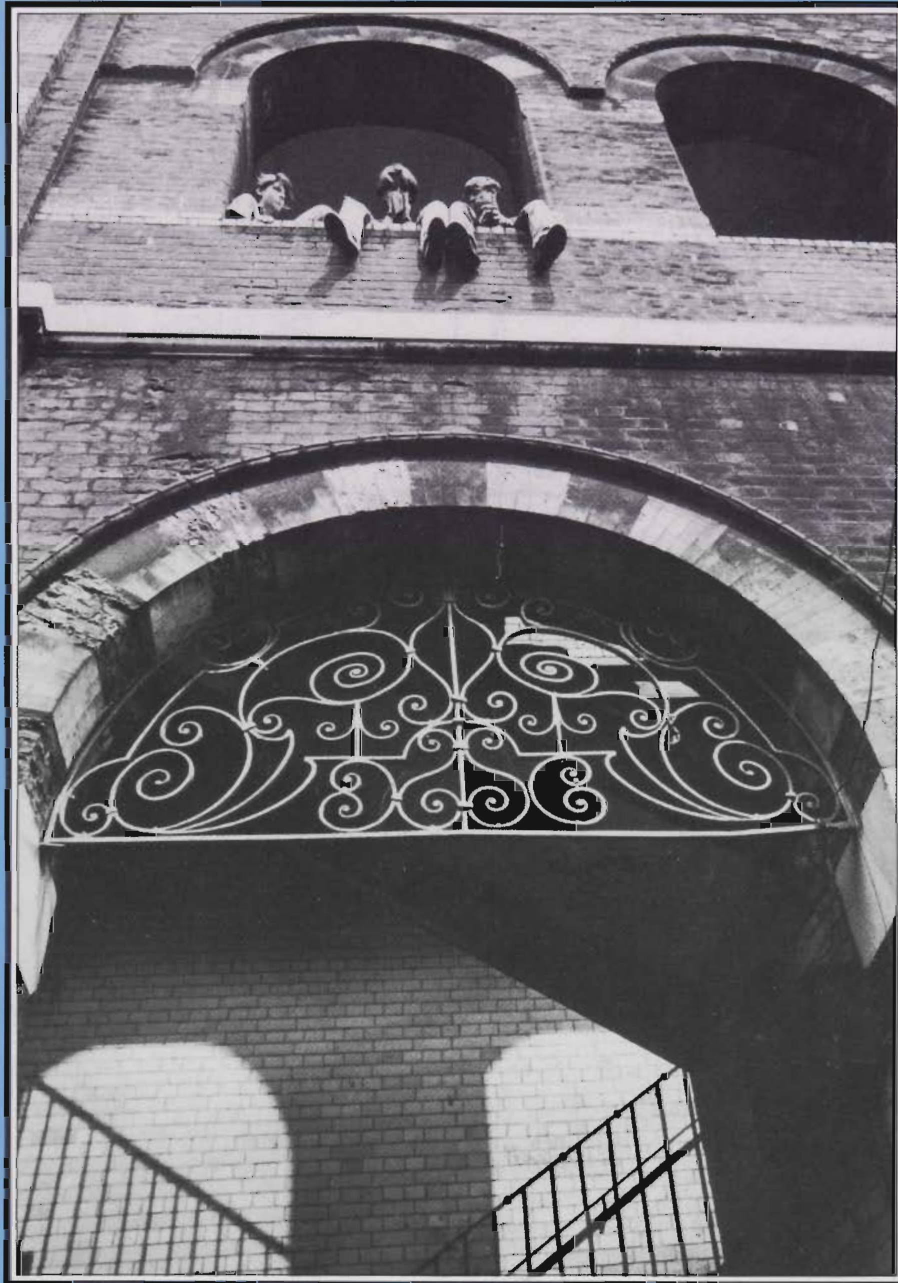
DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN

September/October 1990



Dangerous games. Solvent misuse special, including deaths, prevalence, and how you can help. See contents page

INSIDE SOLVENTS REVISITED 8-13 MINDING THE KIDS 16

BLACK PEOPLE & DRUG SERVICES 14 DRUG USERS IN COURT 6

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September/October 1990
Vol 5 issue 5
THE JOURNAL ON DRUG MISUSE IN BRITAIN

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

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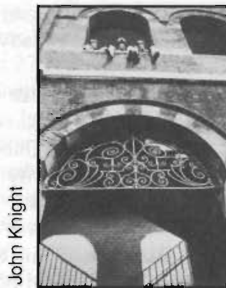
John Knight

The persistent fad

A drug misuse problem that probably accounts for more deaths than any other, that remains persistently popular among adolescents, but has fallen from the headlines and the political agenda – we revisit solvent misuse, the drug panic of the '70s. Deaths statistics on page 8; extent of use on page 12; how you can help on page 10

Una Padel **6** **FAIR TRIAL FOR JUSTICE PROPOSALS**
Drug agencies have legitimate concerns about court-ordered treatment, but there could be something in it for their clients.

John Ramsey et al **8** **DANGEROUS GAMES**
Reasons to be concerned – latest figures show 1 in 25 of all deaths among boys aged 10-14 were related to solvent misuse.

PRACTICE NOTES Richard Ives **10** **HELPING THE SNIFFERS**
The options for working with solvent misusers – from doing nothing through residential treatment to social action.

Richard Ives **12** **THE FAD THAT REFUSES TO FADE**
Evidence that sniffing solvents is Britain's biggest youth drug misuse problem.

Joy Awiah et al **14** **'THE LAST PLACE I WOULD GO'**
One of the first research projects to document why young Britons of African and Asian descent shun drug services.

PLATFORM Patricia Kearney et al **16** **WHO'S MINDING THE KIDS?**
What do you do when your clients are or may be abusing their children? Asking the question is a good start.

NEWS 4 Low priority for **drug/HIV education,** but cases still rising (page 4); **tranx court cases** a step nearer (page 4); late reprieve for **drug rehabs** (page 5).

LETTERS 18 Ann Dally on why she promotes **'stabilisation'** not **'maintenance'**.

REVIEWS 19 Two new education materials – a Christian approach in **A Little More Ice?** and TACADE's **Taking Drugs or Taking Part** on drugs in sport.

LISTINGS 20 **Publications. Courses. Meetings. Organisations.**

Cover photo: note this is a posed photoograph; thanks to the children for their help

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■ **After the July Cabinet reshuffle John Patten takes over responsibility for drug policy in the Home Office from David Mellor. The Home Office is the lead department on drug misuse and it's likely that Mr Patten will also take over chairing the Ministerial Group on the Misuse of Drugs. At one time Patten held ministerial responsibility for drugs at the Department of Health.**

■ A longitudinal study of over 45,000 Swedish men conscripted in 1969/70, consisting of over 90 per cent of the eligible population, found that those who admitted to using cannabis over 50 times at conscription were nearly three times more likely than non-users to be dead by 1983.[1] However, this excess mortality disappeared when other factors leading to mortality were taken into account, indicating that cannabis use was not a direct cause of death. In contrast, injecting drugs or heavy alcohol use were both directly associated with elevated mortality rates.

1. Andreasson S. *et al. Scandinavian Journal of Social Medicine*: 1990, *18*, p.9-15.

■ **A MORI survey of more than 10,000 9-15 year-olds undertaken for the Health Education Authority found that half the children who were regular smokers had tried drugs of misuse, including 38 per cent who'd tried cannabis and around 10 per cent each who'd sniffed solvents or taken amphetamines, Ecstasy or "acid".[1] Just 2 per cent of the non-smokers had tried any of the drugs.**

1. *Parents Against Tobacco*: June 1990, p.1.

■ Midwives and other health professionals involved in antenatal care should develop skills and confidence in the assessment of drug use in pregnancy and practice simple interventions to safeguard health. This is the major conclusion of research which randomly screened women attending two London antenatal clinics. Eight per cent had alcohol or drugs in their urine with, at 6.5 per cent, cannabis being the most common.[1]

1. London M. "Services for pregnant drug users." *Psychiatric Bulln.* 1990, *14*, p.12-15.

■ **In a double blind trial over 40 per cent of 45 healthy subjects who regularly drank 4-6 cups of coffee a day experienced withdrawal headaches when switched from ordinary to decaffeinated coffee. All but 7 of the subjects were unaware of the switch. Also statistically significant was an increased ability to fall asleep while on decaffeinated coffee.[1]**

1. Dusseldorp, M.van. *British Medical Journal*: 16 June 1990, p.1558-9.

Drugs and AIDS cases accelerate but low health priority

A survey of health authorities in Britain suggests most give a relatively low priority to health promotion work on AIDS/HIV or on drug and solvent use.

The survey by the Institute of Health Services Management asked authorities about their Health For All priorities. Less than 1 in 5 of those identifying priorities mentioned AIDS/HIV and only 1 in 8 mentioned drugs/solvents. Topping the list (at 59 per cent) was heart disease.[1]

Even areas where drug-related HIV spread is a top priority may be unable to fund the initiatives necessary to stem the epidemic. In Edinburgh 1 in 100 of young men are thought to be HIV-infected, mainly through sharing injecting equipment, but Lothian Health Board's financial crisis means work on a planned residential detoxification centre will probably not start this financial year, after having been put back from the previous year. However, work has begun on a hospice to house those already infected.

Latest Department of Health statistics suggest cutting drug initiatives may be a short-sighted way to balance health authority budgets. The bulletin records a cumulative total of 117 cases of AIDS among drug injectors up to June 1990, of which 51 had died.[2] But it also says these figures are increasing rapidly with AIDS cases in injectors up over 90 per cent in a year. "It is possible that in a few years time over half the UK cases of AIDS could be in the heterosexual contact and injecting drug abuse categories," comments the report.

Recent evidence from Glasgow shows that sharing of injecting equipment continues even in an area with relatively easy access to injecting equipment. Interviews with over 100 people buying injecting equipment at a retail pharmacy in an area of widespread social deprivation revealed that while less than a third would *borrow* injecting equipment, over a half were prepared to *lend* theirs to others,[3] potentially putting them at risk.

■ Last year 187 syringes and 98 needles were found in prisons in England and Wales, but the problem of drug-related HIV spread in custody could be much bigger than these figures suggest. Research among formerly imprisoned drug injectors attending one of two London drug agencies showed that 47 out of 50 had used an illicit drug in prison and 33 had injected.[3]

The crucial finding is that 26 – over half the sample – had shared injecting equipment while in custody. Compounding the risk of HIV spread from and to these former prisoners is a high level of multi-partner sexual activity inside and outside of prison. Most of the injectors had been imprisoned for drug-related offences.

1. Disken S. *Health Service Journal*: 10 May 1990. Response rate was 55.7 per cent.
2. Department of Health. *Quarterly AIDS figures*: 10 July 1990.
3. McKeganey *et al.* "HIV-related risk behaviour among a non-clinic sample of injecting drug users." *British Journal of Addiction*: 1989, *84*, p.1481-1490.

More mixed messages Stewart Seale

Tranquilliser cases move closer to court

In July the writs being served on tranquilliser producers took another step towards trial when the Lord Chief Justice assigned high court judge Mr Justice Kennedy to hear and oversee the proceedings.

Drug giants Roche and Wyeth now face writs from about 2500 individuals claiming damages related to benzodiazepine dependence and long-term use. Their cases are being handled by 500 solicitors coordinated by a committee chaired by Michael Napier of solicitors Pannone Napier. Andrew Tucker of Pannone Napier says the case against these companies is based on allegations that they failed to do enough research into long-term use and the possibility of addiction, and did not provide the warnings which could reasonably have been expected with regard to their products. Spotlighted specifically are the drugs Valium and Ativan made by Roche and Wyeth respectively.

