VOL 26 | ISSUE 6 | **NOVEMBER/DECEMBER 2011**

Druglink

REPORTING ON DRUGS SINCE 1975

DrugScope

- Prison treatment
- Long term tokers
- Heroin trail
- Doctors

Through the K-hole
The rise of ketamine in Britain

VOL 26 | ISSUE 6 | **NOVEMBER/DECEMBER 2011**

Druglink

K: is the party over?

Our latest *Street Drug Trends* survey indicates that increasing numbers of people are coming forward with problems associated with the chronic use of ketamine. How severe these problems can be are underlined by the article on page 10 on the potentially devastating impact of ketamine specifically on the bladder.

Druglink first reported on ketamine back in 2000, with a two-part article by world expert Dr Karl Jansen in which the dangers inherent in taking ketamine were manifest, not least tales of regular users compulsively injecting the drug – a phenomenon now reported in our survey. Then, the drug remained 'underground', enjoying a relatively benign image and popular with clubbers as indicated by the *Mixmag* annual drug survey.

Ketamine was first mentioned in our drug survey in 2005 and controlled the following year as a Class C drug, by which time it received its first listing in the British Crime Survey (BCS). Since then, those aged 16-24 who say they have ever tried the drug has, according to the BCS, more than doubled from 140,000 in 2007/08 to nearly 300,000 in 2010/11. In this year's *Druglink* survey, three-quarters of agencies surveyed cited the drug while London now has two specialist services established to help those in trouble with a range of club or party drugs including ketamine. Use is no longer confined to the party drug scene.

Recent news about drugs has focused either on the apparent fall in the number of heroin and crack users or the somewhat over-heated response to the range of new substances emerging in the wake of mephedrone. And of course, we have been waiting for the much-touted crystal meth 'epidemic' for at least the past five years. As well as being one of the strangest drugs around – part stimulant, pain-killer and hallucinogen – ketamine may also be unique in the length of time it has taken to emerge – more overtly as a drug that can cause serious problems.

Harry Shapiro, DrugScope's Director of Communications and Information

DrugScope

DrugScope
Prince Consort House
109–111 Farringdon Rd
London EC1R 3BW

Telephone
020 7520 7550
Email
info@drugscope.org.uk
Web
www.drugscope.org.uk

Druglink is for all those with a professional or occupational interest in drug problems and responses to them – policymakers and researchers, health workers, teachers and other educators, social workers and counsellors, probation and police officers, and drug workers.

DrugScope is the UK's leading independent centre of expertise on drugs and the national membership organisation for those working to reduce drug harms. Our aim is to inform policy development and reduce drug-related risk. We provide quality drug information, promote effective responses to drug taking, undertake research, advise on policy-making, encourage informed debate and speak for our members working on the ground.

SUBSCRIPTIONS
Subscription for the year (six issues): £55
To subscribe call
020 7520 7550

DRUGLINK STAFF
Editor Max Daly
Online Jackie Buckle
Director of Communications and Information
Harry Shapiro
Editorial Assistant
Ruth Goldsmith
Book Reviews Editor
Blaine Stothard

ADVERTISEMENTS
Email
maxd@drugscope.org.uk
The inclusion of an advertisement, flyer or free sample in *Druglink* does not imply any endorsement of a particular product or service by DrugScope or *Druglink*.

Design
Helen Joubert Design
helenjoubertdesign.com

Print Holbrooks Printers Ltd, Portsmouth PO3 5HX

CONTRIBUTIONS
Druglink welcomes letters and other contributions. Send direct or contact
Max Daly
Tel: 020 7520 7562
Email:
maxd@drugscope.org.uk

Material published in Druglink does not necessarily represent the views or policies of DrugScope

ISSN 0305-4349

News

2 **Drug policing faces damaging cuts**
3 **Prison's opiate reduction regime 'endangered lives'**
4 **Tobacco giant snubbed in attempt to access teen smoking data**
5 **News focus: Heroin over the hill?**
Is this the end of an era and what has been the driving force behind it? By **Harry Shapiro**

COVER STORY: STREET DRUG TRENDS 2011

6 **The ketamine zone**
Max Daly and **Peter Simonson** take a look at the results of this year's UK-wide drug trends survey.

10 **K.O.**
For one Sussex girl, ketamine use ended with a near fatal addiction. **Joe Lepper** reports

12 **Going green**
An ongoing study among long term cannabis users paints a picture of reluctant skunk smokers whose often low-level addiction has had both good and bad impacts on their lives. By **Caroline Chatwin** and **David Porteous**

THE HEROIN TRAIL

14 **Politics of the poppy**
As the Western powers prepare to leave Afghanistan, informed opinion concludes that the ten year war against opium growing has been an expensive failure. By **Harry Shapiro**

18 **The opium cables**
How Druglink used Wikileaks to reveal the secret story of heroin's journey from Afghanistan to the UK. By **Adrian Gatton**

Also in this issue...

22 **The quiet revolution**
The way drug users are dealt with by GPs has transformed in the last three decades. **Dr Chris Ford**, who retired earlier this year from her post as one of Britain's specialist drug misuse doctors, look back out how things have changed in primary care

Regulars

24 **Reviews**
27 **Drugworld Diary**
28 **Factsheet**

Doctor's warning

The risks from forced detoxification from heroin are being ignored, specialist drug GPs have warned. Birmingham GP Steve Brinksman, clinical lead at the SMMGP network (Substance Misuse Management in General Practice), said over zealous application of the 'recovery agenda' could be fatal to drug users who are forced into detox or rehab before they are ready.

Heroin downturn

The number of people needing treatment for dependency on heroin or crack cocaine has fallen by 10,000 in the last two years, to just under 53,000, according to figures released by the National Treatment Agency (NTA). "All the evidence is that fewer people are using heroin, especially younger people," Paul Hayes, chief executive of the agency said.

New drug tactics

A report by the Advisory Council on the Misuse of Drugs has said the government should look into setting up a US-style Analogue Act to tackle and the new generation of psychoactive highs. It said that the Medicines Act could be used to target the sale of new substances over the internet. The report added there had been 42 confirmed deaths associated with mephedrone in the UK.

Good point

A self-destructing syringe that makes re-using needles impossible is being trialled in Africa. British designer Marc Koska came up with the design, in which the plunger breaks as soon as it's pulled back, after seeing a nurse in Tanzania inject a baby with the same needle she had used on an HIV patient.

Out of it

Max Daly is leaving his job as Editor of *Druglink* after eight years at DrugScope. His book on the UK drug trade, *Narcomania*, will be published by Heinemann/Random House in July 2012. Harry Shapiro will take over as Editor.

Tobacco giant snubbed in attempt to access teen smoking data

A university has rebuffed a tobacco company's attempt to analyse sensitive research it carried out into the smoking habits of thousands of teenagers.

Philip Morris lodged a Freedom of Information (FOI) request with the University of Stirling to access research it carried out into young people's attitudes to tobacco marketing and what made them start smoking.

Senior academics at the university said it would be "catastrophic" if Philip Morris, which makes Marlboro cigarettes, was able to see the data, because it was not information tobacco firms could legally obtain themselves.

Prof Gerard Hastings, of the university's Centre for Tobacco Control Research, said agreeing to the request could have resulted in a major breach of confidence because interviewees in the study gave personal information in the belief it would go nowhere else. Hastings added that it could also jeopardise future research because of a lack of trust in where information could go.

But the university declined to hand over the research on the grounds that the cost of retrieving it would be too high. Its response has been accepted by the Scottish Information Commissioner.

Drug policing faces damaging cuts

Police admit they will have to scale down their efforts against drug dealers because of shrinking budgets, according to a survey.

Half of police forces in England and Wales told a survey by the UK Drug Policy Commission (UKDPC) that they expect to spend less time and money breaking up the drug market. Activities such as covert surveillance, test purchasing (where undercover police buy drugs from dealers on the street), forensic information and other intelligence gathering work would be worst effected.

The authors of the report, *Drug enforcement in an age of austerity*, said the budget cuts would damage the efforts of police to identify and pursue the high level drug importers and traffickers. It concluded that police would have to focus their efforts on the most visible, short term issues "at the expense of activities of long term and deeper benefit".

This could, the report said, weaken one of the key planks of the government's 2010 drug strategy is to "make the UK an unattractive destination for drug traffickers by attacking their profits and driving up their risks". The report found there was a perception among the forces who responded that drug-related policing was faring worse than other police activities.

However, many forces said that they expected to spend more time hunting down the proceeds of drug selling, with increases efforts to detect money laundering and seizing assets. This activity is able to raise money for police forces as in some cases assets recovered by the police are re-channelled into enforcement efforts.

Prison's opiate reduction regime 'endangered lives'

Max Daly

A prison's attempt to reduce high levels of opiate prescribing resulted in an "unsafe" drug treatment regime which led to inmates being put on suicide watch and others at risk of overdose, a report by the prisons watchdog has revealed.

The findings by HM Inspectorate of Prisons into events last year at HMP Wayland, a category C jail in Norfolk, will send a stark warning to Britain's prison estate of the problems associated with weaning inmates off heroin substitutes too abruptly.

A comprehensive opiate dose reduction programme was introduced at HMP Wayland in May after public services firm Serco took over the running of healthcare at the Norfolk jail and three other Norfolk jails in a contract worth £24m last year.

But an unannounced visit and investigation by prison inspectors found the regime was introduced too quickly and care plans ignored, with some patients experiencing swift and substantial drops in dosing levels. Despite this, many prisoners told inspectors their requests for symptomatic relief medication, such as tranquillisers, had been disregarded – a policy inspectors said created "psychological, sociological and ethical risks".

As a result of the new regime, involving more than 100 prisoners on the jail's integrated drug treatment system (IDTS), inspectors said inmates became frustrated and anxious. Prisoners were abusive and threatening to clinical staff and the needs of dual diagnosis patients were not met. Four inmates were put on suicide watch. Prisoners were topping up their reduced methadone doses with illicit drugs bought inside jail, resulting in an increased risk of overdose.

The report said: "The change has been introduced suddenly with little consultation or communication with prisoners or relevant professional staff. In some cases previously agreed care plans and case review conclusions appeared to have been disregarded."

When inspectors visited the jail in June, only two out of four specialist IDTS nursing posts were filled, 13-week reviews were frequently cancelled, there was no co-facilitation of group work with CARAT workers and individual prisoners received inadequate support.

The report said that clinical staff made repeated references to the treatment contract and budget, citing the need to save money as being the driving force behind the problems of the new regime.

CARAT workers told inspectors that concerns over the methadone reduction regime had been ignored by clinical staff. Wayland's drug treatment regime, "had the combined effect of rendering the IDTS programme unsafe and increasing the level of risk in regard to self-harm, suicide and overdose", the report said. Chief Inspector of Prisons Nick Hardwick said Wayland's opiate dose reduction programme was "very poorly implemented, caused significant disruption to the prison and risk to individual prisoners".

The prison's drug treatment programme was criticised in a second damning report, published by the Independent Monitoring Board. It blamed Serco's "complete management failure" and raised a number of concerns around staffing levels, budget cuts, bullying and the "deterioration" of healthcare services.

The report said: "The complete management failure of Serco within healthcare and the IDTS programme has greatly affected many regimes in the prison. Recently, the IDTS programme was found to be clinically unsafe. The board fully recognises the hard work and dedication of staff, but they are put under extreme pressure because of staff shortages and morale continues to be very low."

Both the Ministry of Justice and Serco, which has contracts to run public services including health, nuclear power, tagging, education, transport, science and defence, denied claims that budget constraints were to blame for the problematic drug treatment regime at Wayland. Since the inspection, Serco has added increased "flexibility" to its system, which has now been approved by the National Treatment Agency.

METHADONE IN JAIL: A GROWING CONTROVERSY

Prisons have come under increasing pressure to re-assess their methadone treatment programmes following accusations from some think tanks and politicians that prisoners are being 'parked' on methadone and that the opiate substitute is being used as an informal, expensive 'chemical cosh'. In March the NTA issued new guidance that emphasised that prisoners do not remain on open-ended maintenance regimes when detox or gradual dose reduction would be more appropriate.

But drug treatment in prisons is a policy the Ministry of Justice knows it must handle with care. A spate of suicides of young women in Styal Prison in the 2000s was blamed on inadequate drug treatment which effectively forced some inmates to go 'cold turkey' in their cells.

In the last five years the government has paid out £3.5m to prisoners for failings in treating addiction in prison. In 2006 the Labour government paid out £750,000 in compensation and £700,000 in costs to 197 inmates who claimed they had been forced to go "cold turkey" while in prison. *Druglink* revealed that legal advice given to the then Prisons Minister Gerry Sutcliffe, and obtained by this magazine, said the Prison Service's "appalling" record of clinical negligence had left the government little option but to settle out of court.

Earlier this year the government agreed to pay more than £2m in compensation and costs to settle claims by 499 former and current prisoners who said the suffered from systematic failure by the Prison Service to ensure they received acceptable standards of treatment for their addiction.

South America round-up

A Mexican drug cartel are being targeted by Anonymous, the hacking activist network. Hackers have blocked the website of an alleged collaborator with the words 'Gustavo Rosario is a Zeta' and launched an anti-Zeta video featuring a man wearing the movement's trademark Guido Fawkes mask. In September a female blogger who was critical of the Zetas was executed by the group.

Peru has overtaken Colombia as the world's largest producer of pure cocaine, according to the US Drug Enforcement Agency (DEA). However, Colombia remains the largest cultivator of the raw ingredient that makes the drug, the coca plant. "It is not something to be proud about," said Peru's President Ollanta Humala.

Marijuana should be legalised worldwide, says Colombia's President, Juan Manuel Santos. It would allow a shift on focus to harder drugs and the violence and trafficking associated with them. He said the move would have to happen multilaterally, otherwise it would not work.

DRUGS QUOTE

Hull parents warned of cheap new drug as tiny pills sold for as little as 50p.

The 'new' drug unearthed in this *Hull Daily Mail* headline? Valium. The story goes on to mistakenly describe their effect as like amphetamines.

The druggies will come from all over Swindon and get their needles and on the way they will break in homes and get money to take drugs.

