HIV spread in these groups.

Martin C Donoghoe

The author is a research fellow at the Centre for Research on Drugs and Health Behaviour of the Charing Cross and Westminster Medical School in London. The centre now incorporates the work of the Monitoring Research Group commissioned by government to evaluate syringe exchange.

IT HAS BEEN three and a half years since the UK's syringe exchange experiment began. Throughout it has been subject to the closest critical scrutiny and probably the most intensive monitoring of any service for drug injectors in the UK.

As researchers, we have been in the privileged position of being able to assess the implementation, impact and development of a new and innovative service. This article discusses what we have learned about the successes and limitations of syringe exchange, and considers its usefulness as an HIV prevention strategy.

The evidence presented draws on three years of research by the Monitoring Research Group, in the main funded by the Department of Health with additional funding from the Scottish Home and Health Department.

Since 1988, this research has been extended beyond the 'pilot' government-funded syringe exchanges to study other exchanges and the behaviour of injectors who do not attend any syringe exchange service.

Defining syringe exchange

Syringe exchange began officially in April 1987 when the UK government launched experimental exchange programmes. Before this, some agencies had already started their own schemes – as early as September 1986 in the case of the Kaleidoscope project in Surrey. The pioneering work of schemes such as Kaleidoscope, Cleveland Street in London, and the Maryland Centre in Liverpool, should not be forgotten.

Agencies participating in the pilot experiment were required to provide injecting equipment on an exchange basis so that used equipment did not become a health risk to the general public, and to discourage the circulation of used equipment in the drug injecting population.

Exchanging equipment remains an important feature of the strategy, although more recently it has been suggested that distribution of equipment could be separated from collection and disposal.

Although commonly known as 'syringe exchange', this strategy goes beyond the straightforward exchange of sterile injecting equipment for dirty works. It should be considered as a strategic response to the potentially high levels of HIV infection among injecting drug users and as part of an overall prevention strategy rather than an isolated solution to an isolated problem.

Syringe exchanges in the UK differ in their institutional and funding base and staffing and in the service they are able to offer; not all offer the full range of equipment and services.

A recent survey of 19 exchanges throughout England undertaken between April and June 1990 shows they offer a range of equipment (see figure 1).[1] All the schemes offered a choice of needles and syringes, swabs and condoms, and most provided containers for the return and disposal of used equipment. Others have been more imaginative, responding to local needs for a variety of other equipment.

This survey also showed that many syringe exchanges are able to offer a range of services beyond syringe exchange, including advice, counselling and practical help (see figure 2). Staff in many exchanges counsel about the risk of HIV transmission – a *risk reduction* strategy. Some also pursue a more general *harm minimisation* approach aimed at reducing other health, social and economic risks associated with injecting and drug use; these strategies include not only less damaging drug use, but also paths to abstinence. Many exchanges undertake *primary medical and social care*, including referral to other helping and treatment agencies.

Risk reduction, harm minimisation and

primary care are all part of the 'syringe exchange' strategy, but are not uniformly practised by all workers in all agencies. Over the past three or four years, syringe exchanges have been important testing grounds and vehicles for the promotion of these new ways of working with drug injectors.

Measures of success

When first introduced in the UK, many people expected syringe exchange would be *the* major intervention that would change the risk behaviour of injectors. As a result, syringe exchange has been assessed against extremely high standards, though still in its infancy in comparison with some other approaches to helping drug users.

The success of syringe exchange as an HIV prevention strategy will ultimately be judged by the levels of HIV infection among drug injectors and their sexual partners. At this stage it is too early in the history of the epidemic and methodologically difficult to make a conclusive case for the impact of syringe exchange on levels of HIV. Interventions made now will be reflected in the AIDS figures anything up to ten years from now.

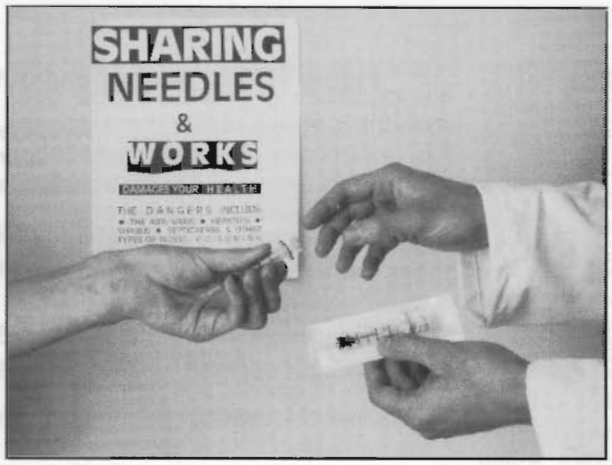
In the shorter term, any strategy to reduce the spread of HIV can be measured against other criteria:

- Was the programme established and operated as planned?
- Did it reach and retain potential clients?
- Were they helped to change their HIV risk behaviour?

Establishing syringe exchange. The UK experience of establishing and developing syringe exchange has been remarkably unproblematic. There was little public, professional or political opposition in the UK – in contrast to resistance in some other countries, notably in the United States.

Syringe exchange is now an accepted part of our response to the prevention of HIV transmission, with government ministerial and departmental support. This is reflected in the expansion and development of the strategy; there were an estimated 120 exchanges operating in England at the end of 1989.[2]

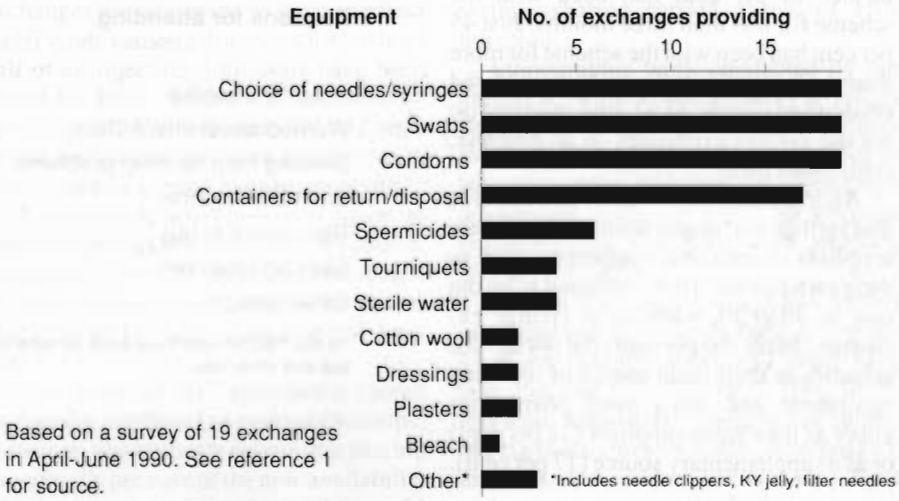
Reaching clients. In the first year of monitoring (1987/88), 15 schemes saw approximately 2500 new clients. Syringe exchanges continued to attract clients in substantial numbers in 1989/90. Latest estimates based on a recent survey of a sample of 19 schemes are given in figure 3. On average, each saw 53 clients over a four-week period and each client made an average of three visits. Among these schemes, the syringe return rate averaged 81 per cent of syringes issued.



