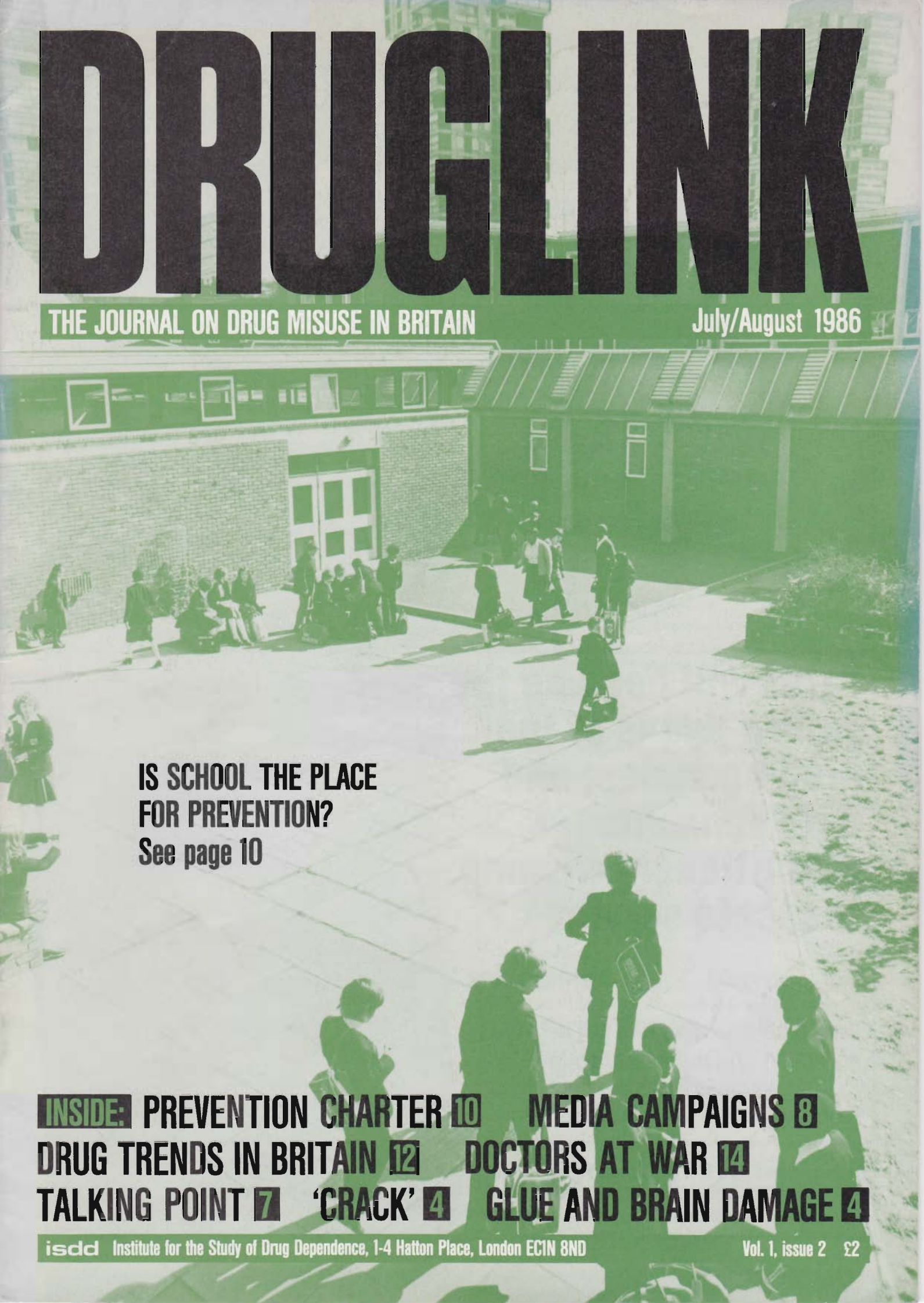
DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN

July/August 1986



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See page 10

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Gerry Stimson *New Society*

Drug problems: where to get help was compiled and published by BBC Drugwatch and the Standing Conference on Drug Abuse.

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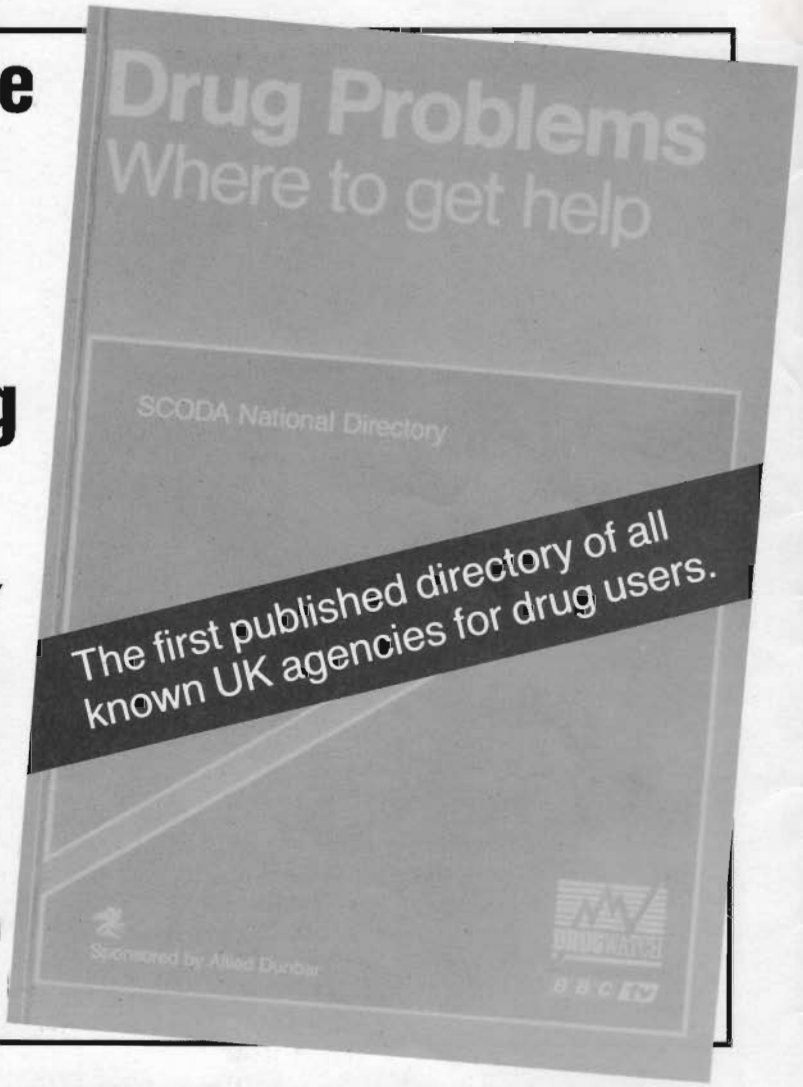

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THE JOURNAL ON DRUG MISUSE IN BRITAIN

DRUGLINK is produced by the Institute for the Study of Drug Dependence (ISDD). **Druglink** aims to inform and update specialist and non-specialist workers occupationally, professionally, or academically involved in responding to drug misuse in Britain. Subjects covered include illegal drug use, legal use of substances such as solvents, and drug dependence.

ISDD provides Britain's national library and information service on the misuse of drugs and drug dependence, and conducts related research. **ISDD**'s reference library of books, scientific articles, reports and UK press cuttings is unique in Britain and an important international resource. Services to library users include current awareness bulletins, publications and an enquiry service. **ISDD** is an independent charity grant-aided by the Department of Health.

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DRUGLINK is a forum for the recording and interpretation of facts and opinions on drug misuse in Britain. **Druglink** does not represent the views or policies of ISDD.

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IN THIS ISSUE

isdd INSTITUTE FOR THE STUDY OF DRUG DEPENDENCE

1-4 Hatton Place, London EC1N 8ND Phone 01-430 1991

'Crack' takes cocaine smoking to downmarket USA

'Crack' is a smokable form of cocaine derived from the more familiar cocaine hydrochloride powder. Both are powerful stimulants. Despite recent media presentations of 'crack' as a totally new drug, it is simply free base cocaine produced by an easier method.

According to the US National Cocaine Hotline, 'crack' took off in November 1985 and now accounts for half their calls. Crack's popularity stems both from its chemical and its financial characteristics.

Cocaine hydrochloride's water-solubility makes it suitable for sniffing up the nose (entering the bloodstream via the nasal membranes) or dissolving in water for injecting. But heat destroys the chemical, which in any event fails to give off the copious fumes required for smoking.

Compared to the hydrochloride, free base cocaine is relatively insoluble in water, but melts at a lower temperature, releasing sufficient fumes to make smoking a viable proposition. This simple change in route of administration makes 'free-basing' cocaine an unusually attractive and, for some, destructively addictive chemical experience.

Cocaine free base — 'crack' included — is most effectively smoked through a water pipe, but can be sprinkled on a cigarette. 'Designed' as they are to incorporate oxygen quickly and efficiently into the bloodstream, the lungs — as any tobacco smoker can testify — can also do the same job for less neutral vapours.

With free base, the result can be an immediate euphoric 'rush' as the cocaine bypasses the relatively slow nasal absorption process. Seconds later the rush 'speeds down' to a plateau of elation lasting five to twenty minutes.

To maintain the high and avoid the agitation and depression that can follow, inhalations may be repeated as often as every five minutes until supplies or users are exhausted. Persistent use may end with hallucinations, paranoia and a psychotic episode. Controlled, occasional use is possible, but chronic use can be hard to resist if supplies are available.[1] In one US follow-up study, all the cocaine users who developed "compulsive" patterns of use were free-basing.[2]

Free base cocaine has been around in the USA since 1974. The production process is tricky, involving volatile inflammable solvents such as ether. Solvent vapours have been known to ignite during free-basing episodes causing accidental burns.

As with other forms of free base, the 'crack' production process starts with cocaine hydrochloride and ends with the cocaine alkaloid (or base) freed from its hydrochloride appendage (hence 'free base'). But this time the transformation is achieved with little more than household baking soda.

According to the US National Institute on Drug Abuse, "'Crack' is . . . processed from cocaine hydrochloride . . . using ammonia or baking soda (sodium bicarbonate) and water and heating it to remove the hydrochloride . . . the cocaine powder is next processed into crystals . . . and then packaged into transparent vials resembling large vitamin capsules. Crack is often called 'rock', although it should not be confused with rock cocaine (a cocaine hydrochloride product for intranasal snorting)."[3]

The final product may contain many of the impurities from the original hydrochloride plus a sodium bicarbonate residue which, when smoked, makes the crackling sound that gives 'crack' its name.

Before 'crack' appeared, free base was beyond the resources of most cocaine users. With already expensive cocaine hydrochloride 'in the hand', few would delay gratification and risk losing all or part of their supply by attempting to transform it into the even more expensive free base.

But 'crack' free base is easy to produce, cheap to buy and relatively safe to use. Sold in ready-to-smoke form weighing about 300 mg per piece, it can be purchased for $5 to $10 on the streets of New York and other major US cities.

Why 'crack' is cheaper than the cocaine powder needed to produce it is an unresolved mystery, but the theory is that major traffickers exploited 'crack' to reduce cocaine prices and hence widen the market.[4]

In the UK cocaine may be gaining in popularity but 'crack' has yet to appear in anything other than sporadic and unsubstantiated reports, free-basing remaining very much the province of an 'elite' minority. Obviously the situation could change, but reports of mounting free base casualties in the USA may have helped alert British drug users to the unusually high risk of psychological dependence.

1. Siegel RK. Cocaine smoking. *Journal of Psychoactive Drugs*: 1982, *14* (4), p 271-359.
2. Siegel RK. Changing patterns of cocaine use: Longitudinal observations, consequences, and treatment. In: *Cocaine: pharmacology, effects, and treatment of abuse*. NIDA, 1984.
3. National Institute on Drug Abuse. *NIDA Notes*, no. 2, May 1986.
4. Pye M. Crack of doom. *Observer*, 15 June 1986.

Permanent glue sniffing brain damage 'unproven'

A research review published in the *British Journal of Psychiatry* has concluded that the evidence for permanent brain damage from toluene misuse remains inconclusive. The review concentrated on toluene as the solvent most commonly implicated in solvent misuse.

Dr Maria Ron of the National Hospitals for Nervous Diseases found that severe, prolonged abuse of toluene-containing solvents (most commonly in glues) can cause physical abnormalities in the cerebellar area of the brain lasting weeks or months. Symptoms can include poor coordination, tremor, and nystagmus.

However, only a small minority of severe abusers are affected and symptoms can decrease with abstinence. It is not known whether some permanent damage might remain.

One important source for these (and other) findings was a paper published in 1983 by researchers from the Addiction Research Foundation in Toronto[2]. In this study the "impaired" group (with at least four signs of neurological abnormality) had sniffed solvents for an average of seven years, including daily use for at least the previous year. At the time of the study, they were consuming on average the equivalent of ten tubes of adhesive a day.