Pinning down which (if any) company is liable is complicated by the fact that many individuals switched brands or were switched to cheaper generic equivalents. The move to generic equivalents was given a sharp boost when in 1985 most benzodiazepines (including Ativan and Valium) were placed on the 'limited list' of drugs which could not be prescribed by name at the NHS's expense.

The Department of Health's first warning of the addictive nature of tranquillisers came in 1988, urging that fewer and shorter prescriptions should be made. That year Wyeth changed its datasheet information for Ativan, reducing the recommended dose for severe anxiety from 8mgs to 1 to 4mgs a day, and dropped its recommendation for mild anxiety altogether.

However, these actions may be seen as too little too late; not all doctors were made aware of the changes and it is possible that many prescriptions were maintained at the old level.

The move to assign a high court judge is a significant step within the process of channelling the case to court. While Pannone Napier is satisfied there is a case to answer, the solicitors also expect the timescale to be years in what may prove to be one of the largest group actions seen in a British court.

■ Friday 13 July proved ultimately unlucky for TRANX UK when it closed for lack of funds. After failing to secure continued funding from local and health authorities (see **Druglink**, May/June 1990) and struggling for several months on donations, the money finally ran out.

TRANX founder Joan Jerome is currently negotiating with "various projects" to restart the tranquilliser advice service and hopes to be operational by the end of the year.

Steve Sampson

■ On 30 July a Notting Hill shopkeeper was sentenced to three months' imprisonment for 'offering to supply' equipment believing it was to be used for drugtaking. This is the first prosecution under the 'paraphernalia' provision of the Drug Trafficking Offences Act 1986 and is being seen as a test case. Among the items concerned were hubble-bubble pipes, scales and cigarette rolling papers.[1] Lee Harris was later freed on bail pending an appeal. A defence fund has been established.[2] Police say that if the appeal fails further prosecutions will follow.

1. Guardian: 31 July 1990
2. Committee for an Open Debate on Drugs, undated press release.

■ After private practitioner Dr Ann Dally was banned from prescribing controlled drugs in 1987, 26 of her former patients attended the Maudsley Hospital's drug dependency unit. A study designed to test Dally's predictions that they would quickly deteriorate when forced to reduce their prescribed drug use found that 18 of the 26 agreed to phased reductions aiming to eliminate injecting.[1] However, after six months half the patients left in favour of a private clinic which, the researchers say, did not put them under the same pressure to reduce.

1. Strang J. *et al. British Journal of Addiction*: 1990, *85*, p.771-4.

■ A Northamptonshire businessman has entered his design for a non-reusable syringe in the Design Council's Year of Invention competition and has been shortlisted for the finals. If successful and widely adopted it could provide a technical solution to preventing HIV spread through needle sharing.[1]

1. *Times*: 31 July 1990.

■ Evidence is mounting that anabolic steroid use by athletes can lead to withdrawal symptoms and adverse behavioural consequences. In a study of eight weightlifters depression was noted as the main withdrawal symptom,[1] while a new British review says multiple high-dose steroid use ('stacking') often leads to increased aggression and hostility.[2] Such evidence may help legitimise attempts by some Government ministers (including ex-Sports Minister Colin Moynihan) to override advice from the Advisory Council on the Misuse of Drugs that the drugs do not need to be controlled under the Misuse of Drugs Act.

1. Brower K.J. *et al. American Journal of Psychiatry*: 1990, *147*, p.510-2.
2. Choi P.Y.L. *et al. Clinical Sports Medicine*: 1989, 1, p.183-7.

Eleventh-hour victory for English community care campaigners

A late Government U-turn appears to have safeguarded the future of residential drug and alcohol services in England, but not for Scotland and Wales.

On 27 June as the NHS and Community Care Bill was completing its last parliamentary stage, Secretary of State for Health Kenneth Clarke introduced an amendment enabling him and his successors to give local authorities specific sums reserved ('ring-fenced') for the care of drug and alcohol dependents (see box).

The ring fencing amendment

After the Government amendment the NHS and Community Care Act now reads: "The Secretary of State may, with the approval of the Treasury, make grants out of money provided by Parliament towards any expenses of local authorities incurred... in making payments, in accordance with directions given by the Secretary of State, to voluntary organisations which provide care and services for persons who are, have been, or are likely to become dependent upon alcohol or drugs."

The amendment addresses fears that drug users would lose out if local authorities were left with the choice of spending their general allocation on addicts as opposed to the elderly or other needy groups.

Less than a fortnight before Baroness Hooper had repeated the Government's rejection of ring-fenced drug and alcohol funding saying that "to single out any particular aspect of service provision would tie the hands of local authorities".

Her statements led to an intensification of the lobbying campaign spearheaded by Kazim Khan at SCODA in alliance with Turning Point and Alcohol Concern.

Kenneth Clarke's story that in the end the "pressure from all sides" paid off seems the simplest explanation for his policy reversal.

A more cynical interpretation is that the Government intended to safeguard its investment in drug and alcohol services, but left it to the last minute to give dissidents less chance to argue that ring fencing should be extended to the entire community care budget.

Kenneth Clarke was challenged on exactly this point, and explained that exemptions were only being made for "unpopular" groups and involving relatively small sums.

Unexpectedly the Government amendment includes a preventive element allowing funding for people "likely to become dependent on alcohol or drugs". Kazim Khan has been told that the intention is to allow the funding of counselling and support work which might help pre-empt the need for rehabilitation.

In July the widely reported statement delaying implementation of the community care legislation included the commitment to start paying the new drug and alcohol grant from April 1991, two years before full financial responsibility for community care is to be passed to local authorities.

Not until April 1993 will the social security income support payments now paid by right to residents of drug and alcohol services be transferred to local authorities for them to spend at their discretion in community care or other areas.

At that point the ring-fenced drug and alcohol grant will need to fully replace present social security payments to drug and alcohol rehab residents, now running at an estimated £20 million p.a. The grant running for two years from April 1991 is set at a much lower level – £2 million in the first year – because social security payments continue during this period.

According to Kenneth Clarke the initial £2 million is "new money", but at the time of writing the permitted uses of it are unclear.

Department of Health thinking is that it should be used to enhance and expand the voluntary sector to strengthen it in the run up to full implementation of the new community care proposals, rather than to replace current local authority top-up funding.

From left to right, Diane Hayter (Alcohol Concern), Les Rudd (Turning Point) and far right Kazim Khan (SCODA) join with Viscount Falkland to lobby for special drug and alcohol funding

Local authorities will need to bid for the money of which 30 per cent must come from their own budgets, leaving £1.4 million to come from the Treasury. One concern is that hard-pressed authorities will be unwilling to raid their general budgets for the 30 per cent so will not bid for the money, particularly if they are currently unsympathetic to drug users.

It has become clear that drug rehabs will not need to take on the mammoth task of negotiating payments from local authorities across the UK for residents from their areas. Instead all the funding will come via the 'home' local authority hosting the rehab, which will be given an allocation based on the number of beds in its area.

■ Draft community care guidelines for local authorities spotlight drug and alcohol centres as examples of voluntary agencies to which local authorities might wish to contract the crucial assessment procedure, which will form the basis for deciding on a care plan for the individual.

This encouragement should help reassure agencies concerned that inexperienced local authority case managers may make ill-informed assessments. But the guidelines also make it clear that the final decision on a care plan must remain with the local authority which holds the purse strings.

Also welcome is the stipulation that local and health authorities should agree emergency admissions procedures, another major lobbying point for drug and alcohol agencies concerned that delays could see the client's motivation waver. Here again a "crisis for alcoholics or drug addicts" is spotlighted as one justification for emergency admissions.

■ Turning Point is mounting a national survey of residential drug and alcohol projects to establish a benchmark for estimating how much money the Government will need to allocate in 1993 in order to replace current social security and 'top-up' payments made to rehabs.

Another objective is to prepare local authorities hosting residential projects for the fact that most of the residents they will need to fund will not come from their own area.

FAIR TRIAL FOR JUSTICE PROPOSALS

Drug agency clients could benefit from government criminal justice proposals

Implementing the White Paper *Crime, Justice and Protecting the Public* could prevent offenders being sentenced on their record and make courts justify imprisonment. These together with greater use of probation orders requiring treatment could help keep drug users out of prison, as long as some drug agencies cooperate and ensure treatment is ordered only where the offender would otherwise be imprisoned.

Una Padel

The author is senior project officer with the HIV/AIDS and Drug Using Offenders Project at the Standing Conference on Drug Abuse (SCODA).

"FOR MOST OFFENDERS, imprisonment has to be justified in terms of public protection, denunciation and retribution. Otherwise it can be an expensive way of making bad people worse." This extract from the White Paper *Crime, Justice and Protecting the Public* conveys the Government's apparent commitment to reducing the numbers sent to prison for less serious non-violent offences.

The White Paper contains proposals likely to find their way into the Criminal Justice Bill to be published in December. As one might expect, the Government is concerned not to give the impression that it has 'gone soft' on crime; references to just deserts, punishment and reparation abound. But beyond the rhetoric are a number of potentially positive aspects which should not lightly be dismissed.

For the first time there is an attempt to introduce some coherence into the sentencing process. Traditionally sentence has been determined according to a mishmash of factors such as: the seriousness of the offence; the previous record; whether there is a social enquiry report with a realistic recommendation for a community-based sentence; and the prevailing attitude towards that type of offence in the area.

In contrast, the White Paper recommends that sentence be decided simply according to the seriousness of the offence. Specifically excluded is the offender's previous record – which could be good news for those whose drug use regularly brings them before the courts for offences of similar gravity.

Under the new proposals sentencers would have to give their reasons, in open court, for passing a custodial sentence, which would be open to appeal. Such provisions have already helped reduce the number of young offenders sentenced to custody over the last few years.

The Government also proposes to extend to adults the requirement that before passing a custodial sentence the court should consider a social enquiry report from the probation service detailing which community-based sentence might be appropriate.

Less welcome are the suggested additions to the range of community penalties, including curfew orders possibly enforced by electronic tagging, and the new 'combined order' enabling courts to construct sentencing packages by combining existing penalties. Recognising that all community-based penalties involve some restrictions on liberty, the Government proposes that the appropriate sentences should be decided by matching the degree of restriction to the seriousness of the offence.

The underlying assumptions are that sentencers under-use community-based sentencing because it is perceived as being insufficiently restrictive, and that too small a range of options currently exists. In fact England and Wales have a wider diversity of non-custodial penalties, yet a higher proportion of the population is imprisoned here than anywhere else in Europe.

Increasing the severity of community-based sentences is intended to reduce the number of non-violent offenders being sent to prison. But without any real restrictions on the court's power to imprison for minor offences, there is a risk that those now receiving non-custodial sentences will simply be subject to greater restrictions, with no net impact on the rate of imprisonment.

Treatment orders

Allusions to the potential for conditions of treatment requiring drug users to undergo a treatment programme as part of the probation order have caused particular controversy in the drugs field. A Home Office press release issued the day after the White Paper highlighted this option, making it seem like something new. In fact, such conditions have been possible for years, but have rarely if ever been imposed, though the attention now given to this possibility is likely to result in increased use.

Involvement in the criminal justice system would not be new to most drug agencies. Work currently undertaken includes: preparing reports on clients who

come before the courts; liaising with the probation service about people on probation who voluntarily attend the drug service; visiting clients in prison; contributing to pre-release courses and prison officer training; providing advice and counselling 'surgeries' in prisons; and, in the case of some residential centres, accepting residents subject to conditions of residence at the project as part of a probation order.