John Knight

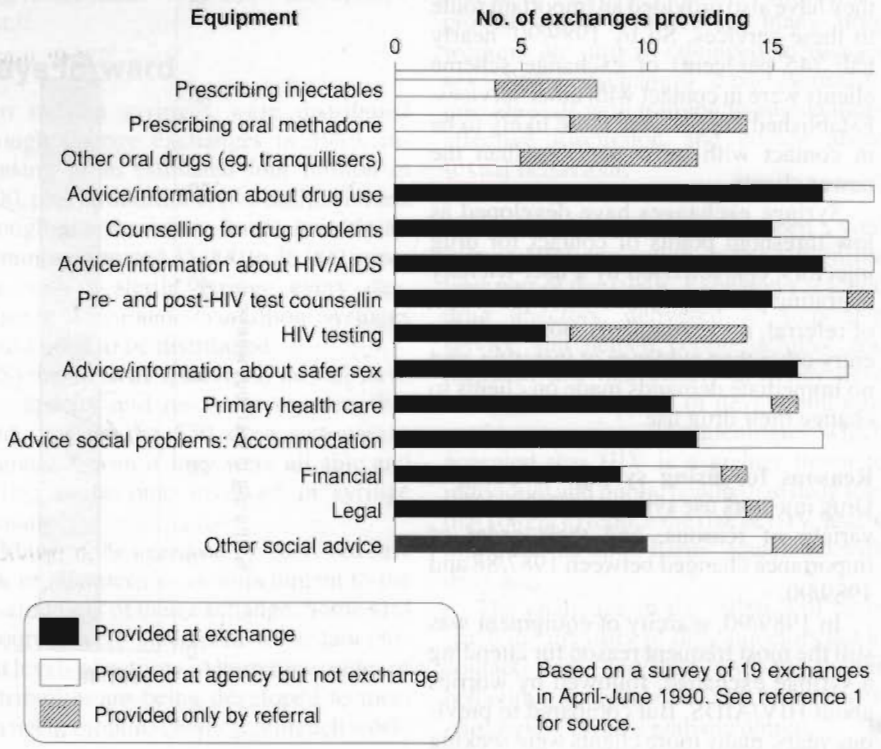
How Druglink portrayed the syringe exchange experiment in 1986. Now much more than new syringes are available from exchanges

Figure 1. Equipment available from English syringe exchanges



Based on a survey of 19 exchanges in April-June 1990. See reference 1 for source.

Figure 2. Services additional to syringe exchange



Based on a survey of 19 exchanges in April-June 1990. See reference 1 for source.

If these schemes are typical, the 120 exchanges in England see 6320 clients per month, issue 331,800 syringes and collect back 270,720 syringes. A crude estimate based on these figures suggests that 4 million syringes were distributed from syringe exchange schemes in England in 1989/90.

Retaining clients. In 1988 we reported on the low rate of client retention in syringe exchanges; continued attendance was only one outcome for clients, contradicting the way many thought the schemes would operate.

From our recent research we know that 41 per cent of clients were entering syringe exchange schemes for the first time.[3] A further 14 per cent had been with the scheme for less than three months. Just 45 per cent had been with the scheme for more than three months and may be considered established clients. Most drug injectors do not use syringe exchanges on an ongoing, continuous basis.

An important observation in 1988 was that syringe exchanges were not monopoly suppliers of injecting equipment, even to their own clients. That continued to be the case in 1989/90, when most syringe exchange clients (60 per cent) did not use the schemes as their main source of injecting equipment and many used pharmacies either as their main suppliers (21 per cent) or as a supplementary source (17 per cent).

Contact with other services. In 1987/88 only a quarter of syringe exchange clients were in contact with other services. Syringe exchanges continue to reach drug users not in contact with other services, but they have also provided an important route to these services. So by 1989/90, nearly half (45 per cent) of exchange scheme clients were in contact with other services. Established clients were more likely to be in contact with other services than the newer clients.

Syringe exchanges have developed as low threshold points of contact for drug injectors, characterised by a user-friendly operating philosophy with no requirement of referral, no waiting lists, no criteria for entry other than evidence of injecting, and no immediate demands made on clients to change their drug use.

Reasons for using syringe exchanges. Drug injectors use syringe exchanges for a variety of reasons, and their order of importance changed between 1987/88 and 1989/90.

In 1989/90, scarcity of equipment was still the most frequent reason for attending a syringe exchange, followed by worries about HIV/AIDS. But compared to previous years, many more clients were seeking

Figure 3. Four weeks input/output at 19 exchanges

	Average per scheme	Range
Clients seen	53	3-299
No. of client visits	164	8-942
Syringes issued	2765	212-15084
Syringes collected	2256	0-12031

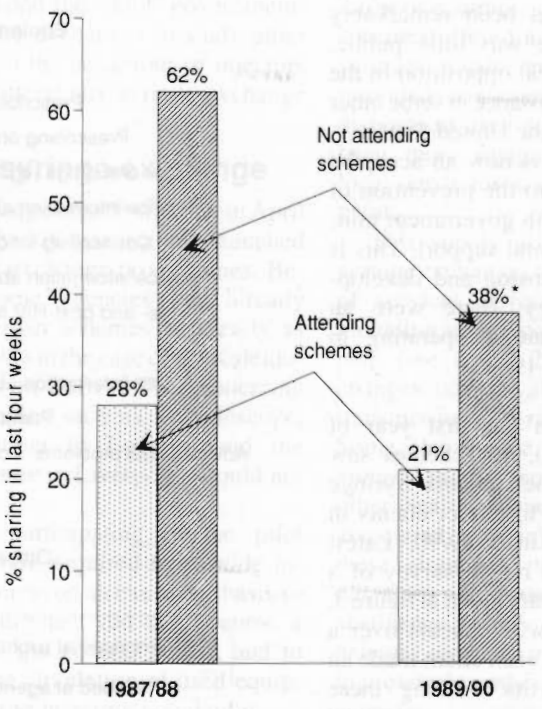
Based on a survey of 19 exchanges in April-June 1990. See reference 1 for source.

Figure 4. Reasons for attending syringe exchanges

Reasons for attending	1987/88 %	1989/90 %
Scarcity of works	55	41
Worried about HIV/AIDS	46	32
Seeking help for drug problems	–*	17
Can't afford works	15	14
Reluctance to buy	18	14
Seeking other help	16*	6
Other reason	4	18

*In the 1987/88 data there were no separate categories for help seeking relating to drug use and other help.

Figure 5. Syringe sharing rates among injectors inside and outside exchanges



*Figures collated in 1989

help for drug and other problems, or attending for a variety of other reasons, including use of the many services now provided by syringe exchanges (see figure 4).

Reaching special groups. In 1988 we reported that schemes were least successful at attracting younger injectors, women, and injectors with higher levels of HIV risk behaviour. Evidence from our later studies suggest that the ability to attract these clients has not greatly improved since then, and that there has also been a failure to attract non-white injectors and those with shorter injecting careers.

In 1989/90 women constituted a fifth of exchange scheme attenders, the average age of all attenders was 27 years, and on average they'd first injected 8 years ago – all figures are practically unchanged since 1987/88.

Changes in risk behaviour. There is considerable evidence that syringe exchange helps many drug injectors achieve and maintain low-risk behaviour. Our research shows there has been a steady decline in reported syringe sharing rates since 1987.

In 1987/88, 28 per cent of injectors attending syringe exchanges said they'd shared syringes in the previous four weeks. By 1989/90, the rate was down to 21 per cent.

Injectors not using exchanges also reduced their sharing rates, but continue to share syringes more often than those attending the schemes (see figure 5).[6]

Decline in sharing among non-attenders reflects the greater availability of syringes, itself partly facilitated by exchanges and other measures such as syringe distribution and exchange through pharmacies, and media and education campaigns.

At many schemes clients are allowed to supply their injecting friends with syringes, and in a recent study 54 per cent of clients did so.[7] Unavailability of syringes is no longer (as it was in 1987) the main reason given for sharing, and many injectors no longer see sharing as 'typical'.[8] Syringe sharing has become a less common event; in recent research, many exchange scheme clients had not shared in the previous two years.[9]

Evidence of impact on HIV

There is some evidence that syringe exchanges are beginning to have an effect on HIV rates among drug injectors. About half of all injecting drug users have been tested for HIV. Among 220 recruited to one of our studies last year, 192 had been tested; only 4 per cent were positive, with lower rates in syringe exchange clients.[10]

These low levels have been found in other samples of drug injectors in London. In January 1990, 200 injectors attending a syringe exchange in London were tested, revealing an HIV prevalence rate of 2 per cent.[11]

Low levels of HIV prevalence cannot be directly attributed to syringe exchange. However, our research shows that sharing *specifically* because of the non-availability of injecting equipment dropped from 51 per cent of syringe exchange clients in 1987 to 19 per cent in 1989. We have also identified a hierarchy of sharing where ownership of the syringe rather than the drug determines who uses the syringe first.[12]

Ways forward

Two million syringes were distributed through syringe exchanges in 1989, increasing to an estimated four million in 1990, plus an additional two million issued through pharmacists.[13] But to provide all Britain's estimated 35,000 to 75,000 injectors with a sterile syringe every day, between 13½ and 27 million syringes would need to be distributed.

Syringe exchanges alone do not have the capacity and resources to meet this need, nor do the 550 drug services in England,[14] even if they were all able and willing to become involved in syringe exchange.