The review found evidence of abnormalities in other parts of the brain after severe, prolonged toluene abuse, similar to those seen in chronic alcoholics, and a suggestion of associated intellectual impairment. Isolated cases of damage to the peripheral nervous system were reported. There was no reliable evidence of toluene misuse causing lasting psychiatric disturbance or anti-social behaviour.

Dr Ron's review seems to suggest a small minority of relatively old (20s and above) extremely heavy, long-term toluene misusers suffer brain changes affecting the coordination of movement and perhaps also intellectual ability. Whether these changes last beyond the weeks and months covered by the available studies remains to be seen.

It is, she says, "doubtful whether [volatile solvents], and in particular toluene, can cause persistent impairment in a sizeable proportion of . . . the age-group commonly involved in the practice". On the available evidence, it seems the vast majority of adolescent toluene misusers will not have suffered any detectable form of brain damage.

In passing, Dr Ron dismisses the conclusions of a well-publicised British paper from 1981 which suggested that toluene inhalation was an important cause of "encephalopathy" in children.[3] The use of this term to describe transient signs of solvent intoxication was, she said, "unjustified".

Dr Ron's review was based on a report done at the request of the Medical Research Council.

1. Ron M.A. Volatile substance abuse: a review of possible long-term neurological, intellectual and psychiatric sequelae. *British Journal of Psychiatry*: 1986, *148*, p.235-246.
2. Fornazzari L., Wilkinson D.A., Kapur B.M. *et al.* Cerebellar, cortical and functional impairment in toluene abusers. *Acta Neurologica Scandinavica*: 1983, *67*, p.319-329.
3. King M.D., Day R.E., Oliver J.S. *et al.* Solvent encephalopathy. *British Medical Journal*: 1981, 283 (6292), p.663-665.

Prison is UK's 'main response' to drug problems

Tackling drug misuse, the Home Office's glossy strategy paper, contains only five paragraphs about drug misusers in prison. This is surprising because in terms of both numbers and cost, imprisonment is Britain's main response to the problem.

Nobody really knows how many people are in prison as a result of using drugs. Many are convicted of crimes, such as burglary, committed in support of a habit, but not recorded as drug offences. Others, sent down for drugs offences, show no outward sign of addiction and so are not picked up by prison doctors or included in their figures. It is quite possible for people to appear in one or both sets of statistics or in neither.

Since it opened in 1983, the Parole Release Scheme has interviewed 234 prisoners with a history of drug problems, building up a revealing picture of drug misusers in prison.

Of the people we saw, just half were in for drug offences and less than a third had received treatment for drug dependence from prison medical officers. If our clients are representative, then something of the order of 7000 people may be imprisoned for drug or drug-related offences each year in Britain, and around 10,000 prisoners have a serious drug problem immediately prior to sentence. The cost of imprisoning these drug users could be over £100 million per year.

These are guesstimates — the precise figures are unknown — but it is certain that many tens of millions of pounds are spent each year to keep drug users in prison, many of whom return within a few years.

Three-quarters of the people we interviewed had been imprisoned before and almost as many had been re-convicted within two years of their previous offence, much higher than the overall re-conviction rate of 58 per cent for men and 39 per cent for women. With currently fashionable drugs such as heroin and cocaine more likely to attract custodial sentences, it seems that the number of drug misusers in prison is set to grow as 'new' prisoners join the seven in ten old hands who re-offend.

On average the people we saw had been using drugs for 10 to 15 years. Most had begun before the age of 16. All had repeatedly come before the courts, yet in all this time only a third had approached, let alone been accepted by, any residential rehabilitation service.

An even smaller proportion, just one in seven, had made use of any drugs advice or counselling agency. On the other hand, 55 per cent had been on probation orders and 56 per cent had received medical treatment for addiction, often outside of NHS clinics. At least in the South East, it seems the majority of people in prison for drug-related offences have bypassed the network of non-medical drug agencies.

This does not seem to be the result of informed choice. We first assumed that anyone who had been using drugs for half their life would have a fair idea about the help available. We were wrong. Much of our time is taken up with providing very basic information to prisoners.

Telling people what their options are and helping them follow those up must be better than continually sending drug users back to prison, presumably in the hope that they will eventually grow out of it. Better still, how about a service to offer courts proper alternatives to custody in the first place?

Stephen Tippell and Nicola Matera

The Parole Release Scheme is a three-year pilot project designed to develop the opportunities available to prisoners with a history of drug problems, who are eligible for release on parole. The PRS is operated by Cranstoun Projects Ltd and has just published its monitoring report for the period September 1984 to March 1986.

Prevention and community action 'crucial' says Mellor

David Mellor, Under-Secretary of State at the Home Office with special responsibility for drugs, told a conference at Brighton that "prevention is going to be the key" to dealing with drug problems.

Speaking to nearly 400 delegates on 15 July, Mellor emphasised that we have "got to catch people before they get into drugs" by countering the "insidious" peer group pressure pushing youngsters into drugtaking. If this was the aim, Mellor's underlying strategy was to use media and professional initiatives to "unleash the energy of the whole community".

At one point Mellor cautioned that drugtaking for the present generation should not be allowed to become as acceptable as drinking four or five pints of lager, "which we all used to do in our generation". Later he emphasised the "drinking sensibly" message.

In a speech that traversed the whole range of the government's strategy on drugs, Mellor admitted that a free society like Britain could never be anything other than a "colander" to illegal drug imports. It was hard, he said, to make moral judgments on peasant farmers in third-world countries scratching a subsistence from drug cultivation when drugs were the only crops they could sell.

Treatment was important (nearly £17 million government pump priming money had gone into the helping services) but prevention was the "most crucial thing". Youngsters had to be helped to "just say no".

Mellor appeared satisfied that the government's anti-heroin campaign had shifted teenage opinion against drugs but said it had failed to reach parents. A campaign aimed more directly at parents was being implemented. ("Whether we win the hearts and minds of parents will determine whether we win the battle.")

David Mellor was speaking at a conference organised by the TVS television company to launch its half a million pound regional "campaign against drug abuse", due to culminate in ten hours of programming in November plus a free helpline and back-up materials. The theme of the conference was to get professionals and voluntary groups "working together". For more information on the TVS campaign contact Mark Hill on 0622 684641.

New DHSS parents' leaflet

Drugs — what you can do as a parent (code DM4), issued in June 1986 by the DHSS and the Welsh Office, replaces *What every parent should know about drugs* (DM1) and *What parents can do about drugs* (DM2).

The new leaflet is the same size as the old DM1, consisting of a 'concertina' of eight folded panels fronted by a picture of bleary-eyed adolescent. As an aid to spotting drugtaking there are pictures and descriptions of illegal drugs. The advice is low key ("don't jump to conclusions", "try not to over-react") and the information generally accurate.

Still available is ISDD's *Drug misuse: a basic briefing* (DM3), giving much more extensive information on drug effects and drug laws. Leaflets DM3 and DM4 are available free of charge from DHSS Leaflets Unit, PO Box 21, Stanmore, Middlesex HA7 1AY.

A youth version of *Drug misuse: a basic briefing* was produced last year for BBC Radio One's Drug Alert campaign. Called *Drug alert: the basic facts*, this leaflet was written by the Plain English Campaign and preserves in an easier-to-read style most of the information in the original. The basic facts leaflet and its companion leaflet, *Drug Alert: how to get help*, are available from Drug Alert, BBC Radio One, London W1A 4WW.

Drug alert: the basic facts is being updated for a new Radio One Drug Alert campaign this Autumn.

In case of difficulty, all these leaflets are available from ISDD in quantities of 50 or less at the cost of postage only.

Opiate and cocaine deaths figures

Unpublished figures from the Home Office Drugs Branch show 274 deaths in 1984 associated with the use of opiate-type drugs and/or cocaine.[1]

The figures collate 'addiction' deaths reported by coroners, deaths of addicts known to the Home Office, and officially recorded overdose deaths. The sum total is probably the best available estimate of deaths of people addicted to opiate-type drugs or cocaine, or whose deaths are associated with the use of these drugs. Some of the deaths will bear little relationship to the deceased's use of drugs.

217 of the 274 deaths were due to drug overdoses including 100 where opiates (heroin, morphine, etc) were involved and 46 involving methadone, the drug most often used in the treatment of opiate addiction. Just eight deaths involved cocaine. (The "involvement" of a drug does not necessarily mean it *caused* the death.)

The figure of 40 deaths involving dipipanone (Diconal) had decreased from a peak of 93 in 1982 (when it was involved in more overdose deaths than the opiates) and is likely to decrease further as a result of prescribing controls brought into effect on 1 April 1984.

For a full report on deaths figures up to 1980 see "Drug abuser deaths" by H.B. Spear in the *British Journal of Addiction* 1983, vol. 78, p.173-178.

1. The drugs involved are: cocaine; dextromoramide; diamorphine (heroin); dipipanone; hydromorphone; levorphanol; methadone; morphine; opium; oxycodone; pethidine; phenazocine; piritramide.

AIDS advice for drug workers

A new AIDS-guidance leaflet for drugs workers published by the Standing Conference on Drug Abuse (SCODA) has come out against compulsory screening and recommends risk-reduction advice if clients will not stop injecting.

Facts about AIDS for drug workers says drug agencies should not conduct compulsory tests for the AIDS virus on all their clients and should only test on the basis of "informed consent" after adequate counselling. Drug users who will not stop injecting should be advised to:

► *always* use their own equipment and *never* share with anyone;

► *never* mix drugs in a spoon used by other people or flush works in water used by them;

► *always* dispose of needles and syringes safely so that others cannot be stabbed accidentally or re-use them.

The leaflet also lists 'safer' sex guidelines for agency clients, and gives basic hygiene advice for drugs workers at risk of contracting AIDS or other infectious diseases from their customers.

Facts about AIDS for drug workers is the first public policy statement from SCODA — the national representative organisation for drugs agencies — on how their members should cope with the AIDS risk. It is available from SCODA (same address as ISDD) at £0.20 inc. p&p.

Training video aids understanding

A framework for understanding drug problems, familiar to many drugs workers in the North West but previously unavailable in published form, has now been produced in video format by the North West Regional Drug Training Unit (NWRDTU).

Understanding problem drug use is a training pack consisting of a 28 minute video financed by the DHSS, plus supporting material intended as background reading or discussion triggers. Among these is another training pack, *So you think you know about drugs?* co-produced by ISDD and the NWRDTU and available as a separate publication from both organisations.

The framework embodied in the video consists of three, three-way classifications, dividing *patterns of drug use* into experimental, recreational or dependent; *drug problems* into problems to do with health, lifestyle or the worker's difficulties in 'managing' the situation; *responses to drug problems* into prevention, care or control.

The aim is to help those working with drug users to assess the situation and relate the type of drug use to the associated problems, leading to a more considered and appropriate response.

In the tutor notes are suggestions for using the pack including a one-day seminar. There is no prohibition on using the pack with the general public, but it is intended for training professionals and others working with drug users.

The NWRDTU is working on two more videos, on women and drugs and on emergency overdose guidelines, and has secured £30,000 funding from the Regional Health Authority for three more.

Understanding problem drug use is available from the NWRDTU, Kenyon Ward, Prestwich Hospital, Bury New Road, Manchester M25 7BL, phone 061-798 0919. The purchase price is £31.00 inc. p&p and the pack can be hired (or previewed for possible purchase) for £7.00 inc. p&p.

Still available for purchase or on free loan is the government's training video *Working with drug users*, consisting of a three-hour video divided into 12 modules, plus supporting materials — contact CFL Vision, SSVC, Chalfont Grove, Gerrards Cross, Bucks. SL9 8TN.

Met to release Drug Warning book

On 25 September 1986 the Metropolitan Police will release *Drug warning*, described as an "illustrated guide for parents and teachers . . . a complete factual dossier on all the drugs currently being misused in the UK". The book is to be published by Macdonald at £12.95 or £6.95 in paperback.

Drug warning is based on the Met's own in-service training pack, *Drug abuse: a handbook for guidance*. The handbook was produced in March 1985 to guide police officers giving talks on drugs to schools, other youth groups, parents and professionals.

Despite strong interest, the Metropolitan Police refused to release copies of their pack to outsiders, promising a 'public' version at a later date. *Drug warning* seems to be it.

If the forthcoming publication follows the format of the earlier handbook, the body of it will consist of an illustrated drug-by-drug briefing on effects, patterns of use, history, law, slang, etc for over 20 drugs or drug groups, including some only rarely seen in Britain, such as the hallucinogen mescaline.

Drug statistics, more on drug law and slang terms, and information on treatment are also available in the old handbook.

Hopefully *Drug warning* will correct some of the more excessive statements about actual or potential drug harm to be found in the original, but retain the 'inside' information on the drug market (where the drugs come from, what they look like, 'trade names', etc) known to the police but mostly hidden from the rest of us.

Drug Warning: profits will go to SCODA's trust fund for drug services.

BENEFITS OF THE 'POOL HALL'

During its short tenure as a centre for drug dealing, the existence of the 'pool hall' in central London had some beneficial side-effects for police, dealers, users and welfare workers alike.