A Neighbourhood Watch resident explains why he signed a 1,000 signature petition against a new pharmacy and needle exchange.

Smirnoff: The number one beverage alcohol brand on Facebook worldwide.

Drinks company Diageo announces a tie-up with the social networking site, despite concerns over the impact on its young members.

She did not want to die. She was looking forward to the future. She was very determined to do everything her own way, including any form of therapy. She had very strict views.

Amy Winehouse's GP, Dr Christina Romete, who had been treating the star for several years, at the singer's inquest.

inside DrugScope

The challenge of public health

High up on the agenda of the sell-out DrugScope conference was the prospect of Public Health England (PHE) taking over the control of a drug treatment budget that will no longer be ring-fenced. Although around 25% of an expected £4bn budget is supposed to be allocated to drug and alcohol treatment, there is no guarantee that it is on these services that the money will be spent. Local Health and Wellbeing Boards will have up to 17 areas of responsibility including tobacco control, obesity, mental health, workplace health, sexual health services, the list goes on.

But the threat to services does not just come from pressures to satisfy other transparently obvious public health objectives. On the very day of the conference, MPs on the Health Committee were warning that local authorities could 'play the system' by, for example, using funds to fill potholes and grit the roads on the grounds of a public health benefit, a claim backed by the President of Association of Directors of Public Health who warned of a 'real risk' of disinvestment. For their part the Local Government Association while suggesting this was 'unlikely' nevertheless stated to the BBC that they were against any form of ring-fencing adding councils were 'best placed' to decide how to spend money locally.

Speaking at our conference, NTA chief Paul Hayes said that the majority of staff moving over to PHE are from Health Protection England, not an agency that has had experience in the problems of drug and alcohol use.

Finally the challenge to services might come from the public health model itself. The imperative within public health is to move people from damaging and destructive behaviours to healthier options, whether it is reducing alcohol, smoking, or fatty foods – so that you reduce the overall numbers of people who need intensive, high cost interventions. How services dealing with a client group so beset with complex needs will fare in such an environment remains to be seen.

You can email:
Marcus Roberts
Director of Policy and Membership on
marcusr@drugscope.org.uk

IS HEROIN OVER THE HILL?

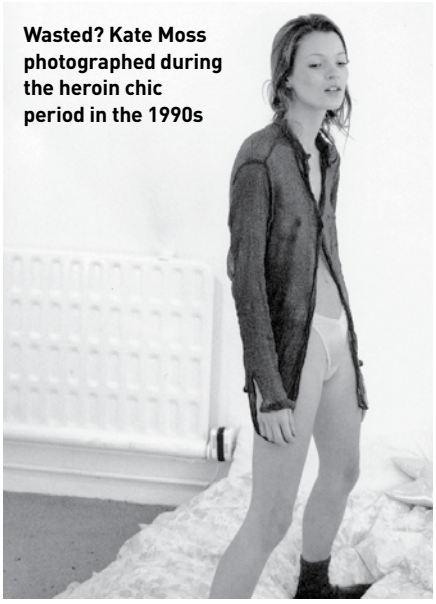
The number of young people taking up heroin has for the first time in decades begun to fall. Is this the end of an era and what has been the driving force behind it? By **Harry Shapiro**

For the first time in living memory, there is evidence that the overall population of heroin users in England has fallen. Since the mid-1960s, when the use of heroin started to spread from the middle classes to young working class people, numbers rose steadily, with some plateaux until the early 1980s. Then a toxic mix of high youth unemployment and the arrival of smokeable heroin from the middle east, sent the numbers soaring, creating the problem we have been dealing with ever since. So why have the numbers started to fall?

There is plenty of evidence that drug use trends occur in cycles, fluctuating and returning for a variety of reasons, including availability, price, purity, enforcement activity and legislation. The arrival of new drugs, especially with substances on the recreational and clubbing scenes, is sometimes simply a question of fashion. LSD for example, is hardly available in the UK these days – a combination of the difficulty of getting hold of the necessary chemicals, the arrival of ecstasy and the greater use of magic mushrooms.

The 1980s crack epidemic in the USA largely blew itself out for reasons which academics still fail to agree upon. One very controversial observation, made in the 2005 book *Freakonomics*, was that the decision in the States to legalise abortion in 1973 meant that eventually fewer single women from poor communities were having unwanted children. By the early 1990s, say the book's authors, this led to a reduction in the numbers of potential teenage criminals, drug users and dealers needed to keep the crack epidemic on the boil.

If you were looking for a similar, albeit less dramatic upstream impact in the UK, you could point to the relatively prosperous period we enjoyed up to 2008, in comparison with the 1980s. Another factor could be the absence now off any



Wasted? Kate Moss photographed during the heroin chic period in the 1990s

notion of 'heroin chic', a 1990s concept of heroin use as sexy and fashionable, attributed to a mix of the media, music and fashion industries. Although how much impact these had on actual use is questionable. Even so, heroin use does not appear to be cool anymore, a point underlined by the general reaction of most young people to the chaotic lives of Pete Doherty and Amy Winehouse, whose behaviour was described as sad, rather than aspirational, by a group of teenagers quizzed by MPs in March 2008.

The treatment system too has played its part. The past decade has seen massive government investment which has created one of the most comprehensive and accessible treatment systems in the world, whatever its faults might be. According to the National Treatment Agency, we now have fewer people coming into heroin treatment. Those that do are getting older and more people are leaving treatment and not coming back.

At the other end of the age spectrum, very few young people are seeking treatment for heroin, but instead are doing so for alcohol and cannabis. This is a reflection of the changing pattern of problematic adolescent drug use. Now the vast majority, around 90 per cent are treated for cannabis and alcohol problems.

Generally, most levels of drug use in the general population, as shown by the British Crime Survey, are flat or in decline. Most notably, cannabis use among young people has been falling since 2002. Again, there is no obvious reason for this, but educated guesses would include the fact that with so much strong herbal cannabis around, weed has become too hot to handle for most young smokers. Maybe, with cannabis use more 'normalised' over the years, it is simply part of the repertoire of fashionable accessories that can be dropped on a whim. By contrast, the strength of current cannabis also helps to explain why those young people who are perhaps self-medicating problems with cannabis can develop serious problems.

With all the current gloomy prognosis about the economy, especially around youth unemployment, we may yet see an upswing in the problematic use of drugs. Yet the real elephant in the room is alcohol. It cannot be a coincidence that while young people might have been turning their backs on syringes, many have embraced the bottle with open arms – and mouths.

When the choice is between cheap, easily available, high strength spirits and the uncertainties, dangers and expensive of the illicit drug market, it is not difficult to understand why there is so much concern around teenage drinking. Whatever messages young people might have absorbed about drugs, those about alcohol are being drowned in a sea of cheap vodka.

THE KETAMINE ZONE

Ketamine is on the up again, tranquillisers are replacing low grade heroin, potent ecstasy pills are back and the artificial division between legal and illegal drugs is crumbling. **Max Daly** and **Peter Simonson** take a look at the results of this year's UK-wide drug trends survey.

Ketamine, the powerful hallucinogenic anaesthetic, has been the biggest riser in the UK drug market in the last year, according to *Druglink Street Drug Trends 2011*.

Feedback from the investigative survey, carried out among frontline drug services, police forces, drug action teams and user groups in 20 town and cities across the UK, has revealed that the use of ketamine had increased in 15 of the 20 areas since 2010.

The findings, which follow a significant upturn in the use of ketamine at Glastonbury Festival this year (*Druglink* July-August 2011), further cement the fact that the drug has been steadily on the rise in Britain since its position was first established as a very niche substance in the clubbing and free party scenes in the early 2000s.

Ketamine, high doses of which can shift users into an intense, out of body state of dissociation, disorientation and hallucination known as a 'k-hole', is either snorted as a powder, mixed with water as a drink or injected.

Evidence suggests that the drug is being used in an expanding number of settings by a widening demographic. Experts questioned have seen a marked increase in the numbers of young people using ketamine in contexts such as pubs, clubs, house parties, homes and parks. Respondents said that more young people are taking ketamine on a daily basis, with one interviewee likening the regular use of the drug to daily patterns normally associated with cannabis.

As a result, a growing number of heavy consumers of the drug – from teenagers to more seasoned middle-aged users – have developed serious problems such as addiction, impaired mental health, physical injuries while intoxicated and bladder damage (see 'K.O.' feature on p10).

The survey also found that as well as spreading geographically, especially from urban to rural areas, ketamine use has moved onto the heroin and crack scene – with reports of people injecting the substance, partly it appears in response to the low quality of heroin being sold on the streets. Several experts reported that ketamine was being used by some

ONE SERVICE MANAGER IN NORTH EAST SAID THE DEMAND FOR BENZOS IS SO HIGH THAT THE FLATS ON SOME ESTATES WHERE PEOPLE BUY ILLEGALLY IMPORTED TOBACCO AND ALCOHOL HAVE NOW TURNED INTO "KNOCK-OFF BENZO HOUSES"

people in the same way heroin was used in the 1980s – to blot out trauma and social exclusion.

As with the former legal high drug mephedrone, which mimicked ecstasy and cocaine, ketamine now has its legal doppelganger – in the form of methoxetamine (MXE). The drug is sometimes advertised online as a "bladder-friendly" ketamine substitute, has similar effects to its illegal counterpart and according to one expert has "an expanding fan-base". Several parts of the country reported increases in the use of MXE.

Bristol and the surrounding rural areas was one of the first parts of Britain to witness significant pockets of ketamine use, amid its squat, free party and student scenes, in the 2000s. But use of the drug continues to grow. "Ketamine is part of Bristol's recent history," said Steve Jackson, a manager at the Bristol Drugs Project. "But in the last year we have seen more people using the drug heavily.. We are getting more experience of working with users reporting compulsive or addictive usage of ketamine, with people using large amounts on a daily basis, some injecting and reporting withdrawal symptoms."

Jackson added that hospitals are reporting increasing numbers of (severe) cases of bladder damage and that local services are developing detox regimes to use with ketamine users. He said: "For some people suffering from severe bladder pains because of their use of ketamine, the only way they have found they can numb the pain is by using more ketamine."

The survey found a growing ketamine scene among the younger population in the extreme south west of the country. Bruce Barnard, a drug worker at the Freshfield Service in Penzance, said: "In Cornwall we are now seeing higher use by young people, who are traditionally reluctant to engage in treatment with compulsive use problems. Ketamine can be seen at most music events, with people 'pigging it' (snorting large amounts) and collapsing at the side of dance floors. As well as concerns about compulsive use, we have had a number of women report to us with concerns over their vulnerability whilst on ketamine."

Drug services are having to adapt treatment approaches to accommodate the problem. Neil Brooks, Team Leader at Chill Out, a Nottingham Healthcare Trust service that works with non-injecting drug users said: "Nottingham is a city which has seen more of what can be described as 'hard-core' ketamine use in the last year. Our services find these clients difficult to deal with as they need longer periods of treatment, as they often have health issues related to their ketamine use, such as urinary tract and mental health problems. One client needed over a year in our service."

Until this year ketamine had been slow to move out of the gay clubbing scene In Liverpool, where the drug is known in some circles as 'gay man's smack'. Respondents say its use is now spreading to mainstream clubs. Senior drugs researcher Dr Russell Newcombe said: "It's got a reputation as a drug which can make you unable to handle yourself in public, though its effects vary enormously according to the dose

DELHI DIAZEPAM

Raj, a 34-year-old Londoner, makes £500 a week from selling illicit benzodiazepine pills. How does he get hold of them and why did he get involved? Interview by Peter Simonson.

Raj has a wife and two children and lives in a decent part of north London. He uses heroin and benzos occasionally. Before being involved in the drugs trade he worked in IT. He started using heroin when he was 17 and soon became a runner for a local north London dealer.

He heard through the Indian community that a lot of money could be made importing and selling benzos with little trouble from the authorities. The only drug conviction he has is for heroin possession a decade ago. He says he knows of loads of people who import benzos into the UK in the same way that he does.

"I order them from an uncle who is a chemist in India. He orders them from a pharmaceutical company. I get 2,000 pills shipped over with an import license then delivered to the door via DHL every month. The packages are accompanied by legitimate documents and prescriptions.

"I sell 20 pills for £20, sometimes 25 for £20. The pharmaceutical company sells 2000 pills for the equivalent of £20, so although I pay for shipment and other extras, there is a good profit for me although I sell the pills for so little.

"My main customers are heroin users, but I also sell them to normal people who can't get anti-anxiety scripts from their GP. I sell some benzos, like Midazolam, Clonazepam and Xanax, for £3 as they are much stronger."

WE ARE GETTING A LOT OF COMPULSIVE, ADDICTIVE USAGE OF KETAMINE, WITH PEOPLE USING LARGE AMOUNTS ON A DAILY BASIS, SOME INJECTING AND REPORTING WITHDRAWAL SYMPTOMS

taken – sniffing quite small doses can give a mildly trippy coked-up buzz, while injecting large doses is about as hallucinogenic as anything ever gets. People are, as the hippies put it, 'gone'."

Its widening appeal to a larger group of clubbers was first highlighted in Druglink Street Drug Trends 2005. Then, ketamine had surfaced as a rising substance within the local drug scenes of eight of the 20 town and cities questioned. It was classified as a Class C drug in 2006. The British Crime Survey has recorded a rise in ketamine use in England and Wales since the drug was added to the questionnaire in its 2007 report.

Ketamine's supply into the UK largely comes via internet orders from regulated and unregulated pharmaceutical agents in India and China. The drug was originally imported into the UK in liquid form inside rosewater bottles. And was easily available in street markets and pharmacies. But since enforcement agencies in both the UK and India clamped down when the drug became illegal in Britain 2006, the trade moved off the streets and onto the web.

The price of a gram of ketamine has remained relatively unchanged from last year, at £21 a gram compared to £20 a gram in 2010. Average prices per gram ranged from £8 in one part of the UK to £40 in London.