Many of the agencies we surveyed saw lack of resources as an impediment to the development of their exchange. Some said resources were inadequate to sustain current levels of activity. Alternative routes of distribution are being developed to meet this need: mobile schemes; outreach work; secondary distribution using drug injectors and ex-users; and involving more pharmacies. Imaginative schemes such as the use of community health outreach workers in Peterborough need to be resourced and developed.

In the absence of adequate supplies of equipment available when injectors need them, syringe hygiene should be promoted. To this end a pilot bleach project is being developed.

Syringe exchange is clearly working to help some injectors change their risk behaviour, but syringe supply alone is not enough to prevent sharing. Concerns about lack of knowledge of how the virus is transmitted are no longer an issue in the UK; in 1988, 97 per cent of injectors questioned knew that even occasional syringe sharing carried a risk of HIV infection.

Ethnographic work conducted by our colleagues showed that injectors no longer share as a matter of course.[15] Syringe sharing is no longer part of the etiquette of everyday drug use, but an uncommon occurrence resulting from exceptional circumstances. Our own work supports this interpretation.

Syringe exchange has had less impact on sexual risk behaviour of drug injectors. Most are sexually active and many have non-injecting sexual partners. Drug injectors were found to be engaging in a variety of sexual activities, including heterosexual anal sex, and condom use was rare. Staff and clients continue to find discussions about sex difficult, and syringe exchanges by definition still emphasise drug use and syringe sharing.

In spite of our recommendation in 1988 that drug injectors urgently needed improved sexual counselling, many drug workers are still ill-equipped to discuss sex. Some exchanges have begun to provide staff with training to enable more effective discussion and advice about sexual behaviour.

SYRINGE EXCHANGE has been a vital part of HIV prevention in the UK in the later part of the 1980s. Exchanges reached drug injectors, delivered an important service and helped people achieve and maintain low risk behaviour. They have been at the sharp end of developing new working practices and ideologies which accepted that HIV is a greater threat to individual and public health than drug use, that sought to reduce the risk of HIV, and to minimise the other harms associated with drug use.

The challenge in the 1990s will be to reach the majority of drug injectors not in contact with services, and to change behaviour to *minimise* risk where risk *elimination* is not a realistic option. ■

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17. Dolan K.A. *et al*, op cit.

Reaching out could be copping out

Outreach is not necessarily the solution to low client contact – and if it is, it needs considerable planning

Before spending large amounts of money on a detached/outreach work scheme to reach drug users who don't come to existing services, it is wise to examine those services to see if they might be made more attractive. If outreach work still seems to be an option, cast around for local experience and use it. Plan the scheme carefully and be clear about the goals. Be aware of the implications for existing services and recognise that such a different style of work will require a different style of management.

Lifeline Project

This article is extracted from a booklet edited by Rowdy Yates and Mark Gilman of the Lifeline Project in Manchester based on the work of a Lifeline working party. *See page 14 for details.*

'OUTREACH WORK' is often used as a catch-all title for a variety of initiatives including detached or out-of-centre work. This has normally meant working with people on their own territory and was first developed in New York in the late 1950s with the type of street gangs made famous by *West Side Story*. The reason for this development was that these young gang members were not using established youth work provision. Going out to meet them was seen as the best way to make contact with them and ultimately control them.

The new-style youth work crossed the Atlantic in the 1960s and initially appeared as informal drop-in coffee bars, staffed by youth workers to attract mods and rockers and other youth groups.

This developed into outreach work with youth workers moving out of their 'bases' and working more on the street. The initial premise was always to attract people into already established services.

In the 1970s, drug projects, because of concern that a majority of illegal drug users did not use drug services, began to look at outreach approaches. By this time the youth service had redefined its approach to detached work and no longer assumed any correlation between contacts on the street and take-up of established services. However, little attempt appears to have been made by drug services to examine the experience of the youth service in establishing and operating outreach initiatives.

In the late 1980s and early 1990s it is the growing concern over HIV and AIDS among drug users that has prompted the latest wave of interest in outreach. And, while the emphasis has shifted to detached work proper, the failure to consult with and learn from others with a greater experience of the medium has continued to be almost a badge of pride.

Part 1 of the 1988 Advisory Council on the Misuse of Drugs (ACMD) *AIDS and Drug Misuse* report recommends that drug services make contact with as many of the hidden population of drug misusers as possible. The sense of urgency brought about by the presence of HIV is necessary, appropriate and well intentioned.

However, before the number of bids for outreach workers begins to decimate another rain forest, there is a need to be sure that these new initiatives are not usurped by agencies eager to avoid some painful introspection. It is often far easier to send out an 'outreach' worker to contact drug users than to conduct a thorough examination of why drug users do not attend the service currently on offer.

Research your agency

Outreach has fast become yet another 'buzz word' among drug workers and their managers. Consequently there is an urgent need to clarify some of the key definitions and principles. Why does a drug agency consider outreach?

Outreach could be one way of responding to the recommendation of the 1988 ACMD *AIDS and Drug Misuse* report to contact as many drug users as possible.

The establishment of an outreach initiative could also be seen as recognition that, at present, those drug users with whom we have contact may be of a particular type, eg, white, male opiate injectors. There is a growing concern that, for example, amphetamine users are under-represented in our services as are black people and women. Outreach work can be targeted towards an under-represented group.

Recognition that our information about what is happening 'on the streets' is often partial and dated could be a reason for considering using an outreach approach. One can find several examples of outreach work being allied to a research exercise.

At some point in their history most drug agencies will be approached to comment on and/or give advice about local drug using patterns. Agencies often resort to

outreach as a means of gathering this information while simultaneously providing a service to local drug users by making them aware of services, where they are and what they offer.

Some existing drug workers have not had the luxury of a 'preliminary intra-agency review'. That is, they were not employed as outreach workers but as office-based clinical workers. Lack of take-up of these office-based services have forced some of these workers to 'reach out' from their offices in order to establish any kind of contact with drug users. Some of these workers have built up a caseload of drug using clients in this manner and, in some instances, have thereby established the need for a drug service in that particular area.

We acknowledge that many drug agencies will not have the resources to conduct in-depth evaluations of the services they offer. However, some priority should be given to an evaluation of current client satisfaction, no matter how limited or modest.

One community drug team in the North West used the skills of a student who was on placement with them to conduct a client satisfaction survey. Although modest in design, this evaluation has proved invaluable in planning, monitoring and evaluating service development.

There is little or no point in employing outreach workers in areas where existing services do not 'score' reasonably well against a checklist of the facilities that should be provided by office-based services (see below).

> ***"It would be a great shame if 'reaching out' to drug users legitimated 'copping out' of serious reviews of existing practice"***

All agencies that employ outreach workers must make a real commitment to act on the criticisms that outreach workers will collect. Much of the drug workers' time is spent acting as advocates for drug users who are denied access to services by virtue of their drug using status. It would be a great shame if 'reaching out' to drug users legitimated 'copping out' of serious reviews of existing practice.

Lastly, it should be remembered that a lack of take-up in drug services might just be a reflection of the number of drug users in that area.

Learn from youth work

During our investigations we identified a process that is regarded as a standard and commonsense procedure by the youth service and many other agencies with a tradition of undertaking outreach work. By adapting this process, an outreach project can be planned in five stages.

❶ **Identifying the Project Target**. This stage of the process usually relies on the identification of a group of potential clients that are not currently using services. These groups usually come to the attention of agencies as a result of hearsay information gleaned from other clients, other workers, or the press.

❷ **Research**. Before a project is put together any responsible agency will check the hearsay via its own experience and that of other agencies. This process should confirm whether or not there is a need for an outreach project.

❸ **Project Design**. At the third stage a detailed project design proposal is drawn up showing the purpose of the project, what its aims are and how they might be achieved. The proposal will include details of how the project will be staffed, how those staff will be supported, what base it may have, its relationships with other agencies and how its work will be developed. The design should also indicate how the project is to be reviewed and evaluated.

❹ **Project Implementation**. This entails the conversion of the design into practice. What must be ensured is the provision of sufficient resources and the creation of a positive environment from which the staff can operate.

❺ **Evaluation**. An ongoing evaluative component should be timetabled and built into the project design. For example, an outreach project that is initially funded for three years should produce an interim report after twelve months and a more comprehensive evaluation report early in the third year.