Robert Power

Very few heroin users in the West End were unaware of the existence of the 'pool hall'. It was the one place in London where it could be guaranteed, that between ten in the morning and ten at night, heroin would be on sale. It was somewhere where you did the business, had a cup of tea, maybe a game of pool, chatted to one or two people, and then left.

Small groups of users gathered around 'their' dealer. Some sat on the hard benches skirting the room, others hugged the coffee bar or leant on the balustrade that led to the stairs and the street below.

Noticeably apart from the main activity of dealing and scoring, Maltese gamblers played on 'their' pool table, where one evening £1,000 had been staked on a single frame. Jo, the sole employee, would dispense expensive cups of tea and coffee, and, when he'd been drinking (which was often) he would mouth off about the pimps, prostitutes and junkies who were his patrons.

A constant flow of people moved up the stairs. Even before their heads came into view between the struts of the banisters, the assembled dealers made their offers. "You looking? Want some gear? After smack?" To 'just say no' was like going into a transport cafe at breakfast time and refusing a cup of tea.

If you were not there to score your presence needed to be vouched for. My first visit was with Mark Lee, the detached youth worker from the Hungerford, an accepted outsider and a liked and well-known face. I then got to know Tom, a well-respected and established dealer, who would always account for my presence to others: "He's okay, not one of the filth. He's doing some kind of research".

Generally, nobody stumbled into the 'pool hall' by mistake. Its unmarked door was squeezed between strip-joints, its stairs were particularly unwelcoming and poorly lit. But, for the West End's heroin using population, it was a veritable oasis: a certain score in a relatively safe and secluded environment. It functioned in a business-like manner, off the streets, bothering no-one.

One Monday night in January, I counted 11 dealers there. Some months later I met a Scot who had heard about the place from drug-using friends in Falkirk, and headed straight for it on arriving in London. I knew of one dealer who fortnightly travelled over from Dublin to deal in the 'pool hall'. Asked why, he said it was such an organised place to do business from.

For vastly different reasons, workers in the drug-field valued the 'pool hall'. Its existence enabled detached workers to maintain and nurture contacts that would otherwise be lost in London's transient drug-using population. Posters highlighting health hazards of drug use, and giving names and addresses of services and agencies, were displayed on the walls, reaching an audience that may not be in contact with any of the available services.

Similarly, probation officers and social workers could more easily locate and pass messages on to their clients. For researchers, its value was self-evident. The 'pool hall' also had advantages for the drug squad. Raids on the building were commonplace, an accepted risk of its use; a good catch was always ensured. Police used a room across the street to take photos of the comings and goings; they once asked Jo to clean the windows because their photos were coming out blurred.

Then one day at the end of January, without any hint or warning, the 'pool hall' stayed closed, to re-open months later re-furbished as a casino. Now there is an entryphone on the door and admittance is strictly controlled. However, it is unlikely to be pure coincidence that on the day of closure the police were out in heavy numbers, stopping and searching all those who approached the building.

Scoring was back on the streets. One evening shortly after the closure, 20 plain-clothed and uniformed police (some with dogs) were active around the place.

The 'pool hall' was a dealing and scoring centre for some 18 months, and no doubt in the near future some new location will take its place.

Drug users who frequent such places are unlikely to be reached by advisers and helpers through normal channels, like drug agencies and youth clubs. Their centralisation, albeit at such informal markets, offers unique opportunities for all those interested in drug misuse prevention and drug education. Clearly, conflicting political, judicial, social, and professional interests make the legitimisation of these informal markets a non-starter. However, such places have a function, to a great degree incidental, over and above the one intended by the drug users themselves.

Robert Power is a Research Officer at the Drug Indicators Project (DIP). He is currently working on a three-year study of help-seeking among regular drug users.

MEDIA CAMPAIGNS

From the start, the government's anti-heroin campaign was controversial, opposed by 'experts' but favoured by politicians. Nick Dorn of ISDD's Research and Development Unit describes the background to the campaign and the evaluations of its impact, reminding those of us south of the border that a separate campaign has been underway in Scotland. This is the first in a short series comparing approaches to prevention north and south of the border.

Nicholas Dorn

The English and Welsh 1985/6 mass media campaign consists of two television commercials aimed at young people, plus advertisements in the youth press and a street poster. Commercial one, code-named *Control*, is a slippery slope story about a young man's loss of control. Commercial two, *Dummy*, features cardboard cut-outs of a young girl falling backwards with a loud crash, then talking, without enthusiasm, to camera.

Some television and print material were also prepared for parents, but take-up of these by the general population has been relatively poor, so they are less significant than the youth-orientated materials.

In mounting the campaign, the government passed over opinion in the fields of health education and drug misuse. In its *Prevention* report, the Advisory Council on the Misuse of Drugs had counselled against any national mass media campaign, especially one relying on fear. The government commissioned Andrew Irving Associates, a market research firm, to see if the Advisory Council's warning was soundly based. Irving's report gave the government the go-ahead to conduct a mass media anti-heroin campaign.

Unfortunately, the research was done so fast that neither a literature review of previous research nor the compilation of a set of relevant questions was feasible. The Health Education Council had wanted more time for research — a position which the Commons Social Services Committee subsequently described as symptomatic of a "lack of urgency".

Evidently, at a political level there had developed something approaching a consensus that the various 'experts' were out of touch and a campaign was needed *soonest*.

What sort of campaign?

According to Andrew Irving Associate's report, the aim of the English/Welsh campaign should be to build upon young peoples' existing beliefs about the "progressive decline" of the heroin user. Behind this aim lay the objective of convincing "those at risk ... of the undesirability, and dangers of heroin misuse".

Irving was, however, careful not to endorse a scare campaign, calling instead for a "a low key, honest, factual campaign". Whether this advice was followed in the development of the two TV commercials and other youth-orientated materials is a moot point.

The intended message in *Control* and *Dummy* is that heroin use leads to degradation. This degradation is presented in sex-specific ways: boys lose control, and girls lose their looks. Rough versions of the commercials were prepared by the Yellowhammer advertising agency and then tested by another firm, Cragg Ross and Dawson Research Partnership. Cragg Ross described the advertising prepared by Yellowhammer as "not low key but aims to be intrusive and compelling".

From the perspective of the general public, the government cannot fairly be described as having adopted 'scare' tactics. As all the market researchers discovered, most young people are very anti-drug in attitude, and they demand strong images and messages about heroin. For them a portrayal of heroin use is 'true to life' if it shows sunken eyes, double rings below; lank, unkempt hair; thin and wasted body; the downcast head.

A report notes that young people interviewed "spontaneously offered creative advice" to the ad-men, asking for spots and sores, pale yellowing skin, loss of possessions, and deterioration. Some of these popular stereotypes can be seen in the two English/Welsh commercials, where they serve as props to the loss of control theme. But the commercials stop short of more vivid portrayals of death and destruction.

This seems to be the balance struck between a factual approach on the one hand, and a full-blown scare approach on the other. Had the campaign followed the fantasies of the majority of adult respondents, it would have featured "youngsters injecting themselves, vomiting over themselves, shaking uncontrollably, lying in formless heaps, etc. Many youngsters believed the same thing. The popular feeling was that such images would be both unforgettable and very frightening".

Parents' leaflets: on the left, 'straight' information; on the right, how to 'spot' drugtaking and how to cope.

THE CAMPAIGN is not only an anti-heroin campaign as such — it is also an intended stimulus to parental and community self-help. As MP Sir David Price asked a witness before the Social Services Committee: "Could it be that the Department [of Health] have another objective — I do not know — and that is a general reassurance of the public that the government are doing something? Or would that be unfair?"

Sir David is correct, since Central Office of Information papers described one of the objectives of the campaign as: "to help convince them [the public] that heroin is, or should be, *their* concern; and to reassure them that the government is taking action". As part of the campaign there were magazine advertisements and TV commercials aimed at parents, inviting them to write off for pamphlets. *Control* and *Dummy* could be seen as helping to provide parents with sufficient interest and motivation to get involved in the national response to heroin and other drugs.

Whatever young people and parents might think of the government's campaign, it certainly caught the attention of TV programme planners (in a way that a purely parent-directed message might not have done) and generated a rush of programmes about young people and drugs. When thinking of the good or the harm that might result, one has to consider not only the government's own commercials but also the broader programming they have provoked.

Query over outcomes

What young people will make of the campaign in the longer term, and of the rising tide of media interest in which the commercials have become a relatively minor element, is an open question.

The government commissioned Research Bureau Ltd (RBL) to carry out a 'benchmark' survey of young people just as the campaign got under way, a further sampling in Autumn 1985, and a third measure in early Spring 1986. Their reports suggest there has been a strengthening of anti-heroin attitudes and beliefs. Their work has, however, been criticised on methodological grounds by DHSS Research Liaison Group referees.

The Autumn 1985 sample was, for example, less adventurist in several ways than that drawn in the preceding Spring, and this sampling difference *may* have contributed to some of their findings about

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Les Kay challenges drugs and preventi
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"Since the *Prevention* report[1] of the Advisory Council on the Misuse of Drugs (ACMD) in 1984, increasing resources have been devoted to preventing drug problems. The ACMD said prevention initiatives should *either* reduce the chance of someone using drugs *or* reduce harm from this use.

To date, most efforts have targeted the first option, and the most significant have been aimed at secondary school children through personal and social education. There has also been the publicity campaign launched by government through press and television.

Failure of these approaches means effort is now being directed to alternative approaches which focus on the community rather than the school. There has also been a shift from primary (reduction of use) to secondary (harm-reduction) strategies.

In what follows I explore some issues raised by these developments, first by presenting a six-point 'Prevention Charter' which might form the basis for our work in this area, then by listing some of the new prevention options suggested by this framework.

1 Admit we don't know how to prevent drug use

There is no evidence to demonstrate *any* behavioural change as a consequence of *any* educational strategy for reducing drug use or drug problems.

After reviewing approaches to education about drugs for adolescents, ISDD concluded: "none of these approaches have been shown to reduce either; 1) drug/alcohol experimentation, or 2) any type of harm that may be associated with experimentation, or 3) the chances of experimentation developing into heavy use, in the British situation."[2]

In the USA, the message is the same.[3]

The clear, unpalatable truth, is that *we don't know how to prevent drug use*. We should stop colluding in the fiction that better prevention strategies could solve the drug problem. Better to be honest and say we don't yet know how to do it.

We may also have to concede that it is just not possible. At the moment we are acting as if the prevention of drug problems *must* be possible. Prevention activities should be the product of scientific enquiry, not an act of faith.

2 Don't repeat mistakes

Many educational approaches have stumbled on the simplistic assumption that providing the right sort of knowledge will help restructure attitude, which in itself determines behaviour.

Behaviour is a much more complicated product of a range of factors than this model allows for. For example, it may be that behaviour can restructure attitudes, rather than the reverse.

Most smokers are aware of the harm being done to them. Probably most feel they should stop. But these views do not necessarily carry through to behaviour. Many go to an 'early' grave still holding those views *and the cigarettes*.

What is true for education in schools also holds for public education. The current advertising campaign emphasises the nastiness rather than the horror of drugs, an approach described in government circles as the 'chill factor'.

Once more psychological research has clearly demonstrated the pointlessness of these approaches based on manipulation of fear.[4] The government's own Advisory Council on the Misuse of Drugs has argued against a national campaign targeting one drug or any form of drug education that aims to scare.[5] Despite this advice, backed up by solid research, we plough on with the same old approach.

3 Controlled experiments only

Given the above, future attempts at preventing drug use can only be justified as innovative and carefully evaluated experiments. The main lessons we have learnt from previous evaluations have been methodological.

We realise the importance of measuring the impact of a specific programme at a number of points in time rather than just at the end. From work on smoking, we also understand the importance of the differing impact of prevention messages on different groups. Results from blanket programmes may hide what could be significant variations in their impact on these groups.

Our evaluation methods should also learn from the past and be sufficiently rigorous to produce reliable results.

4 Unshackle PSE from prevention

'Prevention' has itself been mystified. For example, we assume prevention and education are allied and supporting concepts. Prevention and education may instead be mutually exclusive, antagonistic concepts.

Current approaches to personal and social education (PSE) aim to enhance the power of young people to make their *own* decisions about important life events. Prevention assumes that we can set off with a set of objectives, which we can transfer to young people who will then adopt them as their own. But autonomous decision-making implies they will be able to resist not just peer group pressure, but *our* influences too.

We cannot logically demand that young people become more autonomous, *and* do what we want them to do.

Education should be about positive outcomes such as healthy lifestyles rather than narrow, negative, 'don't do it' messages. If we can unshackle PSE from prevention, teachers can get on with what they are good at, while we try to find other ways of preventing drug harm.

5 Expose hypocrisy

Among professionals, issues of relative harm from different forms of drug use have been adequately dealt with. Most will quickly recognise that problem drug use can embrace a wide range of substances, including legal drugs. But we are failing to translate these insights into the public arena.

For many people 'killer heroin' has assumed a demonic status. Yet harm from heroin use is miniscule compared to harm from 'killer alcohol' or 'killer tobacco'.