However, use of probation orders with conditions of treatment could involve far more agencies in a more formal relationship with the criminal justice system. Some drug workers seem to see this as entirely negative. Fears have been expressed about working with people whose principal motivation is avoiding prison, and about the increased level of cooperation with authority such conditions may imply.

No place to get better, but drug agencies could use Government criminal justice changes to keep more drug users out of prison

The question of motivation is important, as someone attending a project simply because they have to may disrupt others who are more highly motivated. But perhaps the more likely scenario is that, rather than attending and causing difficulties, the unmotivated client may simply stop attending, leaving project workers to take the individual back to court, playing a part in his or her eventual imprisonment.

This understandably worries drug workers concerned not to appear authoritarian, but in fact supervision of the probation order is the responsibility of the probation officer, who would have to decide what to do if the client fails to comply with any of the conditions of the order.

If a treatment condition clearly is not working then liaison between the drug agency and the probation officer may enable any difficulties to be overcome, or result in an alternative solution which can be presented to the court.

Assessment crucial

Fundamental to the whole process is a thorough assessment of the needs of the drug user before sentencing. Cases are usually adjourned for social enquiry reports before a probation order is imposed; under the White Paper proposals the same will apply if the court is considering a custodial sentence.

If a treatment condition is to be considered then the drug agency should have the opportunity to assess the offender at this stage. This would provide a chance for the agency to assess the client's suitability for its programme and for the client to see what is available and whether they are prepared to comply.

Negotiation of the terms on which any drug agency input might occur would be possible at this stage, including agreement on frequency of attendance and levels of information sharing between the agency and the probation officer.

Many drug users on probation now attend drug projects on a voluntary basis and it is important that this remains the usual situation. In future if conditions of treatment were added where now 'straight' probation orders were imposed, then obviously the overall effect would be negative. Additional restrictions inevitably increase the chances of the probation order failing.

> ***Workers should consider whose interests are being served by refusal to cooperate***

The White Paper recognises this and the problems some may have in complying with a plethora of requirements: "It is important that the courts should be realistic... The lifestyle of many offenders, especially young adults, is often disorganised and impulsive, particularly if they drink too much or are addicted to drugs... Each order should be tailored both to the seriousness of the offence and the characteristics of the offender."

But if those otherwise seriously at risk of going to prison wish to seek help and are assessed as suitable by the drug agency, then a probation order with a condition of treatment may provide a positive opportunity.

Drug agencies would inevitably have to play an important role in refusing to accept treatment conditions on those who would now receive ordinary probation orders. Drug agencies could play a proactive role in limiting the use of treatment conditions similar to that played by intermediate treatment schemes. These schemes have had a major impact in diverting juveniles from custody, and an important component of this has been effective 'gatekeeping' so that most schemes only accept those who would otherwise end up in young offender institutions.

An important element in ensuring that reports and assessments from drug services are influential in court is to improve the court's level of knowledge about drugs, treatment options and local drug agencies. Many magistrates and judges rely largely on information gleaned in their day-to-day lives rather than any specialist knowledge. It is hardly surprising that sentencing often reflects media stereotypes, where 'drug dealers' on whatever scale are 'evil' and drug problems can only be resolved by becoming entirely drug free.

There are a number of ways in which this can be achieved: by contacting the clerk to the justices to suggest an input into the training of new magistrates; through the probation committee of magistrates which acts as the management committee of the local probation service; by agencies holding 'open days' for magistrates and judges; by providing literature about the service geared towards sentencers; even by inviting a magistrate or judge to join the agency's management committee.

Some drug services will feel that it is inappropriate for them to become more heavily involved in court-based work or to have any part in what is seen by some as compulsory treatment (though the defendant has to consent, inevitably there is pressure to do so). However, workers should consider whose interests are really being served by a refusal to cooperate, and whether the occasional acceptance of treatment conditions would fundamentally alter their service.

Though individual services may not wish to be involved, it is important that some provision is available in each area in the interests of consistency and justice.

ANY DRUG WORKER who has operated in a penal setting can be under no illusion about the damaging effect imprisonment has on every aspect of a prisoner's life. Some drug users convicted of the most serious offences will always be sent to prison. But the provisions in *Crime, Justicce and Protecting the Public* may provide an opportunity for drug services to play a vital role in reducing the number of drug users subjected to the harm and degradation of imprisonment. As such these proposals deserve to be given a fair trial. ■

DANGEROUS GAMES

UK solvent deaths 1983–88

Evidence that solvents contribute to more deaths in the under 20s than any other drug

An ongoing study of UK deaths associated with the abuse of volatile substances (VSA) has used consistent recording methods since 1983. Over that period the number of such deaths increased from 82 to 134 and in some under '20s age groups the rates of death more than doubled. From accounting for less than 40 per cent of VSA deaths in 1983, gases and aerosols were involved in nearly three-quarters of the deaths in 1988.

John Ramsey, Kate Bloor & Ross Anderson

The authors are researchers at St George's Hospital Medical School in London. *They acknowledge the help of OPCS, the British Aerosol Manufacturers' Association, and Resolv. The study is funded by the Department of Health.*

THIS ARTICLE DESCRIBES the methods used in our study monitoring deaths associated with the abuse of volatile substances (VSA) – more commonly known as solvent misuse or 'glue sniffing' – and reports on some of the more recent trends.[1] Our study monitors deaths associated with the deliberate inhalation of a volatile compound to change mental state. The study has been running since 1981, and since 1983 we have systematically ascertained deaths in the UK by three methods:

– a press clipping agency service;
– regular letters to coroners;
– liaison with the Office of Population Censuses and Surveys (OPCS), who have provided access to their associated digit coding system.

Associated digit coding was introduced by OPCS to provide an additional method of monitoring particular kinds of deaths. OPCS usually code the underlying cause of death, but the associated digit system allows particular causes to be identified whether or not they have been assigned as the underlying cause. Data for cases related to VSA are available from 1981 onwards.

Further details about identified deaths are obtained from inquest and post-mortem proceedings. Medical, circumstantial, socioeconomic and toxicological information is extracted from these documents. This method allows us to examine a broad range of deaths associated with volatile compounds and to make a judgment based on all the available data as to whether it falls within our definition of VSA.

We include cases where death may not have resulted directly from the toxic effects of a volatile compound, but where it was related to intoxication with these substances, sometimes circumstantially. The number of deaths recorded is to some extent influenced by the way they are ascertained and by the level of public awareness of the possibility of deaths being linked with VSA. Given that our research methods have been consistent since 1983, we can assume that variation due to these factors has been minimised, but we should still be cautious about the trends and patterns shown.

Our statistics should not be read as indicative of the level of abuse. The mortality rate depends not just on the size of the population at risk, but also on the compounds abused, the method of abuse and many other factors. Patterns of abuse and deaths may significantly differ, and changes in the observed rate of death may not reflect changes in the rate of abuse but may result from some change in the practice.

To illustrate the point, the mortality data consistently show many more deaths among young males (90 per cent) than females (10 per cent), while most studies of the practice show roughly equal numbers misuse volatile substances. Health education and legislative measures to address the health and social problems of VSA should take account of these differences.

Death rate doubles

Between 1983 and 1988, the number of deaths for males and females from *all causes* in the age groups 10-14 and 15-19 have decreased. The UK population in these age groups is also decreasing. In contrast, over the same period we have observed a steady increase in VSA deaths in these age groups. An important issue is whether the practice or just the mortality is increasing.

As a straightforward rate per population, between 1983 and 1988 VSA deaths increased from 3.7 to 10.5 per million for boys aged 10-14, and from 0.6 to 2.1 for girls. For 15-19 year-olds, the VSA death rate rose from 17.9 to 28.9 per million for men, and from 1.0 to 3.9 per million for women.

The indication that death related to VSA is increasing is further substantiated by the fact that VSA deaths make up a higher proportion of all deaths in those age groups. In 1983 1.4 per cent of all male deaths in the

1. A report giving more details is available from the Department of Public Health Sciences, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE – ask for *Trends in deaths associated with abuse of volatile substances 1971-1988*, Report no. 3.
2. British Aerosol Manufacturers' Association, June 1990.

age range 10-14 were associated with VSA, rising to 4 per cent in 1988.

There have also been some significant changes in the kind of substances causing death. We classify these as follows:

❖ **gas fuels** which contain butane and propane.

❖ **pressurised aerosols** which formerly contained halons, many of which now contain butane (90 per cent of British aerosols are now halon free[2]).

❖ **solvents in glues**, which mainly comprise toluene.

❖ **other solvents** which comprise a wide range of products and chemicals but principally 1,1,1-trichloroethane in thinning and cleaning agents.

Gas deaths up

There is a statistically significant upward trend in deaths associated with both gas fuels and pressurised aerosols, while there is little or no change in deaths associated with solvents in glue or with 'other solvents'. It is difficult to know whether this is due to a corresponding change in the practice or to some other factors (see table and pie charts).

During the years covered by our study, much effort has gone into restricting the access of youngsters to products containing volatile substances from hardware and stationery shops. Videos and other material have been made available to retailers advising them how to prevent youngsters obtaining these products.

Possibly this strategy has been more successful for products containing toluene (principally adhesives) than for the other compounds. Also many schools have restricted the use of correcting fluids containing solvents and the manufacturers have developed products without the solvent. However, butane in the form of cigarette lighter refills or camping gas is probably available from retailers not as effectively targeted by the campaign. Similarly, the wide range of aerosol products misused are available from many sources.

The question remains as to whether young people have switched from glues and 'other solvents' to butane and aerosols. It is possible instead that the same products could be being abused now as in previous years, but in a more dangerous manner.

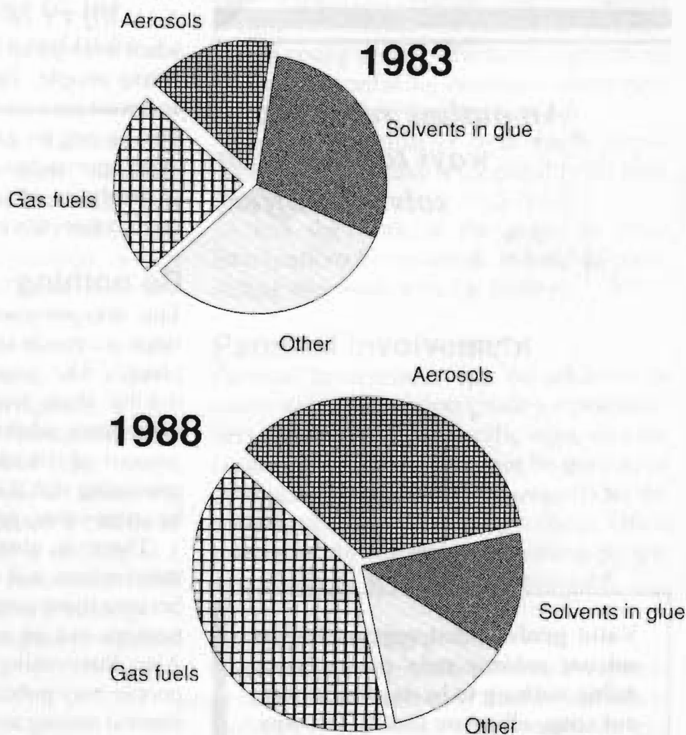
It is also relevant to consider VSA mortality in relation to mortality from the misuse of other substances, though comparisons are difficult. Preliminary analysis of the data for 1987 suggests that all 37 deaths in the 15-19 year age group officially classified as from drug dependence were from VSA. Another five deaths classified as from the non-dependent abuse of drugs did not involve VSA. Other drug abuse-related deaths may be under other classifications. However, it appears that in that year most young deaths from substance abuse were from VSA. If this finding is substantiated it should be considered by health educators. ■

