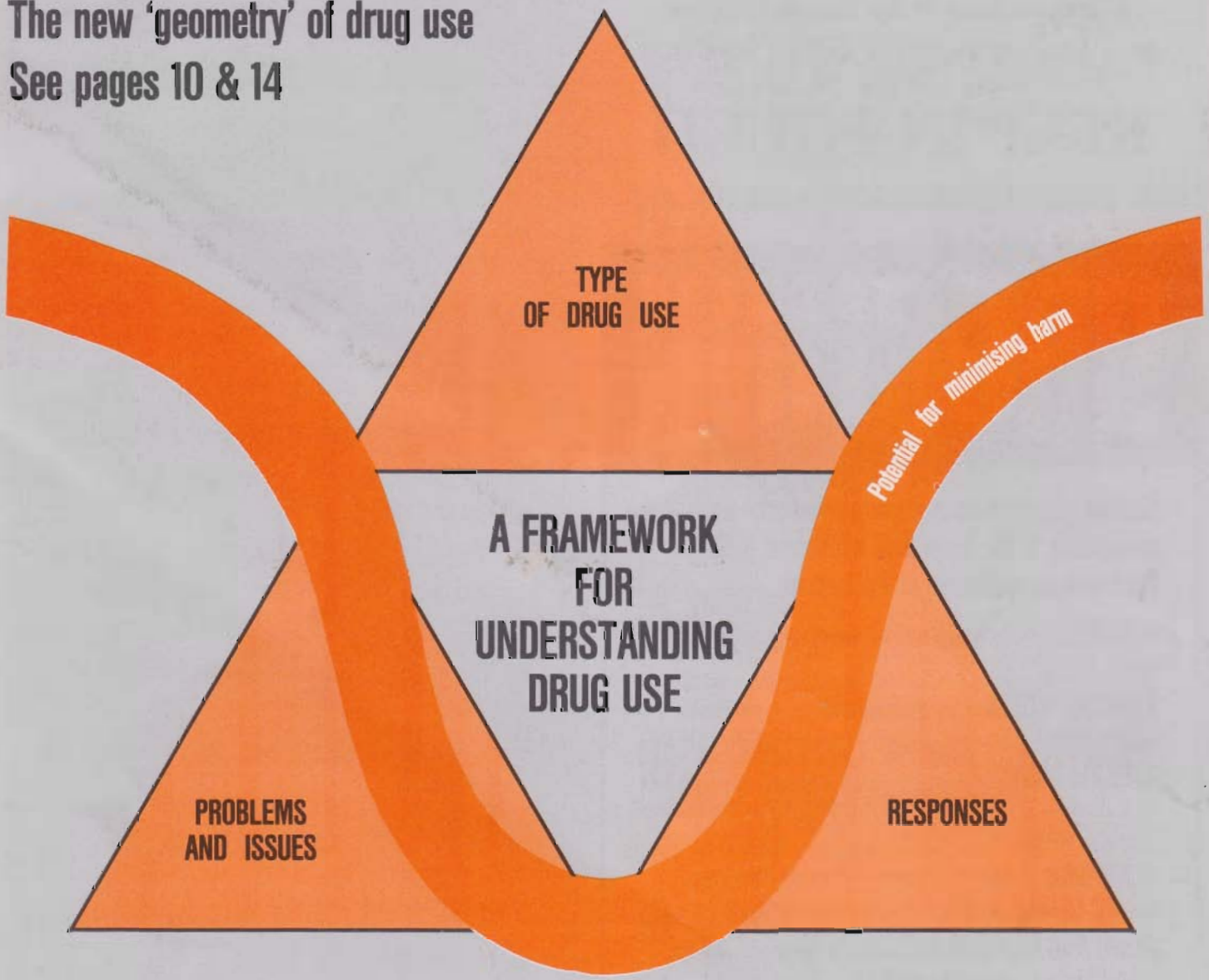
DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN March/April 1987

The new 'geometry' of drug use

See pages 10 & 14



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IN THIS ISSUE

isdd **INSTITUTE FOR THE STUDY OF DRUG DEPENDENCE**
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Help services 'sparse' say DHSS inspectors

A report from the DHSS Social Services Inspectorate[1] published on the 9 January reveals that government directives, and the millions allocated from central government funds to stimulate help for drug misusers, had failed to produce anything like a coherent and sufficient pattern of services in all but a handful of local authority areas.

In 1985, two years after the launch of the central funding initiative and nearly a year after health authorities had been instructed to plan drug misuse services, the Department's inspectors examined 20 local authorities throughout England containing centrally funded drug projects and therefore likely to have a relatively high prevalence of drug misuse. But in only two areas was there "any evidence" of a network of services, and one of these had been established for alcohol users. "All forms of specialist provision were sparse, unevenly distributed, and founded largely on 'happenstance'."

Ominously, local authorities and health authorities evidenced "almost no long term financial commitment" to the support of centrally funded projects once the government's pump-priming grants (usually up to three years) had expired.

In the two years since the study many more millions have been allocated, totalling £17.1 million in January 1987, and it is likely that more of the statements of support from local funders, required before grants are given, have been turned into financial commitments.

Nevertheless the report confirms fears that the central funding initiative would result in patchy and financially insecure service provision. Disposal of the money was (and is) on the basis of health authorities and voluntary organisations (local authorities can only apply for training funds) applying for grants, rather than on the basis of a systematic assessment of need and agreement on a required level of provision.

The report also reveals a crucial difference between central government and local social services departments in their perceptions of 'the problem'. While government has concentrated on the young heroin user and more recently on cocaine and amphetamines, social services were much more likely to be dealing with solvent, alcohol, or prescribed drugs problems. Most had no contact with young heroin addicts unless they were parents. In one London borough, "over one third of the parents of children on the at-risk register . . . were 'in some way involved with drug abuse'".

Not surprisingly, many departments showed a "lack of commitment" to tackling drug misuse. Only one had drawn on mainstream funds to support a specialist drug misuse post outside hospital drug dependency units and to date few have applied for training grants from central funds.

Edwina Currie's (Parliamentary Secretary for Health) response[2] to the report welcomed the evidence of an expansion of services and recognised the difficulties in planning and running services where different authorities are involved, but made no proposals to ameliorate these difficulties.

Reports of good practice in selected health authority areas prepared by the new NHS Drug Advisory Service (see ***Druglink*** September/October 1986, p.6) are expected to stimulate less well provided areas to improve services, but attaining a uniformly adequate level may yet require more active central intervention.

THE DHSS INSPECTORS also reported on 14 voluntary residential rehabilitation and counselling/advice projects and four of the new community-based drug teams, being set up by statutory authorities along lines recommended by the Advisory Council on the Misuse of Drugs in their 1982 *Treatment and rehabilitation* report.

Here "staff stress and high turnover" characterised projects stretching their personnel and management systems to meet increased and more varied demands and to incorporate increased resources.

In the 20 areas studied, voluntary counselling and advice services were the major sources of advice for drug misusers. Although these projects emphasised the need for a planned network of services, the Inspectorate comments that "nothing illustrated the need for planning so clearly as the huge range and variety of aspirations of these . . . services, most of them already overpressed and stretching their resources to the limit".

1. *Social Services Inspectorate Project on Drug Misuse*. DHSS, 1987.
2. DHSS Press Release, 9 January 1987.

Designer drugs controlled

On 1 April 1987, two classes of 'designer' drugs[1] causing concern in the USA became subject to stringent Misuse of Drugs Act controls in the UK. A range of potential chemical derivatives of fentanyl and of pethidine will (like the original drugs) be added to class A of the Act, meaning that anyone attempting to illegally produce or import them faces a maximum sentence of life imprisonment. Unlike fentanyl and pethidine themselves, these derivatives will not be available on prescription for medical use.

In the USA, fentanyl derivatives with effects similar to heroin — but in some cases over 1000 times as potent — are thought to have caused over 100 deaths. However, there is no evidence of misuse of pethidine or fentanyl derivatives in the UK — the legislation is intended to pre-empt attempts by illicit chemists to sidestep drug laws by synthesising chemicals not specifically named in the Misuse of Drugs Act's schedules.

The relevant sections in the new law do not name particular drugs, instead referring to "any compound . . . structurally derived" from the two drugs by a number of different chemical routes. Similar legislation was enacted in 1977 to control structural derivatives of tryptamine and phenethylamine, the latter including MDMA or 'Ecstasy', another synthetic causing concern in the USA.

The legislation also adds nine drugs to class C (the least severely penalised) of the Misuse of Drugs Act, including the stimulant fencamfamin, formerly marketed as Reactivan.

None of the newly controlled drugs are contained in any medicinal product currently marketed in the UK.

1. Drugs chemically 'designed' to avoid existing drug control legislation but to have effects similar to controlled drugs.

Solvent deaths advice supported

Mechanism of death	Substance				
	Gas fuels	Aerosol sprays	Solvents in glue	Other	TOTAL
Trauma	2	0	32	0	34
Plastic bag	5	3	7	6	21
Inhalation of stomach contents	14	3	1	11	29
Direct toxic effects	37	17	6	33	93
Other	2	3	1	5	11
TOTAL	60	26	47	55	188

Deaths associated with misuse of volatile substances, 1984/5

Unpublished figures from the solvents research project at St George's Hospital Medical School confirm that glues are less likely to cause death by their direct toxic effects than other misused solvents. In 1984 and 1985, 13 per cent of deaths involving solvents in glues but 62 per cent of those involving other solvents were attributed to direct toxic effects. This discrepancy is even greater than in the years 1971-1983, when 30 per cent of glue-related deaths and 59 per cent of other solvent-related deaths were attributed to toxic effects.[1]

These latest figures support the advice given by ISDD[2] and other organisations that simple health education could prevent a large number of solvent-related deaths, even if sniffing itself could not be prevented. Over two-thirds of the glue sniffing deaths in 1984/5 were due to "trauma" — injuries sustained during intoxication — and 15 per cent were due to plastic bags being placed over the head causing suffocation. Advice not to sniff in dangerous situations and not to use large plastic bags might have prevented many of these deaths.

Possible explanations for the figures are that glues are less toxic than other solvents; that glues, being more easily detectable and less likely to be found in the home, are sniffed in more isolated and dangerous places than aerosols and lighter fuels; or that adults' increased knowledge of the signs of sniffing is causing glue sniffers to seek more out of the way spots. Only more detailed analysis will be able to resolve these questions.

These figures extend the analysis of solvent-related deaths recently published in the *British Medical Journal*.[3]

1. Anderson H.R., MacNair R.S. and Ramsey J.D. Deaths from abuse of volatile substances: a national epidemiological study. *British Medical Journal*: 1985, *290*, 26 January, p304-7.
2. See: ISDD Research & Development Unit. *Talking about a volatile situation*. ISDD, 1981. Available from ISDD, £0.40 inc. p&p.
3. Anderson H.R., Bloor K., MacNair R.S., *et al.* Recent trends in mortality associated with abuse of volatile substances in the UK. *British Medical Journal*: 1986, *293*, 6 December, p1472-3.

Leading private doctor faces 14 month ban

On 30 January, Dr Ann Dally, a private doctor and president of the Association of Independent Doctors in Addiction, was found guilty of serious professional misconduct in her treatment of an addict patient. However, the General Medical Council's professional conduct committee — the profession's own disciplinary authority — cleared her of the general charge of irresponsibly prescribing in return for fees.

Over three and a half years earlier the same misconduct verdict was reached regarding Dr Dally's prescribing to another addict.[1] Then she was "admonished" and warned. Because of what they called her "blatant failure" to heed the earlier warning, this time the GMC decided to impose a 14 month ban on her prescribing of drugs controlled under the Misuse of Drugs Act.