Rough estimates for the UK would suggest less than 150 deaths from heroin, up to 10,000 from alcohol, and about 100,000 from tobacco. Many more people drink or smoke than use heroin, but the assumption that we have 'killer heroin' and, by implication, 'safe alcohol and tobacco', bears no relation to the truth.

There are reasons why we have been hesitant to expose this hypocrisy. Most of our agencies are funded by a government which has put a relatively large amount of money into the field because of its concern about 'killer heroin'. Establishing in public that alcohol and tobacco are also major drug problems can be a risky business, threatening our continued professional survival.

Our understandable failure to confront these issues may well have become part of the problem. Turning the situation around will require consistent attention from us and a determination not to duck out of sight when the flak starts to fly.

6 Promote community harm-reduction

This is the element which opens up a whole new range of work. To date, we have done little to address the second of the two main objectives identified by the Advisory Council — preventing drug harm. I would argue this is because we have been bogged down pursuing the chimera of primary prevention, or prevention of the *use* of drugs. There is a vast, practically unexplored range of secondary prevention options designed to reduce *harm* from drug use.

In what follows eight such options are identified. Some of the issues and questions raised by each option are explored. One thread running throughout is the need for more useful local information on drug use,

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1. Advisory Council on the Misuse of Drugs. *Prevention*. London: HMSO, 1984. Available from ISDD, £4.25 inc. p&p.
2. ISDD Research and Development Unit. *Drugs in health education: trends and issues*. London: ISDD, 1984. Available from ISDD, £0.40 inc. p&p.
3. See for example: Moskowitz J. M. Preventing adolescent substance abuse through drug education. In: National Institute on Drug Abuse. *Preventing adolescent drug abuse: intervention strategies*. Rockville, Md: NIDA, 1983.
4. Leventhal H. Findings and theory in the study of fear communications. In: Berkowitz L. *ed. Advances in*

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workers to break out from ineffective
o explore new community approaches
be ready to face the flak.

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drug problems and the community's needs. Much of the work conducted so far has been based on some very questionable assumptions.

Public education/information

The tendency in the past has been to target youth as the main problem. But the assumption that more parents are damaged by their youngsters' illicit drug use, than there are youngsters damaged by their parents' licit use, may be completely wrong-headed. We simply do not know which is the more important problem.

This is clearly an important issue to resolve if we are to work out what we should be saying to whom about drug problems. We will need to learn, from our colleagues in youth and community work, the methods and issues involved in community consultation.

We also need to identify and key into local information systems. This will entail a much more systematic approach to work with organisations as diverse as community pharmacists, local libraries, tenants groups, advice centres, trade unions, service organisations, etc.

Diversion options

Once more there is a need to start from a survey of the whole range of drug-related problems in different groups and from people's expressed needs, rather than from our beliefs about what they might need. It would be easy to dream up what seem to us exciting and fulfilling activities to act as a diversion to bored young drug users. We may well miss the target completely.

We should also think about ways to allow the community to become more involved in decisions about services. There is a useful body of experience of neighbourhood consultations in programmes of local crime prevention conducted by NACRO.[6]

Our interests in prevention here dovetail with those of local authorities currently shifting the emphasis toward neighbourhood services.

experimental social psychology, volume 5. Academic Press, 1970.

5. Advisory Council, *op cit.*

6. NACRO Crime Prevention Unit. *Neighbourhood consultations: a practical guide.* London: NACRO, 1982. Available from NACRO at 169 Clapham Road, London SW9 0PU.

7. Thus Liverpool Health Authority's employment policy on *Procedure in relation to problem drinkers* (sic) starts with the assertion that: "The authority recognises alcoholism as an illness and will make every reasonable effort to ensure that employees suffering from this illness are supported."

Social action

Treatment agencies indicate that many of their clients are in acute housing need, unemployed and suffer chronic financial problems. To reduce drug-related harm we could look towards housing, unemployment and welfare rights options as an alternative or supplement to individual treatment, taking care not to pathologise social deprivation itself as a treatable condition.

This raises questions about whether our responses should be specialist or generic. For example, should we be arguing for special employment projects for drug users, or trying to open up existing employment provision?

Campaigning

Targeted campaigns could be launched at district level. For example, reducing the prescription of tranquillisers could involve work with GPs and the public, and with the media. Self-help groups for tranquilliser users would need to be set up or supported, taking us into liaison work with clinical psychologists, local voluntary agencies, tranquilliser users themselves and staff from primary health care teams.

Local campaigns could also work directly on the hypocrisy of tobacco and alcohol advertising. In many cases government *Heroin Screws You Up* posters have been sandwiched between adverts promoting alcohol and tobacco. Many local authorities supporting the new drug initiatives receive financial support from alcohol and tobacco interests.

Here we should be working much more closely with colleagues in tobacco and alcohol campaigning agencies.

Casualty-reduction

There are still many myths believed by drug users about, for example, overdose, how to treat a coma, AIDS, and other infectious diseases. Should every drug user we come across be given a package of first aid advice? What should it be? What sort of literature do we need and is there a need for further training? At whom should a casualty-reduction message be aimed? What should be its content?

Experience suggests these initiatives may attract opposition from those who interpret casualty-reduction efforts as encouraging drug use. This should not deter us, but should inform the wording and targeting of our efforts.

Early intervention

The major obstacle to greater *community* involvement in early intervention is the mystification of certain forms of drug use.

Most people have been led to switch off their common sense understanding of life's difficulties when confronted by drug problems. Parents who take in their stride the teenager coming home drunk on cider, recoil in horror when they come home intoxicated from glue. Reactions if heroin is involved vary from a door slammed in the face to cardiac arrest.

A major objective of our community education/awareness activities should be to dispel this mystique. We should help people to recognise and value the understanding and skills they have from their own use of drugs. There is a great deal for many people to learn from their struggles to get by in an increasingly brutal and uncaring world.

Changing the climate

To turn round public debate from hysteria to rational discussion, we will need to address the media and local opinion leaders who shape public discussion.

We have been reactive, often rightly criticising press articles emphasising the horror, depravity and hopelessness of drug problems, but ourselves failing to provide a positive alternative. To change the climate we will need to take a more pro-active approach, identifying and cultivating key journalists to whom we can promote positive messages of success and progress by individuals and organisations.

This implies developing expertise in media relations. Working parties might be set up at national (SCODA has already done this), regional and district level, perhaps involving journalists and editors.

Some of the most powerful local opinion leaders are local politicians, business and trade union leaders, church people and members of local service and community organisations. Such people can be reached through developing a more community-oriented training programme at district level.

Workplace policies

In the workplace we have to start with the sometimes unhelpful legacy of alcohol policies. It has often been assumed, in my view mistakenly, that it is necessary to revert from the 'problem drinker' model to a disease model,[7] in order to persuade managements to deal with the issue compassionately.

The result is that workplace alcohol policies have often concentrated on the *consequences* of use rather than the *causes*. With both alcohol and drugs there is a wide range of issues which can lead to problem drinking/drug taking, including conditions of work such as isolation, lack of job security, overwork, boredom, etc.

These are all bread and butter issues for trade unionists and managers. Those concerned with alcohol policies have been led away from addressing these issues by the re-introduction of the disease model. In developing new drug policies we will have to break out of this blind alley.

IN THE OPTIONS above I have done little more than identify some of the questions. The range of issues yet to be adequately discussed is so large because we have yet to engage seriously in these discussions.

It *is* sensible to proceed with care to avoid repeating previous blunders. However, as Groucho Marx once said: "If you don't stand for something, you'll fall for everything." Many of us have been reluctant to stand up clearly for anything and are now in danger of ending up immobilised by fear of making further mistakes.

Planning is needed, but we also need to address some key areas immediately. In the North West a start has been made in exploring, demonstrating and evaluating new prevention options in small-scale experimental programmes. These might provide a model for others to develop.

There is clearly a need for much more discussion and debate about the relative merits of various approaches. Hopefully these notes will stimulate a response which furthers such a discussion.

RECENT TRENDS IN DRUG USE IN BRITAIN

How many? what? how? — simple questions about drug use with no simple answers. Research from the Drug Indicators Project has helped fill the information vacuum. Project co-ordinator Richard Hartnoll sketches recent developments in the pattern of drug use in Britain.

Richard Hartnoll

Recent trends in problem drug use should be viewed against wider socio-economic, cultural and political events in Britain. Economic growth, rising living standards and relatively full employment of the 1960s and early 1970s has given way to recession and economic stagnation. Unemployment has risen sharply, more so among the young, the unskilled and minority groups. Many inner-city areas have experienced steady deterioration in housing conditions, transport and other services.

Over the same period, the youth culture(s) of the late '60s and early '70s disintegrated, loosening informal constraints which helped define what drug use was acceptable to particular groups and what was not. Optimism has been replaced by cynicism, despair and anger, particularly among the young, unemployed working class and minority groups. Ageing 'hippies' have few options left.

Such a sketch of Britain sliding deeper into gloom is neither complete nor 'balanced'. Nor is it a sufficient explanation of problem drug use — the rapid expansion of non-medical drug use in the 1960s occurred at a time of boom. But it does provide part of the background against which some groups and individuals start or continue to use drugs.

This brief account of recent trends in non-medical drug use in Britain is based in part on our own research in London[1], in part on the available research and statistical evidence, and in part on experiences from around the country. Different regions of the country present a variable picture.

Cannabis

Cannabis is the drug most commonly used for non-medical purposes in Britain. Use increased dramatically during the early 1970s, may have stabilised in the mid-1970s and has since steadily increased. Eight out of ten drug seizures and convictions involve cannabis, usually small amounts.

Since the '60s cannabis use has diffused across all classes, though it is most common in the under-40s. In line with this development, cannabis use no longer functions as a symbol of affiliation to an 'alternative' culture.

Good quality 'hash' (cannabis resin) retails at around £20-£28 per quarter ounce; for some regular users this might last less than a week. Due to increased cost, cannabis is now bought in smaller quantities than it was ten years ago, a fact which may imply less heavy use by the majority of users.

*Richard Hartnoll and co-workers at the Drug Indicators Project have been researching the extent and pattern of problem drug use in north London since 1980. Their work has been the main source of recent government estimates of the prevalence of opiate use in Britain. The Project has published a manual — **Drug problems: assessing local needs. A practical manual for assessing the nature and extent of problematic drug use in a community** — available from ISDD at £5.75 inc. p&p.*

Cocaine

During the 1960s, cocaine use was largely restricted to heroin addicts receiving both drugs on prescription. After treatment of heroin addiction was transferred to special drug dependence clinics (in 1968), cocaine became relatively uncommon.

During the mid-1970s, cocaine gained popularity, especially where there was style, champagne and money. Cocaine also became widely used — though usually on an intermittent or occasional recreational basis — by a broad section of the drug using population from all classes. It is usually sniffed — smoking of freebase[2] is not common.

During the mid-1970s, cocaine gained popularity, especially where there was style, champagne and money.

Cocaine sells for £55-£70 per gram (typically 30 to 70 per cent pure). A couple of casual users might consume a quarter gram in an evening. Regular users with sufficient resources might use one to two grams a day. Since 1983, prices have fallen while Customs seizures have markedly increased. Coupled with fieldwork observations, these indicate increased supply, though not perhaps as dramatic as some American-inspired reports suggest. It is not used extensively by adolescents and is probably more common in London and the South.

Amphetamines

Amphetamine stimulants, once widely used for both medical and non-medical purposes, are rarely prescribed today. During the early and mid-1970s, illicitly manufactured amphetamine sulphate powder became available and fairly widely used. In the late '70s, it might appear from enforcement statistics alone that amphetamine use dropped considerably, but it remained available on the street, though at a higher price. Recent statistics suggest a considerable increase, an impression confirmed by fieldwork and a fall in price, indicating large quantities on the illicit market.

Amphetamine powder is usually sniffed; the exceptions are some opiate injectors and that group of multi-drug users who commonly inject opiates, barbiturates and stimulants. Although seemingly more of a working class drug than most controlled drugs, amphetamine is nevertheless used by various groups throughout society.

Amphetamine is common in some colleges, studios, construction sites, and in the music business. In some of these groups it it used as an aid to maintaining long periods of concentration or physical work, in others purely as a recreational drug. A minority of individuals are compulsive users. After cannabis, amphetamine is the drug most commonly used by adolescents.

Amphetamine sulphate powder 20 to 40 per cent pure retails at around £10-£12 per gram, similar to the price ten years ago. A compulsive user might get through several grams a day, while a casual user with no substantial tolerance to the drug's effects could take several weeks to consume half a gram.

LSD

Widely used in the late '60s and early '70s, LSD became less apparent through the '70s, though there are indications that use is increasing again. As with other controlled drugs, LSD has lost much of its mystique, and is now used less as a self-conscious instrument of 'mind-expansion' than as simply a 'fun' drug, a trend associated with the dissolution of the '60s 'counter-culture' movement.

Although used more casually than in the '60s, LSD is supplied, and therefore probably used, in units of lower average strength. Today a single, usually weak, dose of LSD costs around £2-£3.