Deaths associated with volatile substance abuse in the UK

Note the upward trend in deaths over this period of consistent data collection

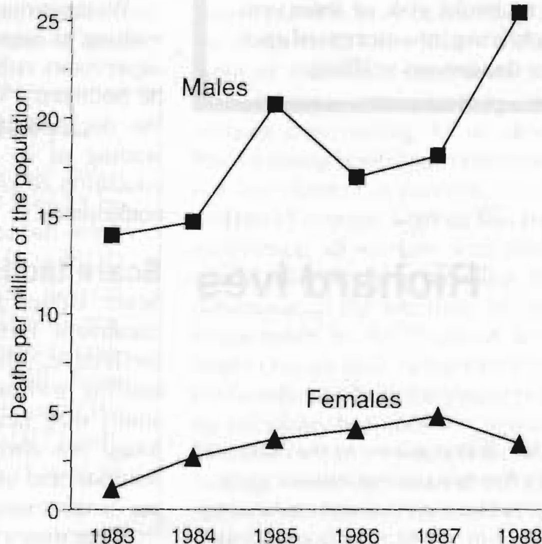
	All deaths	Gas fuels	Aerosols	Solvents in glue	Other	Not known
1983	82	19	13	24	26	0
1984	84	31	10	15	28	0
1985	118	30	20	37	31	0
1986	102	37	23	18	22	2
1987	114	37	33	21	22	1
1988	134	53	46	16	17	2

Substances involved in deaths



This chart underlines the fact that the increase in deaths has been due to a disproportionate increase in deaths involving aerosols and gas fuels. In 1988 nearly three-quarters of deaths involved these substances

Death rates associated with volatile substance abuse among 10–19 year-olds



Population changes do not account for the rise in deaths, as mortality rates too have tended to rise

HELPING THE SNIFFERS

An outline roadmap of ways to work with solvent sniffers

Valid professional approaches to solvent misuse may range from doing nothing to in-depth individual counselling or family therapy and action in the local community or wider society. They are not mutually exclusive. Workers should carefully tailor their mix of responses to the local situation and to the particular individual(s) involved to avoid risk of intervention backfiring into increased and/or more dangerous sniffing.

Richard Ives

The author is consultant to the National Children's Bureau solvent misuse project and a freelance consultant and trainer specialising in young people and drugs.

A VARIETY OF approaches can be taken when attempting to deal with solvent use by young people. These are listed in the panel and most are commented on in the main text. This is not an exhaustive list, neither are these approaches mutually exclusive – it is probably an advantage to pursue some of them consecutively or concurrently.

Do nothing

This may sometimes be the best approach, since so much sniffing is only a 'passing phase'. The youngsters will certainly be risking their lives and their health, but sometimes adults must tolerate a certain amount of risktaking by adolescents – appreciating that if it was not sniffing it might be some other, perhaps riskier, activity.

There is always the danger that any intervention will cause some youngsters to become more committed to solvent sniffing, perhaps out of a desire to oppose adults. Also, intervening with one group of young people may publicise sniffing and generate interest among another group. For example, if sniffers are seen by other youngsters to be getting special treatment (in the form, say, of a club or IT-type work) they may engage in visibly deviant behaviour – including glue sniffing – in order to gain a similar amount of attention.

Workers may need to ensure that 'doing nothing' is seen as a positive option by their supervisors rather than a response of 'can't be bothered'. This may involve recording the decision together with the evidence leading to it. It may also require some education of colleagues and people in the community.

Scare tactics

Scare tactics are often advocated as a 'treatment' method, although known to be ineffective. Most young people who try sniffing will only do so a few times and adults may never discover it. If they *are* found out, then a low-key talk giving an accurate and unsensationalised account of the dangers may be all that is needed.

More than a talking to, the young person may need to be listened to. Sniffing may be a response to loneliness, feeling inadequate or lacking self-esteem or confidence. It may be related to ill-treatment, abuse or neglect at home, at school or elsewhere.

If so, it is important to find this out and help the young person overcome these difficulties without sniffing. Frightening young people is not the best way to build a relationship of trust within which such help can be provided.

Policing

It may be possible to reduce solvent sniffing by operating various controls over young people's behaviour. For example, strict enforcement of the Intoxicating Substances Supply Act by local shops, and tightening up control of such products at home, in school and in youth projects, may make it hard for young people to obtain sniffable substances.

One side effect of such controls may be to drive determined sniffers to use more harmful products. It is possible that the apparent rise in the sniffing of aerosols and butane gas and of associated deaths (see p.8-9 of this issue of *Druglink*) are partly due to restrictions on the availability of glue.

Information and education

Information about the effects of drugs and solvents specifically designed for young people is in short supply, and some which is available is misinformation. This may lead young people to become distrustful of all adults' warnings.

As Brecher wrote about the anti-glue campaigns in the USA in the 1970s: "Children may be ignorant but they are not stupid. When the evidence of their own experience contradicts adult propaganda, they (like sensible adults) rely on their own experience – and tend in the future to distrust a source of information which they had found unreliable in the past."

It is therefore important that any information aimed at young people is accurate, unsensational, and carefully written and designed to communicate clearly and responsibly.

Some possible approaches

- collect information; it's easy to be panicked into 'doing something' with little evidence that anything needs to be done, so get the facts first
- do nothing
- policing
- scare tactics
- provision of information and education
- activity substitution – individually or with groups
- individual counselling or therapy
- parental education and involvement in treatment
- family counselling or therapy
- self-help groups for sniffers
- education for professionals
- community action; intervening in the network of local social relations within which the young person acts – an option not just for community workers
- social and political action

Activity substitution

If it is true that some young people turn to drugs and solvents out of boredom, then a logical intervention strategy would be to provide interesting alternative activities: 'highs without chemicals'. These may not simply be diversionary – giving youngsters something else to do – but actually therapeutic. For example, a youth club may give shy youngsters more contact with other young people, or rock-climbing may provide a controlled experience of risktaking.

But to some extent youngsters may be sniffing precisely *because* they find engaging in new experiences difficult and frightening. For them the experience of sniffing has come to be a safe and controllable one. Being asked to do new and unusual activities may prompt them to increase their sniffing. If this is the case, then great care must be taken to plan appropriate activities.

Workers should carefully consider the learning experiences being offered, controlling what variables they can, and place boundaries around the experience to create an atmosphere of safety where learning can take place. This might mean, for example, that a camping trip could be prefaced by activities such as cooking over portable gas stoves in the safety of the normal group meeting-place.

Individual therapy

If solvent sniffing is a symptom of underlying problems or discontents, then one approach is to offer sniffers the chance to explore these more deep-seated problems.

Individual counselling is one common way of doing this. Telephone helplines can be considered a variant on this method. These are a good way of putting people in touch with treatment options and of giving information, but properly trained counsellors can also help callers make significant progress in dealing with their habit.

For severely dependent youngsters residential rehabilitation is often recommended. This option can be very useful to give a breathing space, to provide a young person with a model of a different approach to their problems, and as a way of containing a young person in crisis. However, changes during treatment may not be sustained after discharge, so follow-up work is essential.

> ***More than a talking to, the young person may need to be listened to***

Residential detoxification facilities are mainly reserved for opiate users, but some do take solvent sniffers. Such a facility can be especially useful when a user has (or has developed) a medical condition which needs attention. 'Time out' from everyday life, the chance to rest, eat regular and nutritious meals, and opportunities to discuss oneself with sympathetic and experienced staff, can be very therapeutic.

But there are risks of 'contamination' through contact with users of other drugs, and of hindering the process of achieving abstinence if the unit operates a 'medical model' of sniffing. Regarding sniffing as a 'disease' or an 'addiction' removes control of the behaviour from where it belongs – with the individual – making the process of change more difficult.

Group therapy

Reasons for running groups for sniffers might include:
– to use resources more effectively;
– to address the group aspects of sniffing – the way a group of youngsters might sustain the habit among themselves;
– to use the relationships and the skills of group members in the treatment of others;
– already being a group worker with a group of youngsters who have taken up sniffing, for example, in a residential home.

Groups can be run in various ways but there are some factors which it is always important to consider:
– select members very carefully (for example do not mix chronic sniffers with experimental sniffers);
– have a clearly defined and limited life known and understood by all participants;
– have a structured programme which participants cannot opt out of and stay in the group;
– have a high worker:participant ratio;
– provide adequate advance training for staff and opportunities to discuss what is happening in the group during its life;
– have clear boundaries about acceptable behaviour in the group and be prepared to enforce them (for example, whether sniffing is allowed); this may be particularly important to young people who have experienced mixed and confusing messages about their behaviour in their family; but also
– have a participative style which allows young people to take responsibility for their own actions;
– link the work of the group to other interventions (for example, individual counselling and work with the family).

Parental involvement

Parental involvement can be achieved in many ways, some appropriate for practitioners unable to take on specific work with the family. The recruits need not be parents of current sniffers but could be people from the community who are willing to help. Often parents of ex-sniffers or of young people who might be at risk can be recruited.

Family therapy

If solvent sniffing is indeed often a response to family problems rather than an individual pathology, it follows that work with the family may be more appropriate than working only with the sniffer. Perhaps the biggest problem for practitioners is to help the family to understand (and admit to) their contribution to their child's behaviour.

Family work has been in vogue in recent years. But it is very demanding and, while the results will often justify a considerable input of resources, inexperienced workers may become enmeshed in the family without contributing to its development. Prior training is vital and concurrent support is a key element in success.

However, even without this training and experience, all workers with young people would benefit from keeping the family dimension at the forefront of their minds. Suggestions to the client as to how they might change their behaviour in relation to the family may help the young person make the necessary transition to a new stage of the lifecycle (getting a job, a boy- or girlfriend, leaving home, etc) even if the family does not support this transition.

For the full story...

This article is a highly cut-down version of the new ISDD booklet by the same author. To get the full story, send your cheque for £2.50 to ISDD and order *Working with Solvent Sniffers*. Also by Richard Ives – a new booklet from ISDD for parents concerned about sniffing, £1.50. Read about both these publications in the Autumn supplement to ISDD's publications catalogue with this issue of ***Druglink***.

1. Brecher E. *Licit and illicit drugs*. Boston: Little Brown and Co., 1972.
2. Shooter M. *In*: Ives R. *ed*. *Solvent misuse in context*. National Children's Bureau, 1986.

Self-help groups

Self-help groups are based on the premise that people with similar problems can help each other overcome them. But they need facilitation; since sniffing is predominantly a young person's habit, groups for sniffers may need extra help to get off the ground and maintain momentum. It is a difficult balancing act for a professional to at the same time provide the support a group requires while abdicating the leadership role in order to enable the participants to take control.

Self-help groups need not be thought of only as curative but also as preventive. Taking control of some part of one's life is likely to increase self-esteem; since low self-esteem is a predisposing factor in drug and solvent use, redistributing resources towards activities operated by young people themselves may be a useful preventive strategy. On the other hand, it may mean that resources do not reach the most disadvantaged groups since these may find it harder to operate in self-help 'mode'.

Support for professionals

Referral to another agency is often a necessary part of any treatment programme. Somewhere in the network of agencies help may be available for the person being referred.