The other big change in Britain's drug market over the last 12 months has a familiar ring to it. Our 2008 survey revealed rapidly rising levels of tranquilliser use across the country. And this year, tranquillisers, most commonly the benzodiazepine, diazepam, have again increased to new levels. Diazepam, along with similar substances such as Tramadol and phenazepam, reported a rise in use in the last year in 16 of the 20 areas investigated.

The trend is almost certainly a result of the heroin drought that affected much of the country from around November 2010. The drought drove the purity of the drug at street level down to record lows of 13 per cent (see *Druglink* March-April 2011) for several months in some areas. One drug service said that one of its heroin users had taken £150 worth of the drug the night before a drug test, which later came up as negative. The rise in tranquilliser use has been accompanied by a fall in the use of heroin, mainly intravenously, in several of the areas questioned.

Diazepam and other tranquillisers have for decades been used in the illicit drug market as a cheap alternative to heroin and methadone. But the survey found services are dealing with increasing numbers of people for whom tranquillisers are their primary drug of addiction. In addition to the growing numbers of opiate users taking up benzos, experts reported an increase in people aged under 30 using the pills with alcohol at home, in pubs or at music festivals.

Most areas reported increases in a range of legal, black market and illegal substances – such as alcohol, speed, crack, Subutex, methadone and ketamine – by primary heroin users.

Some areas report that during the heroin drought users were using the cold water extraction method to remove the paracetamol from prescription codeine pills in order to get an opiate high. One

area in south west England reported that toxicology tests had shown some heroin was being cut with speed and Subutex. Other areas told of heroin users taking up the injecting of speed and ketamine to compensate for their lack of a powerful opiate high. One service manager in north east said the demand for benzos is so high that the flats on some estates where people buy illegally imported tobacco and alcohol have now turned into "knock-off benzo houses".

Meanwhile, after an absence of more than a decade, high MDMA-content ecstasy pills have returned to ten of the 20 towns and cities. Pills are selling in some areas up to £15 each, pushing the average price of ecstasy up to £4 from last year's average price of £2.65. The increase in potency of pills has reduced the amount of pills people are taking per session, with one or two pills sufficing instead of doses of five or more.

The use of the often illegally sold, injectable tanning aid Melanotan has spread from the north east and Wales to London, Portsmouth, Nottingham and Blackpool. Another substance on the rise after a decade of decline are amphetamines. Nine of the 20 towns and cities reported that the number of people injecting speed has risen.

The line between the illegal and the legal market in psychoactive drugs is becoming more blurred than ever before, with many 'legal' brands containing banned substances such as mephedrone. For drug users it is increasingly hard to know whether the white powder they are buying is against the law or indeed, how many different substances have been combined to make it.

The internet drug trade continues to shape-change and provide new products containing a chaotic medley of illegal and legal compounds. Alongside the recent popularity of MXE mentioned above, the potent legal high Black Mamba, which mimics the effects of cannabis, has emerged as an alternative to the banned Spice and experts in Birmingham, Manchester and Liverpool all noted its growth.

"Black Mamba is probably the most popular legal high in Liverpool at present," said Russell Newcombe. "The number of legal highs being sold by head shops and websites has hugely increased, and though little hard data is available, my impression is that, with the exception of cannabis, many legal highs – for instance, salvia, nitrous oxide, khat and methoxetamine – are as popular if not more popular than the standard controlled drugs."

AVERAGE STREET DRUG PRICES 2011

(Druglink Street Drug Trends 2011)

Prices (£)	2011	2010
Herbal cannabis (standard) per qtr ounce:	**30**	**30**
Herbal cannabis (skunk) per qtr ounce:	**46**	**50**
Resin cannabis per qtr ounce:	**26**	**26**
Heroin per bag:	**0.15g for 10**	**0.2g for 10**
Cocaine per gram:	**50**	**42**
Crack per rock:	**0.15g for 10**	**0.2g for 10**
Ecstasy per pill:	**4**	**2.65**
MDMA powder/crystal per gram:	**35**	**32**
Amphetamine per gram:	**10**	**9**
Ketamine per gram:	**21**	**20**
Diazepam per 10mg pill:	**1**	**1**
Mephedrone per gram:	**17**	**19**

K.O.

The number of young people using ketamine has doubled in four years. But for one Sussex girl who started taking the drug with her friends in the local park at 16, it ended with a near fatal addiction. **Joe Lepper** reports

Emily, now 21, first took ketamine when she was 16. Within five years, weighing just 33 kilos and with barely functioning kidneys and bladder, she was admitted to hospital. There, doctors gave her family the devastating news that her condition was life-threatening. "The worst part was my family watching this happen," says Emily. "They put a catheter in and it caused me more pain than I have ever experienced. I couldn't move for nearly two weeks." After a month in hospital, mostly on a urology ward surrounded by elderly patients, Emily had regained enough weight to be discharged and her kidneys and bladder began functioning better. But doctors have told Emily there could be long-term damage to her bladder, as well as her heart, which was weakened by malnutrition. Her heavy ketamine use suppressed her appetite.

In 2009 an investigation by Druglink charted a worrying rise in ketamine use among young people such as Emily – despite the fact it was made an illegal Class C drug in 2006. It found many long term users had serious health problems, usually connected to the bladder. Drug experts interviewed at the time predicted that its widening availability, fast dependency and the lack of information about the health risks of ketamine would cause a further rise in use among young people. Two years on and these fears have been realised. The 2011 British Crime Survey found use among 16-24–year-olds had doubled in four years – from 0.8 per cent in 2006/2007 to 2.1 per cent in 2010/2011.

Emily, an Indie music fan whose dress code is a hat, long hair and baggy clothes, says ketamine was easy and cheap to get hold of while she was studying for her A Levels in the Sussex town where she lives with her mother. She says it was the drug of choice among her peers and that she knew of 14 year olds who regularly took it.

Druglink's 2009 investigation revealed the average price of a gram of ketamine fell from £30 to £20 between 2005 and 2008. Emily says when she last bought the drug in the summer, a gram cost just £10, with 12 grams costing £90. Her father John, who took her to the hospital after becoming concerned about her weight loss, says: "If someone was to design a perfect drug for a teenager who is depressed and doesn't have much money, this would be it." The drug, which was created in 1964 as an anaesthetic and is still commonly used in veterinary medicine, also has a hallucinogenic quality. Physician John Lilly, who repeatedly took it in the 1970s, described the experience of using the drug as like being "a peeping Tom at the keyhole of eternity." This sense of detachment was another attraction for Emily, who has been jobless since leaving sixth form at 18.

Emily first started taking ketamine at night in her local park and later at parties. Her father explains: "She went to the park at night when she was 16 and there'd be a group of kids laughing and drinking, another lot taking dope and another on ketamine like zombies. She looked at them zombies and realised they were most like her."

Emily says: "I was quite depressed trying to get through college. It takes your mind to a different world so you forget the bad stuff. But in the end, ketamine becomes the bad stuff."

A report on ketamine by the Independent Scientific Committee on Drugs (ISCD) released in July found the bladder damage that Emily is experiencing is common among long term, regular users. Caused by ketamine-related ulcerative cystitis, otherwise known as 'K-bladder', it can require reconstructive bladder surgery in extreme cases. Short and long-term memory loss is another side effect of prolonged, regular use. Users are also at risk of accidents, such as falls and knocks, because of the disassociative nature of the drug. The ISCD report reveals that among a group of 90 ketamine users 12 per cent were involved in an accident as a result of taking the drug and 83 per cent knew someone who had been. There were 22 deaths in 2008 for which ketamine was mentioned in post mortem toxicology reports. Like with most drugs, users who are unhappy or depressed, are vulnerable to problematic use. The inquest in July into the death of 18-year-old Adam Gary Sephton, who was found hanging at a football field near his home in Barnsley, heard how he bought £900 worth of the drug the week before his death. The inquest heard that he had been taking ketamine for around two years and had been upset during that time about twice failing to land a job at the company where his father worked. His friend, Keiron Baker, told the inquest that Sephton had feared he would never find work.

Dr Celia Morgan, a lecturer in educational psychology at University

Come down: Emily, now 21, spent a month in hospital while her condition was life-threatening

College London, co-authored the ISCD report. She says: "While they may think they get an anti-depressant effect, the body is quick to adapt to ketamine. This is what can create a dependency – they take more and more as their body builds up a greater tolerance." Ketamine's anaesthetic qualities also make it tough for users to give up, says Dr Morgan. During withdrawal, they experience "extremely painful" cramps. Users turn back to ketamine to stop the pain, creating a perverse cycle of continued use. Lack of awareness about the damage it causes to the brain and bladder is also a factor in its growing popularity, says Morgan. She wants to see more promotion of its harm, perhaps even a national health campaign, adding "if people are aware that you may have to have a colostomy bag, bladder surgery or infertility problems after heavy use of the drug, then that could make a difference." She also calls for more coordinated support for users, urging drug workers to ensure they have strong links with urologists and other health professionals. The drug has long associations with the free party and dance music scenes in the Bristol and Bath areas of England. Consequently, the Bristol Drugs Project (BDP) works closely with local urologists, GPs and accident and emergency staff.

BDP chief executive Maggie Telfer explains ketamine has been used in the city for around a decade and long-term users with urinary tract problems began emerging three years ago. Telfer says: "Building relationships with urologists has helped us explain to users what is happening to their body. We can also help urologists who often deal with a far older patient group, in dealing with younger people."

Val Curran, professor of psychopharmacology at University College London, who co-authored the ISCD report with Dr Morgan, says the support given to ketamine users in the Bristol area is rare in England. "Users outside of Bristol tell us they can't get help as ketamine is not a priority," she says.

But she is optimistic more areas will follow BDP's lead. In the summer of 2010, UCL held a 'K Day' workshop

"I WAS QUITE DEPRESSED TRYING TO GET THROUGH COLLEGE. IT TAKES YOUR MIND TO A DIFFERENT WORLD SO YOU FORGET THE BAD STUFF. BUT IN THE END, KETAMINE BECOMES THE BAD STUFF"

to build understanding among health professionals and users of ketamine. And last month, Chelsea and Westminster hospital opened its Club Drug Clinic, to support users of drugs such as ketamine, mephedrone and GHB.

Promotion by BDP among GPs focuses on encouraging them to ask those repeat cystitis patients about ketamine use. Accident and emergency staff pass on a card with BDP's contact details to those who present themselves with ketamine related injuries or symptoms. Consultants also signpost the support BDP offers to users with cystitis. BDP is also working with the Bristol Urological Institute to develop a pain management regime to help users deal with their ketamine related ulcerative cystitis.

BDP's experience means it is able to track the latest trends in ketamine use. They are seeing a small minority of users injecting the drug, in its liquid form. This gives users a quicker, more intense hit.

A recent price rise in Bristol has also been noted. During September the price per gram doubled to £20 – a hike likely to have been sparked by a drug law change in India, where the bulk of the UK's ketamine supply comes from. Earlier this year ketamine was included in India's Narcotic Drugs and Psychotropic Substances Act. Those caught smuggling the drug no longer get bail and first time offenders get a minimum of 10 years. Despite emerging evidence of its harm to users, Telfer is against raising its classification. "When you consider that it causes far more harm to people's health than many other drugs a higher classification would seem logical, but there is no evidence that it would actually reduce its use." Meanwhile back in Sussex, Emily believes a classification on a par with heroin would help raise awareness of the harm it causes. She says: "Politicians are idiots to let a drug as harmful as ketamine to remain Class C. It shows how little they know what is happening on our streets." She is adamant she will not take ketamine again and now awaits firm news from her local urology team about the possible long-term damage the drug has caused to her bladder and kidney. Emily, who her father describes as "very caring", adds: "The worst thing was knowing that other people can end up like this and could die if they don't seek help. It hurts me that this is happening to my friends as well." *Some names have been changed to protect people's identities.*

■ **Joe Lepper** is a freelance journalist

GOING GREEN

An ongoing study among long term cannabis users paints a picture of reluctant skunk smokers whose often low-level addiction has had both good and bad impacts on their lives.

By **Caroline Chatwin** and **David Porteous**

Much of the academic research conducted thus far into cannabis use tends to focus on young and potentially vulnerable people, who come to the attention of the researchers either by being apprehended by the police or by being referred through treatment programmes. Unsurprisingly, this has led to a focus on the problems that heavy cannabis use can cause, such as truancy, poor educational attainment and developmental problems. There has, in contrast, been a real lack of investigation into people who have been using cannabis for a much longer period. What information there is tends to centre around dependency and mental health issues.

This study attempts to redress the balance somewhat, by using in-depth interviews with lifelong cannabis users to construct a comprehensive and reflective picture of their patterns of cannabis use. It looks at how their use has changed over the years, as well as how it has impacted, either positively or negatively, on several areas of their lives, namely on health, employment and relationships.

In order to participate in this ongoing study, cannabis users must be 35 or older, have been using cannabis for at least 15 years and must be currently using cannabis on at least a weekly basis. These fairly stringent parameters have, thus far, resulted in a small but unique sample of 23 long term, heavy cannabis users with a strong response bias from white, British, middle class, middle-aged men. Although numbers are currently too low to draw any generalisations about long-term cannabis use, some interesting issues have already been exposed, suggesting further research in this area would be fruitful.

For all the interviewees, cannabis use had become habitualised within their normal routines. They used cannabis frequently, but did not consume particularly large quantities – between an eighth and a quarter ounce a week. All reported that they usually smoke the drug, but many did so without the addition of tobacco. Three of our sample

grew their own supply, but the rest were reliant on sourcing their cannabis from elsewhere.

Most interviewees did not use the type of cannabis they prefer. When asked about their preferred type of cannabis, there were as many answers as there were research participants. Interestingly, however, only one participant mentioned 'skunk' as a preferred type of cannabis – and he was careful to specify that this was only if it was not "commercially grown skunk that is full of chemicals".

Nearly all, however, stated that, in reality, they would use whatever type of cannabis was available to them at any one time – and that this was usually skunk.

Participants were also asked to reflect on how their patterns of use had changed, as they became more experienced consumers of the drug, over time. Unsurprisingly, all stated that their use had greatly increased over time, as cannabis became more available to them, instead of only being accessed through friends. Many also implicated the practice of using cannabis alone, on top of using with friends, as being a defining factor in continuing use.