Barbiturates and tranquillisers

During the early 1970s, barbiturate use by heroin addicts and young multi-drug users aroused particular concern. Changes in prescribing practices have steadily reduced availability, but 'barbs' remain a problem among some heavy multi-drug users. The sources are still physicians, pharmacy thefts and diversion from legitimate prescriptions. There is no evidence of illicit manufacture. In London, barbiturate use is now largely restricted to the more chaotic, multiple drug use scene in the centre of the city.

Attention has rightly been focussed on the issue of long-term prescribing of tranquillisers. However, they are also used as 'street drugs', replacing 'barbs' in poly-drug combinations.

Solvents

Glue sniffing gained much publicity a few years ago. Since solvent use is not illegal and is not recorded in any systematic way, it is hard to know its extent. It is likely that there has

been an increase, both in experimental use (which may involve quite high proportions of adolescents) and in regular use, and that this has *not* diminished in recent years. One change in some areas is a switch from glue to butane gas.

Solvent use appears to be concentrated in particular areas, such as an estate or a school (this may be partly an artefact of selective reporting), often fading quickly in the manner of other adolescent fads and reappearing elsewhere. A minority of youngsters 'at risk' because of personal, family or social difficulties, become heavily involved as a means of coping with their problems, rather than as the more common transient social activity.

Heroin

Heroin addiction first appeared as a 'problem' in Britain in the 1960s. The number of known addicts increased dramatically, though the absolute numbers were, by current standards, small. Excessive heroin prescribing by a small number of doctors was virtually the exclusive source until 1968, when heroin prescribing for addiction was restricted to licensed doctors, based in special drug dependency clinics or psychiatric units.

The early and mid-'70s witnessed a relatively small growth in heroin addiction. Illicitly imported heroin from South East Asia became the major source as heroin diverted from legitimate prescription became more scarce. Police activity and a later series of bad harvests appear to have temporarily limited supply, and prices rose steadily until 1977/78.

The first major increase in heroin supply was partly associated with the influx of Iranian refugees following the fall of the Shah. Since 1981, Pakistan and Afghanistan have become the primary source.

Since 1970, the number of people using opiates regularly has risen, probably by at least ten-fold. The primary drug involved is heroin.

The current price of illicitly imported heroin in London is £80-£100 per gram (typically 30 to 60 per cent pure) in gram quantities. In larger quantities (eg, a quarter ounce, approx seven grams) the price is lower, perhaps £60 per gram. Relative to inflation, the price has halved since 1978, though since late 1985, it has started to rise again. Prices are higher in other areas, such as Scotland.

Opiate addiction treatment clinics have reduced their prescribing of heroin. In 1977, 19 per cent of addicts attending London clinics received some heroin; by 1984, this had dropped to six per cent. Over 70 per cent of addicts attending London clinics received oral methadone only in 1984 compared to 29 per cent in 1977. Most of the remainder received ampoules of methadone for injection (21 per cent compared to 52 per cent in 1977).[3]

Since the late '70s, the incidence and prevalence of heroin use and addiction, as recorded by the Home Office and supported by numerous informal sources, have increased significantly. Illicitly imported heroin has become much more available. Intermittent, recreational use of heroin (usually sniffed or smoked rather than injected) has become more widespread.

Until 1980/81, heroin users and addicts were more likely to be in their mid- to late-20s or 30s than in the '60s, when heroin use was predominantly an adolescent/early adult phenomenon. Since then much younger people have become increasingly involved, and the proportion of females among known addicts has increased to 30 per cent.

Increased availability and use has been particularly noticeable outside London, especially in large urban conurbations such as Merseyside, Manchester, Edinburgh and Glasgow. It has also continued to increase in London. In the more depressed parts of some cities, heroin use appears to be developing into a pattern usually associated with the ghetto conditions in some North American cities. The major difference is that heroin use in the UK is still mostly restricted to the white British or Irish population. However, it appears that the situation in some black or other ethnic groups may now be changing, though information is not readily available.

As well as increasing in some working class urban communities, heroin use has expanded throughout a wide range of social groupings, including the children of the middle and upper classes.

A much smaller proportion of the total addict population is in treatment than 15 years ago. Then about half the heavy opiate users in Britain were seen and notified by doctors; now the proportion is likely to be a quarter or less. This implies that the total number of people in the UK who used opiates regularly (and were dependent, at least to some degree) at some stage during 1985 was in the order of at least 60,000 and perhaps 80,000. The numbers using regularly at any one time ('point prevalence') would have been lower, at least 30-35,000.

In London, the rate of increase of new heroin users may have levelled off.

Synthetic opiates

Use of synthetic opiates illegally 'diverted' from the legitimate medical market has remained relatively stable. They are used both as drugs of choice and as substitutes for heroin, though heroin's increased availability has diminished their relative importance.

Methadone is prescribed to addicts in treatment at drug clinics, and by physicians outside hospitals under circumstances that may or may not be considered part of a treatment programme. Since stricter prescribing controls imposed in 1984, Diconal use has diminished, but use of codeine and DF 118 appears to have risen.

Despite controversy over the prescribing of synthetic opiates, there can be little doubt that heroin is the major opiate involved in non-medical use.

Multi-drug use

Multi-drug use has become more widely recognised since the '60s, though this change may have as much to do with perceptions as with drug using behaviour, which for a long time has often included more than one drug.

THE MAIN FEATURES

- ► Since 1970, the number of people using opiates regularly has risen, probably at least ten-fold. Most of the increase has occurred since 1978. The primary drug involved is illicitly imported heroin. This increase may now be slowing down.
- ► The illicit drug market has expanded, especially for cannabis, heroin, amphetamine sulphate and cocaine. Sums of money involved have increased dramatically. It has also become more organised and attracted the attention of criminal groups who, several years ago, would not have wanted to become involved. This is particularly true of cannabis and amphetamine, and, in the past five years, of heroin.
- ► Very few addicts now receive heroin on prescription from drug dependence clinics. Methadone is usually prescribed instead. A few years ago, most methadone was prescribed in injectable form; now most clinics prescribe oral methadone only to the majority of new patients or to patients returning into treatment.
- ► Private doctors and GPs have re-emerged as a source of opiates other than heroin. Methadone and DF 118 are the most commonly prescribed (legal restrictions on prescribing to addicts apply only to heroin, dipipanone and cocaine). Similarly, prescriptions are the original source of most barbiturates and of some stimulants such as dexamphetamine, diethylpropion, Ritalin, etc.
- ► Boundaries separating subcultural patterns of drug use became blurred as the 'youth cultures' of the late 1960s and early '70s disintegrated. Multi-drug and combination drug use have become more apparent. Dealers are more likely to supply a variety of drugs, although some still supply only cannabis as a matter of principle.
- ► Younger drug users appear to be using cannabis, solvents, amphetamines, pills such as Valium, and alcohol. Apart from alcohol, these are inexpensive and unlikely to lead to convictions for drug offences, though the consequences of use may still be disturbing. In the past five years, a minority have started to use heroin. In areas such as Wirral or Glasgow, this is a substantial minority.
- ► Cannabis ('ganja') is integral to the culture of significant parts of black communities. Among Asian communities drug use is less apparent, though there is some opium and cannabis use. Depending on their degree of integration into British culture, other ethnic communities have assimilated to the general pattern of drug use in Britain. There are recent suggestions of some heroin use among blaek and Asian communities.

1. Hartnoll R., Lewis R., Mitcheson M., *et al.* Estimating the prevalence of opioid dependence. *The Lancet*, 1985. *I* (8422) p.203-5.
2. Freebasing cocaine involves chemically converting cocaine hydrochloride so that it can be smoked through a pipe, a route of administration that gives a much more immediate effect than sniffing. However, this is an exceptionally expensive method of taking cocaine.
3. Galton I. *A review of prescribing practices amongst London drug dependence clinics 1977-1984.* Unpublished. Middlesex Polytechnic, 1985.

DOCTORS AT WAR

The government's decision not to extend legal curbs on prescribing to addicts leaves two ways of enforcing control on 'errant' doctors. In the second part of a two-part article, Mike Ashton of ISDD describes how these have recently been put into effect, as doctor opposes doctor over proper practice in addiction treatment.

Mike Ashton

In the last issue of *Druglink*, we recounted how recommendations from the Advisory Council on the Misuse of Drugs (in their *Treatment and rehabilitation* report), which would have banned most doctors from prescribing opiates for addiction, were turned down by the government. But there are still at least two ways of 'eliminating' the individual 'injudicious' prescriber.

In 1982, as the Advisory Council's report recommending prescribing controls was being written, an Uxbridge doctor was struck off the medical register for allegedly prescribing Diconal "on demand" to private patients. His unorthodox treatment of addiction had been judged "serious professional misconduct" by the General Medical Council's Professional Conduct Committee, the medical profession's own disciplinary authority. In 1983, two doctors treating addicts privately in central London were similarly dealt with, the first a 'Harley Street' doctor said to have been "motivated by greed", the second, a Soho practitioner "misled by the enormous financial rewards".

All three cases involved addict patients who had died, reflected in headlines such as "Doctors Who Trade in Misery", "Dr Death" and "Victims of the Pusher Doctor". Alongside the professional push towards prescribing controls there developed a veritable press campaign against the prescribing doctor — "How Doctors Feed the Heroin Black Market", a London *Standard* headline in November 1982, typified the theme.

Between 1972 and 1984 the GMC's Professional Conduct Committee acted against 38 doctors for improper prescribing, of whom 17 were in private practice.[1] In July 1983 they made probably their most significant decision, the fallout from which led the GMC's president to defend its actions in the medical press:[2] the leader of the Association of Independent Doctors in Addiction was admonished for serious professional misconduct in her treatment of an addict patient.

Leading 'independent' disciplined

In November 1981, Dr Ann Dally organised the meeting which founded the Association of Independent Doctors in Addiction (AIDA), "a forum for doctors in both NHS and private practice who encounter addicts outside the clinics". A 'Harley Street' (actually, Devonshire Place) doctor specialising in psychiatry, Dr Dally became the Association's first president. In numerous interviews and articles in the medical and national press, she condemned the "drug dependency establishment" for its 'inflexible' and 'restricted' approach to treatment.

From the start AIDA emphasised its commitment to "high standards of practice" in the treatment of drug dependence. It came as a shock when the treatment offered by the Association's president to a Diconal addict living in Coventry, was condemned by the medical profession's disciplinary panel.

Dr Dally was charged with prescribing "otherwise than in the course of bona fide treatment", amounting to "serious professional misconduct". The fact that the charge was found proved and the defendant involved have been seen as signalling a significant extension of the GMC's role in controlling prescribing.

"The practitioner owes a duty not merely to the patient but also to the public into whose hands such drugs may fall"

After the last wave of concern over prescribing in the '60s, it had been established that the GMC had very limited powers. Proof of mistaken, negligent, excessive or even reckless prescribing was not enough. It had to be proved that the doctor did not even believe this was the right treatment ('bad faith'), and that their conduct amounted to serious professional misconduct — issues of interpretation, rather than fact. Dr Dally's case illustrates how far the committee is now prepared to go in interpreting imperfect or risky addiction treatment as professional misconduct. Whether the judgment was 'right' or 'wrong' is not at issue here — it is what the judgment means in the struggle over prescribing controls that concerns us.

LEGAL ADVICE to the committee hearing Dr Dally's case defined two criteria which, if either were satisfied, would mean prescribing was not bona fide treatment. The first, prescribing without honestly believing this was the right treatment for the patient, was the accepted basis for disciplinary action.

The second criterion for non-bona fide treatment, prescribing in the knowledge that the drugs might be sold on the illicit market, but "not caring" if this happened, was more of an innovation, and appears to have formed the substance of the successful case against Dr Dally. In the words of the prosecuting counsel, the "practitioner owed a duty not merely to the patient who was being treated but also to the public at large, that is to say, those into whose hands such drugs may fall . . . ".[3]

Later the *Lancet* carried a barrister's opinion that the evidence against Dr Dally "seems to fall well short of proof of lack of good faith".[4] In the same issue, an editorial spoke of "bewilderment" among journalists and observers at the hearing's decision to admonish AIDA's leader, commenting that "the evidence did not emerge as compelling".

Britain's other leading medical journal published the views of a well-known GMC member and medical author. His colleagues on the GMC had, he said, stuck to the rules. But observers might understandably have got the impression "that this was a political trial in which the 'establishment' was out to 'get' Dr Dally because of her heretical views . . . I wonder if without the background political noise a case which in the end the GMC adjudged to amount to 'reckless' prescribing for one patient would have reached the council chamber for the full ritual of a 'public trial'".[5]

It took the Professor of an American School of Justice to draw out the wider implications. Long an admirer of the 'gentle' British approach to addiction, Professor Trebach feared the GMC "may well have cut out a major piece of the heart of the most civilised system of drug abuse treatment in the world". As he saw it, the judgment had interpreted a genuine disagreement over appropriate treatment as 'bad faith' on the part of the dissenting doctor. Tolerance, flexibility, reliance on the doctor's judgment, qualities at the heart of Trebach's romantic vision of the 'British system', were now under threat.[6]

GMC lays down the law

Professor Trebach's prophecy may be premature, but the decision against Dr Dally does represent a tougher line on addiction treatment. The GMC's submission to the recent Commons Social Services Committee investigation confirmed their willingness to act against doctors whose prescriptions find their way on to the illicit market, and added that 'irresponsible' as well as dishonest prescribing could be subject to disciplinary procedures (see box).