Convinced that the sentence was unjust, Dr Dally is appealing to the Privy Council. Until the appeal process is completed (the hearing is not expected until May or June) she can continue to prescribe. If the ban is imposed it will prevent Dr Dally prescribing opiates and hence put an end to the bulk of her addiction treatment practice in its current form.

The case has been widely reported as a trial of Dr Dally's treatment policy. Dr Dally is prepared to prescribe injectable methadone (a heroin substitute) on a long-term or 'maintenance' basis to addicts to help them stabilise their lives and avoid having to resort to the illicit market — a practice contrary to that of most NHS drug dependency unit consultants and against the spirit of DHSS prescribing guidelines.[2]

She has been a vociferous critic of what she calls the medical "establishment's" move towards fixed short-term reduction regimes of oral methadone designed to take the addict off drugs altogether, typically in less than six months.

According to her counsel, Dr Dally's patients averaged well over 30 years of age and had an 18 year history of addiction. For these patients, he argued, the conventional short-term oral prescribing regime was inappropriate and ineffective. Injectable methadone maintenance, claimed Dr Dally, helps confirmed addicts sort out their lives and prepare over the years for eventual withdrawal.

Home Office checks on pharmacy records revealed that between 1 March and 31 October 1985, Dr Dally prescribed 99,541 10mg ampoules of methadone to 187 patients (though she says she never had that number of patients at any one time). But according to her counsel, this meant an average 45mg per day for each patient on injectables — not an excessive dose by most standards.

Home Office inspectors reported that of 149 patients receiving long-term treatment during this period, 92 had their prescriptions reduced by only a small amount, if at all, and 77 were prescribed over 80mg of methadone a day — DHSS guidelines say, "even those patients claiming high use of illicit heroin . . . are usually comfortably stabilised on a daily dose of methadone not exceeding 80mg".[3]

42 ampoules prescribed to one patient were marked by the police. Later that day he was found to have just nine left, at least some of the rest presumably having been sold. Evidence like this led Home Office drugs inspector Mr Mackintosh to accuse Dr Dally of being prepared to prescribe to anyone who said they can't cope with withdrawal or manage at the NHS clinics. Many of these, he suggested, were not motivated for treatment but merely seeking drugs.

Dr Dally's successful defence against these charges involved testimony from Dr John Marks, director of Mersey Regional Health Authority's drug dependency clinics, and one of the few NHS consultants prescribing injectable opiates on a maintenance basis.

Faced with evidence that a respectable if minority body of medical opinion supported Dr Dally's treatment policy, the GMC cleared her of the more serious charge of generally irresponsible prescribing for fees. Their decision means that injectable opiate maintenance is still not in itself regarded as irresponsible.

Still before the committee was the less serious charge of irresponsible prescribing for fees in relation to one particular patient. It was found that Dr Dally was at fault for not conducting a full examination before prescribing (there was, for example, no urine test for drugs); for inadequately monitoring the patient's progress; and for failing to refer him to another doctor when, on solicitor's advice, she eventually discharged him after his wife had said he was unemployed and selling drugs.

Writing in the *Lancet*,[4] barrister Diana Brahams said Dr Dally took insufficient heed of the wife's warnings and was at fault in not writing a referral letter, but commented: "Though Dr Dally may not have been vigilant enough in respect of a single patient . . . it is difficult to see what will be gained by forbidding her from prescribing in this area if the alternatives (supplies of impure drugs, dirty needles, and the wave of crime committed to pay for supplies of street heroin) are worse".

At no time did the prosecution challenge Dr Dally's good faith. Home Office drugs inspector Mr Mackintosh believed she was "genuinely motivated" and acting according to her genuine belief about what was right for her patients. The concern now must be that any doctor — especially in private practice — who makes slip-ups in their treatment of individual patients, faces disciplinary action at the GMC, regardless of whether they were acting in bad faith.

In *New Society* (6 February 1987), Dr John Marks is quoted as saying: "If this were applied across the board, every doctor in the country would be suspended . . . If you trawl through any doctor's caseload you will turn up something."

Diana Brahams' charge that "the aim to remove private doctors from practice in drug addiction seems to lie behind the charges" is unsubstantiated, but in its 1985 Annual Report the GMC emphasised the "serious view" taken by its disciplinary committee of cases where private doctors prescribed to addicts who had to sell drugs to pay for the treatment. After the Dally case the acting head of the GMC's professional conduct division, Alan Howes, emphasised that "any doctor who prescribes for addicts must exercise extreme care . . . There are so many safeguards you have to build in".

In many areas clinics only prescribe short-term and GPs do not want to get involved or will only refer on to the clinic, meaning private doctors such as Dr Dally offer the only remaining legal opiate maintenance treatment. Where NHS doctors do not offer maintenance, unemployed or poor addicts may not be able to turn to private practitioners for alternative treatment without the doctor risking their right to prescribe.

Dr Dally's concern now is for her 60 remaining long-term addict patients who she may have to cut off if her appeal fails. In London there is, she says, simply nowhere people like this can go to get the treatment she offers.

1. See: Mike Ashton. "Doctors at War". *Druglink*: 1986, *1*(2), p14-17.
2. Department of Health and Social Security. Medical Working Group on Drug Dependence. *Guidelines of good clinical practice in the treatment of drug misuse*. London: DHSS, 1984.
3. DHSS, *op cit*, p15.
4. Diana Brahams. "'Serious professional misconduct' in relation to private treatment of drug dependence." *Lancet*, 7 February 1987, p340-1.

Seizure law enforced in London

The Drug Trafficking Offences Act came fully into force on 12 January. Courts are now empowered to confiscate whatever can be realised from a convicted trafficker's assets or property up to the estimated value of their entire drug trafficking career. Where the offender's assets are insufficient, a prison sentence can be imposed on a sliding scale to a maximum of 10 years in default of a sum exceeding £1 million.

Once somebody is accused of a trafficking offence, assets can now be frozen to prevent the defendant placing money, goods or property outside the jurisdiction of the court. This provision was put into practice just eight days after it came into effect, when the Metropolitan Police successfully applied to the High Court to freeze the bank accounts of two suspected traffickers. Despite appeals from the enforcement authorities, the Treasury has decided that money or assets confiscated under the new law will be fed into overall national income rather than ploughed back into anti-drugs enforcement.

Government seeks pilot needle exchange schemes

Letters outlining the DHSS's requirements have been sent to about two dozen potential candidates for the government's pilot needle exchange schemes (see last issue of ***Druglink***, p4).

Ten schemes are due to be set up in England: DHSS officials are confident of finding suitable candidates. In Scotland the three relevant health boards have been asked to submit final proposals by the end of February for free needle exchange schemes in Dundee, Edinburgh and Glasgow.

In England a "small amount" of additional funding will be available to help schemes meet the requirements and cope with increased caseloads. Additional operating and monitoring costs will be met through health authorities, but the experience of the Liverpool scheme (see below) suggests that in some areas additional resources required to operate effective schemes could be substantial.

DHSS requirements for the English schemes stipulate that "injecting equipment should only be issued on an *exchange* basis to drug misusers who are already injecting . . . a 100 per cent return rate . . . should be the ultimate aim".

Schemes must provide assessment, counselling and referral for the client's drug problems. Counselling should be "aimed at ultimately helping the client to stop or reduce his drug misuse, or where this is not immediately possible to stop injecting or reduce the risks associated with injecting". Injection equipment should be issued only if after assessment and counselling, the client is still "unwilling or unable" to stop injecting.

Information about the risks of shared equipment and non-sterile methods, and advice on safer sex, should be offered. HIV-testing and test counselling should be available at the scheme or by referral at the local Genito-Urinary Clinic or the client's GP.

Schemes will be required to keep records of clients, treatment given, syringes issued/returned, and to complete questionnaires with each needle exchange client on their attitudes and behaviour with regard to misuse of drugs, injecting practices and sexual activity. Some government Ministers and the coordinator of the Welsh AIDS Campaign have expressed fears that new syringes will simply be shared and do nothing to prevent the spread of AIDS, so questionnaire replies on injecting practices may well be crucial to continued government support for the schemes.

An intriguing final clause in the DHSS requirements says central government "will organise consultation with local police and prosecuting authorities before schemes are set up", presumably to prevent the schemes being scuppered by police using them as handy centres to pick up drug offenders.

Police attitudes may well be crucial to the success of the schemes. Some drugs workers are concerned that injectors will prefer to dispose of used equipment immediately rather than to accumulate it for return to an exchange scheme, since syringes and any drug traces in them may be found by police and used as evidence in drug prosecutions.

There is also concern over potential conflicts if the same organisation is running a treatment service and a needle exchange scheme. Patients receiving oral methadone prescriptions who asked to participate in their treatment centre's exchange scheme, would be admitting that they were supplementing (or perhaps selling) their oral medication for injectables obtained on the illicit market, 'misbehaviour' that might cost them all or part of their prescription. Even the prospect that pressure will be put on them to cease drug use or injecting may be enough to deter some drug users from attending the schemes.

At the end of January, Allan Parry revealed that Liverpool's Regional Drug Training Centre had issued 3500 syringes since starting their scheme on 5 December and had received 3200 back. With 200 customers the scheme is probably the biggest in the country (see the last issue of ***Druglink***, p7, for a description). Half its users have never before come to notice and most started their drug use by injecting rather than graduating from smoking.

Although 20 Liverpool pharmacies have agreed to supply free injection equipment and condoms to addicts, many prefer to use the Centre to obtain 'consumer' and health advice on their drug use along with the new equipment. Clients receiving maintenance prescriptions from local clinics are generally infection free, but the Training Centre has found that nearly all the rest have health concerns related to injecting. Many of these have damaged themselves through poor injecting techniques, so the Centre has employed a nurse to give medical advice to people having problems with injecting.

The main problem for the Centre is its success. With sometimes 3-4 injectors queuing to exchange equipment, the time that can be spent advising any one of them is limited. The push now is to persuade local centres to establish similar schemes, providing easier access for clients who may have to travel considerable distances to the Training Centre.

● Statistics issued by the DHSS on 9 February, show that up to the end of January 1987, nine intravenous drug abusers (seven men and two women) and a further seven who were also male homosexuals have developed AIDS out of a total of 686 cases. Eight of the 16 drug abuser cases had died.

Child custody ruling 'storm in a teacup' says lawyer

Writing separately in the medical press, a barrister and a solicitor have concluded that the recent House of Lords' decision preventing an addicted mother from gaining custody of her child is not an alarming extension of the law which threatens widespread and unjustifiable care proceedings against drug using mothers.[1]

They point out that drug use in pregnancy, even if it causes avoidable harm to the foetus, is still not sufficient grounds for care proceedings. In the words of the *Lancet* article:

"What this case decides, therefore, is that, in making a care order, magistrates can take into account the mother's conduct when pregnant, but only if this conduct causes harm to the child once it is born and *continues to do so* at the time when the care proceedings are begun. If the mother can show that there is no need to make a care order because she is perfectly able to look after the child, then no order should be made whatever harm has been caused during the pregnancy." (italics added)

Head of Berkshire social services, who applied for the original care order, told the press that there are many drug abusing parents able to care for their children (*Reading Chronicle*, 12 December 1986). According to her deputy, in this case there was evidence that the child was in "moral danger" (*The Independent*, 22 December 1986).

For the layman, the most puzzling feature of the case must be the fact that the mother *never had* custody of the child, so "the actual capacity of baby D's parents to look after her, even though addicted to drugs, was not considered by the courts".[2]

In these circumstances the suspicion remains that the parents' continued drug use was considered in itself to present a risk of future damage to the child. A spokesman for the British Association of Social Workers is reported as warning that: "this ruling should be interpreted as one for automatic separation where the mother abuses drugs. In general we would advocate support through residential and family centres where mother and child could be offered a total care package." (*The Independent*, 22 December 1986).