The manager's responsibility

Managers are responsible for recruiting, inducting and training outreach workers. These workers must possess appropriate skills and qualities for the work. If they are to have any measure of success, those 'doing' outreach work must be adaptable, open-minded, willing to take risks, and able to judge when the risks are unacceptable. Those 'managing' outreach work

Checklist for services contemplating outreach

The following checklist shows what drug agencies should provide (directly or by easy and efficient referral) for drug users. There is little or no point in employing outreach workers in areas where existing services do not 'score' reasonably well on such a checklist.

- ❑ Needle and syringe exchange
- ❑ Prescribed drugs
- ❑ Emergency housing
- ❑ Geographically 'close' drug service (although people will travel to services that they define as 'good')
- ❑ Inpatient detoxification facility
- ❑ Staff with 'good attitude' (when you visit places try asking reception staff for the drug service without identifying yourself as a worker)
- ❑ Legal advice
- ❑ General health care
- ❑ Advice on safer drug use (eg, injection practice)
- ❑ Residential rehabilitation
- ❑ Good quality counselling
- ❑ Practical things to do for 'fun' and/or 'learning'
- ❑ Welfare rights information
- ❑ Service that is open at times convenient to potential customers who are working (although, as with 'geography', there is evidence that people will attend 'good' services as you would do with other medical services)
- ❑ Service that is not seen to be for particular groups of people (eg, young opiate users or old 'benzodiazepiners')
- ❑ Service whose staff are not obsessed with treating an assumed, and often non-existent, manifestation of psychopathology
- ❑ Service that is more than an answerphone
- ❑ Service that is geared up to cater for women (eg, creche facilities, availability of tampons, women-only sessions, women workers, etc)
- ❑ Service whose staff do not use 'social work speak' and then wonder why people look bemused. (For most people, 'support' is something you do to a football team!)
- ❑ Service that is geared up to cater for black people (eg, not a white, ethnocentric set-up)
- ❑ Service that is geared up to cater for young people (eg, there may be a policy not to deal with school age 'children')
- ❑ Service that is geared up to cater for all drug *users*. Most services advertise themselves as existing only for those with drug *problems*.

require exactly the same attributes.

A proper programme of induction to equip both worker and manager to carry out their tasks is essential. The most crucial – yet most often ignored – issue here is that managers too will require flexibility of approach and a clear view of the issues. The absence of informed and flexible management is a major cause of frustration for practising outreach workers. Rather than seeing management as a source of support and direction, many outreach workers regard management as 'something they survive in spite of'.

Clarifying aims and priorities is always an important task of management, and this is all the more important with outreach work. A programme of outreach work may often be unpredictable and may end up looking very different to how it began. Nevertheless, it is important that initial aims are clarified and shared in order to avoid confused expectations of both the work and the workers.

Managers should be open to the fact that the aims and priorities of outreach work may change as the work develops, or external circumstances change. They should be active in assisting staff to review and redefine aims and priorities as necessary. They must also ensure that the aims and priorities of outreach work tally in some way with those of other aspects of an agency's work. This may mean redefining the agency's aims too.

The diffuse and unpredictable nature of outreach work dictates that all work be recorded in some way. Managers must assist workers to find a method of recording work that is effective without being too unwieldy. Periodically they should ensure that these recordings are analysed and reports prepared to inform others and to evaluate what is happening.

Through the process of supervision, workers should be given time to reflect on their work and relate it to other developments in drug service provision.

> ***"Little attempt appears to have been made to examine the experience of the youth service in operating outreach"***

Outreach workers, like most other workers, need to move from the subjective to the objective, in order to develop a sense of perspective and to recharge their intellectual and emotional batteries. Managers should be able to help outreach workers relate to and tie in with other areas of drug service work.

Most of the tasks outlined above can take place through regular supervision sessions. These must offer workers support and validation of their work, together with a measure of objectivity and constructive criticism when appropriate.

In some instances—and particularly where line managers have little or no experience of outreach work—some form of co-supervision, using experienced outreach work managers, may be appropriate. Managers should recognise this possibility at an early stage and ensure a good level of communication between the worker(s), the consultant and themselves.

An arrangement of this kind will have budgetary implications and appropriate time will need to be allotted. Besides emotional support, practical issues such as noting hours worked, etc are very important and will remain the responsibility of the line manager.

Outreach workers are likely to hear all sorts of criticism of their employing agency. Even where outreach work has been developed in a direct attempt to find out why people do not use established services, it can be very hard to hear and accept the criticism that outreach workers may relay. It is, though, the responsibility of managers to do so—and to facilitate the discussion of that criticism within their agency without leaving the burden of that to the outreach worker.

Outreach workers may often find themselves in situations that would not be part of more orthodox forms of work. In particular, they may find themselves in situations where illegal activity is taking place. To be allowed into people's worlds they may have to play a part in that world. Managers and workers must define the professional boundaries and decide together what is and is not acceptable.

Workers should therefore also have a clear idea of who to call on if they do fall foul of the law. And that means a system that will operate when they themselves are working. That can be quite a responsibility. As one manager said, "He (the worker) has my home phone number and knows he can contact me if the police pick him up. But I dread that it'll happen at a time when I'm away or have had too much to drink".

Managers must be concerned to ensure that the personal safety of outreach workers is not put at risk. Exploring those risks and devising strategies to avoid unacceptable risks is of primary importance and should be built into the project design.

There are very few managers with direct personal experience of outreach work. That means that their knowledge and understanding may well be developing at the same time as that of the outreach workers themselves.

While that may be helpful in avoiding too rigid preconceptions and assumptions, it can also lead to managers adopting an approach that is so 'hands off' as to be completely useless.

For example, managers may be so nervous of being judgemental that they never ask questions or say what they think. Or they may ask too many of the wrong sort of questions—a sort of voyeurism.

In effect, because they don't know what to offer they may offer too much or too little. They must therefore be able to clarify with workers how best to carry out their management tasks in a way that fulfils their own needs, the agency's needs, and that of the outreach workers.

Many outreach workers feel a measure of isolation and distance from other workers. It can therefore be of great value to meet and talk on a regular basis with others doing similar work. This should be seen as a legitimate use of time and source of support.

In the North Western and Mersey regional health authority areas, outreach workers have formed their own support groups. A joint support group also takes place between workers in the two regions.

However such support groups should not be seen as an alternative to regular meetings with other drug workers. For centre-based drug workers, such meetings will provide a vital opportunity to develop practice in response to customer need. For outreach drug workers they will serve to limit isolationism, elitism, extremism, machoism, etc. ■

Seeing More Drug Users

This article has been edited from the chapter on Setting up an Outreach Work Scheme in the Lifeline Project publication *Seeing More Drug Users: Outreach Work and Beyond.* The full 39-page booklet deals also with targeting under-represented groups, alternatives to outreach, and communicating with the customers and the community.

Seeing More Drug Users is available from the North West Regional Drug Training Unit, Kenyon Ward, Prestwich Hospital, Bury New Road, Manchester M25 7BL, £2.95 plus p&p.

Powers of arrest for cannabis

After over ten years, the law on cannabis is once again under review – but from the police point of view, a 'parking ticket' approach could have major repercussions

Geoff Monaghan

The author is a detective constable with the Metropolitan Police currently on secondment to Goldsmith's College researching arrest referral schemes. He has been closely involved with Southwark's arrest referral scheme for drug offenders.

IN A REPORT in 1978,[1] the Advisory Council on the Misuse of Drugs (ACMD) recommended that cannabis be reclassified to class C of the Misuse of Drugs Act, reducing the maximum period of imprisonment for its unlawful possession from five to two years. But this apparently 'minor' modification would have far-reaching consequences for enforcement.

The reduction in penalties would mean that unlawful possession of cannabis *would no longer be an 'arrestable offence'* as defined by the Police and Criminal Evidence Act (PACE) 1984. The applicable subsection defines an arrestable offence as one for which a previously unconvicted person over 21 years of age may be sentenced to five years' imprisonment.

Another section gives the police a general power of arrest for *any* offence:
– if the name and/or address of the suspect are unknown and cannot readily be ascertained, or are believed to be false;
– if the suspect fails to furnish what the police consider a satisfactory address for a summons.