But often it is not; in any case, the best person to deal with a youngster with a drug or solvent problem is likely to be the person who knows that youngster best (this is not always understood, or people do not want to believe it). What is crucial is the relationship between people, rather than knowledge about drug effects. Professionals need help and support in their work with drug or solvent using clients and this should be structured into any contract they make to work with such client.

Social action

Use of drugs and solvents cannot be attributed only to individual pathology; neither can it be blamed on the functioning or dysfunctioning of a particular family or community. Mike Shooter put it like this:

"Some children and their families are abusing solvents or alcohol because there is precious little else for them to do. Unemployment and an ever-decreasing faith in the relevance of the education system to their lives has reduced some kids to social isolation. These kids can't afford to get to the leisure centres that are being built in most big cities and couldn't afford to make use of them if they could... get there.

"They are reduced to hanging around, getting their kicks, with other similarly down-beaten individuals, and solvent or alcohol abuse is about the cheapest, most easily available relief from the boredom and despair of their general lives... To do something about that is a general political task and not a psychological/therapeutic one." ■

THAT RE... TO...

Solvent misuse is still the UK's biggest youth drug misuse problem

Surveys of solvent misuse in the UK in the 1980s confirm that, after cannabis, solvents are the most widely misused substances. There has been no discernible drop in usage over the decade; typically 4 to 8 per cent of secondary school-age children have tried sniffing, with wide regional variations. Some surveys show the proportion of girl users as high as or higher than boys.

Richard Ives

The author is consultant to the National Children's Bureau solvent misuse project and a freelance consultant and trainer specialising in young people and drugs.

SURVEYS OF SOLVENT sniffing in the United Kingdom since 1982 have consistently found that solvents are the next most commonly tried substance after alcohol, tobacco and cannabis. If we consider physical harm including ill-health and death, solvent sniffing would almost certainly climb above cannabis.

In most of these studies, secondary school-age pupils have been asked to complete a questionnaire in school time. Nearly all have asked a question which sought to establish whether the respondent has *ever* sniffed. What do they tell us about the dimensions of one of Britain's most serious drug problems?

Most young people know of solvent sniffing. In 1983, a Department of Education survey found that 97 per cent of a sample of young caucasians were aware of glue sniffing.[1] Nevertheless, only a small proportion of young people have sniffed. In Scotland's Lothian region, 5.4 per cent of the men aged 15-16 and 4 per cent of the young women surveyed said they had sniffed solvents.[2]

At the other end of the country, a study of 7343 11 to 18 year-olds in nine secondary schools in East Sussex found that 8 per cent reported having tried solvent sniffing.[3] Similarly, 8.5 per cent of 525 pupils in seven Berkshire schools admitted to having tried solvent sniffing.[4]

Two parallel studies in Macclesfield separately surveyed school pupils and YTS trainees. Six per cent of the sample of 1729 11 to 18 year-olds in ten secondary schools had sniffed. However, as many as 14 per cent of the 294 16 to 17 year-olds on YTS courses reported having tried sniffing.[5]

A study carried out early in 1985 questioned 807 pupils from three schools in Bournemouth and three in Southampton, finding that in excess of 8 per cent had tried solvents.[6]

A survey of 4501 comprehensive school pupils in 28 schools in South Glamorgan was done at about the same time.[7] In four schools home visits were made to survey the non-attenders. Just over 6 per cent of all the

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Sniffing solvents: as many as 8 per cent of youngsters try it and every year over 100 die

Leeds Health Education Unit/Health Education Authority

pupils surveyed had tried solvents but were not sniffing at the time of the survey, and a further 0.7 per cent were currently sniffing. Among children aged 15 to 16, nearly 9 per cent had sniffed or were currently sniffing. However, 58 per cent of the sniffers had tried sniffing before the age of 13.

In a study of 900 young people in schools in the West Midlands a similar proportion (6.6 per cent) were found to have tried sniffing.[8]

Late '80s studies

Two more recent studies have found very different levels of solvent sniffing. In 1986 to 1987 in Pontefract, just 1.5 per cent of 1882 fourth-year pupils in 10 schools reported experimental sniffing.[9] However, 11 per cent of 3073 11 to 16 year-olds in six inner London schools said they had tried sniffing.[10].

A recent review article discusses some of these studies and suggests that 3.5 to 10 per cent of young people have experimented with sniffing and 0.5 to 1 per cent are current users.[11]

In 1988 a large-scale (but non-random) survey of young people's health behaviour found that among 11 to 16 year-olds in schools throughout the country, only 1.6 per cent (of 15,071) said they had used solvents.[12] One striking finding was that a higher proportion of fourth- and fifth-year *girls* reported having used solvents (2.5 per cent) compared to fourth-year boys (1.6 per cent).

This comparatively low proportion of sniffers was confirmed in a more recent survey where (at 2.1 per cent) the *overall* proportion of girls reporting sniffing was higher than boys (1.7 per cent).[13]

A survey of 1063 pupils and students aged 11 to 19 in Portsmouth and Havant found that 4 per cent of respondents claimed to have tried solvent sniffing.[14] Surprisingly, over 7 per cent of 11 year-olds said they had done so.

However, the authors were not convinced that the sniffing reported in the survey was always of the kind that leads to intoxication. "Pupils... may have felt some guilt about their experimental sniffing of the glue or cleaning fluids kept in their own homes – and reported it to the survey as solvent sniffing."

Most of the surveys cited so far were school-based: another place to contact young people is youth clubs. A high level of experimental use was found among 212 people aged between 9 and 28 years old in eight youth clubs or centres in the London borough of Tower Hamlets.[15] Almost a quarter of the males and over a fifth of the females interviewed had tried glues or solvents.

This suggests that young people who attend youth clubs may be more likely to sniff solvents than the general population of young people surveyed through schools. ■

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Use persists despite media neglect

The surveys cited in this article span the '80s. The absence of any discernable trend shows that, despite the wax and wane of media attention, the actual proportion of users has not varied a great deal – users have simply been more or less visible.

This conclusion is supported by Anderson and colleagues' study of solvent-related deaths reported elsewhere in this issue of *Druglink*. Deaths from solvent-related causes increased over the '80s although the extent of media coverage implies that the problem had peaked in 1983.[16]

A further important finding is that while proportionately fewer girls than boys use solvents, there is less difference between the sexes than is usually thought.

We can conclude that a small proportion of children in every secondary school will have tried sniffing. While this proportion may vary by sex, ethnicity, region and so on, it will most likely lie somewhere between 4 and 8 per cent. At any one time a proportion of these children who have tried solvents – perhaps a tenth – will currently be using sniffable products to achieve intoxication, and some will be heavy users.

Most experimenters with solvents will survive the experience and will stop sniffing, but some will carry on for many years, and some will die sniffing-related deaths.

'THE LAST PLACE I WOULD GO'

Black people and drug services in Britain

Asian men and black women talk about drugs and drug services

Interim report of a research project interviewing Asian men in Bradford and African-descent women in London concerning drug problems in their respective ethnic groups and their attitudes to and knowledge of local drug services. The vast majority of both groups were unaware of the main local services and many would not visit them because of anticipated racism and fears of being shamed by agency workers.

Joy Awiah, Saeed Butt & Nicholas Dorn

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IN BRITAIN, illegal drug use and drug problems have been associated primarily with white people. Recently, following great publicity, African-descent males have been portrayed as typical users of crack. By contrast, fewer assumptions are made about drug use and people of Asian descent.

Assumptions about black people and drugs in Britain are generally underpinned by stereotypes, over-generalisations and racist posturing, rather than by evidence, making this a risky area for research. However, our research is not concerned with the extent of drugtaking among black people. We are concerned only with forms of drug use regarded as problematic by the users themselves, and with the implications for the improvement of services.

Our research focused on Asian men in Bradford and African-Caribbean descent women in Haringey. In the 18 months available, it was impossible to cover both sexes in both areas.

Young Asian men

The term 'Asian community' includes a diversity of nationalities, cultures, languages and religions. Most of our Bradford respondents were Muslims with families in Pakistan and Kashmir.

Opinions differed about the extent of illegal drug use. Some respondents felt that young Asian people did not use drugs. Their perceptions of drugs were often intrinsically linked to something that was harmful and illegal. Others felt young Asian people are as likely to use drugs, and to use the same drugs, as young white people.

"Most Pakistanis in England come from small villages. Drug use in Pakistan is mostly associated with people from larger cities. People who have grown up here do not use drugs."
– mid-20s Asian man

"Asian people, I think they use every drug that's going. If they can get their hands on it, they'll try it for the buzz."
– 18 year-old cannabis user

Certainly some young Asian people do use drugs, with cannabis and heroin seeming to be the two most favoured.

"Most of my mates smoke cannabis and I feel and they feel that it doesn't do them any harm, so we carry on using it."
– 20 year-old cannabis user

"Now, at this moment, it's heroin. Primarily it's because of unemployment. Boredom. Now that was the main reason for me to go back on to it."
– late-20s heroin user

Drug use led to problems for some drug users. Depending on the individual, even 'controlled' use could become a problem if it came to the attention of the family.

Perceptions of drug services

Many Asian respondents feared that white professionals in helping agencies would humiliate them by talking over their heads. So even when the user is aware of services, he may still not use them.

"Some people right, that can't go into a place, you know, and speak technology words. They just start saying all this shit and think they're going to get shamed up."
– 17 year-old cannabis user

"I were on powder, I'd seen your posters everywhere and I needed help. There was no way I was going to pick up the phone and ring yer. You're going to find that there's a lot of people like that."
– 23 year-old ex-heroin user

Research methods

The research involved talking to young people in various environments such as schools, youth clubs, youth training schemes and at street level, as well as agency clients. Interviews were conducted individually or in small groups, with questions on perceptions as well as personal experiences.

This article is written two-thirds of the way through our research and the emphases that we draw out here are subject to revision – comments welcome. Our final report will be published in early 1991.

The overwhelming majority of our interviewees had never heard of the Bridge Project. But there was a barrier to using services beyond simple lack of knowledge. Bad experiences of racism with a variety of generic agencies discourage Asian drug users from using drug services. Fears of being misunderstood (culturally rather than verbally) were common, as were feelings of inappropriateness and varying concepts of help. Counselling was often seen as 'just talking' and advice was seen as 'lecturing'.

For example, a heroin user may prefer to go to his GP because he knows that methadone is available – 'practical' help as opposed to counselling at a drug agency.

"I thought there would be loads of people. Officers and that. All like white shirts, ties and suits and that. I come in and there's no one about. It's good, you know like. You don't want to go to someone you think's not on the same level as us. You know, they're casual and that. So you think, yeah, this guy knows what he's talking about and that he can help us."
– 20 year-old cannabis user

Previous experience has created an image in the minds of young Asian people that services would be largely white places where they would be ignored and not understood as young Asians. Any service which aims to make itself more accessible must work on dispelling these images and be seen to do so.

African-descent women

Our other research area was Haringey on the fringes of inner London, where the local authority's Drugs Advisory Service (DASH) is the main drug service. Statistics show that black women never use DASH, despite the fact that people of African-Caribbean descent account for 12 per cent of the local population.

Alcohol seemed the most widely used drug. Most teenage black girls had used it either at home or at a social function such as a wedding. They were less likely to go to the pub, most arguing that pubs were part of the white English culture. Most knew of at least one other woman who they considered had an alcohol problem needing help.

"I needed help. There was no way I was going to pick up the phone and ring yer"

Many interviewees thought users of illegal drugs were mostly either black men or white Europeans. Women tended to view their drug habits in relation to their role within their families and their communities. Here the social rules for men and women were seen as quite different. While it seemed acceptable for men to be seen to be using drugs such as cannabis, this was still not the case for women.