Despite these reassuring words, drug workers will still be concerned that a prejudicial view of drug users' parental abilities in social services departments and courts will lead them to anticipate "risk of future damage" as a result of the parents' addiction when a similar view would not be taken of smokers or drinkers, and without any evidence that the parents have or would actually mistreat the child.[3]

1. Levin J. "Will all addicted pregnant women have their babies taken into care?" *Lancet*, 24 January 1987, p230.
Christian C. "Storm in a teacup causes such a stir". *Doctor*, 8 January 1987, p16.
2. Levin J., *op cit.*
3. See: Perry L. "Fit to be parents?" ***Druglink***, 2(1), p6.

A COCAINE EXPLOSION?

In January cocaine worth £6 million was seized in Essex and politicians renewed warnings that surplus South American cocaine was set to cause a 'cocaine explosion' in Britain. But the UK's top police drugs investigator believes our defences can withstand the onslaught from across the Atlantic.

Colin Hewett

IT IS EASY to put forward arguments to support the contention that cocaine misuse in the UK is bound to increase and, even if 'the cocaine explosion' is an inappropriate description, that this drug will cause more problems than heroin.

The United States authorities have not sought to play down the sheer scale of the cocaine problem in their country, and many people — including the House of Commons Home Affairs Select Committee — have been greatly concerned to hear of their experiences. In the first half of this decade, despite the commitment of resources on a massive scale, they saw the price of a kilo of cocaine drop by a half (from $60,000 to $28,000, and to a temporary $16,000 a kilo when there was a glut in South Florida in spring 1984), with the drug readily available in all states and widely used throughout different sections of the community. In South America, in spite of some successes on the law enforcement front, attempts to reduce levels of coca production have so far met with limited success. Welcome efforts have been made to control essential chemicals, but this inevitably has side effects, such as the dispersal of cocaine laboratories as far afield as Europe.

Reports from the USA — of oversupply in 1982, market saturation in 1983, and now of an estimated 20 tons of processed cocaine hydrochloride available annually for export to Europe — do tend to support the view that the highly organised and commercially successful traffickers see western Europe as a major market. Positive indications of this within Europe are the increasing numbers of arrests of South American couriers — 'mules' working for others rather than entrepreneurs — and the identification of associates of the Colombian criminal organisations probing for opportunities to establish themselves.

Drug misuse is already pervasive in western Europe: the countries are prosperous enough and have fairly well established drug dealing networks. Close ties with South America are not, of course, confined to Portugal and Spain.

We have been seeing some encouraging signs of a possible levelling off of the heroin problem. We have less reliable information about cocaine, but the general upward trend in numbers of arrests and seizures has continued through 1986. There are some parallels with West Germany, where the gap between heroin and cocaine seizures is also narrowing.

ALL SET THEN for the UK cocaine explosion? I think not. We have the awareness of how the problem can develop (an advantage we did not have at the start of the heroin escalation). In the UK and abroad there is far less of the philosophy that the problem will stay elsewhere, and politicians are increasingly prepared to act rather than express concern.

Probably not just because of the high cost, the anticipated demand for cocaine has not yet developed in western Europe, despite recent news media advertising of 'crack'. Misuse has not spread to any great extent from the major cities or from those socio-economic groups able to afford the drug. We certainly have not reached the stage when arrests and seizures are likely to have little effect on an established market.

The reasons are many and complex. Clearly the cheapness and versatility of amphetamines, especially attractive to young people, makes them an increasingly acceptable alternative to cocaine and heroin, which are expensive (averaging £80 a gram) and still comparatively difficult to acquire. Equally, tragic deaths from drugs misuse probably do have a deterrent effect and may tend to dispel myths about the recreational use of cocaine and emphasise its dangers.

In practical terms, much that was initiated in response to the heroin problem is only now starting to impact. The Drug Trafficking Offences Act is timely and is a far better investigative tool than many appreciate. Steps are now being taken to implement the provisions in the Act for reciprocal enforcement agreements with other countries, with the ultimate aim of eliminating safe havens for either the traffickers or for their assets. With strengthened resources for both police and Customs, and — by shrewd use of intelligence — better targeting of those resources to get at traffickers at the right level, we should see significantly more than just an increasing number of arrests and seizures.

Close cooperation nationally and internationally has not been entirely achieved in the past, but recent vast improvements bode well for the future. More drug liaison officers are being posted to key areas abroad and we are hosting more here. Just as the National Drugs Intelligence Unit is a development in the UK, so our colleagues in enforcement abroad have strengthened their national/international organisations — good examples are the *Brigada Central de Estupefacientes* of the Spanish Police and *L'Office Central pour la Repression du Trafic Illicite des Stupefiants* of the French Police.

The 1986 James Smart Lecture was given by Ray Kendall, the Secretary General of Interpol, on "The International aspects of drug-related crime and the consequences for the United Kingdom". He has encouraged his Drugs Sub-Division in so many initiatives. Interpol and the Customs Co-operation Council are working constructively in their different spheres, and together, to harmonise the international enforcement effort.

IT IS OFTEN FORGOTTEN by the pessimists who see the so-called drugs barons as all powerful, that the trail from the coca fields of South America to the cocaine retailers here is a long and difficult one, and the return journey for the profits is equally hazardous. The traffickers have been adept at taking advantage of weaknesses in enforcement systems (the Bahamas are a classic example of this) but now we have the capacity to strike at their weak links, wherever they may be. To take heed of warnings from the USA is far different from accepting it as inevitable that we have to experience a cocaine problem of anything like the scale there. □

Colin Hewett coordinates the UK's National Drugs Intelligence Unit at New Scotland Yard.

Leaves of *Erythroxylon coca*, a hardy plant indigenous to the Andean highlands and the source of cocaine. The economies of some S. American countries now rely on illicit cocaine production. Top cocaine traffickers recently showed they have the power to kill 'unhelpful' Colombian officials, even behind the 'Iron Curtain'.

ADDICTS CAN CHANGE

Will people prepared to inject illegal drugs with secondhand needles be able to change now to reduce the risk of spreading AIDS to each other, and to the general population? Research in London suggests there's at least a 50-50 chance they will, while in America, it's already happening.

Richard Hartnoll, Emmanuelle Daviaud and Robert Power

FEW CONFIRMED cases of drug-related AIDS have been reported in the UK. However, if analyses from countries such as the USA apply here, then drug injection will become increasingly important in the spread of the disease. First, as the HIV virus that causes AIDS spreads among drug injectors, so they will constitute a growing number and proportion of AIDS cases. In the United States, the number of new cases related to drug injection is rising more rapidly than in other risk groups: in parts of New York and New Jersey, and also in Italy, most AIDS cases are now related to injection.[1, 2] In these and other centres such as Edinburgh, over 50 per cent of samples of drug injectors have been found to be infected with the virus.[3]

Secondly, a high level of infection among drug injectors provides a bridge across which the virus can spread to the wider, largely heterosexual population. At particular risk are the sexual partners and future children of injecting drug users, and through them, their sexual or needle-sharing contacts.[4] Following the increase of injection-related AIDS in New York, the incidence of both heterosexual and child AIDS cases is also starting to increase, though at a slower rate than among drug injectors.[5] Most reported heterosexual cases are non-injecting female partners of male drug injectors.

Prostitutes who inject are a particular risk group in terms of communicating AIDS to numerous partners, though the mechanisms and relative risks of female-male versus male-female and male-male transmission are not clearly established.

The likely spread of AIDS among drug injectors and the risk this presents to the wider population, make it imperative that special prevention efforts are aimed at drug injectors and their partners, designed to change both sexual habits and injecting behaviours, especially the sharing of injection equipment. However, intervention needs to be based on a good understanding of the patterns of risk behaviours and on a realistic assessment of how drug injectors themselves, and others close to them, are likely to respond.

Different levels of risk are associated with different patterns of drug use by injection (see table). The main variables affecting level of risk are:
— frequency of sharing equipment;
— number of people shared with;
— whether shared equipment is cleaned *effectively*;
— number of sexual partners and their risk behaviours;
— extent of 'safe sexual practices';
— conception of children where one parent is at risk of being infected.

On all these counts, it is necessary to consider both the risk of *catching* AIDS and the risk of *passing* it on.

PREVENTION EFFORTS in this area must start with the question: What do drug injectors know and think about AIDS and the relevant risk behaviours, and what are the possibilities of those behaviours changing?

The extent of knowledge about AIDS among British drug users and among drug injectors in particular is not known. Impressionistic evidence suggests they are less well informed than the gay population, but that most are aware AIDS can be transmitted by sharing syringes and needles — a fact known to 90 per cent or more of two samples of New York intravenous drug users in treatment.[6, 7]

"Concern about dying from AIDS is great enough to change the behaviour of many drug users."

Of more interest was the finding from both studies that about 60 per cent of these samples reported changing their behaviour to reduce the risk of AIDS. The most common changes were increased use of sterile needles and reduced sharing. Supporting evidence of these behaviour changes comes from the greatly increased (illicit) market in sterile needles in New York.[8, 9] Similarly, a study in San Francisco reports that "the vast majority of [intravenous] drug users expressed deep concern about health and AIDS".[10]

In the course of our own work in London, we have started to ask problem drug takers about their risk-behaviour and attitudes to AIDS. It is too early to report firm findings, but already it is becoming clear that there are a range of responses. On the one hand are probably a small minority who, although they inject, are almost obsessional about using 'clean works' and assert they have never shared and never will.

At the other extreme are people who appear unconcerned and who are likely to continue to share despite the risks: "I've always shared and always will . . . have had lots of dirty hits, but you've forgotten about it by the next day".

A somewhat larger proportion take some precautions to limit the extent of sharing (eg, "only with people I know well"). In some cases, this was connected to pre-existing concerns about the risk of catching hepatitis and other infections.

The responses of what are probably the majority reflect concern and a varying degree of desire to reduce risks. For some, this is a considerable change: "I only use my own needle. I always used to share with my mates, but I don't share at all now". For others, the change was only to protect themselves: "If someone wants to share after me, that's their business. But I'll never use a 'works' after someone else".

Concern for protecting oneself from AIDS will also protect others who may use the syringe afterwards, but *only* if the first user is definitely free from the virus. Unfortunately, in present circumstances, this cannot usually be assumed.

Other drug injectors are more resigned. Thus a prostitute, who asked her clients to use sheaths because of VD, would "only share works with X [her partner], but he shares with other people — I'd like not to share with anyone, but often I can't be

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. The project is at Birkbeck College, 16 Gower Street, London WC1, phone 01-580 6622.

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HOW DRUG USERS NEED TO CHANGE TO REDUCE THE AIDS RISK

High risk behaviours

Frequent sharing of equipment with others.
Sharing with groups of friends, some of whom share with injectors outside that group.
Indiscriminate sharing with many people
Many sexual partners (especially prostitutes).
Never use 'safe' sexual practices.

Medium risk behaviours

Sharing limited to small group of friends.
Sharing limited in frequency.
No use of other peoples' equipment, but will let others use equipment afterwards (low risk for person and others if the original user is not HIV positive, high risk for others if they are).
Usually clean equipment effectively.
One sexual partner now, but some sexual partners, especially drug injectors, over recent years (both partners).
Several sexual partners, but usually use condoms.

Low risk behaviours

Drug use by means other than injection.
Inject, but never shared equipment, or not shared for some years.
Sharing limited to one partner, both partners not shared with anyone else for some years.
Share, but *always* clean equipment effectively.
One sexual partner (both partners no sexual contact with drug injector in recent years).
Always use safe sexual practices (condoms, etc).

bothered to go to the chemist for new 'works'". Another injector, who had found out four months previously that he was HIV positive, said: "before then I didn't take any notice of it [publicity about AIDS]. Now I always try to get new 'works'. But it's hard because the police stop people coming out of [the] chemist. I've been stopped and searched six times". Several others worried about AIDS shared nonetheless if they were desperate or if clean syringes and needles were not available at the time.