If cannabis possession became a 'non-arrestable' offence, police would have to rely on this section to effect an arrest. Before doing so, police must try to persuade suspects to give their names and addresses. For obvious reasons, they would want to verify the information before allowing the suspect to leave.

How long could someone be required to wait while information is checked? Ten minutes has been held to be too long.[2] Any attempt to prevent the offender walking off would take the constable outside the execution of his duty.

No doubt some people reported for unlawful possession of cannabis would seek to establish alibi defences for the subsequent trial; others may give their friends' (or enemies'!) names and addresses, resulting in confusion and possibly distress to innocent parties.

In addition, PACE gives police certain limited powers to enter and search premises occupied or controlled by an arrested person to search for evidence. Many cannabis users also use drugs such as heroin and cocaine. Very often, people arrested in possession of small amounts of cannabis are also engaged in drug trafficking.

Many police officers know from experience that the investigation following an arrest for cannabis possession often results in the recovery of more cannabis, other controlled drugs, stolen goods, firearms, etc. Without this very useful power of search, police would have to obtain a search warrant or get the householder's written consent – unlikely, especially if they have something to hide.

There would be problems too in proving guilt in court. In relation to drug offences, the prosecution must link:
– the finding of the drug in the defendant's possession;
– its packaging (in a heat-sealed exhibit bag) in the defendant's presence; and
– the examination of the drug by the scientist.

Unable to arrest a person in possession of cannabis, police would need to go to ludicrous lengths to satisfy these rules. The patrolling constable would need to carry plastic drug exhibit bags, exhibit labels and a portable heat sealer!

Cautioning for possession of cannabis is another area of concern. Not being under arrest, offenders would be under no legal obligation to appear at a police station to receive a caution. The outcome could be more prosecutions and fewer cautions, reversing the current trend.

A special provision *could* be made to retain cannabis possession as an arrestable offence, as recommended by the ACMD. However, this would create a major anomaly between cannabis and other class C drugs. Most of these are free from the prohibitions on importation, exportation and, when in the form of a medicinal product, possession, so as a result attract little attention from law enforcement agencies. Cannabis, however, *is* subject to these prohibitions, is widely used, and many thousands of people are arrested each year for cannabis offences.

Is a change in the law really necessary? Police stop and search techniques are now far more sensitive;[3] police attitudes far more flexible in relation to cautioning for unlawful possession; and the courts are far more likely to impose non-custodial sentences for simple possession.

Custodial sentences for possession of cannabis must now be relatively rare: "[Recent cases] appear to indicate that a sentence of imprisonment... will not normally be appropriate on a second conviction for possession of cannabis; the point at which the 'continual flouting' of the statute leaves the court with the obligation to consider a custodial sentence seems to be about the fourth or fifth conviction."[4] ■

1. ACMD. *Report on a review of the classification of controlled drugs and of penalties under schedules 2 and 4 of the Misuse of Drugs Act 1971*. Home Office, 1978.
2. Bentley v Brudzinski [1982]. *Criminal Law Review: 825.*
3. "Hard times for the capital's cannabis users." *Druglink*: November/December 1989.
4. Commentary on R. v Robinson-Coupar and Baxendale [1982]. *Criminal Law Review: 536*; see also R. v Osborne [1982], *Criminal Law Review: 834.*

The importance of teamwork

One of the originators of the alcohol/drug team model assesses its strengths and aggravations

Multidisciplinary teamwork in the drugs field protects workers against their own strong emotional reactions to patients, helps them resist external pressures, and prevents burnout. However, staff need to be adequately trained and psychologically suited to this way of working. Careful selection, preferably by the team, is essential. Different professional backgrounds and skills can lead to conflicting therapeutic approaches.

Terry Spratley

The author is consultant psychiatrist specialising in alcohol problems at the Mount Zeehan Unit of St Martin's Hospital in Kent. An earlier version of this article was published in Kent Drug News.

MY EXPERIENCE with multidisciplinary teams started when I was a member of the pilot project which in 1975 recommended the general establishment of special multidisciplinary community alcohol teams. In 1978 our book *Responding to Drinking Problems* described our first attempt to develop such a team.

Sadly, our earlier writing has often been misunderstood. We did not recommend that unskilled workers could do this type of work nor that all personalities are capable of this method of working. Nor did we suggest that community teams could dispense with specialised day units for more difficult drinkers.

I worry that the present drug field is repeating the errors made by the alcohol field – sending out poorly selected, untrained and unsupported teams into the community, like lambs to the slaughter.

The most important advantage for me of working in a team is that the team can help me be more objective in working with substance misuse patients. Working with these patients can evoke extremely powerful emotional reactions which can distort clinical judgments and actions. These 'counter-reactions' are common, not just because of the client group, but also because of the extremely difficult circumstances in which we often have to work.

In addition, we ourselves bring psychological vulnerabilities into our working situation. Specialising in the field does not mean that we are free from such self-caused counter-reactions. Many specialists have particularly strong responses to these patients; it is partly because of these that we specialise in the field.

Personal therapy can help us become more aware of our own counter-reactions, but we deceive ourselves if we think it can make us immune to these and free from irrationality in our therapeutic behaviour.

Counter-reactions can lead us to blindness in our assessments, and frequently either to punitiveness or to collusion in our treatment: I believe collusion is more common in substance misuse workers; it is the rule rather than the exception.

Most workers have powerful psychological needs to be liked by, and to give assistance to, their patients. "Even more than the calf needs to suck, does the cow need to suckle." Being collusive is more damaging to patients than being punitive; patients flee the punitive worker but stay with the colluder, who continues to reinforce their self-damaging behaviour.

Worker counter-reactions also frequently result in attempts to over-control the patient's life, or to under-control of the therapeutic setting.

Collusion control

Working in expert teams provides the best protection we can give to patients against our counter-reactions. There should be a tradition of open and regular consultation within the team. Our own team members have all received at least some personal therapy and have had prolonged and systematic training in substance misuse. They usually have the practical and psychological skills to help me and each other become aware of counter-reactions, and thus avoid some of the damage these can do to patients.

The second big advantage of multidisciplinary team work is that it increases the power of each worker. Lone workers are rarely able to resist the pressures that patients, relatives and referral agents place upon them to act against their better judgment. The risktaking behaviour of substance misusers generates much anxiety in those around them; some patients learn to use this anxiety to manipulate situations to their own ends.

A team is much stronger than an individual in resisting such pressures. As a doctor, without the backing of a team I would be unable to resist the pressure upon

me to overprescribe or to over-admit to hospital. Because of these two issues, doctors especially need to work in teams. Substance misuse doctors working without expert team support probably do more harm than good.

For the same reason, recent official encouragement to GPs to use methadone to detoxify opiate addicts could backfire. Without expert team support – which few GPs have – they will be unable to resist the pressures addicts place upon them and will inevitably overprescribe. They thus inadvertently reward this pressurising behaviour, which will thereby be reinforced, and the addicts will escalate their pressure. Eventually, many more GPs will become frustrated, turn punitive, and then reject these patients as a group.

Obtaining workers for these expert teams is difficult. I do not believe there is a large number of unemployed substance misuse experts clamouring to be appointed. In psychiatry, there is a severe shortage of properly trained and qualified applicants, even for prestige jobs; this is almost certainly true for other disciplines. To obtain staff for our own services we try first to appoint workers with potential, and then train them in the necessary skills – easier said than done!

Ideally, teams should appoint their own members, but frequently this is not possible. Often, members appointed by outsiders are then sent to join teams for which they may be unsuited.

In our team, we try to organise appointment committees so that we at least have the right of veto. Normally we spend a whole day interviewing and involve every member of staff and some patients. We interview in a one-to-one situation, followed by a group, and also include a psychotherapeutic interview.

Roots of the drug team

The current network of drug teams at regional and district level is based on the recommendations of the Advisory Council on the Misuse of Drugs in their 1982 *Treatment and Rehabilitation* report. In that report, the council explained that it aimed to develop a structure "very similar... to that which has been developed for... problem drinkers".

In turn, the community alcohol team model was based on the work of the Maudsley Alcohol Pilot Project led by the author of this article, which reported to the government in 1975. Their recommendations were taken up by the Kessel committee and implemented in the alcohol field.