"My African or West Indian women friends do not take drugs, as far as I am aware. In the States [USA] it was considered cool to have a joint at a party and it was no big deal. But I can't say the same here. It's something seen as 'Well, yeah, my man can do it, but it's not something that I want to do in public. If I'm gonna do it I'll do it at home'."
– 33 year-old black American woman

Women over 22 years of age tended to view drugs differently, especially if they had children. Many knew of black men and white women who used cocaine, but very few knew of other black women who used this drug on a regular basis.

Only towards the end of the research did we make contact with black women users of drugs in class A of the Misuse of Drugs Act. It seems the privacy of their drug use makes them a 'hidden' group, even from women familiar with cannabis:

"I don't think they [women] have a problem with drugs, the only thing they have a problem with is men, not drugs. Since I've been living in this area, I've never known of, or seen anybody who is a heroin addict. I know women who smoke herbs, but they're not addicted, they can stop whenever they want. Drugs is more of a problem for men than it is for women, because socially they do what their friends are doing... Some women I know will go to a club, but they don't go as often as men."
– 22 year-old African-Caribbean descent woman

A minority of younger women (16-18 years-old) were more likely to have experimented with a wider range of drugs, including LSD and ecstasy, but predominantly cannabis and alcohol. None knew of others who were using either cocaine or heroin.

Perceptions of services

The vast majority of respondents had never heard of DASH. Told about it, many felt that even if other women could be persuaded they needed help, DASH would be the last place they would go.

Part of the reason is that by approaching the service women would be admitting that they were a 'drug addict', which would be unacceptable, and cause great shame. Some of these views of African-Caribbean women may well reflect the views of women generally – especially in respect of fears that children may be taken away from them. Even so, for black women the experience of exclusion is greater.

"Do you think black women don't go to the agency because there is no significant problem?"

"No I wouldn't have thought so really. It always reminds me of the argument from employers that: 'Oh well, we want to bring black people to the organisation but obviously they don't want to apply for the job!' To me, it means there is something wrong with the advice agency, rather than there is no problem in the black community."
– 29 year-old part-time youth worker ■

Interim findings and implications for services

■ **Our major interim conclusion is that African-Caribbean and Asian people are less likely to approach drug services than white people, for two reasons.**

The main reason is that the services are perceived as being run for and by white people; experience of racism in the context of other services and in everyday life creates expectations that an approach to drug services would be unrewarding and possibly unpleasant.

The second reason for low take-up is simply that the services are generally not well known, even among white people. ***There is a general need for health and welfare services of all types to take positive action to market themselves better and create non-racist or anti-racist images of their staff and their services.***

■ **More specifically in relation to men, whether African-Caribbean or Asian, services which are drug-specific would be more attractive if they backed up action to address their 'image problem' with real positive action in respect of staff. We have found (and our experience merely confirms experiences in other fields) that having staff of the same race as the 'customers' is the only way to make the services more accessible.** ***Positive action in staff recruitment is desirable.***

■ **For women, whatever their race, there are clearly a number of barriers to help-seeking (lack of free time, lack of childcare facilities, controlling menfolk, etc). For black or Asian women these problems are confounded by real and experienced racism.**

But, for many women (of whatever race) it would be too shameful to present oneself as 'an addict', however sympathetic the drug agency might be, ***so provision also needs to be made through black people's organisations, and through women's organisations, helping them to respond to drug-related problems in the context of broader advice (housing, income support, etc).***

To be able to respond to drug users, these organisations would need an element of resources to cover training and staff time, and would also need close contact with and support from outreach and other workers in agencies specialising in dealing with drug users.

WHO'S MINDING THE KIDS?

Time for drug agencies to develop child care policies

Maintaining the child-focused approach needed for child protection work is particularly difficult for drug agencies, which are often isolated from statutory services and whose clients can themselves legitimately be viewed as victims. Drug agencies can work out their own role within professional child protection networks, taking into account their need to maintain levels of client confidentiality and the agency's distinctive ethos.

Patricia Kearney & Gillian Norman-Bruce

Patricia Kearney is Team Leader, Specialist Services, Adult Mental Health, Wandsworth Social Services. Gillian Norman-Bruce is Senior Trainer, Child Care Training Team, Camden Social Services.

AS WORKERS AND trainers in the drug field, we know the difficulties involved in considering the needs of drug using parents and their children. In recent years there has been formal comment on this matter from influential bodies such as the National Local Authority Forum on Drugs Misuse[1] and the Advisory Council on the Misuse of Drugs,[2] which at least legitimises the debate.

Drug agencies now need to develop this debate further by creating their own child protection policies. This challenge is to do this in a way which is appropriate to the agency and its clients yet meets wider child protection objectives. The challenge is all the greater for drug agencies, traditionally isolated from mainstream child protection work.

We hope to contribute to this process by attempting to integrate issues in the drugs field within the context of current child protection thinking and practice in the statutory sector.

Facing up to abuse

A major characteristic of child protection work is the difficulty professionals have in establishing and maintaining a child-focused view as a priority for all planning and action. 'What about the children?' is a hard question to ask, let alone answer, when workers are faced with competing needs and high anxiety.

To overcome this resistance it is important to recognise it and to understand why a child-focused approach is difficult. The first step is to define child abuse and the essentials of child protection (see panel).

Drug agencies lack a working familiarity with such definitions when their remit is with adult users who, to the agency, are only incidentally parents. This unfamiliarity influences practice.

For example, *Drug Using Parents and their Children* states:
"It is generally agreed that it is not good practice to automatically call a case conference or add a child to the child protection register if it is discovered that one or both parents are using illicit drugs, purely because of drug use in the absence of other anxieties."[5]

In fact, neither is this generally agreed nor is it necessarily bad practice to call a case conference. Calling a conference clearly should not be synonymous with placing a child on the register – this would be to pre-empt the meeting's information-sharing and assessment functions. Reviews following deaths from child abuse from the Colwell inquiry onwards[6] have stressed the lack of and need for adequate inter-professional communication.

Working together

Working Together, the current official guideline for multi-agency child protection work, emphasises: *"It is essential that wherever one agency becomes concerned that a child may be at risk they share their information with other agencies as other agencies may have information which will clarify the situation."*[7]

'What about the children?' is a hard question to ask, let alone answer

A formal venue for information sharing between agencies and professions is vital if workers are to avoid judgments made in isolation, in ignorance, or based on stereotypical thinking. This sharing allows agencies to appreciate each other's policies on issues that complicate child protection work, such as confidentiality. Good practice should mean that professional concern can be articulated, considered and acted upon (or not) as the circumstances of each individual family suggest.

Jud Barker vividly describes the practice dilemmas that confusion about the function of case conferences can lead to:
"Time and again we run across the specialist agency which feels compelled to protect its client from the bogey man social

How would you know these children are OK – and is it any of your business?

services, whose sole purpose in using the at-risk register – we would be led to believe – is to wrench babies from their mothers rather than provide child care and other back-up services and finances which could be the keys to keeping the family together."[8]

The issue facing policy makers in drugs agencies is how to use the obligation to support their clients placed on social services by the 1980 Child Care Act – without having to set in motion processes such as registration purely to provide material and other support to a family. *"Social services departments have a statutory duty to make available advice, guidance and assistance to promote the welfare of children by diminishing the need to receive children into care."*[9]

Formal inter-professional working should increase the likelihood of risk assessment taking into account each individual family's circumstances and help avoid blanket presumptions. Among people working in the drug field, one such presumption is that risk to children depends on the substance being used; for example, that alcohol is 'more dangerous' than methadone. In fact the danger lies in the carer, not with the drug.

Victims can be abusers

Drug workers are well aware of the general view that people who use illegal drugs are, by definition, not fit to be parents. This is certainly an imprecise and unhelpful view – but the basic assumption must be that *all* adults have the potential to abuse children, and that the balance of power lies with them, not with the child.

It is essential to acknowledge this imbalance when assessing risk to a child, whatever a worker's awareness of how badly and unjustly that adult may be treated in other contexts. Difficulty in defining who the client is characterises child protection work in all practice settings but is especially pertinent to drug workers, who understand how their clients could themselves legitimately be viewed as victims. This kind of understanding can place workers in a compromised and powerless position when it comes to fulfilling their professional child protection responsibilities.

To act appropriately, drug workers also need to distinguish child care work from child protection. Understanding this distinction will help prevent them seeing every child-related problem as a child protection issue. But it will also help them identify when child protection concerns give them 'permission' not just to be worried, but to take further action.

Concentrating on the pregnant drug user – as did both the major drugs reports cited at the start of this article – allows workers to avoid having to act on the broader child protection issue.

It is clearly in the best interests of the foetus that pregnant drug users should have information and help to ensure a safe pregnancy. However, this focus ignores the context in which child abuse takes place. Namely, that children up to the age of 18 are legitimately to be regarded as at risk of abuse, and not the foetus. The gender power differential that allows us to consider pregnant women and not their partners also denies the overwhelming fact that most child abusers are men.

Essential definitions

Child abuse

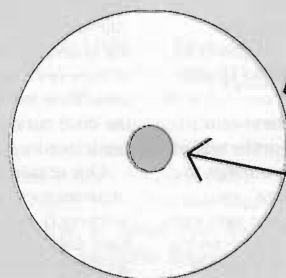
***Protecting Children*, the official guide for child protection assessment, defines child abuse as**

***"Harm to children by parents or carers either by direct acts or by a failure to provide proper care or both... including neglect, physical abuse, emotional abuse and sexual abuse... These categories are not necessarily exhaustive nor mutually exclusive."*[3]**

Child protection

***Protecting Children* also defines the essential nature of child protection work:**

***"All adults, not only parents, have a responsibility to assert and protect the rights of children. Where there is a conflict of interest between the parents and child, the child's interests must be given first consideration."*[4]**



Child care– understanding normal child-development and assessing problems from whatever source

Child protection – facet of child care concerned with assessing risk of child abuse and acting to prevent it

1. National Local Authority Forum on Drug Misuse and the Standing Conference on Drug Abuse. *Drug using parents and their children: issues for policy makers.* Association of Metropolitan Authorities, 1989.
2. Advisory Council on the Misuse of Drugs. *AIDS and drug misuse. Part 2.* HMSO, 1988.
3. Department of Health. *Protecting children: a guide for social workers undertaking a comprehensive assessment.* HMSO, 1988.
4. Department of Health, op cit.
5. National Local Authority Forum on Drugs Misuse *et al*, op cit.
6. Department of Health and Social Security. *Report of the Committee of Inquiry into the Care and Supervision Provided in Relation to Maria Colwell.* HMSO, 1974.
7. Department of Health and Social Security (DHSS). *Working together: a guide to arrangements for inter-agency cooperation for the protection of children from abuse.* HMSO, 1988.
8. National Local Authority Forum on Drugs Misuse *et al*, op cit.
9. *Child Care Act, 1980.*
10. DHSS. *Working together*, op cit.
11. National Local Authority Forum on Drugs Misuse *et al*, op cit.
12. Kearney P. and Norman-Bruce G. "Abusers twice over: an account of child protection training for drug workers." *Journal of Social Work Education*: 1990, 9(1), p.3-13.
13. Dale P. *et al. Dangerous families assessment and treatment of child abuse.* Tavistock, 1986.
14. Yandoli D. *et al.* "Family therapy and addiction." In Bennett G. *ed. Treating drug abusers.* Routledge, 1989.
15. Bor R. *et al.* "A systems approach to AIDS counselling: defining the problem." *Journal of Family Therapy*: 1989, *11*, p.77-86.