A few people reported cleaning equipment in various ways between injections, though the techniques used (eg, washing out with boiling water) were not necessarily sufficient to kill the virus.[11]

It has been suggested that, in contrast to the gay community, it is unrealistic to expect significant changes in risk behaviour among injecting drug users. Reasons given include the observation that drug injectors are not a coherent or organised community through which it is possible to disseminate and reinforce 'safe practices', and that they are so self-destructive or of such low self-esteem that they would not change their behaviour anyway — a variation on the theme of the 'hopeless junkie'.

However, our main impression, consistent with the American studies, is that a substantial number of injectors, perhaps the majority, are worried about AIDS and/or report they have changed their behaviour to reduce the risks. As researchers in New York's public health service have commented: "AIDS is a new type of death associated with [intravenous] drug use. The process is usually protracted and painful, and includes social stigmatisation beyond that associated with [intravenous] drug use. This type of death does not have any of the psychological escapism that might be associated with an overdose death. Concern about dying from AIDS is great enough to change the behaviour of many drug users".[12]

While it is unrealistic to expect all injectors to reduce the extent and frequency of risk behaviours, it might be realistic to aim to encourage significant changes on the part of at least half the injecting population who currently share 'works' or take part in other risky activities. Added to the minority who already use 'safe practices', this could help slow the spread of AIDS, both within the drug using population, and into the wider community.

A MAJOR DIFFICULTY is that very little is known about the needle sharing and sexual behaviours of drug injectors. A few studies in this country have suggested that between 50 and 80 per cent of various samples of injectors in treatment have shared syringes at some time. However, this level of information is inadequate for assessing the current and future levels of risk of spread of the virus. As a basis for effective and accurate targeting of preventive measures, it is important to clarify not only the dimensions and characteristics of different sub-groups at risk, but also the mechanisms involved in the spread of the virus, the extent of various risk behaviours, and the situational factors that encourage or discourage those behaviours. □

US STRESSES NEED TO BRING USERS INTO TREATMENT

QUESTIONS have been raised about the extent to which injecting drug users show an ability to increase their risk-avoidance behaviours in the face of the AIDS epidemic. Much has been made of the fact that the gay community has responded to the threat of HIV infection with changes in behaviour that have modified their health risk. Whether drug injectors will exercise similar restraint in risk-promoting behaviours, particularly in the sharing of needles with other drug injectors, is cause for concern.

It is, or should be, apparent that ultimately the spread of AIDS among injectors can only be contained through increased success in bringing them into treatment and the success of that treatment in changing drug-using behaviours.

While the first line of defence with injecting drug users involves gaining their involvement in drug abuse treatment, to some extent publicity and information about the relationship of AIDS to injecting are affecting the behaviour of individuals who do not commit themselves to treatment. The following evidence is noteworthy: anecdotal accounts of increased sales of (purportedly) new needles in New York City indicate efforts by injectors to contain the threat of AIDS. New York is one of 11 States in which hypodermic syringes can be legally purchased only with a doctor's prescription. A study conducted in Dallas, Texas, suggests that even drug users who do not enter treatment may be modifying their needle-sharing behaviours. It was found that a large percentage report sharing their needles only with other relatives and persons who are viewed as close friends (77%) as opposed to acquaintances and strangers (23%). It must be emphasised that this study is not longitudinal, and one cannot assume these findings reflect changes in behaviour.

Again, the major strategy for containing the spread of HIV infection in the drug-injecting population is to encourage individuals to enter treatment. Strategies exist for making use of (typically) former drug users as outreach workers. Their role is to enter the drug-using community and engage drug injectors in street settings, to encourage their participation in treatment. It has been established that this strategy can be used effectively. Indeed, a variation of that strategy is now in use in several States, eg, New York, New Jersey, and California, to bring into treatment persons at risk of HIV infection through injecting. New Jersey reports this strategy appears to be successful in bringing injectors into treatment.

OBVIOUSLY, once such individuals are engaged in treatment, there is the task of retaining them long enough to allow them to benefit from the services available. There is also the challenge of offering aftercare services that will provide the supports the clients need to allow them to remain drug free even after they have severed formal ties to the programme. Again, with the threat of HIV infection, the importance of aftercare in preventing relapse to injecting becomes particularly significant.

US National Institute on Drug Abuse

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A FRAMEWORK FOR UNDERSTANDING DRUG USE

'Disease' models have been replaced by more realistic but more complex concepts. This three triangles framework is one practical way to organise the confusion.

Andy Malinowski

THE TERM "Problem drug taker" was introduced by the Advisory Council on the Misuse of Drugs in their 1982 *Treatment and rehabilitation* report, defined as:

"any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances (excluding alcohol and tobacco)".

However, this more comprehensive new drug related problems approach requires a clear framework within which to make sense of information and events. Without this, attempts at assessment may become bogged down by the diversity of input, leading to further loss of confidence and yet more confusion.

Together with the three triangles framework suggested here, readers may wish to make use of the assessment guidelines in the *Working with drug users* video training pack (available from ISDD). The framework developed here is based primarily on the ideas and writings of Les Kay and Rowdy Yates, to whom I am indebted.[1]

Implicit throughout this paper is the rejection of the myth that only 'specialists' can deal with problem drug users, and the suggestion that, with adequate information and training, generic workers are able to respond appropriately.

TYPES OF DRUG USE can be classified as either experimental, recreational or dependent (see first triangle in diagram).

► The term 'experimental' refers to drug use in the very early stages of contact with the drug. This type of drug use is *irregular*, in the sense that it does not conform to any pattern, and the choice of substance is often *indiscriminate*, depending on factors such as availability, reputation, subculture, fashion and peer group influence. Situational factors such as time of day, company and setting are largely irrelevant to the choice of drug or the quality of the experience, and may simply reflect chance, curiosity, or coincidence, rather than design. Experimental drug use may be a group or an individual activity, and may develop in to recreational drug use, or simply stop. Form of administration varies and may include injecting.

Taking a drug at a party for the first few times would come under this category, especially where there was some conscious exploration/anticipation of its effects.

► The term 'recreational' refers to a form of drug use in which hedonism is prominent. Without condoning the activity, the term acknowledges that for most drug users anticipated pleasurable effects are the prime motivation.

Recreational drug use is usually *discriminatory* in the type of drug used and the situation chosen for that use. Drug choice is influenced by availability, experience of experimentation, personal taste, expectations, resources and social and cultural factors. The decision to use the drug and the quality of the experience are related to situational factors such as time, company, resources and setting.

Recreational drug use is characteristically *regular* but *controlled*, usually taking place in a social group and meeting a variety of individual and group needs. Injecting would usually be excluded. Whether legal or illegal, recreational drug use is to some extent a 'normative' activity, conforming to various social and subcultural rules and expectations. The setting may vary from a pub to a friend's house, depending among other things on the legality of the drug. Enjoyment, pleasure and sociability would be a prime expectation in this scenario.

► Drug use characterised by physical and/or psychological dependence is distinguished from the preceding types by being more *frequent* (often involving use several times a day), *less controlled* but nevertheless *regular*. Obtaining the drug is more important to the user than its quality or the quality of experience. Situational factors such as time, company and setting are therefore secondary. Injecting is common.

Dependent drug use is usually a solitary or small group practice, displacing rather than complementing social activities. It can be seen as a way of coping with stress and does not inevitably develop in response to the pharmacological effects of the drug.

PROBLEMS AND ISSUES related to drugs can be classified under the headings health and safety, lifestyle and management.

► With more physically toxic substances, *amount* taken over a given period may be crucial to the health and safety outcome.

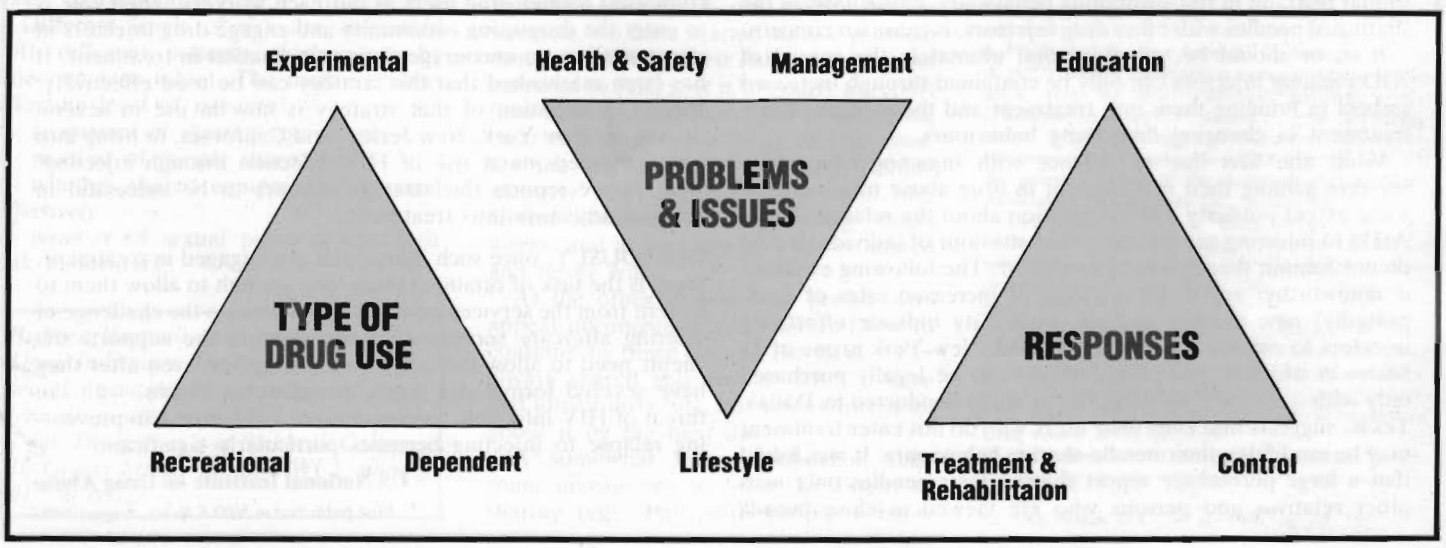
Form of administration can also directly contribute to health and safety problems. For example, injecting rather than smoking heroin risks infection, abscesses, thrombophlebitis, gangrene, septicaemia, hepatitis B and AIDS.

Operating machinery or driving while intoxicated, or being in a *situation* where balance is important, increases the risks.

Lastly, the *frequency* and *duration* of drug use can contribute to phsyiological damage. For example, both alcohol and tobacco used heavily and frequently over a prolonged period may lead respectively to respiratory problems and liver disease. Apart from increasing health risks, frequency of use contributes directly to the development of tolerance and physical dependence.

In practice, all these variables will need to be considered as a related whole.

The author is project leader of the Druglink drug advisory centre, 174 Victoria Road, Swindon, Wiltshire, SN1 3DF, phone 0793 610133.



► Lifestyle problems and issues are specific to the individual user as a member of the wider society, rather than directly related to the drug or its pattern of use. They may *precede* drug use and contribute to its development, or *succeed* and be the result of drug use. Often they are a combination of the two.

An example of the first would be a rootless person lacking confidence and resources, whose dependent drug use becomes a response to their painful situation. An example of the second would be an individual facing criminalisation due to being found with cannabis or other drugs.

Lifestyle problems can be related to wider structural (or *macro*) situations beyond the direct influence of the individual (level of housing stock, provision of education, employment, etc) or to *micro*-level events and circumstances directly affecting the individual and theoretically more open to their influence (eg, personal relationships, day-to-day living).