Following the appointment and a period of observation in the day unit, we send the new member on a year's part-time course in alcohol counselling. This course has a very strong emphasis on supervised clinical work, skills training and counter-reaction work, as well as the usual academic component. After this basic training the new worker begins to feel part of the team – someone whose opinion is of value, to whom other team members might be happy to refer patients, and with whom they might consult.

> ***"Substance misuse doctors working without expert team support probably do more harm than good"***

Providing the importance of mutual emotional support is recognised, the team approach also protects against the well known burnout syndrome. Workers have a right to expect their own team members to help them deal with the pains that working in the field brings. This need not be intrusive nor would it take away all the pain, but rather entail helping the worker to understand the pain and then to use it to learn and grow.

Conflict and challenge

Teams bring together a great range of specialised knowledge and skills and very different conceptual frameworks. These can be very enriching, but can also pose complex difficulties in communication and practice.

Our most interesting examples come from our family team. When we started many years ago, most of us shared a simple view that understanding and working with the family would help all concerned. As team members trained and studied more deeply, conflicts began to emerge.

One important difference was between 'traditional' conceptualisations, which saw the alcohol or drug problem as located *within* the patient, and newer 'systemic' models which saw the 'illness' in terms of its *function* in the family or in wider social systems. For these models, changing the *system* rather than the *individual* was the focus of therapy – an approach difficult to reconcile with traditional approaches when applied to the same patient.

Furthermore, implementing the team approach meant members had to face challenges to deeply held values. I will try to make this concrete by example.

At times when I came out of a therapy session to consult with the family team behind the one-way screen, the team would ask me to say things to the family that I could not even understand, never mind agree with. I was prepared to accept this as I knew that in the heat of therapy it is often difficult for the therapist to understand fully what is happening. I also knew that interventions made on a systemic model were often successful in very entrenched family situations.

But many systemic interventions raised for me worrying moral and legal problems. In situations where drinking is a response to an over-controlling spouse, encouraging the spouse to attempt to get the partner to drink *more* rather than less can certainly be a very effective way to disrupt the status quo. But what of the legal and moral issues involved in such interventions? And how does that intervention fit in with the values of the rest of our services? These values stress the importance of staff being non-manipulative, and of clearly explaining treatments to patients so they can make informed choices.

Non-systemic thinking by team members causes equally serious, but opposite, problems. For example, a non-systemic team member can localise the pathology of the problem within the individual patient and exclude all others. It can then become very difficult for team members to include other people relevant to treatment, such as family, employers or referral agents.

Leadership is the issue which causes the most difficulties to teams. The leadership question is especially difficult for many consultant psychiatrists. There are issues of tradition, power, status, remuneration, and legal difficulties involving the doctor's responsibility for 'their' patient.

Our deeper fears are also of great importance. Like many colleagues, when under threat, I seek to control. Most of the time I am entirely unaware of this until it is pointed out to me. I have had to learn instead to trust and ask for help from the team. When I do, the team usually recognises my needs and helps me. Freeing staff from my over-control encourages their own growth and development.

I recommend great flexibility in organising leadership in teams. There can be rotating leadership, leadership based on external hierarchy, and leadership determined by the needs of the paymasters or clients. A team can have different leaders for different tasks.

THE WAY LEADERSHIP is organised in the substance misuse field is probably of less importance than the ability of the group mutually to cooperate around their common tasks. This ability depends less on structures than on individual psychological maturity and shared values. Nonetheless, leadership of some kind is necessary for the optimum efficiency of any team activity. ■

inside isdd

Starting from this issue, each edition of Druglink will include news on ISDD's latest activities and plans. We kick off in this issue with a full-page starter on the work of the Institute's three operational units.

Information Services

ISDD's library and information service houses the world's most comprehensive English language collection of materials on the non-medical use of drugs. The collection now numbers more than 47,000 journal articles, reprints, and reports. In addition the library holds an extensive press cuttings collection taken from the UK national, local and specialist press. All these items are catalogued, indexed and made retrievable using systems devised by library staff.

The library collection is available to anyone interested in the subject of drug misuse and over 8,000 enquiries at every level of complexity were received last year. The library is open to personal callers but enquirers may write or phone with their information needs.

The most notable recent development in the library has been the computerisation of the database which began in November 1988. Since that date over 10,000 items, both current and from the older part of the collection, have been added to the database. Each computer record has extensive cataloguing and indexing details, often with full abstracts. We have also computerised the subscription lists of library journals, most of which are produced direct from the computer.

Making sense of statistics

ISDD's *Drug Misuse in Britain* produced by the publications unit last December demonstrates the close interdependence of library and publications functions at ISDD. Abstracted references from ISDD's library are integrated with commentary and statistics based on the library's collection, producing as rounded a picture as possible of the pattern of drug misuse in late '80s Britain. *Drug misuse in Britain* is £2.50 from ISDD.

No other drug information service in the world has such a comprehensive or well organised library collection. ISDD's library has already established a relationship with an organisation in Spain which is buying the library's data records. We are discussing a similar relationship with a facility in the Netherlands and, in 1991, will be seeking more customers for the ISDD database overseas. This will not be at the expense of UK user groups and we intend to further publicise our range of services to these groups in 1991.

● Contact ISDD's library on 071-430 1993.

Publications

ISDD's Publications Unit (which produces ***Druglink***) aims to be *the* central distribution point for the best materials for professionals on the misuse of drugs.

Our 'clearing house' function means that – unlike most charities – we stock a wide range of titles, many not our own publications.

The general criteria for inclusion on our publications list is that the publication fills a gap in the literature and that we feel able to recommend it to drug workers.

To broaden the range of materials available and to help agencies cut down on the administrative costs of multi-invoicing, the unit has begun stocking titles on alcohol, tobacco and HIV/AIDS – a service we hope to expand.

Our recent publications have included:

❑ *Drugs, pregnancy and childcare – a guide for professionals;*

❑ *Working with solvent sniffers;*

❑ *Parents: what you need to know about solvent sniffing.*

Publication plans for 1991 include:

❑ A new edition of the *Drug Abuse Briefing*;

❑ Draft publications in non-English languages as part of an evaluative study;

❑ Further titles in the *Drug Notes* series, including over-the-counter medicines and caffeine;

❑ The launch of a new series of booklets offering practical guidance to drug workers.

To those of you who like the look of what we publish, we offer Print-Plus – a print service specially for the drugs field.

● Contact ISDD's Publications Unit on 071-430 1991.

Women and HIV

Edited by ISDD's research and HIV development officer Sheila Henderson, *Women, HIV, Drugs: Practical Issues* was the Institute's main contribution to World AIDS day. The booklet derived from a Department of Health-funded project concerned with enhancing ISDD's ability to meet needs around HIV, drugs and community care. Published through ISDD's Publications Unit, it has already gained a wide readership. (Copies £4.95 from ISDD.)

Research and Development

Publication of *Traffickers: Drug Markets and Law Enforcement* by Routledge in September 1991 will bring to a wide public the findings of our first law enforcement-related project describing the contribution of drug enforcement to the modernisation of policing in Britain.

Also coming to an end is the Referral Project, in which ISDD has stimulated the development of schemes in which police offer people held in custody information about local helping agencies. A report will describe some difficulties and recommend multi-purpose schemes covering debt, housing and health care generally.

ISDD will shortly complete a review of the literature on drug prevention with special reference to local cooperation. Commissioned by the Home Office for its Central Drug Prevention Unit, the report is expected by mid-1991.

In spring, publication of *High Policy*, on how youth work managers evolve drug policies, will round up the DES-funded project that earlier produced the *High Profile* youth work materials.

Drug Questions, the register of drug research in Britain, returns in early 1991 – copies £10 from ISDD. Readers carrying out research are invited to contact Lorraine Olver to ensure that they receive a form for their work to be included.

Together with the Bridge Project in Bradford and DASH in Haringey, we have been exploring service needs of Asian males and African-descent females. (Interim report in the Sept/Oct 1990 issue of ***Druglink***.) A monograph on race-related drugs research is expected by the summer.

● Contact ISDD's Research and Development Unit on 071-242 1878.

New chairperson for ISDD

Dennis Muirhead, Vice-Chair of ISDD since 1989 and a Council member since 1980, has succeeded Dr Philip Connell as Chair. As a solicitor specialising in drugs, he has had close links with the field since the sixties. Most recently he has been the Chair of City Roads Crisis Intervention Centre.

