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Conference briefings

"Get the message"*

JENNY BEARN, Senior Registrar; and JOHN STRANG, Consultant Psychiatrist,
The Maudsley Hospital, Denmark Hill, London SE5 8AZ

"Get the message" was the slogan of European Drug Prevention Week (16–22 November 1992). At the flagship event, an International Media Seminar, we found ourselves asking, what was the message? Princess Diana, the Bishop of Norwich, and a bevy of politicians and media personalities ruminated on how to tell Europe's children not to use drugs, in front of 1000 journalists, press officers, education officers, policemen, soap opera script writers and the occasional doctor.

The Princess of Wales has shown particular concern for substance misusers through her patronage of Turning Point, the Institute of Drug Dependence (ISDD) and the National AIDS Trust. She compassionately argued for a social climate where children can be cherished within the family so that they develop a sense of worth. She felt that drugs are used to fill a vacuum created by a sense of alienation and low esteem stemming from lovelessness. It was unfortunate that the focus of her message was somewhat diluted by the media subsequently reporting this as a metaphor for her private life.

Mrs Virginia Bottomley, Secretary of State for Health, spoke of involving the family, the school, the church, the police, the media and health services.

Media spokesmen examined their own role in the education process, and perhaps not unsurprisingly felt that on the whole they were doing a pretty good job. David Sullivan (Editor of *Today* newspaper) said that "we all accept that we are responsible in the media," and no one looked remotely sceptical. Perhaps the discussion would have been more discomforting if the non-media representation at this session had not been confined to the Bishop of Norwich. It was generally agreed that the media should not be propagandist and so any rigid guidelines for media portrayal of drug issues was firmly resisted.

Nick Ross made the cogent point that one drawback of the simplistic 'drugs are bad' campaigns is the reluctance to acknowledge that taking drugs often makes you feel terrific. By suppressing this information children may find it harder to believe such campaigns, particularly when so many are using Ecstasy recreationally at weekends without any clear detriment to their working lives. Janet Street Porter pointed out the incongruity between expectations that young people should be squeaky clean, when their parents are drinking and smoking. She also underlined the difficulties that parents have communicating with their adolescent children.

William Gayard, Director of Public Information for the United Nations International Drugs Control Programme, spoke of the vulnerability of developing countries, particularly Pakistan, India and Thailand, which ten years ago had a negligible addiction problem. While educational programmes should be culturally appropriate, fostering healthy behavioural patterns crossed cultural borders. Collective responsibility for reducing the drugs problem rested with the family, the community, and governments, since it clearly involves, for example, urban poverty and social inequality.

After the rhetoric, we watched a film of specific education initiatives. For younger school children, the emphasis is on promoting healthy lifestyles, self-esteem and responsibility, and fostering general interests, rather than providing specific drug-related information. Pop music and computer games from the Hackney Drug Project and cartoon comics from Manchester Lifeline were cited as examples of projects raising awareness of drugs in teenagers.

Finally a diverse group of experts took to the stage. James Kay, Managing Director of Healthwise Limited) was keen to avoid the credibility problem if drug misuse is over-dramatised. Children should receive accurate information without moralistic overtones. Teresa Salvador-Llivina, Director of the Centre for the Study of Health Promotion in Madrid, emphasised that many successful European initiatives needed secure funding. Others condemned the recent education cuts which threaten prevention initiatives in this country.

No serious attempt was made to scrutinise the fundamental concept of 'drug prevention' while such vexed issues as the very definition of a 'drug' and society's distinctive attitudes to psychostimulants and opiates versus alcohol and nicotine were rarely mentioned. Prevention was discussed almost exclusively in terms of primary prevention.

**International Media Seminar (European Drug Prevention Week) London, 17 November 1992.*

The message of secondary prevention and harm minimisation is just as important, but more difficult. The seminar highlighted how little physicians and psychiatrists were seen to have an educational and advisory role; Rabbi Julia Neuberger specifically singled out general practitioners.

Drug abuse is one of those issues that everyone feels they can be opinionated about often with a very unclear understanding of their psychological and physical effects. This attitude perhaps reflects a more general uncertainty about where the primary responsibility for tackling drug abuse lies. For instance, is the Home Office's position as lead agency with the Department of Health playing a subsidiary role appropriate? It seems that there are shortcomings in the response of doctors to this issue and a great need for both psychiatrists and physicians to take a higher profile role in educating and advising about the hazards of substance misuse.

Residential scientific conference on the Reed Report and the management of the mentally disordered offender in the community

TOM BURNS, Chairman, Social, Community and Rehabilitation Section

Over 250 psychiatrists attended a conference in Jersey from 26–28 November 1992, arranged by the Social, Community and Rehabilitation Section of the College in association with the General and Forensic Sections to review current practice and research on the mentally disordered offender (MDO). The three days contained two plenary sessions, a parallel workshop session, and a short paper session.

The first session – 'The Response to the Reed Report' – was the day before the report (1992) was presented to the House of Commons. The report's basic principles were outlined by Dr Derek Chiswick from Edinburgh who presented a forensic psychiatrist's response. Despite the aim to treat the MDO within the health care system, less than 40% of providers and 30% of purchasers have diversion from custody schemes in their current or proposed business plans. Professor James Watson, Dr Janet Parrott and Dr Philip Brown from United Medical and Dental Schools described a local project to improve the procedures for transferring mentally ill offenders from Brixton Prison to NHS facilities. They emphasised the importance of a "balance of competence" between forensic psychiatrists and the general psychiatrists who will be responsible for most of the work.

The practicalities of dealing with MDOs in a community setting were outlined by Dr Marilyn Mitchell whose Continuing Care Service Team (developed within the rehabilitation service) had achieved high levels of supervision and a significant reduction in admissions but found early intervention with this small group of potentially dangerous patients posed serious ethical dilemmas.

Dr Reed rounded off the session by reaffirming the principles on which the report was grounded, detailing the process by which consultation documents were produced and reviewed. He stressed the time frame of the report's resource implications – not simply because of their financial burden but for the adequate academic and training input needed for the new consultants recommended.

The second plenary session was devoted to compulsory treatment in the community. Professor Robert Bluglass' presentation 'Compulsory Care in the Community – do we need it' considered the College's recent working party on compulsory treatment orders (CTOs) in context from the first British Association of Social Workers proposal included in the Government's 1974 Green Paper through to the College's 1987 discussion document 'Community Treatment Orders'. The group believed that we did need some form of CTO for patients with established histories of relapse associated with poor medication compliance after successful responses to compulsory treatment. Safeguards would be similar to those provided for Section 3 of the 1983 Mental Health Act with recall to hospital if the patient failed to comply with the conditions of supervision. The order would be time limited although the precise duration along with a number of other details remain under discussion.