Distinguishing between the macro and micro context serves two functions. First, it clarifies discussion of the degree of individual versus social responsibility for the client's present drug use, helpful where individuals blame themselves for their predicament, leading to a further deterioration in confidence and self-esteem. Secondly, an analysis of this kind may provide pointers for future change.

► Problems and issues related to management are specific to the workers and agencies responding to drug use, rather than directly related to the pattern of drug use or the individual user. These 'worker problems' derive either from the policies and structure of the agency, or arise in the course of dealing with a particular customer.

Management issues related to the structure of an agency may be *institutional* (its procedures, regulations and policies), *legal* (the need neither to condone nor to commit criminal acts), or *philosophical* (the agency's values and beliefs). Those related to the management of the customer can be *methodological*, (what to do and how and when), *emotional* (the worker's feelings or prejudices), *informational* (the worker's lack of training and education) or *medical* (eg, the risk of the worker contracting hepatitis or AIDS). Awareness of management issues in working with drug users may facilitate help and minimise inconsistency.

Management problems related to institutional structures often lead to a control response, but such responses and the rules they enforce can occasionally conflict with other institutional interests and the interests of the drug user themselves.

RESPONSES to drug problems can be considered under the headings of education, treatment and rehabilitation, and control. The choice will be determined by the type of drug use, related problems and issues, and by the limits of the responses available.

► Educational advice and information aimed at *reducing potential or actual harm* can mitigate health and safety and lifestyle problems. For example, emphasising use of clean needles and syringes to avoid infection may be the most realistic option when the user is not ready to 'come off'.

Educational responses can lead to management problems. Thus youth workers who advise dependent glue sniffers not to put large bags over their heads (which risks suffocation), may come into conflict with their management, who expect a response aimed solely at stopping the activity.

► There are various types of treatment and rehabilitation response which, according to the Advisory Council on the Misuse of Drugs, should aim:

"a. to enable problem drug takers to utilise personal resources and so modify attitudes, behaviour and skills to achieve a more stable and fulfilling way of life with minimal or no drug related problems;

"b. to provide the social supports and agencies required to facilitate the development of the individual so as to establish or re-establish problem drug takers in the community in roles which they find more stable and fulfilling than those related to their previous drug use."

Whether a treatment and rehabilitation response is appropriate will depend on the type of drug use and on related health and lifestyle problems. Psycho-analysing an experimental drug user may be totally inappropriate and counter-productive, as would referring recreational cannabis smokers to a psychiatrist (not unknown).

► Control responses aiming to *enforce social norms* or prevent socially unacceptable behaviour have direct links with management issues and problems. Such responses may vary from broad legislation (eg, Misuse of Drugs Act) to rules and expected conduct in youth clubs, hostels, schools, etc.

Occasionally control responses conflict with the interests of the drug user, leading to further complications. An example would be a school calling in the police because a pupil was found with an illegal drug, creating a legal lifestyle problem for the pupil and probably also future management problems for the school in their relations with the pupil.

An example of conflict between control and treatment and rehabilitation responses is the refusal of some residential therapeutic communities to admit drug users not drug free for 24 hours. The communities may retain their structure intact, but may also frustrate attempts to 'come off'.

Control responses can affect health problems and issues: restrictive prescribing policies designed to reduce access to legal drugs may result in an increased use of illegal drugs, while a clampdown on the availability of needles and syringes to prevent injecting, may lead to increased sharing and medical complications.

POTENTIALLY each variable in the framework can interact with each of the others: as the *type of drug* use changes so do related *problems* and appropriate *responses*. An *educational response* may reduce *health and safety* problems which may alter *management* issues, and so on. In practice, the framework can be applied to assessment in the following way.

- First, by establishing the *type of drug use* through questions such as: How regular is it? Does it conform to any pattern? Is the type of drug important? What motivates the drug use? Is time, company and setting relevant? Is it controlled?
- Answers to such questions will also indicate the relationship between the drug taking activity and preceding/succeeding *problems and issues*, more fully ascertained by focusing on health and safety and lifestyle issues.
- Questions about the form of administration, its circumstances, and its frequency will indicate the need for *medical care*, such as detoxification or the treatment of abscesses, septicaemia, etc. Questions about lifestyle in relationship to drug use may give us an understanding of its *significance*, eg, is the drug use hedonistic, or a response to stress?
- This information in turn may generate *management* problems and issues as we decide on an appropriate *response*.

THE DRUG USER's participation is the pivot of the framework in practice. The model should be applied *dynamically* as the situation changes or in response to differences between drug users, assessment and response being based on *interaction* between the drug user and the worker in which the user is an equal partner. Too often the user's perceptions, wishes, and self-defined needs are ignored — like at a rehabilitation house where all residents are denied visitors for the first three months, regardless of their individual strengths and weaknesses or needs and wishes. In situations like this 'assessment' is non-existent and the likelihood of the response being appropriate to the individual, is all but left to chance. □

AN EXAMPLE OF HOW MANAGEMENT AND CONTROL CAN CONFLICT

One evening a worker in a hostel for ex-offenders comes across a group of residents smoking cannabis. Following discussion they ascertain this is recreational use, indicated by the type of drug use and the situation, as well as by the residents' perceptions that for them it is a pleasurable, non-problematic activity. It appears their cannabis smoking does not stem from or give rise to immediate health or lifestyle problems, other than the illegality of the act, but hostel policy states no drugs are allowed on the premises and that violators of this ruling will be asked to leave — creating a clear *management* problem with a mandatory *control* response. *Not* applying the ruling could prejudice the institution's survival and weaken the credibility of its anti-drugs stance. However, *applying* it may jeopardise any progress the residents have made (contrary to the institution's rehabilitative aims) and render them homeless (a lifestyle problem). An alternative would be to allow each infringement of the rule to be dealt with individually, making available a wider range of response options.

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ASSESSING PREVALENCE

How much of it is there and what is it like? 'Simple' questions about drug misuse/problems with no simple answers. Joy Mott maps out the options for finding answers and discusses the pros and cons.

Joy Mott

ONE IMPORTANT WAY of assessing the effects of government efforts to reduce the extent of drug misuse,[1] would be the regular monitoring of the number of drug misusers in the population, and of the types of controlled drugs being misused. Such information would also be valuable for the planning of local treatment and rehabilitation services. The DHSS recently attempted to assess the prevalence of drug misuse in all the local health authority areas in England and Wales.[2] However, since no precise advice was given on how drug misusers were to be defined or the time period to be studied, the assessment proved difficult.

The main source of information in the United Kingdom about the number of misusers of cocaine, heroin or methadone (and of 11 other drugs controlled in class A of the Misuse of Drugs Act) is provided by the Home Office Addicts Index. Under the Misuse of Drugs Act 1971, all medical practitioners have a statutory duty to notify the Chief Medical Officer of the Home Office of patients they attend whom they consider, or have reasonable grounds to suspect, have "as a result of repeated administration . . . become so dependent upon the drug that he has an overwhelming desire for the administration of it to be continued."

The number of addicts receiving treatment on 1 January and the numbers of new and former addicts notified during the year are published by the Home Office in the annual *Statistics of the misuse of drugs in the United Kingdom*. The *Supplementary tables* contain details of the number of addicts notified from each police force area. These national and local statistics, of necessity, are a year out of date before they are published.

The notification statistics do not, and cannot, provide precise estimates of the number of drug misusers during any year. Only those regarded as dependent on one or other of 14 specified drugs are required to be notified. It is unlikely that all dependent or regular or occasional misusers of these drugs will be notified as addicts during any particular year. Some will not come, or choose to bring themselves, to the attention of the medical services, perhaps because they are unwilling to be notified as addicts,[3] and some will not be notified by the doctor they attend.[4]

TO OVERCOME these difficulties an 'indicator' method has been developed to estimate the number of drug misusers who come to the notice of the medical and social agencies in local areas. Typically, research workers have used the Addicts Index to count all the addicts notified from the area during a specified time period and have asked all the local medical and social agencies, and the police, to inform them of all the drug misusers known to them during the same period. Coroners Court records may be searched to identify persons who have died as a consequence of drug misuse, and notifications of persons suffering from hepatitis may also be obtained. Drug misusers may also be asked to estimate how many other drug misusers they know.

In effect the method allows for the counting of what the Advisory Council on the Misuse of Drugs called "problem drug takers",[5] and defined as "people who experience social, psychological, physical or legal problems related to intoxication and/or dependence as a consequence of their use of drugs or other chemical substances (excluding alcohol and tobacco)".

The 'indicator' method is the most feasible, quickest and least costly way of monitoring 'problem drug use'.

There are two major problems in attempting to make, and to compare, estimates of the number of drug misusers in local areas using the 'indicator' method:
— ensuring that a drug misuser is defined in the same way in each area; and
— ensuring that unique individuals are counted.

The drug misusers may be defined as "regular opioid users", that is, people who have used heroin and similar drugs on at least six days a week for at least a month during a specified period and when the drugs have not been prescribed for the treatment of a physical disease.[6] Or they may be defined as "people who are proven or reasonably suspected as ingesting psychoactive drugs when there were no justificatory medical reasons, and the way in which the drugs were used had led to medical, social and/or legal problems as evidenced by involvement with specific 'indicator agencies' and when the primary drugs used were opioids, barbiturates, psychedelics, cannabis, inhalants or stimulants".[7] Individuals known to the various agencies may differ considerably in terms of their reasons for making contact, the nature and extent of their drug misuse, and of the types of problem they present.

Ensuring unique individuals are counted presents difficulties since it is possible, even likely, that some drug misusers will be in contact with several agencies. To preserve a confidential relationship with their clients or patients the agencies may be unwilling to identify them other than by their initials, sex and date of birth. These details should be sufficient to reduce the risk of double counting.

Several 'indicator' studies have been conducted using more or less sophisticated statistical methods of analysis to estimate the number of variously defined drug misusers in local areas during certain periods[8] and several more are in progress. A manual describing the method has been prepared.[9] Since these studies have been conducted at different times in different places and with different definitions of a drug misuser, findings are not strictly comparable. What seems clear, though, is that the prevalence of "problem drug taking" is likely to vary greatly in different parts of the country at the same time and in the same part at different times.

The number of notified addicts from the area have been included in all the local estimates. Hartnoll *et al* very tentatively suggested, on the basis of their work in two London boroughs between 1979 and 1982, that perhaps there were five regular users of heroin and similar drugs in the population for each user notified to the Home Office as an addict.[10] Ditton and Speirits working in Glasgow and using different indicators, including the guesses of doctors, the police and a few drug users, suggested there were 10 unknown heroin users for each one notified in 1981.[11] Pattison *et al* had difficulty in locating an area in 1981 in North East England where there were enough "problem drug users" to merit the effort of attempting to count them.[12] Thus, the use of some notional 'multiplier' of the number of newly notified addicts to arrive at a national estimate of the number of opioid misusers is likely to produce an over-estimate in some places and an under-estimate in others.

SURVEYS of self-reported drug misuse among samples of the general population have been used to estimate the general prevalence of drug misuse. Samples have included members of private households, young people attending youth clubs, school children, school leavers and university students. Information has been collected by interviews, or by postal or supervised self-completion questionnaires.

Since respondents are being asked whether they have indulged in an illegal activity, great efforts have to be made to convince them of their anonymity and of the confidentiality of their replies. Even so they may refuse to take part in the survey, or exaggerate or conceal their drug use.

The author is a Principal Research Officer at the Home Office Research and Planning Unit and has conducted research into drug misuse for several years. *This paper was first published in the* Home Office Research and Planning Unit Research Bulletin*: 1986 (21), p57-60, and is reprinted here with minor revisions and corrections.*

They may be more willing to admit to having used some controlled drugs than others. Some may not even know if the substances they have used *were* controlled drugs and what drugs they were.