The positive side of drug advisory committees

Dear Editor,
Your article (***Druglink***, November/December 1990) on the Department of Health-funded study of drug advisory committees (DACs) was unfortunately inaccurate in three principal respects. Given the level of interest in this project, it is important for correct information to be available.

First, our analysis is a preliminary one which, although it produced much useful and interesting material and raised key questions about inter-agency collaboration, is not as definitive in its criticisms of DACs as your article suggested.

In particular, while our research does identify several shortcomings in the operation of DACs, it does not "query whether DACs are an appropriate model for ensuring inter-agency cooperation"; this is one important issue, among many, about which we recommend further research.

Secondly, our study does highlight positive features in the work of several DACs: for example, we found that six district DACs and one regional DAC had been commended by the Drug Advisory Service for aspects of their work; further, the majority of agencies we surveyed found it useful to be represented on a DAC.

Thirdly, this research has been carried out *jointly* by the National Local Authority Forum on Drugs Misuse and the London Research Centre, not just by the latter. A report will be published in early 1990.

Peter Baker
Principal Research Officer, London Research Centre.

Noel Towe
Principal Development Officer, National Local Authority Forum on Drugs Misuse.

The appropriateness of drug advisory committees (DACs) as a model for inter-agency cooperation was indeed an issue recommended for further research in the summary of the study seen by ***Druglink****.*

We presumed that a specific recommendation to expend further research time and money investigating this at least meant there was some query over whether the model was appropriate.

Statements elsewhere support this presumption. "An agreement at national or local level that a wide variety of different organisations with different structures and goals should work together is no guarantee that they will work together effectively. It appears some DACs do work well while many others do not operate effectively."

The summary does point out that NHS assessors (in the form of the Drug Advisory Service) commended the work of a few drug advisory committees. But it goes on to say that the "general picture that emerges from the DAS reports is that both district and regional DACs are not operating in the most efficient or effective way." In a short news report we naturally concentrated on this "general picture" rather than the exceptions.

The fact that most agencies surveyed "considered that their representation on the DAC was useful ***to them****" (emphasis added) is not in itself an indication that these committees were effective in their intended roles. Again, in the few words at our disposal, we concentrated on what seemed to us the main points that needed to be brought to our readers' attention.*

Editor

Addicts Index 'strictly confidential'

Dear Editor,
In "The Last Taboo" (***Druglink***, November/December 1990) there was a suggestion that the Home Office Addicts Index gives information concerning the drug use of staff at drug agencies to their co-workers.

As the officer-in-charge of the Addicts Index, I wish to make our position quite plain. My staff are under the strictest instructions not to divulge information from the Index database except to the doctor who is attending the individual concerned as his/her patient.

As those doctors who have used us to obtain antecedent information will know, we operate on a 'call-back' basis only, and take pains to ensure the person on the other end of the line is the person s/he purports to be (ie, a fully qualified doctor). If we have any reason to be suspicious about the identify of the caller, information is not divulged under any circumstances.

The Addicts Index operates on a strict 'medical-in-confidence' basis. It does not release details on addicts to the police, employers, other government departments or foreign agencies.

Dorothy Gonsalves
Drugs Branch

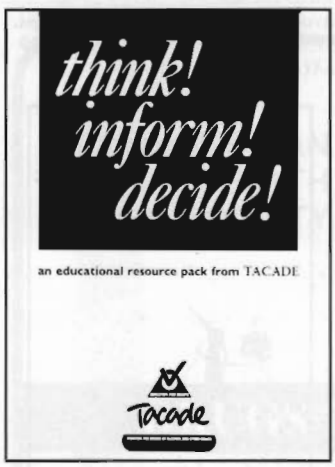
Dear Editor,
It was not my intention to convey the view that the Home Office and its employees would intentionally sanction the release of information to co-workers, employers or anybody else not entitled to receive it and I apologise if I have inadvertently given this impression.

Nevertheless, it is an open secret that the index has as many leaks as a colander. I am unable to offer further examples for fear of jeopardising careers and reputations, but you can take my word for it. In this instance, I am certain that the story I reported is true. Any system is only as good as the people who operate it, and people love to gossip.

For virtually all the individuals on the index, confidentiality is unlikely to be a problem. For people who work in this field, it is obviously a concern. Their co-workers and managers, or staff from other agencies, may have access to that information, albeit indirectly. I have been aware of workers who could benefit from being in treatment but were constrained by the possibility that information would leak.

However, I do accept that the index is often blamed for leaks that may emanate elsewhere, from police inspection of pharmacy records, attending doctors or other drug workers.

Peter McDermott



'Judgmental' TACADE pack or judgmental review?

Dear Editor,
It was the tone of Adrian King's review of TACADE's *Think! Inform! Decide!* (***Druglink***, 5(6), p.18) that most depressed me. I do not think I have ever read a review more devoid of morale. If this pack is as bad and biased as Mr King has it (even more judgmental than his review, no doubt), I cannot help thinking why the taxpayer's money has been wasted on having it reviewed and the review published.

If Mr King is trying to warn us, I feel he is guilty of the same crime as he persecutes TACADE for; indeed, he risks his credibility by departing from his implied ethos.

The extent of his judgments on the product of an organisation that has done so much to raise the profile of drug education in this country, undermines those judgments. (I am dying to have a look at the pack to see if it really is as bad as Mr King says.)

For all his concern about "value-laden facts" and "judgmental starting points", he seems to expect TACADE (as he seems to expect so much else of TACADE) to exhibit no world view. This, to me, seems naive.

I am sure we all sympathise with Mr King. Regrettably, too infrequently does the dynamic for social change come, not from the crystal conduits of 'pure reason' that typify the byways of the initiated, but from the sordid streets of the real world, where the problem is and where most of us live.

Perhaps Mr King would condescend to design a resource for adolescents that he *could* unreservedly recommend, rather than waiting on others to do so.

Mr King might best fulfil his duty by showing the inspiration more befitting a person in his position.

Vince Hatton
London

Dear Editor,
I was sad to read Mr Hatton's letter which might have carried some weight if he had examined the pack under discussion. Mr Hatton seems not to grasp the essential differences between the jobs of reviewer, resource-writer and teacher.

In the classroom, the extent to which pupils become well-endowed with skills in critical thinking, information-gathering, and decision-making, is likely to be a function of the manner in which they are encouraged dispassionately to consider a variety of views and then to think for themselves.

It is the teacher's job to provide access to such a spectrum and guide pupils through it. Teachers need to be well aware of the strengths and weaknesses of any printed resources they use, and the reviewer's job is to assist them by giving honest criticism. It would be pointless for a reviewer to be merely neutral!

I hope Mr Hatton does have a look at *Think! Inform! Decide!* I am sure his desire to be fair to it will ensure that he doesn't miss its good points, reference to which he seems to have overlooked in my review.

Adrian King

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

PUBLICATIONS

Practice guides

❑ **DEPENDENCY MANUAL. J.D. Gardiner and J. Talbot. Northumbria Probation Service, 1990. 70 pages. £15 plus p&p.**
Incorporates harm-reduction and motivational interviewing techniques. An important development in probation work with drug users.
Available from Northumbria Probation Service, Lifton House, Eslington Road, Jesmond, Newcastle upon Tyne, phone 091 2815721.

❑ **TREATMENT OF DRUG MISUSERS IN THE WESSEX REGION: GUIDELINES FOR GENERAL PRACTITIONERS. Philip Fleming *et al.* Wessex RHA, 1990. Booklet. £4.50.**
Guidelines sent to all GPs in Wessex. Could provide a model for elsewhere.
Available from Wessex Drug Dependency Service, St James' Hospital, Locksway Road, Portsmouth PO4 8LD. Cheques payable to the Portsmouth and S.E. Hampshire H.A.

Training guides

❑ **'ON LINE': THE DRUGS LEARNING PACK. A PACK OF TRAINING ACTIVITIES AND INFORMATION FOR TRAINING PEOPLE WHO WORK WITH YOUNG PEOPLE. On-line Project. London: Commonwealth Youth Programme, 1990. 188 pages. £7.50.**
Useful compendium of training activities and factsheets.
Available from Commonwealth Secretariat Publications, Marlborough House, Pall Mall, London SW1V 5HX.