Strikingly, these descriptions of long term cannabis use do not adhere to typical addiction narratives; rather they depict a fairly conventional group of adults who happen to be heavy and long-term cannabis users as well as parents, partners and employees.

Respondents attest, without exception and despite their heavy use, to their ability to maintain long periods without use of cannabis, while suffering only mild irritation. Many have taken regular gaps in use, for example while travelling, living abroad or being pregnant. They described their ability to exercise self-control and moderation for a number of reasons – for example when the cost of cannabis use, to their health or wallet was too high, or before a public speaking engagement or a complicated work task. Furthermore, several have taken steps to minimise the health costs by significantly decreasing their tobacco use or by cutting it out all together.

Ultimately, however, the motivational pulls of cannabis use, in terms of both the pursuit of pleasure and the search for relief from pain, remain too strong for a permanent abstinence from the drug to be a realistic consideration.

Notwithstanding the shift to using alone as a defining factor for our respondents in becoming long-term users, all still enjoyed the shared experience of using cannabis with like-minded friends. For many, using cannabis had become a normal and long-standing activity within their intimate circle, possibly contributing to the longevity of their use.

Close friends, partners and parents were largely cited as condoning and understanding use, rather than providing a censorious response, even if they were not users themselves. It was only in their relationships with children that respondents displayed a lack of openness, suggesting that under certain circumstances, cannabis use retained an element of the taboo. Our group of respondents demonstrated both self control over their use and the ability to 'normalise' its use within their wider lives.

MAJOR MOTIVATIONS FOR LONG-TERM USE WERE THE ENHANCEMENT OF PLEASURE AND GENERAL ENJOYMENT OF LIFE, THE SOCIABILITY OF USE WITH FRIENDS AND THE BOOST TO CREATIVITY

Major motivations for long-term use were the enhancement of pleasure and general enjoyment of life, the sociability of use with friends and the boost to creativity, although the specifics of these proved hard to pin down. Cannabis was described as a 'mood enhancer', a 'catalyst to creativity', a 'relaxant', a 'psychedelic' and a 'disinhibitor'. It was said to provide 'positive thoughts', 'inspiration', 'creativity', 'euphoria' and 'increased sensory information'; to make 'conversations seem to flow more easily', 'music sound fantastic', 'rhythms change, harmonies open up' and to 'let humour bubble to the surface'.

However, more unique to this particular sample was the frequent reference to cannabis as being fundamental to the overall health and well being of participants. All made some reference to the relaxing and stress relieving properties of cannabis and many went further to cite its use in aiding sleep and relieving chronic pain. Some made it clear that they considered cannabis invaluable in treating particular physical and mental health problems such as depression, Asperger's syndrome, restless leg syndrome and Ankylosing Spondylitis, an inflammatory condition of the joints. These are not motivations for use that are commonly cited amongst younger or less experienced users of cannabis and point to a perceived inability to function normally, for whatever reason, without the use of cannabis.

It was generally acknowledged that cannabis could have both a positive (mainly in terms of boosts to creativity) and a negative (mainly in terms of lack of productivity) impact on work. For example, a retired IT consultant cited his three convictions for cannabis possession as a defining factor in his decision to go freelance and a software developer reported being kicked off a consultancy project when outed by work colleagues as a user. Several others felt that their use of cannabis had closed down certain types of employment opportunities.

Furthermore, nine of the sample had been in contact with the criminal justice system because of their use of cannabis, with sanctions ranging from cautions to convictions and, for one, prison. The most serious consequences, as attributed by the users themselves, of a lifetime of cannabis use came not as a result of its inherent properties and associated harms, but because of the illegal status of the drug itself.

While the use of cannabis, as described by our respondents, can be viewed as a fairly normal part of otherwise healthy and fulfilled lives not necessarily subject to the usual patterns of addiction, it has not been without serious consequences.

If you meet the criteria outlined above and would like to be involved in the ongoing study please contact either Dr Caroline Chatwin at c.chatwin@kent.ac.uk or Dr David Porteous at d.porteous@mdx.ac.uk. Alternatively, the web address printed below will take you directly to an online version of the survey which takes between half an hour and an hour to complete and can be submitted anonymously to the research database. https://survey.kent.ac.uk/researchproject

Dr Caroline Chatwin, lecturer in criminology at the University of Kent and Dr David Porteous, principal lecturer in criminology at Middlesex University

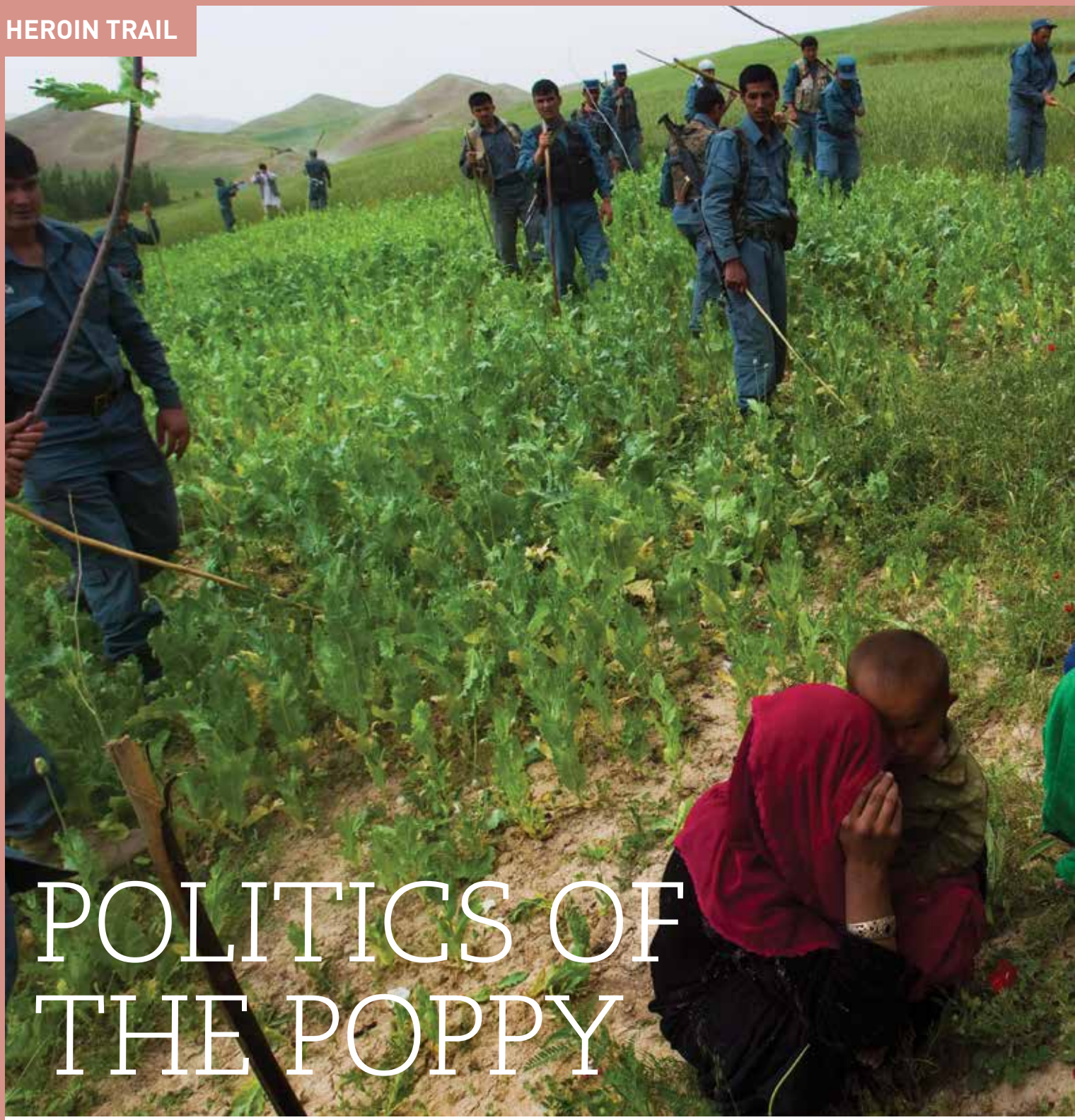


PHOTO © DAVID GUTTENFELDER/PA

POLITICS OF THE POPPY

As the Western powers prepare to leave Afghanistan, informed opinion concludes that the ten year war against opium growing has been an expensive failure.
Words: **Harry Shapiro**. Pictures: **David Guttenfelder**

A mother (in red scarf) and her children weep as Afghan policemen flatten her poppy field during a raid in north eastern Afghanistan. The woman's husband was killed by insurgents, she says, and poppies are her only income.

In October 2001, the US invaded Afghanistan in the search for Osama Bin Laden and al-Qaeda, launching 'The War on Terror'. It effectively replaced 'The War on Drugs' as a key driver of US foreign policy. Or at least that's how the military and the intelligence services viewed the mission.

A year later, General Tommy Franks commander of the American forces in the Persian Gulf told the *New York Times* that "one area American troops will stay clear of is drug interdiction", adding that resolving the issue was up to "the Afghans and non-military agencies".

What he didn't say was that not only were the Americans not engaged with the opium trade, they were, according to one expert, actively collaborating with known traffickers, whose opposition to the Taliban and al-Qaeda was more important to the overall western strategic objective in the region than their drug trade activities. Dr Pierre-Arnaud Chouvy, from the National Centre for Scientific Research in Paris, is a leading specialist in the politics of illicit drugs in Asia. He told *Druglink*: "Between 2001 and 2004, the CIA supported Afghan warlords long involved in drug trafficking in north, eastern and southern Afghanistan, something that had already been witnessed during the secret war in Laos or the anti-Soviet fighting in Afghanistan decades ago." In December 2010, the *New York Times* reported on the arrest of Hajji Juma Khan, jailed in the States under a new narco-terrorism law introduced in 2008. At the height of his power as a drug lord in 2006, the article pointed out, he was flying to the USA for secret meetings with the CIA and DEA.

But politicians on both sides of the Atlantic had a different and parallel agenda. Far from turning a blind eye to trafficking, a report prepared for Congress in October 2001 discussed policy options for counter-narcotics work, because of the link between insurgency, terror and the drugs trade. Three days earlier in his speech at the Labour Party conference about 9/11 and subsequent events, Tony Blair said of the Taliban, "it is a regime founded on fear and funded by the drugs trade. The biggest drugs hoard in the world is in Afghanistan, controlled by the Taliban. Ninety per cent of the heroin on British streets originates in Afghanistan. The arms the Taliban are buying today are paid for with the lives of young British people, buying their drugs on British streets. That is another part of their regime that we should seek to destroy".

Ironic, then, that in the same year the Taliban were being portrayed as the world's drug pusher, they initiated a ban on opium production in the areas they controlled in the south of Afghanistan; overall opium production fell from 3,276 metric tons in 2000 to just 185 metric tons in 2001. There was probably no single reason why the Taliban enforced a ban; an attempt to curry favour with the West is plausible, an attempt to boost the price of opium after years of over-production even more likely, especially since exporting opium escaped any ban. But as draconian as their regime was, it still caused the Taliban problems in the battle for the hearts and minds of the growers who depended on the crop to provide the basics for their families. By 2002, tonnage had risen back to 3,400 metric tons and then soared to 8,200 metric tons in 2007. So with a political ambition to squash the trade and evidence that production levels were on the increase once more, the counter narcotics agenda was included in what now became not just the hunt for Osama bin Laden, but a much more ambitious programme of nation-building in Afghanistan.

Following the fall of the Taliban in December 2001, the Bonn Agreement set out the process by which the political groupings in Afghanistan would work together to create a democratic government. It was also agreed to establish the International Security Assistance Force (ISAF) to help stabilise the country and assist the Afghans in developing their own security capabilities. This was followed in 2002 by a meeting of the western powers to apportion responsibility for re-building the beleaguered country. Given Tony Blair's personal commitment to tackling drugs, it was no surprise that our brief was to oversee counter-narcotics work. And, according to some critics, that's where it all started to go wrong.

Sir Sherard Cowper-Coles was for three years (2007-2010) the UK Ambassador to Afghanistan and Special

At Camp Hanson, in Marjah, a marine rests near an elder awaiting news of his son, arrested for allegedly building roadside bombs. Restoring security will depend in part on reviving a once thriving agricultural economy—one that does not depend on opium.

Envoy to Afghanistan and Pakistan. His book *Cables from Kabul*, published earlier this year, is a trenchant critique of what he sees as the political and military spin surrounding supposed 'progress' in the region. He was and remains especially critical of the anti-drugs initiatives.

During the years of the Bush Administration, the British and the Americans took diametrically opposed views on the best approach to Afghanistan's drug riddle. The Americans favoured aerial spraying based on the model adopted in Colombia, energetically espoused by Cowper-Coles' American counterpart and former US Ambassador to Colombia, William 'Chemical Bill' Wood. By contrast, the British were minded to go for less inflammatory approaches, such as crop substitution and rural development. Cowper-Coles revealed that before he arrived, the British had resorted to a secret programme of buying up and destroying the opium crop as a way of keeping it out of the hands of the drug lords. "It was a ludicrously expensive programme that ran completely out of control and had to be stopped," says Cowper-Coles. The problem was that as soon as the farmers realised they were being effectively paid not to grow opium, they simply grew more.

At the same time, The US started an equally secret spraying programme which aimed to render the plants infertile. "This didn't work either," says Cowper-Coles, "and we got the blame for that. Why? Because however flawed our plans were, we knew that spraying was absolutely the wrong approach. It would have turned an insurgency into an insurrection". In fact, says Cowper-Coles, when the British went into Helmand Province in 2006, not only did they make it clear to the locals that they weren't there to eradicate poppies, but they actually gave back confiscated opium. In the second volume of his diaries, former Labour MP and minister Chris Mullin, recounts that in May 2007, Norine MacDonald, founder of the International Council on Security and Development (formerly the Senlis Council who campaigned for the legalisation of opium for medical purposes), told him that a few weeks before, the Brits dropped leaflets saying, 'We're not the ones who are destroying your crops'. According to Mullin it "led to a dust-up with the Americans resulting in our having to apologise".