What emerges from the controversy and confusion is that the GMC believes doctors treating addicts must have regard, not just to whether the treatment is right for their patient, but whether any drugs of dependence they prescribe may be redistributed and harm other members of the public. In any particular case the issue would be whether the doctor gave due weight to this possibility, a difficult judgment to make.

Since the majority of addicts in treatment sell some of their prescription, a severe interpretation of this criterion might

land even clinic doctors in trouble. Chief Inspector Spear of the Home Office Drugs Branch has recalled a time in the '70s when clinic doctors became alarmed at the increasing street availability of injectable methadone, "but their proposal that general practitioners should be advised against prescribing methadone by injection for addicts had to be dropped when a survey by the Home Office . . . demonstrated beyond doubt that the major sources of the surplus were the clinics themselves and not general practitioners".[7]

EVEN IF THERE is to be no extended licensing system through which to firm the *Guidelines* into rules, the GMC has eagerly seized on the advice from the Medical Working Group[8] as a yardstick for deciding what is, or is not, acceptable medical practice. Speaking to the Social Services Committee, the chairman of the GMC's disciplinary committee admitted "there was . . . a little difficulty in dealing with these cases, that a professional was in a position to argue regarding the validity of the treatment he used . . . the great advantage with this particular document is that we now have . . . the corporate view of what constitutes proper practice in this field . . .".[9]

For the GMC, in some respects the *Guidelines* did not go far enough. Their 1985 annual report commended the *Guidelines*, but also publicised "the serious view taken by the Professional Conduct Committee of evidence that a doctor has prescribed opioid drugs to addicts in private practice where the financial circumstances of a patient were such that he would have needed to sell part of the drugs prescribed in order to cover his expenses in obtaining them, or where the fees charged have varied according to the amounts of drugs prescribed."

The tribunals

Because the medical profession's disciplinary committee was thought unable to act without evidence of bad faith, the Misuse of Drugs Act allowed the Home Secretary to withdraw a doctor's authority to prescribe controlled drugs on proof of irresponsible prescribing. The interpretation given to this charge has officially been described as "narrow" and "legalistic", whilst a Home Office drugs inspector has described the procedures as "rusty" and "creaky". Charges of irresponsibility are referred to a tribunal and then (on appeal) to an advisory body, each body consisting of a legal expert plus doctors appointed by the government.

In the years from 1971 to 1984 the tribunals sat just 15 times resulting in 12 doctors losing their right to prescribe all or some controlled drugs. Half these decisions were made by tribunals sitting in 1983 and 1984, evidence for the Home Office's claim that procedures had been streamlined. There is also evidence of greater urgency — the shortcut procedure allowing a temporary prescribing prohibition at short notice was used three times in 1984, but only once in the preceding years.

Responsibility for investigating alleged cases of irresponsible prescribing and instigating tribunal hearings lies with the Home Office Drugs Branch. In evidence given during Dr Dally's hearing, the Branch's Chief Inspector emphasised that "overprescribing" could not be equated with "irresponsible" prescribing. Despite civil service discretion, the Drugs Branch is known to be concerned that addiction treatment in Britain may become counter-productively inflexible.

"The great advantage with this document is that we now have the corporate view of proper practice in this field"

In an intriguing reversal of roles, the Home Office now opposes the medical establishment's push for blanket restrictions on prescribing, whereas in the 1920s it was the medical establishment that successfully resisted Home Office pressure to outlaw maintenance prescribing, setting ground rules for the 'British system' that lasted unchanged until 1968.

THE EVIDENCE

With important policy issues and the central medical principle of clinical freedom at stake, medical politics and outraged ethical and moral responsibilities heightening emotions, but little more than uninformative official statistics to go on, research evidence on the medical response to addiction in Britain has become almost as much a subject for dispute as the issues it pertains to.

Both arguments reached a high point in the summer of 1983, just months before Dr Dally was called to account before the GMC. "For debate . . ." said the *British Medical Journal*'s lead-in to an article unambiguously titled "Unacceptable face of private practice: prescription of controlled drugs to addicts".[10] A report of a study conducted by two prominent drug dependency unit consultants, the article did indeed provoke supportive and critical comment that ran to greater length than the original.

THE TWO DOCTORS had given 100 of their patients a questionnaire to complete. All 18 questions sought the patients' views or experiences of "private doctors". Two paragraphs in the two page report briefly reported findings from what appears to have been five of these questions, most answered by less than half of the patients in the study. This partial report painted a black picture of some private prescribers' willingness to 'sell' prescriptions for large amounts of injectable drugs, some of which were later resold to help pay doctors' and chemists' fees.

"It is questionable whether it is ever desirable to prescribe controlled drugs to an addict when a fee is paid," was Drs Bewley and Ghodse's comment on their findings. "If neither the General Medical Council nor a tribunal . . . can stop these practices, then extension of the present licensing system to include all controlled drugs . . . is probably the only way that this can be achieved."

'Propaganda' accusation

" . . . the *BMJ* has published propaganda disguised as a scientific paper"[11] was the reposte from an AIDA member. Together with Dr Dally's husband,[12] he highlighted the methodological faults in the research.

A glance at the questionnaire shows at least some of the criticism is justified. Large parts are left unreported, there are leading questions, failure in places to ask the same questions about clinic doctors and private doctors, and invitations to respond with hearsay about the actions of private doctors rather than experiences.

But the fact that more addicts are choosing to turn to 'independent' doctors rather than clinics suggests the central finding — that some private doctors are more 'generous' prescribers — is along the right lines. Answers given by Bewley and Ghodse's patients suggest there may be more acceptable reasons too — 16 out of 38 said addicts went to private doctors because they were treated better, whilst 37 out of 41 mentioned avoidance of clinic regulations.

Predictably, conclusions drawn from these facts were at variance. Bewley and Ghodse argued that the private doctors needed to change or be controlled, others argued that the clinics needed to change to become more attractive to addicts.[13] Far from helping to settle the issue with objective facts, the research simply added fuel to the fire.

THE SAME FATE befell Dr Angela Burr's observations on the illicit market for prescribed opiates in the West End of London. Her admittedly "informal observations" suggested that between 1981

"The Council has hitherto eschewed the promulgation of specific views on the correct regime of treatment for a particular condition . . . Nevertheless, disciplinary inquiries . . . have all too plainly demonstrated the special hazards of medical practice in the field of prescribing to addicts . . . The prescribing of opioid drugs to addicts, unless it is strictly controlled by the practitioner, may foment the growing problem of drug abuse, by increasing supplies to the illicit drug markets, rather than achieve the therapeutic aims of control, alleviation and detoxification. In the public interest, the Committees have felt bound to take a grave view of cases where it was proved that a doctor had undertaken such prescribing irresponsibly or otherwise than in good faith."

The General Medical Council's submission to the Social Services Committee, session 1984-85

and late 1982, more non-clinic doctors had become prepared to prescribe larger quantities of drugs to addict patients — the result, a "thriving market in pharmaceutical drugs from the overspill from doctors outside drug dependency units . . . ".[14] Her conclusion supported Bewley and Ghodse's urgings: " . . . the situation gives cause for concern and would appear to need urgent attention".

AIDA members were quick to reply. Without denying some private doctors were overprescribing, their letters to the *BMJ*[15] ridiculed concentration on the market for prescribed opiates in Piccadilly at a time when "the main black market is in smuggled heroin which surrounds us in every town and is too big to have a centre of exchange". Such 'doctor bashing' — a phrase headlined last year in *Hospital Doctor* to describe the campaign to curb prescribing — was portrayed as an "irrelevance" which "diverts attention from the real issue".

Swings and roundabouts

Concern over prescribing for addiction currently centres on the possibility of surplus supplies being re-sold by the patient, causing physical damage and addiction among other drug users. There remains the issue of which prescribing regime is best for the patient.

Richard Hartnoll and fellow workers at a London drug clinic compared outcomes for a group of heroin addicts prescribed injectable heroin in the early 1970s, as opposed to another group prescribed oral methadone.[16] The study tested a prescribing regime (injectable heroin maintenance) likely to be more common if some of the physicians in AIDA had their way, against one (oral methadone maintenance) favoured by many clinics. How did they compare?

"A decision to prescribe intravenous heroin for maintenance involves clinical, ethical and political judgments"

A year after coming to the clinic, nearly three-quarters of the group given heroin were still in treatment. In contrast, the attractions of oral methadone retained less than a third. But although the heroin group remained in treatment, for most the effect of this treatment seemed minimal. They continued to obtain illicit drugs, remained unemployed and generally maintained a 'junkie' life style, though perhaps less extreme than before.

The group offered only oral methadone tended to react either by becoming very deeply involved with the illicit drug scene, or by abandoning opiate addiction altogether. Most decided to continue their habit, and inevitably had to remain more deeply immersed in the drug subculture than they might have been had the clinic agreed to provide heroin on prescription.

The study indicated that the choice between methadone and heroin must be made more on a 'swings and roundabouts' basis, rather than on the basis of any definite overall advantage. In turn this means that the decision will be influenced by the priorities assigned by prescribers to various outcomes.

This kind of trade-off led the authors to comment that "a decision to prescribe intravenous heroin for maintenance involves clinical, ethical, and political judgments".

LIMITED GAINS

Now the dust has settled, what has been the impact of the original 1982 Advisory Council recommendations and subsequent events on prescribing controls? The answer must be, not nearly as much as many Council members would have wished.

- ► Licensing restrictions have been extended, but only to dipipanone, not to all opiate-type drugs as recommended. Now only licensed doctors can prescribe heroin, cocaine or dipipanone in addiction treatment, but any doctor can prescribe other heroin-substitutes, such as injectable methadone.
- ► Guidelines on good practice have been produced and disseminated, a notable achievement in itself. But they have not been universally accepted, nor do they stipulate that non-specialists should always work with specialist services before prescribing controlled drugs to addicts. Liaison is advised only with respect to long-term prescribing.
- ► Without extended licensing, there is no direct means of enforcing the guidelines or of obliging GPs to work under the supervision of specialist doctors. Nevertheless (as hoped for by the Advisory Council) the General Medical Council appears willing to use the guidelines as a yardstick in disciplining doctors, though their powers to do so are limited.
- ► The Misuse of Drugs Act tribunals and the General Medical Council's Professional Conduct Committee have become more active in disciplining 'injudicious' prescribers. The GMC in particular is keeping a close eye on the ethics of private prescribing in addiction. But neither body is constituted in a way that would allow action against those whose prescribing appears excessive, unwise or mistaken, but not irresponsible or unethical.
- ► The 'climate of opinion' in the country is not decisively against maintenance prescribing, even of injectable heroin — the debate is still alive. Short-term prescribing of oral drugs may have gained favour in the clinics, but it has not yet become a secure and universally accepted feature of addiction treatment policy in Britain.

SINCE THE 1970s, a smaller proportion of addicts (estimated at one fifth or less) are seeing any doctor in the treatment of their addiction, and a smaller proportion of these are being seen by the specialists in the clinics (just 31 per cent of addicts notified during 1984). At the same time the major source of illicit opiates in Britain has overwhelmingly become the illegal importation of heroin rather than overspill from the prescribing doctor — nearly 90 per cent of addicts notified during 1984 were addicted to heroin, as opposed to less than 60 per cent ten years before.

These facts make whatever doctors decide to do with addict patients less significant in the overall sweep of drugs policy than in the days when most addicts were in treatment, and doctors' prescriptions fuelled an alarming escalation of adddiction. But the symbolic significance of how Britain allows and/or encourages its doctors to treat addicts remains potent, as does the impact of that treatment on the individuals involved.

Should Britain's doctors practice 'tough love' policies on addicts who won't stop taking drugs, and should addiction treatment be taken out of the hands of doctors who refuse to toe the line? Should a lifetime opiate prescription be available to any addict who can persuade an inexperienced family doctor this is the only way they can be helped? Thanks to the government's decision not to extend licensing, these kinds of question are very much alive. After all the battles, it is still up to the individual doctor to decide to a degree unknown and unacceptable in many other countries. Even if the natives like to deny there is (or ever was) a 'British system', it must still seem almost intact to observers from more regulated lands.