❑ **REDUCING HARM – EXTENDING CARE: REGIONAL DRUG TRAINING STRATEGY. North West Thames RHA, 1990. 6 pages mimeo. Booklet.**
An attempt to provide a framework for DHAs in accordance with recommendations from the Advisory Council on the Misuse of Drugs.
Available from Regional Development Manager for Substance Misuse Services, NW Thames RHA, 40 Eastbourne Terrace, London W2 3QR.

Drug services

❑ **THE IMPACT ON DRUG SERVICES IN ENGLAND OF THE CENTRAL FUNDING INITIATIVE. Susanne MacGregor *et al.* ISDD, 1991. Research report. £4.95.**
The first comprehensive census of drug services in England. Staffing, finances, methods of working, AIDS/HIV work and more all carefully documented.
Available from ISDD.

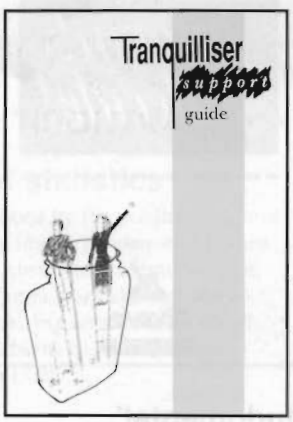
❑ **THE DRUG MISUSE DATABASE. Drug Research Unit, University of Manchester. Department of Health, 1990. Manual and computer software.**
For health authority database managers/operators.
Available from Drug Research Unit, Prestwich Hospital, Manchester M25 7BL, phone 061-798 0544.

❑ **DRUGS SERVICES IN LONDON: A CONSULTATIVE REPORT FOR THE LONDON BOROUGHS GRANTS COMMITTEE. Peter Baker. London Research Centre, 1990. ix, 77 pages. Report. £16.50 inc. p&p.**
An analysis of the extent of problem drug use in London and patterns of service provision.
Available from London Research Centre, Parliament House, 81 Black Prince Road, London SE1 7SZ.

❑ **NEWSLETTER ON DRUGS, HIV, AND AIDS FOR THE SOUTH WEST REGION. Avon Drug Problem Team.**
For drug and HIV workers in the south west of England.
Available from the Avon Drug Problem Team, Glenside Hospital, Blackberry Hill, Stapleton, Bristol, BS16 1DD.

Tranquillisers

❑ **THE BENZODIAZEPINE MANUAL: A PROFESSIONAL GUIDE TO WITHDRAWAL. Diane Hammersley and Moira Hamlin. Birmingham: Withdraw Workshop, 1990. 102 pages mimeo. £15.50 inc. p&p.**
For leaders running benzodiazepine withdrawal groups. To be used with the *Withdraw Pack* (available from ISDD £6.50).
Available from Withdraw Workshops, 515A Bristol Road, Birmingham B29 6AU, phone 021-471 3626.



❑ **TRANQUILLISER SUPPORT GUIDE. Drugline, Preston, 1990. Folder with notes and handouts. £5.**
Guidance on setting up a support group for tranquilliser dependents plus handouts for use by the group.
Available from Drugline, 2 Union Court, Union Street, Preston PR1 2HD, phone 0772 53840.

❑ **ADVERSE EFFECTS OF BENZODIAZEPINES. Claire Gudex. York: Centre for Health Economics, 1990. iv, 33 pages. Report. £3.50.**
Useful review of studies including dependence.
Available from the Publications Secretary, Centre for Health Economics, University of York, York YO1 5DD, phone 0904 433648.

Other

❑ **DRUG MISUSE IN BRITAIN: NATIONAL AUDIT OF DRUG MISUSE STATISTICS. ISDD, 1990. 40 pages. Booklet. £2.50.**
Compendium of official statistics and surveys plus com-mentary and special sections on the new databases and solvent misuse.
Available from ISDD.

❑ **MAINLINERS NEWSLETTER. Second issue Sept.1990. 24 pages. £25 p.a.**
Excellent product from the HIV and drugs self-help group. This issue focuses on women and HIV.
Contact Mainliners, PO Box 125, London SW9 8EF.

❑ **DRUGS: FACT NOT FICTION. Drugline, Preston, 1990. Folder with photocopiable factsheets. £5.**
Drug-by-drug factsheets plus special issues in a loose-leaf format designed to be 'customised' to the particular needs of the recipient.
Available from Drugline, 2 Union Court, Union Street, Preston PR1 2HD, phone 0772 53840.

❑ **ECSTASY: THE CLINICAL, PHARMACOLOGICAL AND NEUROTOXICOLOGICAL EFFECTS OF THE DRUG MDMA. Stephen J. Peroutka *ed.* London etc: Kluwer Academic Publishers, 1990. 244 pages. Book.**
US book of readings including therapeutic and recreational use, toxic effects, and neurochemistry.
Available through bookshops.

MEETINGS

❑ **HIV/AIDS IN PRISON FORUM. 28 January 1991, London.**
Liaison/information sharing meeting for anyone interested in the topic.
Details from Mike Trace, Parole Release Scheme, 93 Fortess Road, London NW5 1AG phone 071-267 4446.

❑ **THE DRUG EDUCATION FORUM. REALISTIC APPROACHES FOR THE '90s. 29 January 1991, London. £12.**
Aims to establish the forum and plan a programme of activities.
Details from Colin Chapman, c/o Redbridge CDAS, Chadwell Health Hospital, Grove Road, Chadwell Heath, Essex RM6 4XH, phone 081-599 3007, ext. 5282.

❑ **EVALUATION OF MENTAL HEALTH SERVICES AND TREATMENTS. Mental Health Foundation. 8 February 1991, London. £25.**
Conference of relevance to drug services including a description of an addiction evaluation package.
Details from Lucie Reader, MHF, 8 Hallam St., London W1N 6DH, phone 071-580 0145.

❑ **LITERATURE AND ADDICTIONS: AN INTERDISCIPLINARY CONFERENCE. University of Sheffield. 4-7 April 1991, Sheffield. £175 residential.**
Details from Secretary of Literature and Addiction, Department of English Literature, University of Sheffield, Sheffield S10 2TN, phone 0742 768555, ext. 6043.

❑ **TRAINING EXCELLENCE. Alcohol Interventions Training Unit (Kent University), Kent Council on Addiction and SCODA. 8-11 April 1991, Canterbury.**
International conference aiming to raise standards of training practice in drugs/alcohol field.
Details from CONCILIA, PO Box 18, Ilkley, W. Yorkshire, LS29 6RA, phone 0943 72763.

COURSES

❑ **CERTIFICATE IN DRUG DEPENDENCE. South East Thames Regional Drug Training Unit. 22 weeks full time from January or June 1991, London. Free in 1991.**
Multidisciplinary course leading to certificated qualification.
Details from Regional Drug Training Unit, 11 Windsor Walk, London SE5 8BB, phone 071-703 6333 ext. 2755/6.

❑ **WOMEN AND ILLICIT DRUGS: IMPROVING OUR RESPONSE. 5-6 February 1991, Manchester. £80/£110. North West Regional Drug Training Unit.**
Details from NWRDTU, Kenyon Ward, Prestwich Hospital, Manchester M25 7BL, phone 061-798 0919.

❑ **A MOTIVATIONAL INTERVENTIONS WORKSHOP. Leeds Addiction Unit. 7 March 1991, Leeds. £35.**
Tutors include leading Australian practitioner. Aims to develop motivational interviewing skills.
Details from Leeds Addiction Unit, 19 Springfield Mount, Leeds LS2 9NG, phone 0532 316920.

ORGANISATIONS

❑ **DRUG EDUCATION FORUM.**
Inaugural meeting 29 January 1991.
See meetings section for details.

FOR MORE INFORMATION ...

☎ ON THE PUBLICATIONS LISTED HERE: phone ISDD on 071-430 1993.
☎ ON MORE NEW PUBLICATIONS AND ARTICLES: order *Drug Abstracts Monthly* – £16 p.a. from ISDD, phone 071-430 1961.
☎ ON A PARTICULAR TOPIC: phone ISDD's library on 071-430 1993.
☎ ON TRAINING: phone the Training Officer at the Standing Conference on Drug Abuse (SCODA), on 071-831 3595.

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