Children at risk

Workers faced with child protection situations are taxed by immediate and worrying questions of some complexity and variety,[12] including anxiety produced by professional contact with children, the nature of client confidentiality, and how to work with statutory agencies. Even workers with confidence in their own practice realise that they still need to find solutions to these problems at organisational and agency levels.

Taking their place in the child protection network need not mean drug agencies become subordinate to social services – each agency must decide what form of participation is appropriate for itself (see panel).

> ***For drug agencies, child protection work is tailor-made to be disregarded***

Joining the child protection network

Much of the current debate in drugs work is about in what form drug agencies might take their place within professional child protection networks.

Working Together **was written because of the complexities facing agencies whose main remit is not with children or with statutory responsibilities:**

"Other agencies besides local authorities have statutory duties and/or powers and all agencies have specific functions and professional objectives. In working together for the protection of children, however, they need to understand that they are not only carrying out their own agency's functions but are also making, individually and collectively, a vital contribution to advising and assisting the local authority in the discharge of its child protection duties."[10]

This does not mean that agencies, with their own legitimate briefs, are subordinate to the workings of the local authority – nor, on the other hand, that they abdicate all responsibility for child protection to the statutory agency or to their own statutory workers:

"'Working together' may never mean 'teamwork'. It is more helpful to think in terms of a network of services and agencies intervening in a case."[11]

In other words, all agencies must hold in common a responsibility for child protection and a resultant awareness of what it would mean, for their agency, to put the child first.

Understanding the cause of our anxiety when faced with children who may be at risk of harm begins to make sense of the common professional phenomenon of not seeing or hearing children in trouble – the 'no news is good news' approach which the NSPCC calls 'professional dangerousness'.[13]

The reality of childrens' experiences and the requirements of professional action are sometimes too much to bear. It becomes easier to talk about 'confidentiality' without first considering that some things are so terrible that they have to be spoken about. We have seen these processes at work in both statutory and non-statutory drug agencies. The playing out of denial will be determined by the status and style of the agency, but the underlying cause is the same.

Consider, then, the position of drug agencies, distanced from the highly structured and legislated milieu of statutory child protection agencies, and with other matters to contend with, such as agency credibility and HIV/AIDS provision. Child protection work is tailor-made to be disregarded, with both the rationale that other work is more important and the fear that such work seems inimical to the value system that drugs work draws its strengths from.

Learning to recognise and work with these processes of denial are major and constant aspects of child protection work. Acknowledging them doesn't make them disappear, but does offer practitioners a way of understanding and controlling them. A substantial body of knowledge exists to aid this understanding, and is becoming formally recognised by such moves as the funding now available from the Department of Health for child protection training in local authorities.

Developments within drugs work itself can also help with the integration of child-focused work into the drugs field. Couples work[14] and HIV/AIDS work[15] both understand behaviour within an interactive context such as the family. Using such concepts is the essential step drug work is taking when it considers child care issues.

INTEGRATING child protection and drugs work has become particularly urgent with the advent of HIV/AIDS. *Drug Using Parents and their Children* clearly sets out policy-making and service-provision requirements for families at risk of infection through drug use. The future increased involvement of child care agencies in drug use, through their work with actually or potentially HIV positive children, means that clear inter-agency policies are more important than ever. ■

LETTERS

'Stabilisation' not 'maintenance'

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.**

Dear Editor,

In your announcement of the publication of my book *A Doctor's Story* (**Druglink**, July/August 1990) you refer to me as a "champion of opiate maintenance". This is untrue and perpetuates misconceptions and untruths that permeate the subject of drug dependency.

'Maintenance' is a word often used to describe and discredit any prescribing more liberal than the speaker likes or than that proposed by the discredited Department of Health *Guidelines*. It can then be sneered at as 'giving the patient what they want', 'prescribing large doses for the rest of their life while making no attempt to help them become drug-free', etc.

Doctors who take this line may even support their arguments by convincing themselves that every time a patient goes through their clinic's 'standard' treatment (which may happen as many as 20 or 30 times) they are 'a little better'. The whole concept of 'maintenance' has been corrupted to support a logically untenable position and maintain the status quo.

If I am a 'champion' of anything in prescribing policies, it is that the addict should have enough drugs to enable them to live an honest, self-supporting and responsible life. I call this not 'maintenance' but 'stabilisation'. Without it most addicts are unable to improve either socially or in their need for drugs. Essential to it are efforts to help the patient reduce the dose but not to impose a predetermined regime.

One reason why the word 'maintenance' is so abused by drug workers is that 'stabilisation' requires hard thinking and difficult clinical decisions which can only be made successfully through close contact with the patient. It is much easier to dismiss proper help as immoral 'maintenance' and continue with the same old failed, and often utterly impersonal, regime.

If the word 'maintenance' is to be used at all (and the pejorative connotations it has collected suggest that it might be better dropped altogether since no one believes in the ideas often ascribed to it) it should mean 'keeping to the same dose until the patient is able to reduce'. So do let's have a bit more honesty in our drug dependence vocabulary.

Ann Dally
London

New education video for young people, with a Christian slant

A LITTLE MORE ICE? UK Band of Hope, 1990. Video plus study guide £14.99, £7 rental.

The founder of the Salvation Army used to say, "Why should the devil have all the best tunes?" The Band of Hope share this philosophy and intend to produce high quality materials for use in Christian education.

A Little More Ice? is well made and a great advance on the shock-horror approach of some earlier attempts to dissuade young people from using drugs. Roy Castle, the presenter, is an attractive personality and an enthusiastic advocate of a Christian lifestyle.

The video does not dwell on the negative effects of drugs. Some of the grim statistics are simply given in subtitles, while most of the images on the screen are of confident people who clearly do not need drugs. Alcohol is shown to be as destructive as illicit drugs, and a warning is given of the dangers of tranquillisers. Strangely, the dangers of tobacco appear not to be given much prominence.

A scene from Yeldall Manor, a Christian therapeutic community and rehabilitation centre, shows that taking drugs can lead to serious problems requiring long-term treatment. This is a much better, more hopeful and more accurate statement than the message of some posters that drug use leads inevitably to death.

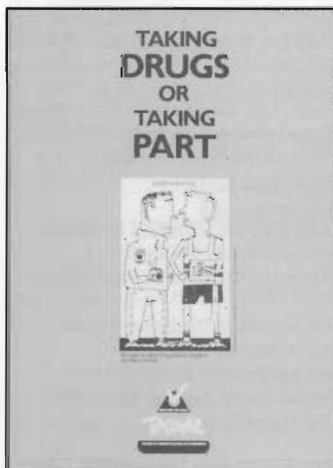
The Blind Beggar, a Salvation Army-sponsored Temperance House, is featured as an example of the kind of positive alternative to the public house which some churches might like to copy. I was not sure that the Salvation Army officer holding a beer mug with non-alcoholic contents looked entirely convincing, but Roy Castle's non-alcoholic cocktail certainly did appear refreshing.

Perhaps it is a weakness that for much of the time an adult is talking directly to the audience – Roy Castle, the Baptist minister and his wife, the youth leader, the Salvation Army officer and the directors of Yeldall Manor and the Band of Hope. Young people appear chiefly as background. This didactic style requires a fairly passive audience, but young people who attend church groups are probably used to this and are more willing than some to take notice of good advice.

For an open youth club, I think the *Minder* video, *A Little Bit of Give and Take*, followed by discussion, would be a better choice. Among evangelical Christians, I am sure this video will prove to be very popular. Unbelievers are likely to find the repeated references to a Christian viewpoint rather off-putting.

Eric Blakebrough
Director, Kaleidoscope Project, Kingston-upon-Thames

A Little More Ice? *is available from UK Band of Hope, 25F Copperfield Street, London SE1 0EN.*



High marks for content for this educational resource on drugs in sport

TAKING DRUGS OR TAKING PART. Mike Ward and Bill Rice. TACADE, 1989. 52 pages. Teaching pack. £9.95.

Ben Johnson and David Jenkins may not have started it, but they have certainly ensured that the issues that surround the use of drugs to enhance sporting performance cannot easily be ignored. The media is quick to jump on any suggestion that a competitor might have used a banned substance and there is no shortage of commentators, sports personalities and politicians who seem happy to condemn this practice, not because of potential damage to competitors, but rather damage to the very fabric of sport itself.

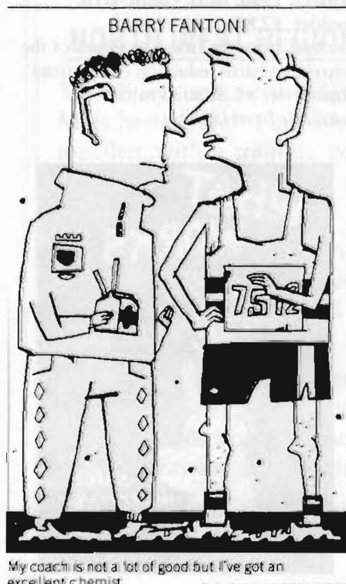
If these people are to be believed the use of drugs in sport is a clear-cut moral issue: drugs are cheating, and cheating is wrong. However, like most issues that involve drug use, it is far from that simple. Drug use in sport is a minefield of claims and counter-claims about cheating, fair play, money and politics.

The high profile media attention has meant that even quite young children have some knowledge about the subject. My own work with primary school children using the Southampton University 'draw and write' (*Jugs and Herrings*) research method show that many, from age 8 upwards, see the use of drugs as a positive way to increase sporting performance. Many GCSE physical education syllabuses now include drugs in sport as a topic, but very little resource material has been available for teachers and others who work in this area with young people. What there has been has tended to take the absolutist line highlighted above.

Taking Drugs or Taking Part is a creditable attempt to introduce both teachers and students to the complex issues involved in this area. It does not take a high moral stance in relation to the subject, but rather introduces the reader to areas of drug use in sport that they will probably not have considered, certainly areas that rarely get mentioned in the public debate.

This new resource is published as an A4-size booklet and, at £9.95, is affordable by most schools. The first section consists of teacher information sheets. These cover the drugs, the history of drug use in sport, the users, the rules about drug testing and the penalties for those found out, and then look at attitudes to cheating, rights of private use v. public performance, etc.

The sheets are easy to read sketches which will not swamp the casual reader, but are sufficiently well referenced to encourage further reading by the more committed. I did, however, find the uniform style eventually annoying as it often resulted in half-empty pages. Areas like ancient history and nineteenth and early twentieth century history could easily have been combined to create one full side instead of two half-empty ones.



My coach is not a lot of good but I've got an excellent chemist.

Most of the sheets have a discussion question introducing moral dilemmas such as "Is there a moral difference between blood doping and altitude training?"

The next section provides seven lesson plans with photocopiable worksheets which cover the issues already tackled in the teacher information. The lesson plans are good and clearly explain objectives and methods. These include brainstorming, small group work, discussion sessions and role play. But the worksheets suffer from the same layout problems as the teacher sheets: the writing is very small and may be hard for less able students to read, while most of each sheet is blank. The final section gives a comprehensive list of banned substances, further reading and useful addresses.

The criticisms of this booklet relate less to content, which is generally very good, but rather to the page layout and presentation. However, this should not deter teachers, youth workers and related workers from using it as a valuable resource in teaching about the complex issues involved in the use of drugs in sport.