NOT ONLY WERE THE AMERICANS NOT ENGAGED WITH THE OPIUM TRADE, THEY WERE ACTIVELY COLLABORATING WITH KNOWN TRAFFICKERS, WHOSE OPPOSITION TO THE TALIBAN AND AL-QAEDA WAS MORE IMPORTANT TO THE OVERALL WESTERN STRATEGIC OBJECTIVE IN THE REGION THAN THEIR DRUG TRADE ACTIVITIES

Mullin also wrote that he attended a meeting in 2007 with Tony Blair and Tobias Ellwood, a Conservative MP and former Army captain who became interested in terrorism following the death of his brother in the Bali bombing of 2002. Ellwood had a plan for phasing out opium cultivation slowly over a number of years while phasing in alternative crops. Apart from wheat, he says "in the 1970s, Helmand grew more peanuts than California and there was a substantial income to be made from pomegranates". But it became clear that while the PM was warm to the idea, he actually had very little influence amid the competing agendas within the plethora of international community interests operating in the region.

Writing about becoming Ambassador in 2007, Cowper-Coles wrote: "In London, and in Kabul, we assembled vast, multi-disciplinary teams of officials and agents and officers charged with working with the Americans and the Afghans on somehow collapsing the Afghan drug economy. In my first year in Kabul, I spent more time and effort on this subject than any other, almost all of it wasted. The energy and enthusiasms of our teams of young advisors knew no bounds. The funds were received from London seemed almost limitless. But in truth, we made little headway in interfering with market forces far more powerful than the governments trying to counteract them."

Until then, the idea that the Taliban and al-Qaeda earned most of their money from drugs went unchallenged. Internationally, the UN Office for Drugs and Crime (UNODC) was especially vocal in this respect and kept up the political pressure on the Coalition forces for robust targeting of cultivation and trafficking. As recently as 2009, in its report *Addiction, Crime and Insurgency*, the UNODC claimed that the Taliban were at the centre of a "perfect storm of drugs and terrorism".

The arrival of President Obama in 2009 initiated a policy shift away from crop eradication and towards alternative rural development, as the White House became more convinced that eradication simply pushed farmers into the arms of the Taliban. There was also increasing evidence that the Taliban were earning far more money from sources other than opium, while al-Qaeda's drug-derived income was apparently relatively limited. Even in the small print of their 2009 report, the UNODC admitted that reducing opium production would have only "minimum impact on the insurgency threat". Most damning was a report published in June 2010 by Representative John Tierney, Chair of the Subcommittee on National Security and Foreign Affairs, which detailed how the Taliban were earning far more through extracting money from US contractors trying to transport aid and military supplies through Afghanistan, than they were earning from opium.

There was an unprecedented spike in opium output through the mid 2000s, since when levels have fallen back to late 90s levels at 3-4000 metric tons. Although the US is no longer funding the Afghan eradication programme in Kabul, some provincial governors have enforced a ban on cultivation – and the 2010 crop was hit by poppy blight, although this is likely to be a temporary setback. So while

PHOTO © DAVID GUTTENFELDER/PA

IN LONDON, AND IN KABUL, WE ASSEMBLED VAST, MULTI-DISCIPLINARY TEAMS OF OFFICIALS AND AGENTS CHARGED WITH WORKING WITH COLLAPSING THE AFGHAN DRUG ECONOMY. IN MY FIRST YEAR IN KABUL, I SPENT MORE TIME AND EFFORT ON THIS SUBJECT THAN ANY OTHER, ALMOST ALL OF IT WASTED

the amount cultivated has fallen back to previous levels, this is still more than enough to provide over 90 per cent the global heroin demand.

Most experts agree that it is impossible to deal with opium cultivation in isolation. Instead, the way forward for the future of Afghanistan as a whole, is described by Cowper-Coles as a 'double-decker' solution: "The top deck is a meeting of all the players in the region who all have a major stake in dealing with Afghanistan's drug problem; Iran for example, has lost thousands of border guards in battles with drug traffickers." Along with Russia and Iran, Afghanistan has one of the highest rates of addiction in the world. Pakistan has serious drug problems while Turkey is only too aware that its ability to deal with the traffic is critical for its application to join the EU. "Unfortunately," says Cowper-Coles, "only the US could broker such a meeting and currently shows no enthusiasm for the idea."

But what about the 'bottom deck' – the future of Afghanistan itself? Vanda Felbab-Brown from the Brookings Institute is a prolific writer on Afghanistan. Her prognosis, with major troop withdrawals on the horizon, can only be described as bleak. "Under the most auspicious circumstances, with a very determined and systematic process towards security, the rule of law and economic development, it [dealing with the opium problem] is still a two decade project. As things stand, the country could go on growing opium for ever."

***Cables from Kabul* by Sir Sherard Cowper-Coles is published by Harper Press**

The opium cables

How Druglink used Wikileaks to reveal the secret story of heroin's journey from Afghanistan to the UK. By **Adrian Gatton**

Dispatch 09DUSHANBE569: Dushanbe, a pleasant enough neo-classical city in Tajikistan, bordering Afghanistan. A mobile phone number belonging to a man known as 'The Doctor'. Further research reveals his real name is Saidabror K*******. Born in 1965, he lives in an apartment on F***** Street and is trained as a dentist.

Phone call pattern analysis links 'The Doctor' to people in Russia, India and Afghanistan – even to the shores of the UK. Who is at the end of a mysterious Kabul phone number used by this man becomes a matter of intense interest to agents at the America Drug Enforcement Administration (DEA). 'The Doctor's' role in that riddle will be explained later, because it brings us right up to the border of Britain's own fight against the drug trade.

How does heroin get to Britain from Afghanistan? The complex logistics of this black export business are necessarily shrouded in mystery. Secrecy is the name of the game: for drug traffickers of course, and quite often for police and intelligence agencies tackling it (or facilitating it, unfortunately, depending on where they are in the chain). How then can we be accurate cartographers of this trade?

The renowned criminologist Letizia Paoli, of Leuven University, is refreshingly honest about the problem of mapping out the heroin trail: "Knowledge about trafficking … routes derives from the barest of indirect statistical evidence," she wrote, pretty damningly, in her recent (co-authored) book *The World Heroin Market*. The volume of smuggled heroin is equally hard to assess, she adds.

When I rang the Home Office, SOCA and Europol, they helpfully pointed me to assessments, reports and their own maps. But it's all amorphous 'hubs' of activity, with Dad's Army-like arrows pointing this way and that across Asia, the Middle East and Europe. They feel as disorientating as a weathervane in a hurricane. Indeed, the big arrests are publicised, but their 'nodal' significance on the heroin trail is not.

So to create a map of the opiate trail, I went down another avenue of research – generously offered-up by the biggest leak of government secrets in history. By excavating the 250,000 US State Department cables, released by Julian Assange and Wikileaks (the second, and unredacted, data-purge was just a few months ago).

That's how I identified 'The Doctor' in Dushanbe.

Most of these cables have not been cited before – not surprising really, when you consider that if the Wikileaks cables were printed and bound they would be equivalent to a library of 20,000 books. Flashes of insight can be had by using carefully considered keywords or acronyms (try tapping in the phrase 'toll analysis' and read for yourself, or even 'Drugscope', this magazine's publisher).

This insider knowledge we can now be privy to comes from State Department reports, DEA field officers, White House officials, and closed-door discussions between policy-makers, lawmakers, police, intelligence officers and secret informants everywhere from Kabul, Moscow, Baku, Ankara, Istanbul, Sofia, to Podgorica, Brussels and dozens of other cities. Of course some of this will be tittle-tattle, some of it could be malicious gossip – disinformation or just plain wrong. Yet many of the cables identify ongoing international police operations to eliminate major players in this trade. Players who, incidentally, are not mentioned in press reports and press releases.

Doing this cable-bashing, we can track heroin's passage from Afghanistan across Europe and to the UK's borders. It is really a fascinating, sometimes eerie, series of snapshots and vignettes – we can scan across time and the landmass of Asia and Europe, zooming in and out

Dispatch 09DUSHANBE569: Dushanbe in Tajikistan – a key part of the heroin trail

Dispatch 10MOSCOW293: The American Embassy in Moscow, where DEA Director of Operations, Tom Harrigan, met his Russian counterpart

at will, effectively eavesdropping on individuals alleged to be involved in the trade, looking behind the closed doors of anonymous houses in faraway cities, hearing code-names, flipping through drug traffickers' rolodexes, zoning-in on heroin processing labs, reading urgent requests for wiretaps. Call the numbers: I did, they still ring, and ring.

Afghanistan produces nearly all the heroin used in Britain and across Europe. To find the first exporters on the route, this is where the trail must begin.

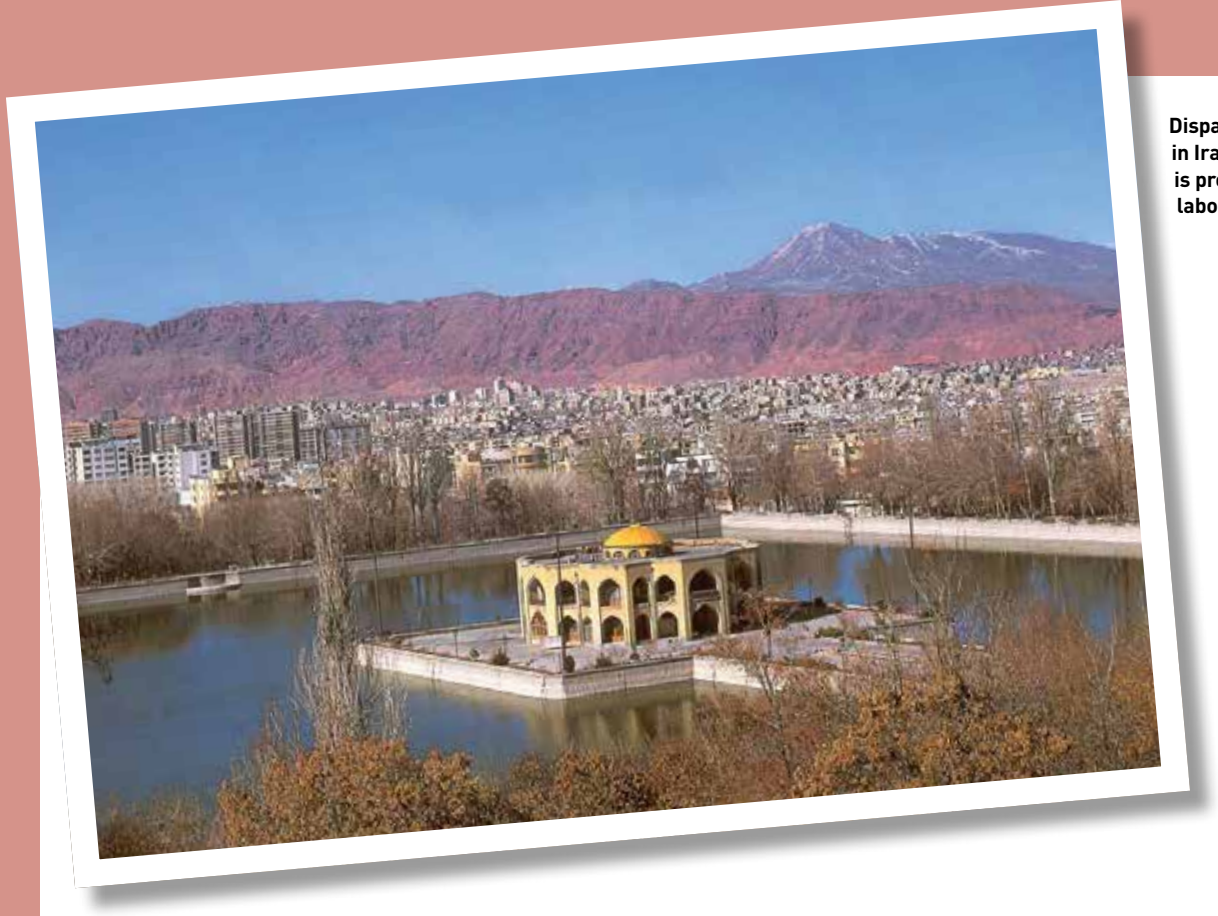
Except to know the identities of Afghanistan's opium barons, we need to drop-in on a meeting held last year in Moscow. Go to diplomatic cable *10MOSCOW293*. This cable reveals how on a freezing day in Moscow, at the US Embassy building on 5 February, the DEA's Director of Operations Tom Harrigan met his Russian counterpart Nikolay Aulov (Moscow, and Russia, has a huge heroin problem, for which the Russians blame the US invasion of Afghanistan). They agree to share intelligence. Harrigan tells his Russian friend that Afghanistan's heroin business is dominated by eight major DTOs (drug trafficking organizations), whose bosses he goes on to name.

British heroin users will never have heard of these men, they could pass them on the street and never know (yes, these kind of lynchpins in the drug world can be found shopping in the West, as recent cases such as convicted Afghani drug baron Hajji Bashir Noorzai, spotted by the DEA in New York, have shown). But British users depend on them nonetheless.

Mr Aulov, for his part, trades intelligence: "There are enough opiates in storage in Afghanistan that can supply the [world] demand for the next five years," he says, discouragingly. The source of Britain's heroin problem is not about to dry up any time soon then.

The meeting also highlights a DEA 'top priority' target, Khairetdin R*******, who is shipping heroin from Afghanistan to Frankfurt "for distribution all over Europe". Aulov and Harrigan agree a joint operation against this Dubai-based operator (he deals in 100kg shipments, Russia is another of his markets, as are far-flung places as Tajikistan and Arizona). Britain's Serious & Organised Crime Agency (SOCA) could expect to be informed of such an operation, given that Frankfurt is a pathway to Belgium and Holland, the final transit point to the UK's ports. Mr R*******'s drug nexus has been revealed partly by 'toll analysis', analysing his phone records (and those of his associates).

Other diplomatic cables shed light on a surveillance operation by SOCA in Afghanistan against Haji Abdullah Khostel – a smuggler and heroin lab owner, who is close to the Taliban.