Household surveys present particular difficulties. Some drug misusers, perhaps the heaviest users or those with the most problems, may not be living in private households. If they are, they may be the most difficult to contact and the least willing to provide information about their drug use in sufficient detail during a single interview session with a stranger. Some respondents, particularly those aged under 16, may be interviewed in the presence of their parents or another member of the household, and this is likely to affect the reliability of their answers. All these difficulties would preclude the option of simply adding questions on drug misuse to any of the existing household surveys which are regularly conducted in this country.

Estimates of the prevalence in the population of any activity or behaviour derived from a sample of that population will be subject to error and the errors are likely to be large when relatively rare or infrequent behaviours are being studied. In the United States, where regular household surveys of self-reported drug use have been conducted since 1972, very small proportions of the samples have admitted to heroin use because it is a rare occurrence and because addicts are unlikely to be found in private households.[13] For all these reasons a national household survey of self-reported drug use, no matter how well designed and conducted, cannot be expected to produce precise estimates of the number of people who have misused any type of controlled drug during a particular period of time.

No national household survey of the self-reported use of all types of controlled drugs has been conducted in this country. Some estimates of the prevalence of the misuse of amphetamines, cannabis, cocaine, heroin and LSD were made from a national survey of public attitudes to drugtaking conducted in 1969.[14]

During the late 1960s and early 1970s there were a number of local surveys of self-reported drug use among samples of school children and university students. Despite the differences in the designs of the survey questionnaires, there was no doubt that the majority of those who admitted to having ever misused a drug admitted to having used cannabis. There were marked differences in the proportions of students from different parts of the country, and between students studying different subjects in the same part, who admitted to having ever used a drug. The 1982 British Crime Survey found some differences in the proportions admitting to having ever used cannabis among the household samples interviewed in England and Wales and in Scotland, and between people living in rural and urban areas.[15]

ALL THREE METHODS of estimating the prevalence of drug misuse in the UK have limitations and disadvantages.

► Notifications of addicts to the Home Office should provide the most reliable estimate of the number of people dependent on certain controlled drugs and who come to the attention of a medical agency, but it seems that not all medical practitioners notify all such patients they see. Some drug misusers may be reluctant to approach a medical agency because they have misconceptions about the consequences of notification as an addict.

► Surveys of self-reported drug use among representative household national or local samples require the cooperation of those selected for interview but the heaviest drug users, or drug users with the most problems, may be the most difficult to contact and the least willing to describe their drug use. To estimate changes in the prevalence of self-reported drug use, surveys would need to be carried out regularly and would need to be specially commissioned. They would take some time to conduct and would be costly, since large samples would need to be interviewed.

► The 'indicator' method of counting the number of drug users in contact with all the relevant local social, medical and law enforcement agencies requires the cooperation of the agencies. Agencies may be more or less willing to cooperate, depending on their perception of the extent of drug use in the area. There may be limits on the number of individuals some agencies are able to reach. Once it becomes known that the agencies are providing some details of their clientele to research workers, drug users may become reluctant to approach them. Great care has to be taken to provide the agencies with precise definitions and, having due regard to confidentiality, to ensure that unique individuals are counted.

The 'indicator' method cannot be used to estimate the total number of people in an area who have ever misused drugs or who are currently misusing them, but it does offer the most feasible, quickest and least costly way of regularly monitoring the number of "problem drug takers" in an area. A repeated series of simultaneously conducted 'indicator' studies in several selected areas, including some areas which do not appear to have many "problem drug takers" at the time, could provide the means of describing the development of drug misuse in a local community and of assessing the effects of policy initiatives to reduce the number of drug misusers. □

THE MAIN SOURCES OF INFORMATION

Method/source	Comments
Official statistics:	
— notifications of addiction from doctors	Limited to people dependent on 14 specified drugs. Only a proportion of these people attend doctors and not all of these are notified.
'Indicator' method:	
— notifications of addiction	Most feasible, quickest and least costly way of monitoring *problem* drug use.
— hepatitis notifications	Cannot be used to estimate total number of misusers.
— medical agencies	Definitions of problem drug use vary.
— social agencies	Risk of 'double counting'.
— police	Requires agencies' cooperation.
— Coroners Courts	Problems of maintaining confidentiality.
— known drug misusers	
Surveys of, eg:	
— private households	Respondents may be unwilling to admit drug use or not know what they used.
— young people at youth clubs	Heaviest, most problematic users most likely to be missed by household surveys.
— school children	Requires specially commissioned surveys of large samples.
— school leavers	Expensive.
— students	
by means of:	
— interviews	
— questionnaires.	

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MINIMISATION OF HARM
A U-CURVE THEORY

U-curves have a long though questionable history in addiction studies. They were traditionally used to illustrate the decline and reform of alcoholics and drug addicts. Nicholas Dorn steals the U-curve and applies it in an entirely new way, reaching surprising conclusions about the relationship between harm-minimisation and types of drug use.

Nicholas Dorn

HARM-MINIMISATION[1] is not only on the agenda for policy-making and public debate in a way that would have seemed inconceivable even a year ago — it is actually at the heart of the debate. It is of course the threat of HIV (the AIDS virus) that highlighted these discussions. The recognition that perfectly legal sexual acts can lead to HIV infection has helped to legitimise harm-minimisation in relation to those acts; the recognition that drug injection can lead to infection in a quite similar manner (via transfer of body fluids) has provided a conduit for the idea of harm-minimisation to stretch from safe(r) sex to safe(r) drug use.

Yet there is fierce resistance to harm-minimisation (as documented in previous issues of ***Druglink***) and the discussion lacks depth. The pros and cons have been argued almost exclusively in relation to clean needles for injecting drug users: the wider potentials for minimisation of social, legal and personal harm/problems[2] are not being addressed and we lack a framework or theory that spells out when, where and how various types of harm-minimisation strategies may be effective. In these circumstances, the debate has tended to deteriorate to the level of assertion and counter-assertion.

The perspective put forward here relates (a) the potential for drug-related harm, and (b) the potential for countervailing harm-minimisation measures, to (c) the stage of people's involvement with drug use, forming a new kind of 'U-curve theory' (see figure).

THE FIRST-TIME USER. The first proposition of the theory is that there is considerable potential for harm — physical, social and legal — at the very beginning of involvement with any intoxicant (eg alcohol, solvents, illegal drugs). It is then that the user is most naive, least informed by any culture of use, and hence relatively prone to getting into serious trouble.

For example, first-time users may be confused about how much to take, where to take it, how to handle the effects, how to think about the experience in retrospect, how to deal with other people's real or imagined reactions, and so on. Looking back to the first few experiences of alcohol of oneself and one's friends, the reader may be able to identify these episodes as rather more open to accidents or unpleasant experiences than subsequent episodes — and that with a drug relatively well integrated into British culture. Initial use of solvents or of illegal drugs may be more hazardous (especially after drinking, or if aerosols or gases are used). The curious youngster who experiments with solvents alone and untutored is especially at risk. With illegal drugs, uncertainty over dose or how to 'handle' the effects is greatest at initial use.

So, harm-minimisation is particularly relevant in areas where the level or pattern of use is such that we can expect a proportion of current non-users will shortly use. Although some health educators say harm-minimisation measures should be restricted to *existing* users, such a restriction leaves unprotected a most vulnerable group — the *about-to-use*. It is surely irresponsible to withhold information that can save lives.[3]

CULTURES OF LOW-HARM USE. When we move on to those populations in which use of an intoxicant is already established on a reasonably stable and relatively undamaging basis (eg, not mixing one's sedatives, using modes of administration other than injection), then intervention is perhaps less urgent. The emergence of 'social' patterns of use, integrated into the rules and supports of cultures and subcultures and informed by some direct experience of drug use, provides its own harm-minimisation methods and channels for sharing information.

Of course, there are limitations to this. Just as 'social drinking' can provide a facilitating environment for the problem drinker, for binges and for public or private violence, so 'social drug use' can provide the context in which a proportion overdo it or otherwise get into trouble. But social networks do provide their own opportunities for norms and knowledge to develop and so for harm to be held down. So, while accurate knowledge about forms of harm and ways of avoiding them (eg, don't inject) should be made available to these social groups, there will often be less need to 'target' them than the novice or heavy abuser.

Indeed, we can probably learn from these groups, and perhaps pass on their experience to novices.

FLIRTING WITH DANGER. With the third group — the minority who become *heavily* or otherwise destructively involved on a continuous or episodic basis — then we are back in the realm of urgent action.

The situation is however rather complicated, because heavy use may be shaped by deliberate flirtations with danger and ironic playing out of stereotyped 'addict' roles,[4] as well as by involvement with intoxication *per se*. Hence it cannot be assumed that direct risk-reduction messages will be heeded. Also, the poor material circumstances of at least some heavy abusers[5] do not lend themselves to harm-minimisation: eg, no money for the bus to get a clean needle; no warm coat to make the walk bearable; no tranquillity in which to consider the pros and cons of making an effort.

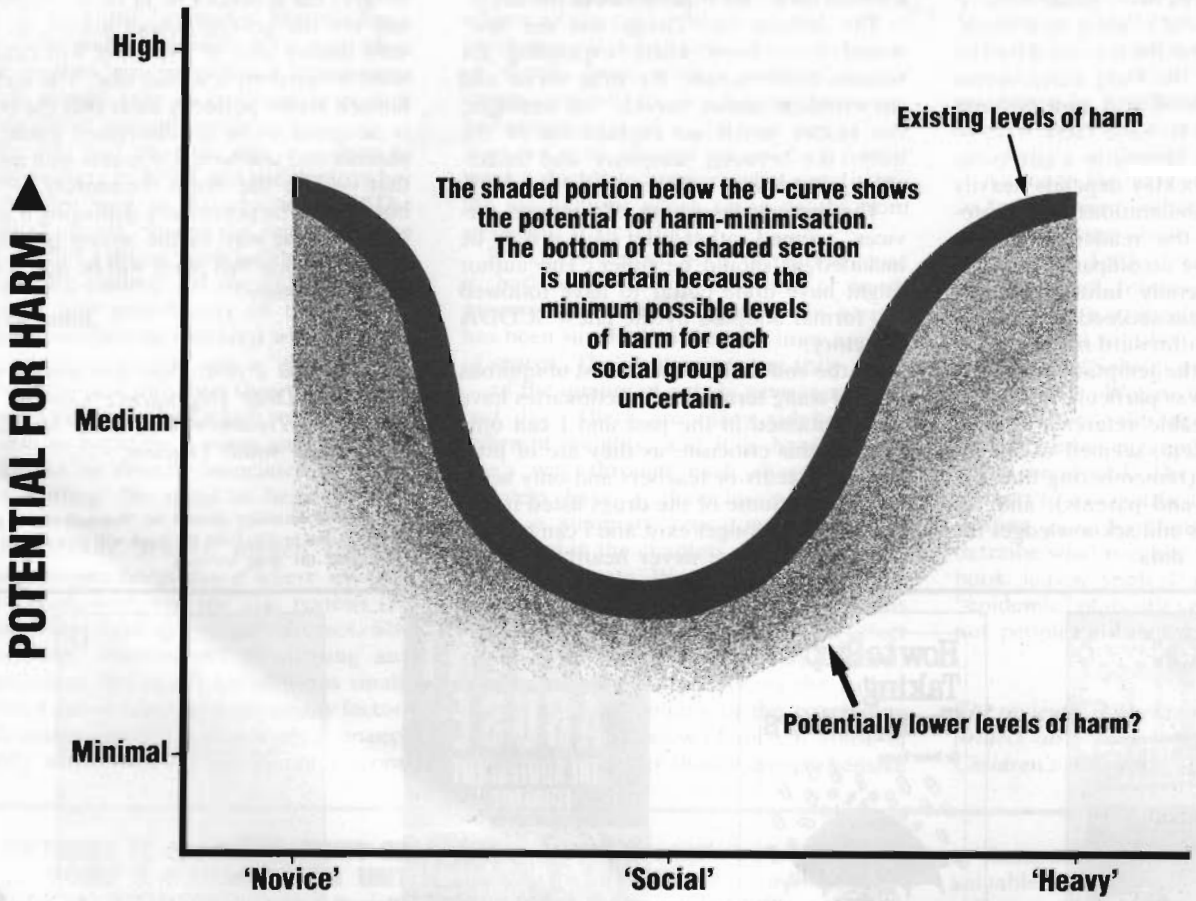
Here, didactic education methods — 'Why not smoke your smack [heroin] instead of injecting it?' — may be quite useless with people who are not well motivated to give up a self-image as a

SOME PRELIMINARY IMPLICATIONS OF U-CURVE THEORY

- With novice users and those who may soon become users, harm-minimisation is a prerequisite to any rounded prevention strategy. Implications of this are currently being dodged by purveyors of mass media and schools programmes.
- With populations in which patterns of drug use are established in relatively stable and controlled forms, the relationship between the population and the educator must be rather more two-way: the educator may learn about harm-minimisation from the users.
- With populations whose involvements with intoxicants are extreme (whether on a continuous or episodic basis) then harm-minimisation is again a priority. But economic, social and health service interventions — changing conditions for users and those around them — will be more efficacious than conventional types of public health information.