"It is questionable whether it is ever desirable to prescribe controlled drugs to an addict when a fee is paid"

1. See GMC's evidence in: *Misuse of drugs with special reference to the treatment and rehabilitation of misusers of hard drugs. Fourth report of the Social Services Committee session 1984-1985*. London: HMSO, 1985.
2. John Walton, *British Medical Journal*, 29 October 1983, page 1300.
3. Transcript of General Medical Council Professional Conduct Committee proceedings 5 and 7 July 1983.
4. Diana Brahams. *Lancet*, 22 October 1983, pages 979-981.
5. Michael O'Donnell. *British Medical Journal*, 1 October 1983, page 990.
6. A later GMC disciplinary decision suggests this apocalyptic prophecy has not yet come to pass. Just three British doctors can still prescribe heroin for addiction outside NHS hospitals. One also prescribes heroin from his NHS hospital clinic in the London area. This surviving fragment of the pre-'68 'British system' came before a GMC disciplinary hearing in July 1985. Although judged to have prescribed heroin "in an irresponsible manner" by not adequately examining and monitoring the patient, the doctor escaped a finding of serious professional misconduct. In this case there was proof that the patient had actually sold some of his prescription.
7. Spear H.B. British experience in the management of opiate dependence. In: Glatt M.M., Marks J. eds. *The dependence phenomenon*. Lancaster: MTP, 1982.
8. The Medical Working Group on Drug Dependence set up by the DHSS produced *Guidelines of good clinical practice in the treatment of drug misuse*. These advised doctors on how (and how *not*) to treat opiate addicts.
9. See footnote 1.
10. Bewley T. and Ghodse A.H., Unacceptable face of private practice: prescription of controlled drugs to addicts. *British Medical Journal*, 11 June 1983.
11. Dale Beckett, *British Medical Journal*, 9 July 1983.
12. See Peter Dally, *British Medical Journal*, 13 August 1983.
13. See Richard Hartnoll and Roger Lewis, *British Medical Journal*, 13 August 1983.
14. Angela Burr. Increased sale of opiates on the black market in the Piccadilly area. *British Medical Journal*, 24 September 1983.
15. See letters from Dr Dally and Dr Beckett, *British Medical Journal*, 22 October 1983.
16. Richard Hartnoll *et al*. Evaluation of heroin maintenance in controlled trial. *Archives of General Psychiatry, 1980: 37*, pp. 877-884.

LIFE WITH HEROIN: VOICES FROM THE INNER CITY. **Hanson B., Beschner G., Walters J.M. *et al.* Lexington, Mass.: Lexington, 1985. vi, 210 pages. £22.50.**

WHEELING AND DEALING: AN ETHNOGRAPHY OF AN UPPER-LEVEL DRUG DEALING AND SMUGGLING COMMUNITY. **Adler P. New York: Columbia University Press, 1985. xi, 175 pages. £16.70.**

Both of these books should be welcomed as original contributions to ethnographic work in the drug field. *Life with heroin* is drawn from the Heroin Life Style study which focussed on black, male, regular heroin users in American inner cities who had never been in treatment. Adler's participant-observation research took place in a community of high-flying cocaine and marijuana entrepreneurs operating at wholesale and import level.

In terms of income, opportunities and skin privilege, the individuals represented in these books could not be more different. Yet both groups are concerned with 'taking care of business' and 'operationalising' their various strategies for survival.

Hanson and Co. neatly pose the question of their black street survivors — "How do they remain treatment free?" — and go on to provide some of the answers. They regularly work (almost 30 per cent), they hustle, they steal, they deal, they borrow, they do odd jobs and they get by. As with the West Coast wheeler dealers, the marketplace is central to their activities, and has become increasingly capitalistic with dealers undercutting each other, offering discounts on bulk sales, and labelling bags for advertising purposes ("Black Magic", "Bag of Fire", "Death Boy", "Silent Partner" and so on).

Most thieving takes place in the ghetto which tends to undermine Preble & Casey's idea that the heroin economy benefits the minority community by providing stolen goods that people could not otherwise afford. With 21 per cent black adult unemployment and about 41 per cent black teenage unemployment in the central cities, opportunities for career advancement are clearly limited. Surviving with heroin can give status (72 per cent of the sample were initiated into use by close friends).

Life with heroin argues that many heroin users live disciplined, organised lives and control their consumption according to economic circumstance. 73 per cent inject only once a day, having first acquired the wherewithal to obtain the drugs. They do not see themselves as having relinquished control over their lives and aggressively maintain their sense of self-respect.

They move, like Adler's dealers, between two worlds — the drug world and straight society. They simultaneously long for and have an aversion to normal life. There are contradictions and ambiguities — they feel weak because they need heroin, but feel strong because they can get it. They are neither 'cool cats' beating the system, nor inadequate failures using junk as a crutch, two favourite academic stereotypes. Most of all, the majority do not want to become "methadonians", "blimps" or "zombies" eternally tied to the "death bank" (methadone clinic). You can see their point.

Patricia Adler obviously enjoyed her research. Life in the fast lane — observed, if not necessarily participated in. She refreshingly admits that she first met her contacts when looking for a little marijuana with her husband. Neither of them regarded recreational cannabis and cocaine use as particularly deviant. As Adler points out, their research could hardly have taken place if they had.

Her subjects (65 dealers and smugglers aged 35 to 40) imported and distributed tons of marijuana and dozens of kilos of cocaine. Her detailed analyses of dealing hierarchies and structures are useful if not particularly original, and at their best in exploring interpersonal relations between members of these hierarchies. The market within which they operate is competitive rather than monopolistic, although at times Adler draws perhaps too heavily on Reuter's theories of disorganised crime.

She rings more than a few bells in her account of the ethical dilemmas encountered in fieldwork — racing home to write up notes on an earlier conversation, manipulating informants, and the uncomfortable feeling that, as Adler puts it, you are "whoring for data".

Unfortunately, the book is marred by a commitment to some fairly woolly existential sociology. False dichotomies are posited between materialism and hedonism, organisation and pleasure. One ends up with the fatuous assertion that "the rational organisation of drug dealing and smuggling in Southwest County is only understandable when it is seen in the service of irrationality" (ie, having a good time).

One senses that Adler is trying to get Jack (or in her terms the "brute beast" in man) back into the academic box. Somehow the dope dealers of Southwest County and the black inner-city heroin users, in their own ways, seem to have got it right. Somehow, in some way, Patricia Adler seems to have got it wrong.

Roger Lewis

Roger Lewis is co-author of Big deal *(Pluto Press, 1985) and has conducted extensive research into the illicit drug market.*

HOOKED? NET: THE NEW APPROACH TO DRUG CURE. **Meg Patterson. London: Faber and Faber, 1986. 280 pages. £4.95**

You've seen the TV films, you've read the newspaper articles, you've probably heard the buzz on the streets. Now here at last is the book. But what a disappointment it is. Rather like the electro-acupuncture* which Doctor Patterson promotes, the book tries to answer too many questions at the same time. It also tries to appeal to different potential readers at the same time.

The author seems to have fallen between two stools and would have served her cause better by sitting on one stool or the other — by either preparing a properly scientific report and discussion of her work or — alternatively — unashamedly going for the popular appeal. From the scientific point of view, there are far too many gaps in the data — especially as Doctor Patterson is claiming a remarkable 98 per cent success rate. Surely, anyone working in the drug field who was achieving such a success rate would realise the immense importance of obtaining high-quality data to substantiate such a spectacular claim.

For a book published in England in 1986, it is oddly out-of-date. The reference to addicts selling their prescriptions of 100 per cent heroin supplied by drug dependency units is scarcely a valid criticism in Britain today, where such prescriptions are so extremely rare. Similarly, in her chapter on the inadequacy of current treatments, the author states that "drugs and sterile syringes are supplied free to all registered addicts". Surely she must know that this is not so?

Another perplexing feature of the book is the attempt to combine such a mechanical cure for addiction to all substances with the author's belief in the importance of psychotherapy and spiritual rehabilitation. Doctor Patterson clearly grasps the broader nature of the changes required for so many of the individuals who get into difficulties with drugs.

As she says, "the cure for addiction, like the cure for tuberculosis, involves fundamental changes in society", and she quotes Stanton Peele in drawing attention to the "atrophy of the addicts' other interests and abilities". It would be interesting to obtain the views of Stanton Peele on discovering that he had been cited in apparent support of NET.

Perhaps the end of the book reveals its true target. A glossary explains to the reader the meaning of words such as adrenalin, antagonist, and Ativan — so presumably the book is aimed at the general public. If so, then my greatest fear with this book is that the general public reader might be distracted by the patchwork of quotations and not notice the inadequacy in the data.

What a tragedy it would be if such a book were to reassure the general public that a simple physical cure existed, for what the author herself acknowledges is a much more complicated problem.

Dr John Strang

**Editor's note:* Dr Patterson's treatment method involves the use of a small portable 'black box' which delivers an electric current behind the ears, said to relieve withdrawal and promote recovery from addiction.

Dr Strang is the regional specialist in drug dependence at the North West Regional Drug Dependence Unit in Prestwich Hospital, Manchester.

ESCAPING THE DRAGON. **Tom Field. London: Unwin, 1985. 112 pages. £2.95**

Among the growing body of literature on heroin, Tom Field's *Escaping the dragon* is a welcome addition, not least for its readability and clarity in imparting useful information without the dryness of style that often seems to characterise writings of a factual nature. This, perhaps, is due to the fact that the author speaks from his own experience (and that of the many others he quotes abundantly), adding a personal dimension to what otherwise might have been another descriptive piece of work.

With a scrupulously methodical approach, Field takes us through the various possible causes of heroin addiction, the effects of the drug, and the loss of control over one's life often experienced as a consequence, as well as the many ways in which help — the crucial concern of the book — can be given.

He lists easy availability, lack of knowledge about heroin, peer pressure, dissatisfaction with a social and spiritual vacuum, lack of opportunities, and chance (very important in his opinion) as some of the factors contributing to the relatively easy slide into the private world that heroin facilitates.

He also stresses the much greater impact of the psychological dependence that heroin creates over the physical one, and the difficulties of overcoming it once caught in its web.

But where he is most successful is in his portrayal of the user as an ordinary individual, often led inadvertently to addiction, which makes us understand and sympathise with him/her rather than judge or reject, as myths or prejudices might have accustomed us to do. This demystification of the image of the drug user is crucial to bring about the sustained support and willingness to help that Field advocates so strongly as necessary to ensure recovery and avoid relapse.

This short book, packed with information on all aspects connected with heroin and its use, is aimed at parents, counsellors and friends to whom it should be of particular interest, if only to make them feel more confident, understanding and knowledgeable and to dispel their fears and misconceptions about heroin use. The last chapter offers a guide to professional facilities available to problem drug users which they or their families might find very useful.

Despite the book's positive and encouraging way of dealing with heroin problems and its emphasis on the importance of education and caring, I regretted the tendency to make strong moral assertions which colour the first few chapters. For example: "Parents' attitude to religion often discourages belief among their children. This is unfortunate because religious belief is a wonderful prop."

Also, Field's one-dimensional view of the solution to the problem of heroin addiction (total eradication of the drug) is unrealistic and somewhat undermines the book's credibility, in view of the fact that drugs (legal and illegal) are part of our everyday reality, and the best we can do is to learn to live with them.

Veronique Brooke

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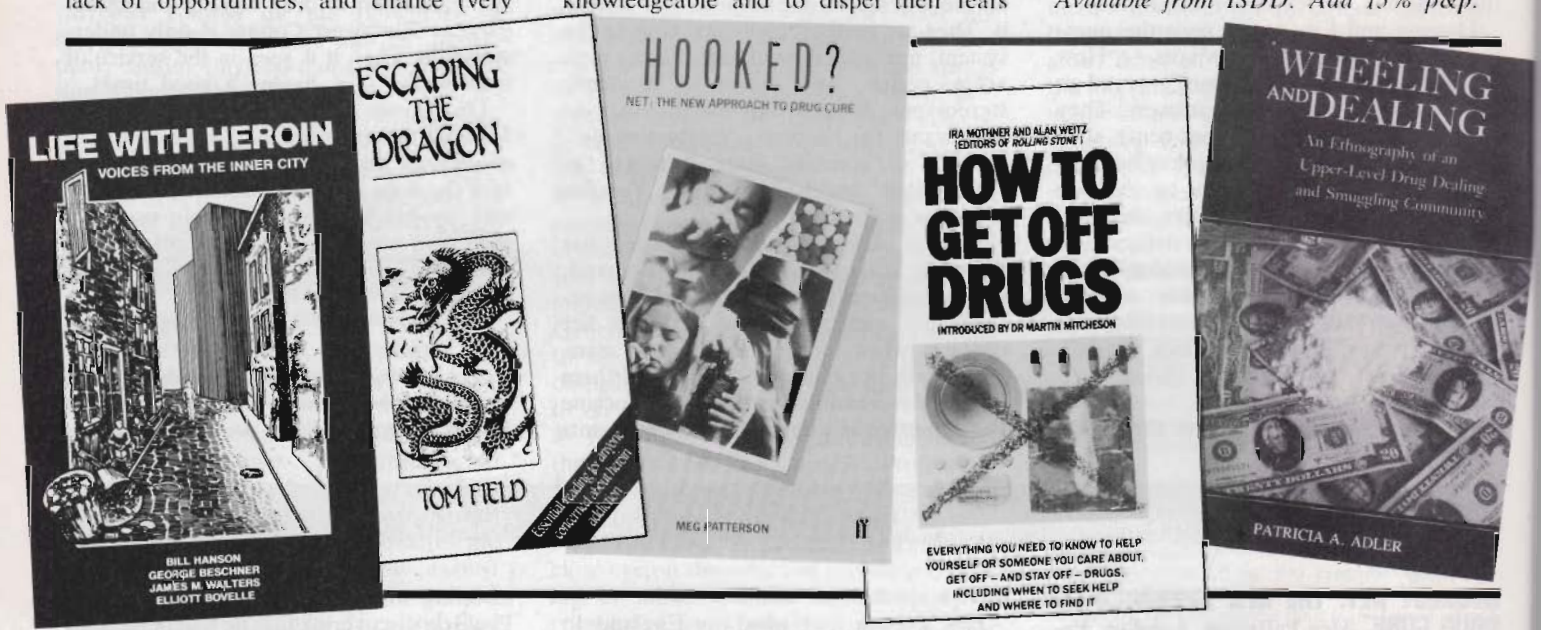

HOW TO GET OFF DRUGS. **Ira Mothner and Alan Weitz. Harmondsworth: Penguin, 1986. £3.95. 304 pages.**

The co-authors of this book, interestingly, are the editors of *Rolling Stone* magazine. It's a sign of the times when people from a magazine which did so much to contribute to the sex'n drugs'n rock'n roll mythology come out with what will probably be a best seller to the people most damaged by that mythology.