Dispatch 08BAKU904: Tabriz in Iran, where raw opium is processed in secret laboratories

Haji Abdullah Khostel was one of Afghanistan's top three heroin barons, flooding Britain with millions of pounds of heroin. SOCA's operation was a success and he was jailed in 2009 – even a £1m bribe didn't get him a get-out-of-jail card.

However, while Pakistan also plays a big part in transporting heroin to Britain by air or by ship, the diplomatic telegrams show Iran is the major trans-shipment country for Afghan heroin bound for Western Europe and Britain. Haji Abdullah Khostel was a big exporter to Iran. Mr Aulov, back at the meeting in Moscow with DEA Director Harrigan points out that Afghan-based drug traffickers are using Iran as a key conduit for shipping opiates.

Iran is fighting its own war on drugs: it has at least 1m opiates addicts and this figure may be much higher; 3,700 border guards have been killed in skirmishes with traffickers. Towers, trenches and fences mark its border with Afghanistan yet the drugs keep coming. The problem for Western governments trying to stem this tide is their poor diplomatic relations with Tehran.

Dispatch *08BAKU904*, sent from the US Embassy in Baku on 23 Sept 2008, says: "Iran may be emerging as a major processing as well as transshipment center for Western-Europe bound heroin." Furthermore, Iran has its own heroin labs: "He [the embassy's secret source] said that interrogations and other intelligence over the last six months suggest that a significant amount of raw heroin and opiates are being processed in laboratories in Tabriz [near the Azerbaijini and Turkish borders], and perhaps other locations in Iran."

Iran is, together with Afghanistan, the major laboratory for turning opium into heroin.

The embassy's source complains that the Iranians are not helpful when it comes to sharing information. Back in Moscow, however, Mr Aulov tells Director Harrigan that he will provide the Americans with intelligence supplied by their Iranian friends.

After Iran, we go to Azerbaijan. The cables show that Azerbaijan is a crucial leg of the heroin trail to the UK – trans-shipment has "sky-rocketed" says one dispatch (*08BAKU904*). Azerbaijan is not a direct route to the West, but the Turkish army's significant presence in Kurdistan, where they are fighting a war with the Kurds, has forced traffickers to move drugs via this Caspian oil state. Hence in just four years Azeri heroin interceptions have exploded from 2kg a year (2003) to 250kgs in 2007. This is only five per cent of what they think is being moved altogether. The heroin is 'ready for market' – and 95 per cent of this importation is headed for Europe, according to the embassy's secret source.

Who handles this trade? In a 6 March 2009 cable, 09BAKU175, marked 'Secret', an officer at the US Embassy profiled suspected Iranian agents living in Baku (this as part of America's non-stop covert war against Iran). We see through this diplomatic keyhole, so to speak, into the urbane world of one Mr S**** S******, a "mild-mannered and well dressed" Iranian gentleman who runs a marble shop in the centre of Baku; the city is undergoing a boom and many residences and office buildings are built with marble.

However, behind this apparent façade, Mr S****** is described as "a well-known mafia-like figure from Iranian Azerbaijan". The dispatch says his shop is generally shut and Mr S****** is seen "holding court" in the elegant cafes and restaurants on the boulevard 28 May Street. The Embassy describes him as a "liaison" between the Iranian and Russian/Azerbaijini narcotics traffickers.

The "vast majority" of heroin entering Azerbaijan is headed for Western Europe, officials say. The route, according to sources quoted in a number of cables, is Iran-Azerbaijan-Georgia-Black Sea (and thence to Turkey and the Balkans) and even Iran-Azerbaijan-Russia-Baltic Sea route (and into Eastern Europe).

Unofficially, the Embassy's UNODC

source, speaking privately, suspects that even more heroin could be reaching Europe via Iran and Armenia, than by the Iran-Azerbaijan route. The official names a very high-level former political figure who may be profiting from the trade. Kuwait is another outlet for Afghani heroin trafficked through Iran.

Now we come to the behemoth of heroin trafficking: Turkey. There are scores of cables (the US has historically had a big diplomatic presence in Turkey, a key ally).

The entire route is summed up well at a meeting with US Ambassador to Turkey, Ross Wilson in March 2006, and mentioned in a cable: "Most of the world's supply of opiates originates in Afghanistan and passes through Turkey on its way to Western consumers."

This is the world of the Turkish babas, or godfathers, who control Europe's heroin trail. In February, Steve Coates, the deputy director of SOCA, explained to British MPs that the heroin coming to Britain – enough to fill a 40-foot container truck – is run by five Turkish crime groups, controlled by kingpins based outside the UK.

Many babas have strong links with London and Liverpool. Many, such as the alleged "most dangerous drug baron in Turkey" Hursit Yavas, picked up last November in a drugs bust in Istanbul, have strong UK connections – Yavas lived in London and served time in British jails. Or their contacts come out to Istanbul, like Michael Showers, the flamboyant Liverpudlian drug runner who was arrested last year in Istanbul during a drugs swoop (and is awaiting trial). The drug barons live outside the UK, however. But now SOCA and the Turkish police collaborate closely to catch them.

Telegram 06ANKARA6373 from November 2006 is old, but neatly explains what many later cables repeat: "Turkey remains a major route, and storage, production and staging area, for the flow of heroin to Europe. Turkish-based traffickers and brokers operate in conjunction with narcotics smugglers, laboratory operators, and money launderers in and outside Turkey. They finance and control the smuggling of opiates to and from Turkey. Afghanistan is the source of most of the opiates reaching Turkey." The opiates come overland via Pakistan, Turkmenistan, Azerbaijan, and Georgia."

In another cable the Embassy in Ankara assesses that "multi-ton amounts of heroin are smuggled through Turkey each month". A small amount of heroin is refined in Turkey, although, as other cables reveal, a lot of refining is now done in Afghanistan itself (NATO bombers occasionally destroy these opium bunkers). Turks have interests in Iranian laboratories, including the Tabriz area.

MANY OF THE CABLES IDENTIFY ONGOING INTERNATIONAL POLICE OPERATIONS TO ELIMINATE MAJOR PLAYERS IN THIS TRADE. PLAYERS WHO, INCIDENTALLY, ARE NOT MENTIONED IN PRESS REPORTS AND PRESS RELEASES.

The Turkish National Police has been collaborating closely with SOCA. But the US Embassy cables reveal worries about the TNP's boss. His alleged ties to heroin trafficking are well-enough established that he is ineligible for a US non-immigrant visa." This is worrying in a country where the state has so often been under suspicion of playing a key role in the heroin trade.

From Turkey the drugs move into the Balkans – en route for the UK. The routes and local players become varied. Some heroin travels straight across Europe on sealed TIR trucks. Other consignments get routed in more complex ways; the cables carry reports of drug trafficking through Bulgaria ("most states have a mafia, but in Bulgaria the mafia has a state"), Serbia, Macedonia, and particularly the badlands of the western Balkans – particularly Kosovo (often used as a "warehouse" for heroin).

The small break-away republic of Montenegro on the Adriatic Sea emerges as one staging post for heroin passing from Turkey, according to the local embassy's telegram 07PODGORICA229, from July 3rd, 2007. The cable picks out the Rozaje criminal clan's alleged role in heroin: "Very powerful financially, and connected to criminal structures in Kosovo, they are centrally involved in the smuggling of heroin from Afghanistan and Turkey. Lead figure is Stefan Kalic."Indeed, in July this year his wife and brother were arrested – Stefan himself is on the run, thought to be in Turkey. His network is Balkan-wide, as the cables explain.

Drugs bound for the UK cross Europe en route for the key ports to Britain: Antwerp, Rotterdam, Amsterdam, Hamburg in Germany, also Le Havre in France.

Belgium is a vital staging post if you're a heroin trafficker feeding the British market. US Cable ID: 09BRUSSELS1514 from 2009: "Turkish groups, predominately from the Kurdish region of Turkey, control most of the heroin trafficked in Belgium. This heroin is principally shipped through Belgium and The Netherlands to the UK. Authorities find it difficult to penetrate Turkish trafficking groups responsible for heroin shipping and trafficking because of the language barrier and Turkish criminal groups' reluctance to work with non-Turkish ethnicities."

And that's where our friend 'The Doctor' comes back in. The DEA, working in a unique collaboration with the Tajik Ministry of Interior, have tracked down a key associate through that mystery phone number in Kabul. It is a Tajik trafficker (linked to crime groups in Europe, say the cables). The DEA working with the Tajiks, have bugged his phones and his associates' phones. Surveillance teams have been deployed. It emerges that 'The Doctor' is also a key contact of one of the top eight trafficking Afghan drug barons mentioned by Tom Harrigan to Aulov. The DEA operation now ties in with operations in Dubai, Russia – and even Belgium. Tajikistan, it's said, has not historically been a major route to the UK. But could 'The Doctor', based 2000 miles away in Dushanbe, be pioneering a new heroin pathway to Britain? Interestingly, another cable reveals a British citizen is also a major player in Tajikistan. Is it time to open a SOCA office in Dushanbe?

Some names and identifying features have been redacted for legal reasons

Adrian Gatton is a freelance investigative journalist and film director

THE QUIET REVOLUTION

The way drug users are dealt with by GPs has transformed in the last three decades. **Dr Chris Ford**, who retired earlier this year from her post as one of Britain's specialist drug misuse GPs, looks back at how things have changed in primary care.

I have learned that if we don't know where we come from, we won't know where we are going, so without apologies I shall start at the beginning. Like all my contemporaries, I had no training in drug dependency. In fact in my training practice it was reinforced that we could treat the *effects* of drug use – such as abscesses – but needed to leave everything else to the psychiatrists, as it was a complex psychiatric condition.

In 1964 with the publication of the second Brain Report showing that there had been a significant rise in the incidence of addiction to heroin and cocaine and that the main source of supply was a small number of over-prescribing doctors, it recommended the establishment of special treatment centres, especially in the London area, where addicts could be isolated from the community and treated. These became known as Drug Dependency Units and they were psychiatry-dominated specialist services with an emphasis on abstinence-based treatments. In the early '80s, with a dramatic increase in heroin use from imported heroin, this model continued. GPs were not seen as a useful source of help. This may in some way account for my lack of training, which became starkly apparent during my first week as principal GP when a young man came to see me with his mother.

James was just 18. He looked sad and very anxious and I asked him how I could help him. He told me he had recently started injecting heroin after smoking it for the past two years and desperately wanted to stop. He had attended the local specialist drug service, but they had a long waiting list and he really wanted help now. I explained I wasn't sure what to do but asked what he thought I could do to help. He suggested methadone so I looked it up in the British National Formulary guide and wrote my first methadone prescription. James settled well in treatment. He told his friends and others came. Each one of these patients taught me lots and showed amazing change. My GP partners were supportive, as general practice is about cradle to grave and everything in between. Problematic drug and alcohol use was prolific in Kilburn, so why wouldn't we care for these patients like any other?

The second group of patients, including Beryl Poole (now helpline manager for the Alliance), taught me about partnerships, boundaries, instalment prescribing and so much more. It soon became clear that people who used drugs were as varied as any other group of patients, often had a range of problems including general health, mental health and social problems, but all wanted help to stop and/or reduce the harms and most importantly – to be treated like anyone else.

As the numbers grew it became apparent that more help was needed and community drug teams were introduced to support general practice in this work, but most often ended up doing the work directly, largely due to many GPs' reluctance to take it on – which usually was because they had no training, and had been told that they should not get involved.

Luckily I didn't know any of this and I was not only learning from the patients, I was enjoying every minute of this work. By the time I was seeing over 30 patients with drug problems, I felt I perhaps I needed a little training. I tried to find a course but there weren't any, except the 1984 Clinical Guidelines that were completely unhelpful and strongly stated that GPs should not do this work.

My local CDT kept sending me questionnaires about what help they could be to us as GPs and eventually, I scribbled on one – 'stop the questions and provide some help' and faxed it back. Two weeks later the manager of the CDT came along with Brian Whitehead, a drug counsellor, and said I could borrow him for three months. Twenty-one years later we are still working together. We soon realised that we were managing the most complex people in general practice. Many of these patients had not settled in specialist services.

Change began to happen in the specialist services in the late 1980s with the coming of HIV and the real need for more harm reduction. The NHS and Community Care Act 1990 created a market in health and welfare and allowed voluntary organisations to compete in the new mixed economy of care. This was followed by a definite change in government policy in 1995, with the Department of Health's report into drug treatment services, which supported the role of primary care in this work. Shared care schemes were popping up all over the place, and we developed one in Brent.

We knew a few others doing similar work and realised that there might be many colleagues nationally in this situation. A small group of us got together and decided to hold a conference to share experiences and develop a support network. As I was a member of the Royal College of General Practitioners (RCGP) HIV Working Party at that time we arranged it through the College and the first conference entitled *Management of Drug Users in General Practice* was held in 1996 with 100 delegates. The energy at that conference was magical and so much happened.

Delegates felt at home, friendships were formed and learning took place. I had 'persuaded' my patient Beryl Poole to do a keynote speech. She had never spoken in public before and became more and more nervous. But we had thoughtfully included a speaker from the Department of Health, to kick off the conference. He was appalling and full of prejudice, so his talk freed Beryl up to deliver an amazing speech of great quality. This conference is now in its 17th year and we still have a key-note opening speech from a person who uses drugs.

Our original small group of two grew to include Clare Gerada, Berry Beaumont, Judy Bury and Jean-Claude Barjolin and we realized that there was little literature in the drugs field aimed specifically at general practice. We decided to produce a newsletter. The first newsletter sent to the mailing list of 243 was well received and it soon developed into a quarterly newsletter entitled Substance Misuse Management in General Practice (SMMGP). The mailing list rapidly increased, reflecting a real need to build a primary care network for sharing ideas and information regarding the care of people who use substances. So far, so good – and so unfunded!

It was apparent that extra staff were needed and we managed to get funding to firmly establish SMMGP in August 1999. We believed (and still do) that with the right training and support most GPs would take on this work as it fits perfectly into the model of general practice: patient-centred care (caring for the person not the drug; and their family), long-term care throughout the journey, management of all health and well-being; and seeking help when working above competence and confidence.