Nicholas Dorn is Assistant Director (Research) at ISDD and has been involved in research in the areas of education, social work and community and family responses.

HOW THE POTENTIAL FOR MINIMISING HARM MAY VARY WITH LEVEL OF INVOLVEMENT IN DRUG USE



heavy and/or chaotic user (while such methods might work better with novices). Social and health care interventions are more likely to be helpful — eg, supplying clean needles on a local basis; attempts to find positive aspects in the subculture to which prevention can be allied; economic reforms and community programmes yielding job and other opportunities to provide some stability. There are also opportunities to work with parents, spouses and friends in ways that help them to moderate the harm suffered by heavy users, and to reduce their own distress.

SOME IMPORTANT DISTINCTIONS. No framework or theory can be applied rigidly to every individual case, since there will be variations in types and levels of risks faced *within* each social group or population. Nevertheless, some overall framework is always needed as a guide at the macro level, ie, when planning prevention strategies in relation to *groups*.

Some groups are more open to drug-related harm than others. With this in mind, we can make a distinction between the degree of harm faced by each group, and the potential for minimising it. Whatever the level of harm within a social group, the potential for reducing harm will always be less than that level, because it is impossible to get rid of all drug-related harm except by absolutely preventing drug use (and nobody knows how to do that). We can strive to minimise harm, but have to accept that there will always be a residue.

With limited resources and imperfect methods, each of us has to decide where to put our energies —which group to focus on (novices, users, heavy users, etc) and what methods to adopt with that group. Such decisions can be difficult to take, but there seems little justification for ignoring the issue.

AS WITH ANY attempt to bring together disparate experiences, this account of the prospects for harm-minimisation with social groups would benefit from challenges, revision, and subsequent elaboration.

One clear shortcoming of this account is that it understates the differences in types (as distinct from levels) of harm likely to befall different social groups. Another possible difficulty, epitomised by the U-curve diagram, is that the shape of the curve is arguable. Should it be re-drawn so that novices are shown as being more open to harm than heavy users? — or vice versa? Should the curve be flatter, more accentuated, or a rather different shape? Given any particular social group, how great is the potential for reducing each of the various aspects of harm (social, legal, physical, etc) and by what means can these various aspects be addressed? Answers to these questions are still elusive.

The purpose of putting forward this preliminary note is to offer U-curve theory as an alternative to the 'for-or-against' debates on harm-minimisation up to now, and as a stimulus to something better. □

1. The term harm-minimisation is used in preference to the alternative, harm-reduction, since the aim is to explore the possibilities for reducing drug-related harm to a minimum rather than merely reducing it. The term harm-reduction betrays a certain ambivalence in the stance of those who use it.
2. See: Advisory Council on the Misuse of Drugs. *Treatment and rehabilitation*. HMSO, 1982.
Advisory Council on the Misuse of Drugs. *Prevention*. HMSO, 1984.
3. This would be an arguable point if drug education were effective in relation to the goal of preventing experimentation, but — since it is not even partially so — the only course of preventive action open to a *health* educator (or indeed any rational person concerned about reducing human suffering) remains harm-minimisation. If one likes to add in a little inert 'use-prevention' for appearance's sake, then so be it.
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DRUG WARNING: AN ILLUSTRATED GUIDE FOR PARENTS AND TEACHERS. David Stockley. London: Macdonald, 1986. 160 pages. £12.95 hardback, £6.95 paperback.

"This remarkable book is designed as a *Baedeker* to guide the inexperienced traveller in this difficult area. It succeeds in that aim, but unlike so many guide books it also makes fascinating reading as a narrative." This quote from the foreword by The Right Honourable, the Lord Lane, seems fair enough. The book is a well laid out drug-by-drug guide to basic facts, easy to dip into to find the answer to a particular question. David Stockley depends heavily on the supporting illustrations and photographs to inform the reader, but it is encouraging that the accompanying text is accurate and generally informative. In general the author has succeeded in stating the facts in a straightforward manner without succumbing to the temptation of overstating his case. I was particularly pleased to see that the sizable reference section covering statistics, etc, seemed useful for the general reader (remembering that it is aimed at teachers and parents), and the author also explains and acknowledges the limitations of such data.

There are a few points warranting criticism which could easily be corrected in future editions. Perhaps the main one is that the photographs of the drugs are frequently of enormous quantities, the like of which a parent or teacher would be most unlikely to see. Photographic illustrations in such a book should obviously concentrate on small, user-quantities of the drugs.

The section on "Drugs and the law" would have been worth expanding for readers from outside the drug scene and the criminal justice service: for example, the reader needs an explanation of the difference between 'summary' and 'indictable' offences.

The section describing "Treatment services" seemed rather brief — if it is to be included, it should be fuller. The author might have done better to have followed the format adopted by the latest SCODA directory.

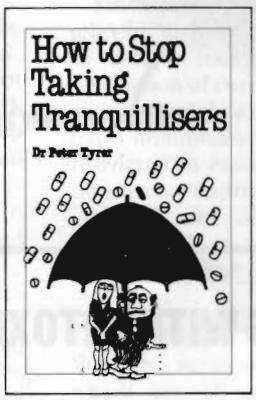
At the end there is the almost ubiquitous A-Z of slang terms. Such dictionaries have been criticised in the past and I can only support this criticism, as they are of little help to parents or teachers and only serve to titillate. Some of the drugs listed in the dictionary no longer exist and I can honestly say that I have never heard an addict refer to his needle and syringe as his "artillery". Perhaps such slang changes too rapidly and is too local to lend itself to such a dictionary, for I was surprised to find no reference to two commonly-used terms — 'gouching' and 'tooting'.

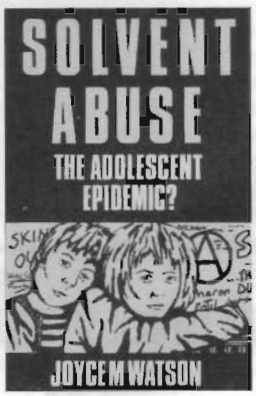
In general, despite these criticisms, a worthwhile book and a useful addition to a library, but it should be in the staff library and not the general school library. In the staff library and at ISDD, it will occupy what is currently a vacant slot. The author himself seems perfectly clear that the book is designed to be an illustrated guide for parents and teachers. He seems well aware that — like the drugs themselves — the book could be potentially damaging if used in the wrong way by the wrong people. I only hope that this point will be noted and taken seriously.

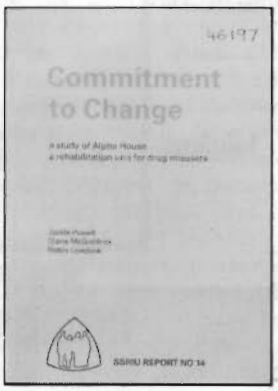
John Strang

Dr Strang is a consultant psychiatrist and heads the Drug Dependence Clinical Research and Treatment Unit at the Maudsley Hospital in south London.

P.S. David Stockley should be thanked warmly for deciding that profits from the book will go to SCODA's trust fund for drug services.







HOW TO STOP TAKING TRANQUILLISERS. Peter Tyrer. London: Sheldon Press, 1986. 112 pages. £7.95 hardback, £2.50 paperback.

This is the latest book in Sheldon Press' series "Overcoming Common Problems". All the books are based on a self-help model and aimed specifically at those suffering from the problem identified in the title of each book. This book takes the same approach, drawing on Peter Tyrer's extensive research and clinical experience in the field of benzodiazepine dependence.

The author takes the reader step by step through the process of withdrawing; beginning with the basic facts about tranquillisers, moving onto alternative withdrawal procedures, and then onto how to stay off the tablets. It concludes with a list of the agencies (state and voluntary) that someone withdrawing can use for further help.

This book is the best of its kind presently on the market. Within less than a hundred pages of text it provides sensible, comprehensive and unsensationalised advice on giving up tranquillisers. A number of aspects stand out. Firstly, it is written in such a way as to be accessible to a large audience. Secondly, the author communicates the variety of experiences to be expected on terminating tranquilliser use, without making it sound overly complicated or frighteningly unpredictable.

He has largely avoided the shock-horror approach, typical of many books in this field, and which is so often counter-productive in helping people to relinquish tranquillisers. Instead, his down-to-earth attitude enables a number of myths to be exploded — such as how coming off tranquillisers is 'more difficult than coming off "hard" drugs' — and enables the reader to make an informed decision as to whether or not to withdraw.

Peter Tyrer rightly pays attention to the psychological components of withdrawal, recognising that users' attitudes to their drugs, and the reasons for their prescription, play an important role in the withdrawal process. An important implication of this is that one's problems do not end as soon as one has relinquished tranquillisers. The necessity of a further adjustment period for many, in which it is important to learn new ways of coping with stress, is rightly identified.

The book does have some shortcomings however. Firstly, in a field with limited empirical data, I found myself sceptical of some of the author's 'facts' — such as his statements regarding the relative dependence potentials of each of the benzodiazepines. I also queried the validity of his *Womans Own*-type 'how can I know if I'm dependent on tranquillisers' questionnaire — especially as the 'score' derived from it is used to determine whether one should rapidly withdraw or not.

In the absence of good evidence on the circumstances in which dependence is most likely to occur, it makes sense to be overly cautious and always withdraw slowly. Failure following rapid termination of use is often sufficient to ensure that the user is very resistant to trying again later.

These deficits in the book are, however, minor compared with the informed help it has to offer. Indeed, workers in the area of tranquilliser dependence could well learn as much from this book as their clients.

Paul Grantham

Paul Grantham is Acting Principal Psychologist in Bolton, chairs the Benzodiazepine Interest Group, and is currently conducting research into nitrazepam dependence.

SOLVENT ABUSE: THE ADOLESCENT EPIDEMIC? Joyce Watson. London: Croom Helm, 1986. 234 pages. £17.95 hardback, £8.95 paperback.

It's good to have a book about solvent sniffing by Joyce Watson, who has spoken so often and published so many papers on the topic. Dr Watson's scientific training means that she examines the evidence dispassionately and with little prejudice and reaches non-judgmental conclusions which should help to continue to reduce panic about solvent sniffing.

She has had the time and resources to study sniffing in detail and she deploys her knowledge well in the chapter on "The medical effects" where she reports on the 788 sniffers (101 of them habitual) she has personally studied. Of the 788, only one showed any abnormality of the nervous system and this disappeared when sniffing ceased. In only eight was a 'glue sniffers' rash' seen, and only two showed any liver abnormalities, both of which were found to be due to hepatitis A virus and therefore could not be directly associated with solvent sniffing. No renal or heart damage was observed.