Ian Clements
Health Education Coordinator, Bury

Taking Drugs or Taking Part *is available from TACADE, 1 Hulme Place, The Crescent, Salford, M5 4QA, phone 061-745 8925.*

PUBLICATIONS

Services

■ THE IMPACT ON DRUG SERVICES IN ENGLAND OF THE CENTRAL FUNDING INITIATIVE. Susanne MacGregor *et al.* ISDD, 1990. Research report. £4.95.
The first comprehensive census of drug services in England.
Available from ISDD.

■ MAINLINERS NEWSLETTER. First issue August 1990. 12 pages. £25 p.a.
Well produced and interesting relaunch of the newsletter from the HIV and drugs self-help group.
Contact Mainliners, PO Box 125, London SW9 8EF.

■ REGIONAL DRUG SERVICES DIRECTORY. South West Thames Regional Drug Problem Team. London: SWTRDPT, 1990. Directory.
Arranged in sections according to type and extent of provision. To be regularly updated.
Contact Regional Drug Problem Team, St George's Hospital, Blackshaw Road, London SW17 0QT.

Education

■ SPEED AND AMPHETAMINES. Julian Chomet.
■ THE PRESSURE TO TAKE DRUGS. Judith Condon.
■ DRUGS AND ORGANISED CRIME. Denise Randall.
■ ACID AND HALLUCINOGENS. Philippa Algeo.
Gloucester Press (Aladdin Books), 1990. 62 pages. Illustrated books. £6.95.
Latest in the publisher's *Understanding Drugs* series for young people. Speed and crime books reveal US origins too clearly, other two could be useful.
Available through bookshops.

■ AIDS AND DRUGS. Nicholas Bevan. Gloucester Press, 1990. 62 pages. Illustrated book. £5.95.
In the publisher's *Understanding Social Issues* series for young people.
Available through bookshops.

■ WHAT IS HEALTH? DRUGS. Gay Gray *et al.* Oxford: OUP, 1990. 29 pages. Booklet. £2.50.
Activities and ideas for project work for students involved in school and college health education programmes.
Available through bookshops.

Pregnancy/childcare

■ DRUGS, PREGNANCY AND CHILDCARE: A GUIDE FOR PROFESSIONALS. Harry Shapiro. ISDD, 1990. 48 pages. Booklet. £2.50.
The first comprehensive guide to a difficult area of drugs work.
Available from ISDD.

■ DRUGS IN PREGNANCY AND CHILDBIRTH. Judy Priest. London: Pandora, 1990. xv, 224 pages. Book. £5.99.
Practical guide mainly concerned with therapeutic drugs.
Available through bookshops.

Solvents

■ WORKING WITH SOLVENT SNIFFERS. Richard Ives. ISDD, 1990. Booklet. £2.50.
Guidance for professionals from a leading UK expert.
Available from ISDD.

■ PARENTS: WHAT YOU NEED TO KNOW ABOUT SOLVENT SNIFFING. Richard Ives. ISDD, 1989. Booklet. £1.50.
Level-headed advice and information for parents who want to know more.
Available from ISDD.

Tranquillisers

■ BENZODIAZEPINES: CURRENT CONCEPTS. BIOLOGICAL, CLINICAL AND SOCIAL PERSPECTIVES. Ian Hindmarch *et al.* Chichester: John Wiley, 1990. x, 292 pages. Book. £32.50.
Collection of papers including patterns of use and dependence.
Available through bookshops.

■ ESCAPE FROM TRANQUILLISERS AND SLEEPING PILLS: A PROVEN DIY WITHDRAWAL PLAN. Larry Neild. London: Ebury Press, 1990. 160 pages. Book. £4.99.
Step-by-step guide.
Available through bookshops.

Harm-reduction

■ THE BEST OF SMACK IN THE EYE: THE BUMPER FUN ISSUE. Lifeline Project, 1990. Illus. comic-style booklet. £2.85.
The best from the first five issues of the innovative harm reduction comic from Manchester's Lifeline Project.
Available from ISDD.

■ WHAT WORKS? SAFER INJECTING GUIDE. 2nd edition. Andrew Preston *et al.* Exeter Drugs Project, 1990. 22 pages. Cartoon-style illus. booklet Up to 25 copies £0.85 each, discounts on bulk orders.
For injecting drug users – techniques to minimise risk of physical damage or infection.
Available from Exeter Drugs Project, 59 Magdalen Street, Exeter, Devon, EX2 4HY, phone 0392-410292.

Other

■ THE NATURE OF DRUG DEPENDENCE. Griffith Edwards and Malcolm Lader *eds.* Oxford: OUP, 1990. x, 240 pages. Book. £30.
Conference papers plus discussion plumbing the roots of addiction from the historical to the genetic.
Available through bookshops.

■ DRUG ABUSE AT WORK: A GUIDE TO EMPLOYERS. Health and Safety Executive. London: HSE, 1990. 19 pages. Booklet.
Information on workplace drug policies and the risks of drug abuse.
Contact your HSE area office.

■ ASIAN DRUG PREVENTION QUARTERLY. Development Associates Inc. (USA). Newsletter.
News on drug use and prevention programmes in Asia.
Available from Development Associates Inc., 2924 Columbia Pike, Arlington, Virginia 22204, USA.

COURSES

■ DEVELOPING THE EDUCATIONAL SKILLS OF PARENTS. ADFAM National. 24-26 September 1990, York. Residential course.
Drug education with families.
Details from ADFAM, 82 Old Brompton Road, London SW7 3LQ, phone 071-823 9313.

■ CERTIFICATE IN ADDICTIVE BEHAVIOUR FOR GPs. St George's Hospital Medical School Division of Addictive Behaviour. One academic year part-time from 2 October 1990, London.
Details from Ms Mari Ottridge, Division of Addictive Behaviour, St George's Hospital Medical School, Cranmer Terrace, Tooting, London SW17 0RE, phone 081-672 9944.

■ MOTIVATIONAL INTERVENTIONS WORKSHOP. Leeds Addiction Unit. 26 October 1990, Leeds. £30
Aims to develop skills in using motivational interviewing counselling.
Details from Leeds Addiction Unit, 19 Springfield Mount, Leeds LS2 9NG, phone 0532-316920.

■ CERTIFICATE IN DRUG DEPENDENCE. 22 weeks full time from January or June 1991, London.
■ THE MANAGEMENT OF PROBLEM DRUG USE. 15 sessions part-time from September 1990 and January 1991, London.
South East Thames Regional Drug Training Unit.
Multidisciplinary courses leading to certificated qualifications.
Details from Regional Drug Training Unit, 11 Windsor Walk, London SE5 8BB, phone 071-703 6333 ext. 2755/6.

■ 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.

MEETINGS

■ THE FAMILIES OF DRUG USERS. Family and Drugs Research Group. 27 September 1990, Bath. £35.
Speakers and workshops concentrating on practice issues in working with families.
Details from Gill Hayes, Conference Organiser, 3 St Mary's Close, Off Bathwick Hill, Bath BA2 6BR, phone 0225-330562.

■ CURRENT DRUG ISSUES IN SCOTLAND. University of Glasgow. 10 October 1990, Glasgow. £25 or £17.50 for non-statutory agencies.
Conference covering patterns of and responses to drug misuse in Scotland.
Details from Tara Lavelle, Behavioural Sciences Group, University of Glasgow, 4 Lilybank Gardens, Glasgow G12 8QQ.

■ AIDS AND THE EPIDEMICS OF HISTORY. Royal Society of Medicine. 17 October 1990, London. Non-fellows £40.
RSM History of Medicine section symposium.
Details from Miss Haron, RSM, 1 Wimpole Street, London W1M 8AE, phone 071-408 2119.

■ DRUG USE AND THE FAMILY – HOW DO THEY AFFECT EACH OTHER? ADFAM National. 20 October 1990, London. £12.50.
Annual conference of national drugs and families help group.
Details from ADFAM, 82 Old Brompton Road, London SW7 3LQ, phone 071-823 9313.

ORGANISATIONS

■ ALCOHOL AND SUBSTANCE MISUSE FOR OCCUPATIONAL THERAPISTS.
Special interest group for Occupational Therapists. Second AGM on 8 October 1990.
Contact Sue Newall, Secretary, S.I.G. Alcohol and Substance Misuse, The Maudsley Hospital, Denmark Hill, London SE5 8AZ, phone 071-703 6333.

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.

SOCIAL WORK

The Simpson House Drug Project is city centre based, acknowledging the many implications of chaotic drug misuse in an individual's life and in the community.

DRUGS PROJECT LEADER

Simpson House, Edinburgh
£15,102 - £16,497

The Project Leader would carry a small case-load, be responsible for the management and co-ordination of the project and for five Project Workers involved in providing a balanced approach between sessional, individual and family counselling, groupwork and support groups, employing traditional as well as innovative and diversionary techniques linked to a wide range of agencies.

Applicants with a range of qualifications will be considered, but a current direct awareness of the diversity of substance misuse and associated HIV implications is vital.

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Unqualified £11,241 - £12,345
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Two vacancies exist for Project Workers, one full-time (40 hours) and one part-time (20 hours) to work particularly with people with HIV/AIDS. Both posts are for an initial three year period.

Working as part of a highly motivated team you should have previous work experience in the health or social services area as you will often become involved in the counselling of both individuals and their families.

The above positions require all applicants to have a live Church connection and a true sense of Christian commitment.

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For further information and an application form, please write quoting reference: 16/D to:

Director of Social Work
The Church of Scotland
Board of Social Responsibility
121 George Street
EDINBURGH EH2 4YN

Closing date for return of applications 19th September, 1990.

Help us practise what we preach.

MID GLAMORGAN HEALTH AUTHORITY

Punishment in the Community

Thursday 25th October 1990
at
Hensol Conference Centre, Mid Glamorgan
(Junction 34 – M4)
Cost £8 (includes buffet lunch and refreshments)

This event for drugs workers and other professionals will deal with the implications of the White Paper *Crime, Justice and Protecting the Public*

- community-based sentencing for drug users
- HIV issues within the prison system
- working with drug users within the criminal justice system
- priority issues for the drugs services

For further information please contact
Dieter Kessel, Conference Organiser, Hensol Castle, Nr Pontyclun, Mid Glamorgan CF7 9YG
Phone: 0443 224455 or 0443 237373 (ext 3431)

DRUGS/HIV TRAINING OFFICER

based at

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This is a challenging and rewarding post that involves innovative work in an emotive and sometimes contentious area. You will work as a member of a team, but initiative and individuality are also required.

Experience of designing and running training courses is essential as is knowledge of HIV issues. Knowledge of drugs issues an advantage.

CLOSING DATE: 24th October 1990

SALARY: £14,160 – £15,102

Application form and job description are available from: Lifeline Project Ltd, 463 Chester Road, Stretford, Manchester M16 9HA. Telephone: 061-848 7227.

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(Race Relations Act 1976, Section 38(1)b applies.)
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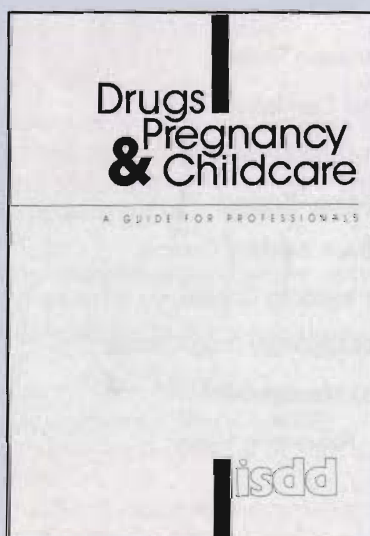

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