With the blossoming of shared care schemes and the 1999 Clinical Guidelines it was recognized that standard national training was required for GPs and other primary care workers. Thanks to the vision of Clare Gerada, the RCGP Certificate in the Management of Drug Misuse was born in 2001. They were an immediate success, almost as if people had been waiting for them. They are annually updated and still run to packed houses. This has led to more training by general practice for general practice. We developed the first guidance specific to primary care covering the use of buprenorphine in opioid dependence treatment in primary care. This has been followed by a raft of other guidance documents for primary care.

It wasn't all positive during this period, with much of the new cash from *Tackling Drugs to Build a Better Britain* in 1998 attached to the criminal justice system. For the first time, NHS and voluntary sector providers were competing with each other for this new money: what we had viewed as a health and social problem became more of a criminal one. The increase in funding had some positive impact, with more national protocols, a move away from post-code treatment and getting more people into treatment. It strove to drive up quality, although the increase in data collection rose enormously. During this time the involvement of the voluntary sector grew, as did the number of GPs seeing their own patients; a growing number of GPs moved on to run specialist services, both within the NHS and voluntary sector. Some retained the range of care offered by primary care, but others became more like prescribing services.

SMMGP continued to go from strength to strength. It has a growing membership, which informs and responds to changing policy. The number of practices involved in working with people who have drug problems went from under one per cent in 1994 to over 40 per cent in 2011. Then last year the incoming Coalition government made a strong call for abstinence, saying methadone was not cost effective. Fortunately after much work behind the scenes a more balanced Drug Strategy was published in December 2010. The strategy has recovery at its heart, with much more responsibility placed on individuals, a more holistic approach and a new focus on housing, employment, offending and localism.

But as this re-balancing of treatment occurs, we must not let the pendulum swing too far the other way. Services are to be monitored on their "number of successes" which tends to equal being drug-free and out of treatment, with no understanding that this is not patient-centred or evidence-based – and could in fact be dangerous to people's health.

Primary care is not immune to these changes and is at real risk. UK General Practice, where everyone can register and receive the full range of health care at no cost at the point of access, is like nowhere else in the world. With general health funding likely to end up in some sort of GP commissioning groups, I feel there could be a real risk to primary care based drug treatment.

It seems likely that commissioning for mental health and drugs and alcohol will remain largely in public health. But every area will have a Health and Well-being Board, in which GPs will be involved and have influence. Will GP commissioning be a good thing or not for patients with drug and alcohol problems? I hope so. In our area we are soon holding a re-launch-come-training day for shared care. We haven't been able to get even five minutes on any one of the local three GP commissioning groups as they 'have more pressing problems'.

The challenge to the fundamentals of the NHS is against a backdrop of a worsening economic situation and the social and welfare structure being under attack and dramatically reduced. But I do know from travelling to other countries that we have the best drug policy and treatment in the world and we need to defend it, as well as develop it to ensure that the gains of the last 25 years are not lost.

For an optimist, there are other signs to be hopeful. The recovery agenda has much to celebrate. Many of us working in primary care feel we have been supporting people along their self-defined journey, but I'm excited about the call for us, as healthcare professionals, to do even better. But we must take care to support the most vulnerable and those that aren't able to reach the artificial markers that policy makers have set. Also for primary care to be able to do this, we need the right resources such as access to psychosocial interventions, in-patient detox and rehab services, housing and employment services.

What will be the role of GPs in the drug treatment system in five years time? I hope and feel it will be continued improvement. That is to provide total care to patients who use drugs: general health care, HIV and hepatitis care, mental health care, substitute prescribing and detoxification. Patients need to be supported by a compassionate, multidisciplinary team providing a range of services, as well as robust specialist services to call upon. But ultimately, with the GP remaining the key-worker.

Dr Chris Ford, GP, Clinical Director of IDHDP and former Clinical Director SMMGP

Weed all about it

A belated welcome to two books which provide valuable overviews of cannabis science and policy and also provide excellent introductions to the ongoing debates that surround cannabis use.

Reviews

THE SCIENCE OF MARIJUANA
2nd edition
Leslie L Iversen
New York: Oxford University Press, 2008
273pp
ISBN-10: 0195131231
ISBN-13: 978-0195131239

POT POLITICS: MARIJUANA AND THE COSTS OF PROHIBITION
Mitch Earleywine
New York: Oxford University Press, 2007
382pp
ISBN-10: 0195188020
ISBN-13: 978-0195188028

A belated welcome to two books which provide valuable overviews of cannabis science and policy and also provide excellent introductions to the ongoing debates that surround cannabis use.

Leslie Iversen, Chairman of the Advisory Council on the Misuse of Drugs, is a retired Professor of Pharmacology at Oxford University. The Science of Marijuana reflects his neuropharmacological research interests with a focus on the brain's chemical messenger system and its implications for the development of new cannabinoid-related medicines.

This second edition of his book incorporates findings from the flood of laboratory research papers and trials of cannabis therapeutic products published since the first edition in 2000. In the period since then, the standardised cannabinoid medicine Sativex has been approved for use as a prescription medicine in the UK as an add-on treatment for spasticity in multiple sclerosis patients who have not responded adequately to other anti-spasticity medication. It is also under investigation for the treatment of various types of chronic pain.

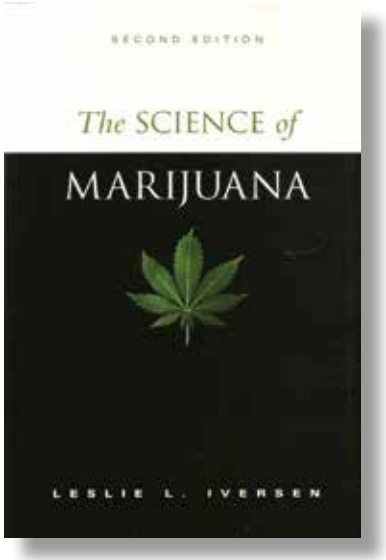
Iversen critically appraises the clinical trials supporting Sativex, and discusses other areas of potential use for cannabinoid-based medicines. Addressing the issue of patient safety, he provides a summary of research on the short and long-term effects of cannabis. The last portion of *The Science of Marijuana* moves away from a pharmacological focus on cannabis to a discussion of its recreational use and a brief history of policy responses. The author is a veteran of the saga over the downgrading and subsequent upgrading of the classification of cannabis – and thus cautious about the prospects for changing the legal status of cannabis anytime soon.

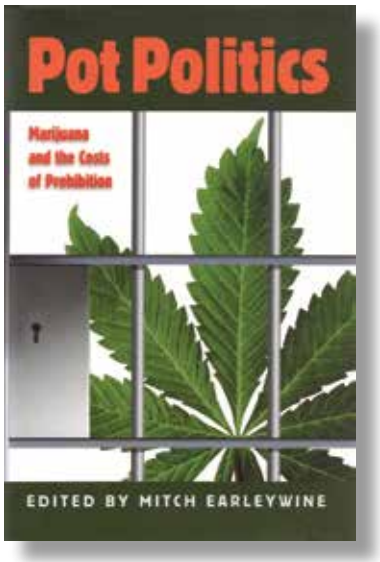
Mitch Earleywine's book is aimed more directly at those interested in debating cannabis policy. He tries to encourage what he terms the "judicious use of reason" when thinking about cannabis policy and provides a beginner's guide on how to evaluate research evidence that could have a bearing on the policy debate. Subsequent chapters, from a gathered array of mainly American researchers, provide guides to some of the knottier areas of cannabis research, such as the effects of cannabis on driving ability, drug testing in the workplace and the costs to society of cannabis prohibition.

What distinguishes this book is a large section devoted to ethical and religious perspectives on cannabis, which is then used to support the editor's attempt to examine how values can guide principles for policy decisions. Earleywine concludes that if compassion is valued then the use of medical use of cannabis should be allowed, and if justice is valued then the penalties for the possession of cannabis for medical use should be removed. While "legal highs" have received the media's attention in recent years, cannabis remains the most popular illicit drug and the 2010 National Survey on Drug Use and Health has shown a resurgence in its popularity in the US after years of stabilised patterns of use.

The policy debate about the good sense of criminalising such a widespread activity as cannabis smoking continues. Both sides of the debate will find information that is of value to them in these two books: Iversen's book as a concise and accessible guide to cannabis science, the Earleywhite volume for those with more time to ponder policy issues.

In an ideal world where evidence is prized more than opinion or conviction, drug policy makers, journalists and editors might learn something of value from these two books.





John Witton National Addiction Centre, Institute of Psychiatry, King's College London

Loaded

Drug Nation describes itself as "essential reading for anyone who wants to be informed about the drug situation today". Given the breadth of issues related to drug use, the range of substances and the many debates and disputes that enliven this field, this is an ambitious claim. It is to the credit of all concerned that in many ways it achieves that lofty ambition.

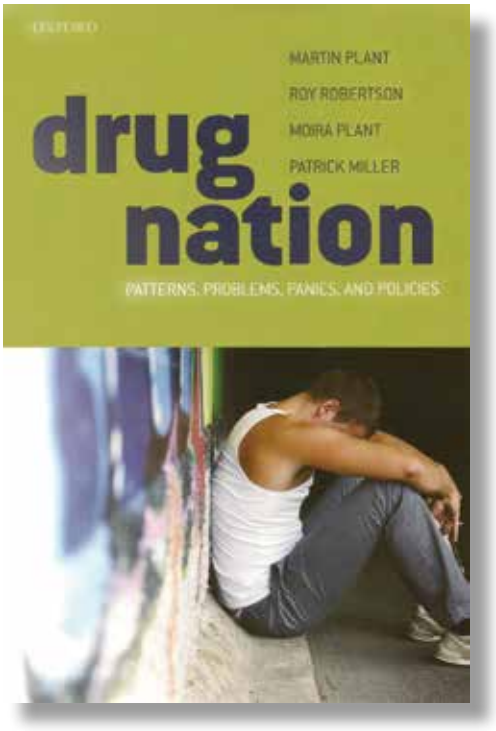
Reviews

David MacKintosh
Policy Adviser
London Drug and Alcohol Policy Forum.

That is not to say this is a general primer for anyone with a passing interest in alcohol or drug issues. It does a useful job of unpacking some of the concepts that cause confusion, a good example being the concise and logical look at the gateway (here referred to as the "stepping stones") theory of the progressive use of moiré harmful drugs. Likewise, the tour of dependency, treatment management, detoxification and rehabilitation will be of great use to many by providing a clear model of explanation for non- specialist colleagues.

I also found the in-depth history of mankind's relationship with intoxicants interesting, but some may consider the consideration of Neanderthal man's use of ephedra of limited relevance today. However, I for one welcome the bringing together of a range of sources which provide a useful context for considering and understanding the use of intoxicants in today's world.

Given the expertise of the authors and the impressive list of other contributors, it is no surprise that this publication brings together a wealth of broad data. This is its strength. But at times the quantity and detail will challenge those without some level of specialist knowledge. Setting different data sources together is a potentially risky business, but the authors create some useful mental pictures. A fine example is comparing the amount of diamorphine produced in the UK with that seized by enforcement agencies.



The sections covering the recent debates and controversies about the classification of drugs and the changes to the Misuse of Drugs Act provide some insight into the process. Unfortunately Drug Nation was obviously finished prior to the banning of mephedrone and the subsequent realisation by most politicians that the seemingly endless supply of new substances presents a challenge that the creaking mechanisms of the MDA just can't respond to effectively.

THE TONE IS RATHER REMINISCENT OF A GOOD LECTURE

I would have liked to have seen a greater exploration of the dynamics between advisers, researchers and government. Referencing situations where the dominant scientific view does not sway political decision-making as the "collision between rationality and irrationality" underplays the very real pressures faced by politicians and policy makers. This extends to far more than keeping the tabloids happy. If easy decisions were just that then it's a safe bet they would be made. This is one of two examples where the tone is rather reminiscent of a good lecture. The perhaps understandable mockery of the government's drug driving campaign (the one with the rather odd eyes) may play well verbally but in print seemed to make light of a complex issue. While Field Impairment Testing (such as walking along a straight line) may lack scientific rigour, it is in practice one of the few approaches that helps support the conviction of drivers under the influence of drugs.

To conclude, would I recommend it? Absolutely. If not quite the 'everyman' guide, Drug Nation is a valuable reference source which policy makers, service managers and many others, including politicians with an interest in the area, would do well to have to hand. It provides a valuable tool for improving understanding and knowledge about this field. Broken down into more manageable bite-sized pieces it could yet prove to be a guide which would be so beneficial in helping other professionals and the public understand more about drugs and how we can best respond to the challenges they pose.

DRUG NATION: PATTERNS, PROBLEMS, PANICS AND POLICIES

Martin Plant, Roy Robertson, Moira Plant and Patrick Miller
Oxford University Press, November 2010
Paperback, 240 pages, £24.95
ISBN 978-0-19-954479-0

Caught in the crossfire

Reviews

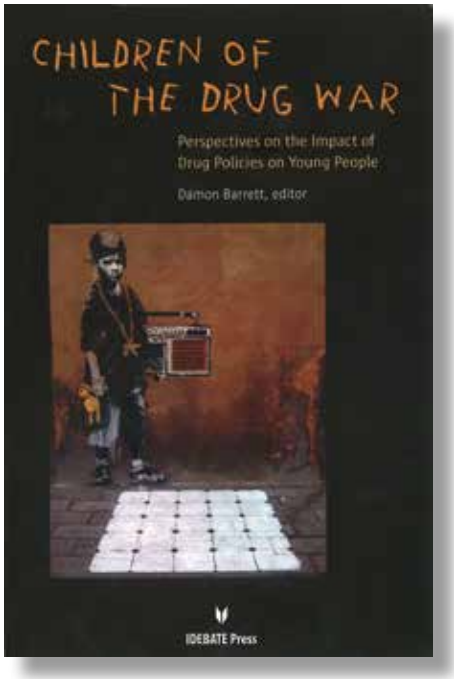
Ilona Szabo is Director of the Igarape Institute and member of the Secretariat of the Global Commission on Drug Policy

At first glance, the boy nicknamed 'Mete Bala' (shoot bullets) had a history much like most teens in Rio de Janeiro´s thousand slums.