In addition, Watson studied cases of young people hospitalised where solvents were implicated, and she also reviews the clinical literature on individual cases. She concludes: "the risk of developing any impairment due to solvent abuse is small. When it does occur, there are many factors such as lack of oxygen or individual susceptibility which might act singly or in combination, making it impossible to predict who might be at risk".

She is also direct about the evidence for 'withdrawal symptoms'. Only one of the 101 habitual sniffers (and none of the others) showed symptoms which might have been physical withdrawal effects, and only 12 of the habitual sniffers "described feelings of desperation about maintaining a source of supply", that is, some sort of psychological dependence. Her discussion of deaths from solvent sniffing is less comprehensive (she devotes only two and a half pages to it in a 234 page book) and does not even attempt the question I most want a doctor to answer: what exactly are the mechanisms which cause deaths from so-called 'toxic effects'?

It's an unpleasant book to read because it has been set direct from a word-processed typescript which (even worse) has been justified so that the lines are full of spaces. The illustrations are truly awful — of the quality of a daily newspaper on a bad day. There are many sub-heads of different weights, and it is hard to find one's way through each chapter. Most chapters have a "Conclusion" which is really a summary repeating information contained in the chapters. There are other repetitious parts. Watson started studying solvent misuse for a thesis and the thesis origins of this book are visible. One effect is the narrow (and often tediously detailed) Scottish focus; it is mainly, as the author admits at the beginning of the concluding chapter, an "overview of solvent abuse in Strathclyde" rather than a comprehensive UK-wide guide to solvent sniffing and responses to it.

Who should read this book? It is said to be for: those who are directly involved in dealing with solvent abusers; those providing services for children; or those who feel they should know more about the problem. But the lack of information about approaches to treatment and prevention techniques means that it is of less use than it might be. Chapter eight is on ways of tackling the problem, but only considers responses in Strathclyde. And, even so, there is little critical analysis of the various Strathclyde initiatives.

Although the book concludes with a plea to treat solvent sniffing in the context of other substance abuse, it does not provide this context. Little reference is made to the use of alcohol, tobacco or other drugs and the text has a strangely detached feel. We are provided with two case histories in the chapter on "Solvent abuse in the family" but, despite Watson's extensive contact with sniffers, the actual experience of sniffing and its meaning for those involved is not presented. The detachment so important to a scientific approach to solvent sniffing is a hindrance when trying to describe what it is like to be a sniffer. This book leaves sniffers in the grip of the "epidemic" of its title: patients and victims, not people with stories to tell.

Richard Ives

The reviewer is working on a DHSS-funded project on solvent misuse at the National Children's Bureau.

COMMITMENT TO CHANGE: A STUDY OF ALPHA HOUSE A REHABILITATION UNIT FOR DRUG MISUSERS. Jackie Powell, Diane McGoldrick and Robin Lovelock. Portsmouth: Social Services Research and Intelligence Unit, 1986. vi, 282 pages. £5.25.

Commitment to change was report number 14 in the series produced by the Social Services Research and Intelligence Unit, which is run under the joint auspices of Portsmouth Polytechnic and the Hampshire Social Services Department. A team of three researchers spent a year researching Alpha House, a so-called 'concept-based' therapeutic community for drug users where residents work their way through a structured programme lasting a year or more. Briefly, their terms of reference were to examine and report on: the content and structure of the clinical programme; staff development; and the geographical territory served by the project. This research report describes how a therapeutic community works, and also gives a statistical account of the throughput of residents. Methods used were tape-recorded semi-structured interviews, observation, and analysis of the records.

The problems posed by this type of research are common in social research, where the funders of the research have in mind management consultancy based on an investigation, rather than social research. The background to the research included at one stage the request to have a "full and independent enquiry into the management both administrative and therapeutic, of Alpha House". Interesting developments in the United States[1] propose "action research" as a way of combining social research with issues involving interpersonal conflict which underly many of the real practice and policy issues facing practitioners.

I was disappointed that the study was not put in the context of other drug abuse research, and that there was little analysis. Resident and staff views were presented, but there was no framework within which to assess the information. Key constructs — "commitment" and "change" — were not explained, nor was there an analysis of how this treatment enables individuals to become drug free. Research in the field of drug abuse generally, however, suffers very much from a lack of theory. One of the recent major drug rehabilitation studies carried out in Sweden concludes: "if we wish to study . . . treatment processes . . . , we need a theory about change in human beings with addiction as a starting point".[2]

Unfortunately, the researchers in this project had only one year to write and research it, symptomatic of the small amount of time and money spent on drug abuse research in this country. Without coordinated research, a clear understanding of the psychological and social processes in the addictions and the appropriate network of services needed will not be developed.

This book provides a good description of a therapeutic community, and will be valuable for those who want to know how such communities are run. The resident and staff interviews provided interesting reading on the observations of those working and living at Alpha House. Quotations from interviews are used effectively and enable the reader to understand the point of view of residents spending time in such a community, and to have an insight into the kind of circumstances that lead an individual into residential rehabilitation. Statistics on through-put compliment the qualitative description of the processes of the programme.

For all those who think that residents in concept houses still wear placards and have their heads shaved, this report is essential reading!

Commitment to change will also be useful for those who work in street agencies or in other services where clients may be considering residential rehabilitation.

Anita Kaye

The reviewer is research officer for Phoenix House, which provides therapeutic communities for drug users in the UK.

1. Argyris C., Putnam R. and McLain Smith D. *Action science*. Jossey-Bass, 1985.
2. Segracus V. Research on the treatment of alcoholics and drug addicts during the 1970s in Sweden. In *Eighth World Conference of Therapeutic Communities, vol. 2*, 1985.

DRUG USERS WANT HELP TO HELP THEMSELVES

Professionals are paid to have ideas about how drug users can be helped. But, given the chance, what would drug users say about how drug problems should be tackled? In Manchester, they found out.

Mike Hindson

IN THE SUMMER of 1985, a survey was undertaken of probation clients in the City of Manchester to discover levels of drug abuse. At the end of the survey, respondents were asked to suggest ways in which people with drug problems and their families and friends might be helped. The answers were illuminating, especially for any practitioners who may regard treatment as everything. Treatment in the medical sense is certainly not overlooked — but drug misuse's causes and cures are to a large degree seen to lie elsewhere.

Many drug users are only too aware of their own weaknesses and therefore would welcome more external constraints on their behaviour, of the kind which require action from central government. In particular, there are calls for extra curbs on drug imports, greater police success in arresting drug traders and harsher sentences for those caught. In other words, users are arguing for a substantial shift in the cost-benefit ratio so that drug use might become both more difficult and more expensive.

The other cause which demands government action is the frequent link between drug use and unemployment and consequent boredom. Self respect is seen as stemming from having a defined role in society, the absence of which allows many to adopt the alternative status of drug user, with its temporary but alluring alternative satisfactions.

Mike Hindson is assistant chief probation officer with the Greater Manchester Probation Service

It is in drug misusers' suggestions for ways of overcoming drug problems that the survey has most to say to those who offer professional services, from either a medical or a social standpoint. While such services are essential, we at times lack the humility to admit that our skills are not totally sufficient, and, at worst, we sometimes spend too much time and energy arguing among ourselves as to who is the possessor of the most relevant skill. At times we lose sight of what is needed, in the desire to be the one who has the best answer.

The required dose of humility is thankfully delivered by the misusers' answers, which reveal that they are encouragingly like the rest of us, not very far down. What they want are more self-help groups for themselves where they can feel totally understood, where they can offer as well as gain support, and gather strength to persevere with good intentions so easily cast aside in isolation. In addition, groups for relatives are advocated, because they also need support but also as a means of increasing their understanding, without which they can so easily and unwittingly lead a misuser to return to the habit.

SUCH SUGGESTIONS hold no fear for professional workers, for our resources are nowhere near sufficient to meet the problem. What the survey does indicate is that instead of working ourselves into the ground offering direct services to misusers, we might do better to divert a proportion of our energies to acting as a catalyst, helping others to set up self-help groups. They will at times need our support and guidance, but the help offered will be considerably increased and often of a more real and relevant quality than we can directly offer. We may lose the satisfaction of being the ones who have the best answer, but at least our new-found humility will have done us proud. □

LETTERS

Volunteer workers not at fault

Dear Editor,

In response to several letters in the last issue of ***Druglink*** written as a result of my article "No free lunches" (see ***Druglink*** September/October 1986), I would like to make a number of points.

I agree that our experience was due to situational factors and not due to the shortcomings of volunteers, nor to the training they received, which was fundamentally 'customer centred' and 'problem orientated'. Indeed, volunteers were consulted over the paper prior to publication, and agreed with the accuracy of its contents.

Maintaining enthusiasm among volunteers was certainly an issue, due primarily to a lack of customer contact. I would agree this can be mitigated by enlarging the role of volunteers and involving them in the development of the project.

Joan Goode, Birmingham Drugline, and her volunteers make useful comments and suggestions which should be considered by anyone thinking of staffing a project with the help of volunteers. Most of the points had already been incorporated by Druglink, including thorough publicity of the project.

Paula Hendry of SAND puts her finger on the central issue when she refers to the time factor necessary for (recruiting) training, supporting and supervising volunteers. I accept her assertion that volunteers can bring a lot to a project. However, I do not believe the use of volunteers is essential to a *broad* and *informed* development of a project.

At the end of the day, projects need to balance the advantages against the disadvantages of using volunteers. To decide against the use of volunteers, as we did in Swindon, is not to reject the principle out of hand. We are in the process of appointing a full-time project worker. It may be that under changed circumstances, volunteers will again play a mutually agreed, satisfying role in Swindon.

Andy Malinowski

Project leader, Druglink, Swindon

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

Alcohol and drugs — let's join forces

Dear Editor,

While agreeing wholeheartedly with all that Don Steele said in ***Druglink*** about the greater extent of alcohol problems in our society and the lack of a proper resource, I think that there are facets of the argument that have not been mentioned.

Firstly, it is erroneous to think that the recent finance made available is restricted to illicit drug use: most agencies include benzodiazepines, antidepressants and solvents in the range of their services.

Secondly, within the important field of training and education, drug agencies such as our own give a high profile to the extent of legal drug problems associated with alcohol and tobacco. Comparisons between the extent of legal versus illegal drug problems and the fact that we are a drug-promoting society, are vital aspects of de-sensationalising the current drug panic.

Thirdly, it would be a great mistake to think that the decision whether to 'take on' the illicit side rests with alcohol agencies. 'Drug' agencies are now starting to encompass alcohol within their services to problem substance users, either by amalgamation or expansion.

The current philosophy is not that a particular substance has horns and a tail or that an individual can catch a particular 'addiction' as a disease. Rather that substances are used as part of coping strategies, a prop against problems, and escape from pressure. Therefore the dependency could be on any drug, legal or illegal, or indeed on substances and habits outside the drug field.

It is therefore *not* clear, as Don Steele suggests, that a choice has to be made between concentrating on the minority 'addicted' to drugs or alcohol, or responding to the whole range of alcohol problems in the population. Indeed, there is a practical reason for joining forces: illegal drugs are currently politically 'trendy' enough to receive some (limited) funding, but times change, and we should be combining our strengths. Being divided, we are easier to rule, and less able to promote the need to look at underlying causes as well as practical problems.

The more important reason to combine is one of similar philosophy — helping those with problem drug use on both sides of the current law, and educating about the complex nature of dependency.

It would be a shame, therefore, if some alcohol agencies became isolated by a reactionary defensiveness rather than joining forces to fight for better services generally.

David Hicks

Coordinator, Drug Concern (Barnet) in north London.