The book is clearly written from the American experience, with strong transatlantic emphases on cocaine, therapies and American drug brand names. Thankfully there has been an attempt to Anglicise parts of it, though both in its historical sections and its descriptions of treatment options it omits or distorts much of the British experience — Wot! No street agencies? Those who buy the book for the introduction by Martin Mitcheson, Britain's home grown guru, will not be disappointed by his usual trenchant observations.

Essentially, the book is a survey of a variety of drug-related dependencies (opioids, amphetamines, alcohol, etc), with useful sections on their history, effects, toxicity and patterns of use. It makes recommendations on how to withdraw and when to seek help and gives generally sensible, supportive advice on coping with the necessary lifestyle change.

Unfortunately, it also offers a set of questionnaires (presumably designed for easy serialisation in *Rolling Stone*) which purport to tell you how badly you are addicted to or involved with each drug. Used without these, it makes a fairly sensible guide for the general public. The questionnaires themselves are rather over the top and quite enough to put the fear of god and the local drug dependency unit into any honest recreational user. Perhaps that was the intention?

The book comes down hard on cannabis, on the basis of some very dubious assertions, and might well panic some parents into forcing 'therapy' on their experimenting offspring, thus giving them a label for life. There is also a lack of critical analysis of many of the treatment options.

Apart from these criticisms and the usual fault of being immediately out of date (the chapter on hallucinogens is sadly out of tune with their fast growing popularity and availability in Britain), there is more than usual to recommend in this 'Cook's Tour' of dependencies.

It's refreshing to see alcohol and tranquillisers in the place they deserve. I was also impressed to find exactly the information on an obscure hypnotic that I'd needed and been unable to get from fellow workers the previous week. The book is cheap and will undoubtedly be widely distributed; it would be a good idea for drug agencies to check it out, because that's what quite a lot of their customers are going to do.

Lisa Power

Lisa Power works for the Angel Project in Islington, north London, a newly set up advice and outreach centre for people with drug-related problems.

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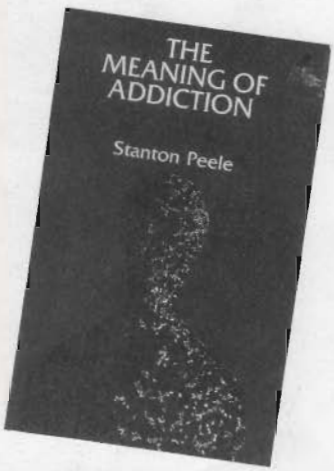
General

► **THE ENCYCLOPEDIA OF DRUG ABUSE. O'Brien R., Cohen S. New York and Bicester: Facts on File, Inc., 1984. xxii, 454 pages. £26.50.**
US reference book with more than 1000 entries and written with a minimum of technical language.
Available through bookshops.

► **HANDBOOK OF ABUSABLE DRUGS. Blum K. New York and London: Gardner Press, 1984. xxv, 721 pages. £83.35.**
Comprehensive review based on a US government-sponsored compilation of all available data on pharmacology and toxicology of commonly abused drugs.
Available through bookshops.

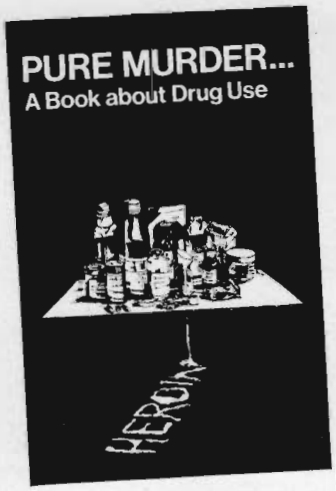


► **THE MEANING OF ADDICTION: COMPULSIVE EXPERIENCE AND ITS INTERPRETATION. Peele S. Lexington, Mass.: Lexington, 1985. xiv, 203 pages. £27.00.**
Attempts to show that addiction is a way of coping with one's environment and that people can change as their life circumstances change.
Available through bookshops.

Prevention

► **DRUGS ABUSE: A DISCUSSION STARTER PACK. British Youth Council Scotland. Folder. £1.50.**
A pack for youth leaders to help promote awareness and understanding of drug use by young people through group work and discussions.
Available from BYC, Atholl House, Canning Street, Edinburgh EH3 8EG.

► **PURE MURDER . . . A BOOK ABOUT DRUG USE. O'Donohue N., Richardson S. Dublin: Womens Community Press, 1984. 96 pages. £3.50.**

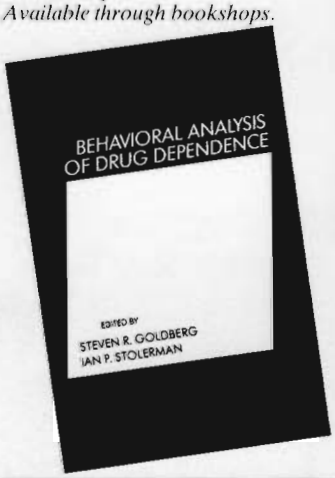


Accounts of how communities in the Dublin area responded to high levels of opiate misuse by young people, with an emphasis on drug use by women.
Available from Womens' Community Press, 44 East Essex Street, Dublin 2, Eire.

► **WHAT ABOUT DRUGS? Cotton A. London [etc]: Foulsham, 1986. 34 pages; illus. £1.75.**
Classroom text in magazine format looking at legal and illegal drugs and the social problems that may arise from their use.
Available through bookshops.

Treatment

► **BEHAVIORAL ANALYSIS OF DRUG DEPENDENCE. Goldberg S.R., Stolerman I.P. *eds*. Orlando [etc]: Academic Press, 1986. xiii, 414 pages. £31.00.**
A collection of papers on behavioural approaches to drug dependence and reporting experimental work with human and animal subjects.
Available through bookshops.



Policy and law

► **INTERNATIONAL DIPLOMACY, STATE ADMINISTRATORS AND NARCOTICS CONTROL: THE ORIGINS OF A SOCIAL PROBLEM. Stein S.D. Aldershot: Gower, 1985. viii, 240 pages. £16.50.**
The development of the international control system from its roots in the Far Eastern opium trade and the pressures which shaped British opiate policy.
Available through bookshops.

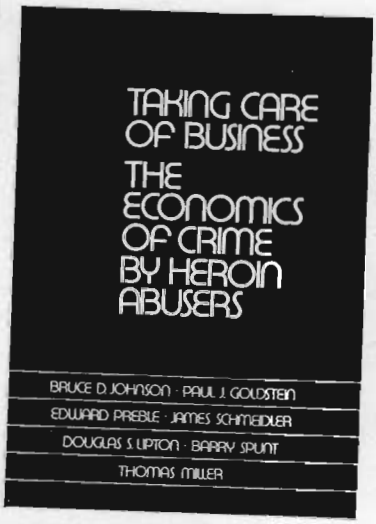
Medical

► **FACTS ABOUT AIDS FOR DRUG WORKERS. SCODA, The Terrence Higgins Trust and the SCODA AIDS Working Party. London: SCODA, 1986. 7 pages. £0.20 inc. p&p.**
The causes of AIDS; infection and drug users; the symptoms and consequences of infection; whether to test; how to reduce risks.
Available from SCODA, 1-4 Hatton Place, Hatton Garden, London EC1N 8ND.

► **OPIOIDS — PAST, PRESENT AND FUTURE. Hughes J., Collier H.O.J., Rance M.J. *et al*. London and Philadelphia: Taylor and Francis, 1984. xv, 226 pages. £24.00.**
Charts the discovery of and subsequent research on the endogenous opioid peptides.
Available through bookshops.

Lifestyles

► **LIFE WITH HEROIN: VOICES FROM THE INNER CITY. Hanson B., Beschner G., Walters J.M. *et al*. Lexington, Mass.: Lexington, 1985. vi, 210 pages. £22.50.**
A descriptive study of inner-city black male heroin users in the USA, most of whom have never received or wanted any form of treatment.
Available through bookshops.



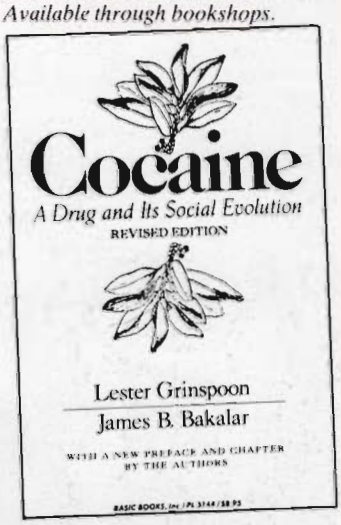
► **TAKING CARE OF BUSINESS: THE ECONOMICS OF CRIME BY HEROIN ABUSERS. Johnson B.D., Goldstein P.J., Preble E. *et al*. Lexington, Mass.: Lexington, 1985. xxi, 275 pages. £31.50.**
Detailed study of the economic behaviour of street level heroin abusers in New York City.
Available through bookshops.

► **WHEELING AND DEALING: AN ETHNOGRAPHY OF AN UPPER-LEVEL DRUG DEALING AND SMUGGLING COMMUNITY. Adler P. New York: Columbia University Press, 1985. xi, 175 pages. £16.70.**
Portrayal of a Southern California community of 'wholesale' drug operators based on six years of participant observation fieldwork and extensive interviews.
Available through bookshops.

Drug specific

► **THE BENZODIAZEPINES: USE, OVERUSE, MISUSE, ABUSE. 2nd ed. Marks J. Lancaster: MTP Press, 1985. x, 165 pages. £16.50.**
A revision of the 1978 edition taking in evidence that dependence can occur at normal therapeutic dosage and recent trends in benzodiazepine use.
Available through bookshops.

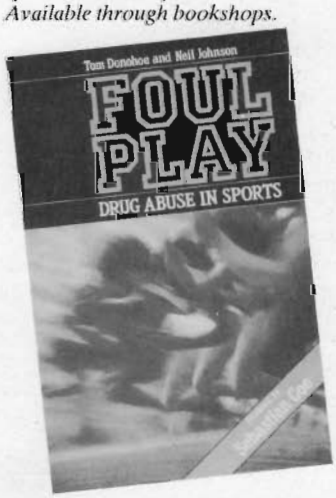
► **COCAINE: A DRUG AND ITS SOCIAL EVOLUTION. 2nd ed. Grinspoon L., Bakalar J.B. New York: Basic Books, 1985. xii, 340 pages. £6.50.**
Summarises the academic literature about cocaine, illustrated by extracts from novels, short stories and interviews with cocaine users.
Available through bookshops.



► **SOLVENT MISUSE IN CONTEXT. Ives R. *ed*. London: National Children's Bureau, 1986. 74 pages. £5.25.**
Collection of papers largely concerned with treatment and prevention approaches to solvent misuse.
Available from NCB, 8 Wakley Street, London EC1V 7QE.

Sport

► **FOUL PLAY: DRUG ABUSE IN SPORT. Donohoe T., Johnson N. Oxford and New York: Basil Blackwell, 1986. 189 pages. £12.50.**
The nature, extent and consequences of the use of drugs in sport to enhance performance.
Available through bookshops.



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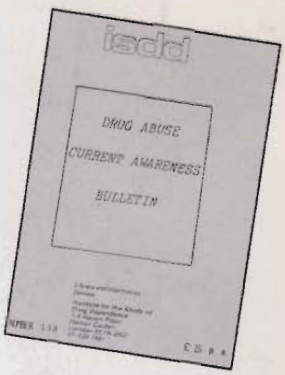

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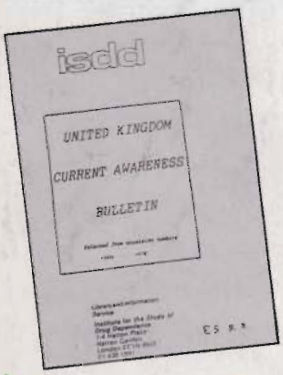

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