Already an accomplished dancer, he harboured aspirations of one day becoming a singer. Yet coming as he did from a marginalised community with few opportunities, these dreams went unfulfilled. Instead, at the age of thirteen, he enlisted as a soldier in the drug trade. At the ripe age of 16, he was already a father to six kids from several different mothers.

When I met Mete Bala in a Rio slum, I was working with a documentary film team to report on the failed war on drugs. We had set up a meeting in a community centre for a group of kids working in the drug trade to tell their sides of the story. At first, Mete Bala was confrontational, proud of his hard-earned reputation. He soon softened when talk turned to his children. Alluding to the violence that accompanies his trade, I asked him: "What happens to your kids when you´re not around?" After a pause, he said: "While I´m alive, I will give them the best that I can."

His dreams were truly short-lived. Two weeks later, Mete Bala was killed in a hail of gunfire. His story is repeated daily across Brazil.



CHILDREN OF THE DRUG WAR: PERSPECTIVES ON THE IMPACT OF DRUG POLICIES ON YOUNG PEOPLE

Edited by Damon Barrett
International Debate Education Association, 2011
Paperback, 288 pages
ISBN-10: 1617700185
ISBN-13: 978-1617700187

Children of the Drug War brings much-needed attention to the real-life experiences and dynamics of drug violence in places like Rio de Janeiro – and indeed around the world. Drawing on a host of authors with direct field experience, it offers a genuinely comprehensive overview of the many ways in which children are implicated and affected by the war on drugs. The volume's 16 chapters and 20 authors feature both academic and journalistic contributions and shed new light on the involvement and exposure of children to misguided government policies.

The sheer geographic and thematic scope of the volume is breath-taking. Chapters focus on the forgotten victims of Mexico's drug war (Barra & Joloy), the experience of women in prisons in Ecuador (Fleetwood and Torres), the bartering of children to pay for opium debts in Afghanistan (Ahmadzai & Kuonqui) and parental drug use and child custody issues in Canada (Kenny & Druker). In painstaking detail, these chapters demonstrate the failures of contemporary drug policies – especially in relation to their inability to protect children.

Yet one of the major strengths of the volume is also one of its weaknesses. Many of the chapters rely almost exclusively on descriptive and anecdotal accounts. Drawing on predominantly qualitative methods, they offer fine-grained, but not necessarily universal findings on the many failings of global drug policy. Such approaches to gathering and presenting evidence mirror much of the current drug policy literature. However, what sets this exceptional volume apart is its focus on what has hitherto been hidden from view: the lived experiences of children and the intended and unintended consequences of drug policies on their wellbeing.

IN PAINSTAKING DETAIL, THESE CHAPTERS DEMONSTRATE THE FAILURES OF CONTEMPORARY DRUG POLICIES – ESPECIALLY IN RELATION TO THEIR INABILITY TO PROTECT CHILDREN

The seminal volume thus fills an important research-policy gap. Indeed, politicians and policy makers would do well to read and internalise the key messages. The war on drugs is often justified in order to "protect our children" from the "scourge of drugs". And yet what this volume demonstrates is that precisely the opposite result is occurring. The rhetoric of "protecting" children should not be used as a pretext for peddling failed policies. Instead, as the volume amply shows, comprehensive solutions that focus on harm reduction among young people are imperative.

There is hope that political leaders and opinion makers are starting to get the message. In June 2011, the *Global Commission on Drug Policy* launched a report with eleven core recommendations. One of these recommendations explicitly focuses on young people and calls for increased investment in prevention strategies that convey honest and evidence-based information on the impacts of drugs. Rather than being threatened and cajoled with moralistic messages, young people need to be well-informed and educated about the risks of drugs and the consequences of their actions.

While the volume explores the daily traumas and tragedies of children caught up in a war not of their making, it does offer some hope. By drawing attention to the many ways in which children are vulnerable to repressive drug policies, it indirectly plots out a roadmap for generating more child-friendly approaches. Indeed, the new approach implied by the authors is badly needed.

drugworld DIARIES

PC Mick Urwin

Alcohol Harm Reduction Officer

Durham Constabulary

SOMETIMES THEY ARE SURPRISED THAT THE MESSAGE I DELIVER IS NOT ONE OF 'DON'T DRINK ALCOHOL'. I'VE NEVER FOUND THAT TO BE A SUITABLE MESSAGE FOR TEENAGERS

One year ago I came off the 'frontline' to take up a newly created role of Alcohol Harm Reduction Officer. It is an interesting and rewarding role, looking at how alcohol affects our day-to-day business, and at ways to combat the problems it causes.

Don't get me wrong, I don't advocate that we all become tee-total – I like a drink as much as anyone else. It's more about getting people to drink sensibly and responsibly, while still having a good time. Where young people are concerned, it's about getting them to recognise and avoid some of the risky and dangerous situations they can find themselves in when drinking alcohol.

Over the last month I have been looking at how alcohol gets into the hands of underage drinkers, speaking to parents and dealing with partner agencies to look at strategies which tackle the problems associated with alcohol.

Last week some of our officers picked up two 14-year-old girls who had been sharing a bottle of vodka in a remote area. One of the girls required hospital treatment after she fell over and suffered a head injury.

It was my role to ensure that both girls were referred to our local alcohol intervention workers. I tried to identify whether the alcohol they were drinking had been bought by them from a shop, and if so, which one. This is so the licensing enforcement team can take action where necessary.

Parents and carers are always a difficult group to engage with, as I found out this month when only eight of them attended a drug and alcohol information event. Unfortunately it tends to take something serious to happen, such as children ending up in hospital, for parents and carers to want to seek more information.

I attended an inaugural meeting of the regional Alcohol Champions group, a network of people from all different agencies, including police, health and local authorities across the North East region. This group has been brought together by Balance, the North East of England's alcohol office, to share good practice and discuss issues around alcohol. There is a real appetite to get a grip on alcohol and the problems its causes.

In the last month I have given talks to year 10 pupils in a number of schools. This is one of the best things about my job and it's positive to see that drinking is seen as un-cool by most of them. Sometimes they are surprised that the message I deliver is not one of 'Don't drink alcohol'. I've never found that to be a suitable message for teenagers, after all, we were all teenagers at one time and pushed the boundaries.

The message is to 'think before they drink' – to consider the risks that they may put themselves in and the consequences that may occur, not only on them but also on those around them and their families. It's giving them an informed choice. Sometimes we talk too much at young people and not enough with them. When it comes to solving problems such as young people and alcohol misuse, you often find that the best solutions come from young people themselves.

38 factsheet

Ketamine

Michael Simpson
Policy Officer
DrugScope

What is it?

Ketamine is a very complex drug, an anaesthetic with analgesic, stimulant and psychedelic properties, chemically related to phencyclidine (PCP). Like PCP, ketamine is a 'dissociative' anaesthetic: patients feel detached and remote from their immediate environment. Illicit users say that under its influence, they assume a different point of view, outside of body and self.

Druglink magazine first reported ketamine use in January 2000, when Dr Karl Jansen wrote a piece explaining the drug's effect on the brain. He wrote that the psychedelic effects probably stemmed from the drug binding to phencyclidine receptors in the brain. He noted anecdotal cases of addiction in users. Druglink magazine followed this up in 2009, reporting increasing instances of use among young people, despite the drug being banned in 2006.

Legal status

Ketamine is a Class C drug under the Misuse of Drugs Act 1971. The legislation came into effect on 1 January 2006.

Prevalence

According to the British Crime Survey (BCS), around 714,000 16 to 59-year-olds are estimated to have taken ketamine in their lifetime, and 207,000 in the last year. It is particularly prevalent amongst young people, with 66 per cent of those who admitted taking the drug in the last year being 16 to 24-year-olds. The relatively high numbers of young people who admitted using ketamine comes despite the fact BCS researchers state that students are under-represented in the statistics because halls of residences are not canvassed.

Use in this age group has almost doubled since the drug was brought under control of the Misuse of Drugs Act. An estimated 0.8 per cent of 16 to 24-year-olds had taken it in the last month in 2006/07. This had risen to 2.1 per cent by 2010/11. A 2009 survey in the specialist clubbing magazine *Mixmag* suggested that as many as 68 per cent of clubbers had tried the drug.

Price

In 2005, the average price of a gram of ketamine was £30. Depending on the locality, it can now be bought from anywhere between £10 and £30, with the latest *Street Drug Trends* survey reporting an average price of £21.

Effects/risks

Ketamine is a dissociative anaesthetic, meaning users will feel detached from themselves and their immediate surroundings. The drug also has painkilling, stimulant and psychedelic effects. Effects are immediate if injected, though this practice is rarer, with most users sniffing the drug. Using the drug this way, the effects will take around 20 minutes to come on, and can last for one or two hours. At a relatively low dosage, users will commonly experience mild dissociative effects, hallucinations, and will feel distortions of time and space. Larger doses may induce a so called 'K-hole', where a user can experience considerable and lengthy detachment from reality.

Concerns over the risks of using the drug have been growing in recent years. While symptoms such as ketamine-induced ulcerative cystitis, where the bladder wall thickens, have only been recently identified, the risk of death from accidents has been long known. Its dissociative effects may make users unaware of potentially risky behaviour. One study found that as many as 83% of 90 ketamine users knew of someone who had an accident from taking ketamine. As a powerful analgesic, ketamine use can make users more vulnerable to physical injury as the seriousness of an incident may not be immediately apparent.

Other health problems that are known to have arisen from frequent ketamine use include kidney dysfunction and increased abdominal pain known as 'K-cramps'. Frequent use may also lead to depression.

There is evidence that heavy use of the drug can lead to dependence. Reports from regular users, suggest that tolerance to ketamine can also develop, with heavy use precipitating higher dosages to achieve similar effects.

frontiermedical® group

www.harmreduction.co.uk

Filter Syringe

with PIN Number

The **Filter Syringe** with PIN number has been designed to provide filtration for every injection and a scratch off panel helps reduce the risk of accidental sharing.

exchange™

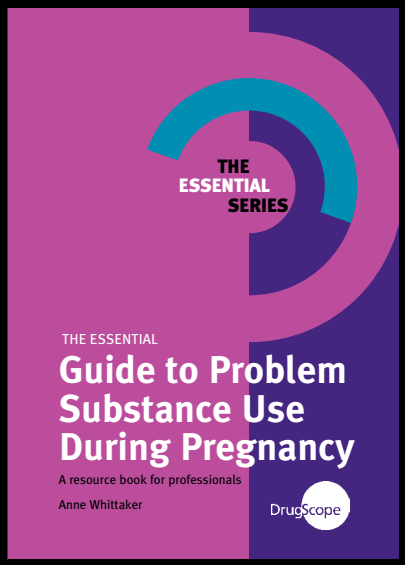
Frontier Medical Group
Newbridge Road Industrial Estate,
Blackwood, South Wales NP12 2YN
Tel: +44 (0)1495 235800
Fax: +44 (0)1495 235808
Email: info@frontiermedical.eu
www.frontiermedical.eu

GP0003_A11_01

The Essential Guide to Problem Substance Use During Pregnancy

"An excellent framework for good clinical practice. A must-read."
Fay Macrory MBE, Consultant Midwife, Manchester Specialist Midwifery Service

"Required reading. It is the 'essential guide.'"
Joy Barlow MBE, Head of STRADA



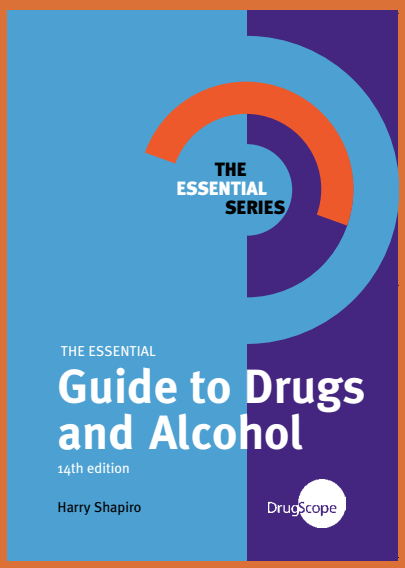
The latest in DrugScope's series of professional resource books, *The Essential Guide to Problem Substance Use During Pregnancy* is the go-to reference guide for all practitioners who provide care to women who use drugs or alcohol before or during their pregnancy.

This unique text was written by Anne Whittaker, a Nurse Facilitator working for NHS Lothian who specialises in drugs, alcohol and blood borne viruses. It establishes a 'framework for care,' synthesising the latest good practice advice, official guidelines and research knowledge, so that all women who use drugs and/or alcohol can be offered appropriate support before and during pregnancy, as well as after the birth of their baby. Information and intervention strategies are provided on topics such as antenatal care, the management of substance use during pregnancy, Neonatal Abstinence Syndrome, breastfeeding, postnatal care and the management of risk and child welfare concerns during pregnancy. The book also features 11 downloadable leaflets and factsheets for use by professionals and service users. Drug and alcohol workers, midwives, neonatal nurses, health visitors, GPs, social workers, and students from all these disciplines will find this guide invaluable.

£15.25 for DrugScope members
£16.95 for non members

Order your copy from HIT at www.hit.org.uk, by email at **stuff@hit.org.uk** or by phone on **0844 412 0972.**

DrugScope's
The Essential Guide to Drugs and Alcohol
on sale now!
Revised and fully updated!



With half a million copies sold since its launch in 1982 and now in its 14th edition, *The Essential Guide to Drugs and Alcohol* is indispensable to everyone with a professional interest in the field.

With an A-Z of illicit substances including new sections on BZP, mephedrone and naphyrone, a jargon buster of key sector terms and accessible tables on seizure stats and prevalence, the guide pulls together vital information in an easily digestible way. Order your copy today!

"It really is an essential resource for users, parents, teachers, scholars and those in the drug sector generally. Excellent!"
Dr Sue Pryce, University of Nottingham

£13.45 for DrugScope members
£14.95 for non members

Order your copy from HIT at www.hit.org.uk, by email at **stuff@hit.org.uk** or by phone on **0844 412 0972.**