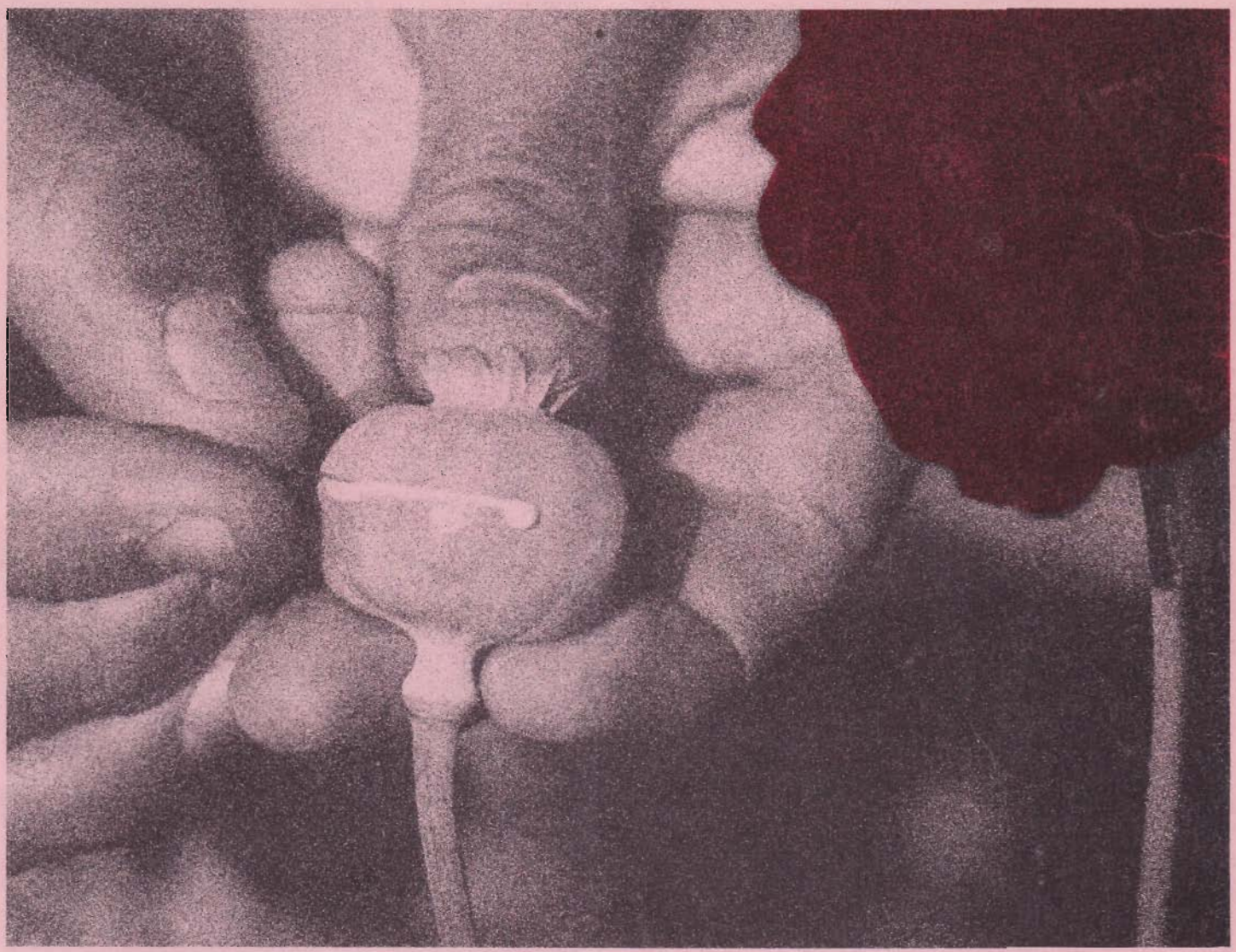
DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN May/June 1986



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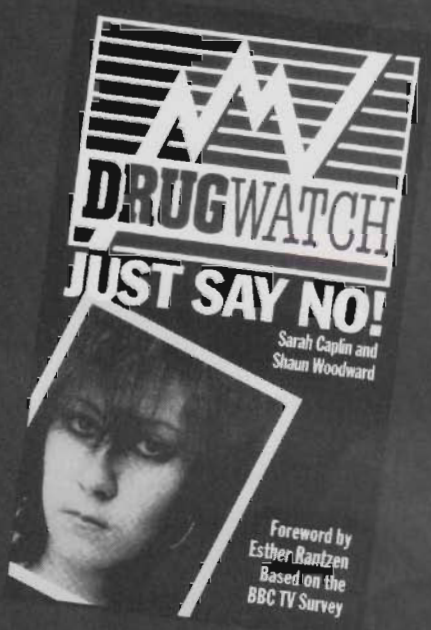

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DRUGLINK

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THE JOURNAL ON DRUG MISUSE IN BRITAIN

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

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

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Cover photo: opium gum oozes from the incised seed capsule of *papaver somniferum*, the opium poppy.

IN THIS ISSUE

isdd INSTITUTE FOR THE STUDY OF DRUG DEPENDENCE

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Studies suggest drugs and unemployment link

Despite loud pooh-poohs from some government quarters, the idea that unemployment is contributing to Britain's drug problem keeps coming back. Parts of Glasgow and the Wirral area of Merseyside are two acknowledged heroin blackspots. Recent reports on both *suggest* a more than incidental link with unemployment and deprivation. But no British study has been designed specifically to test this link, so its existence remains an intriguing but open question.

Drug problems in Glasgow[1] reports on research done in 1983/4. The author plotted indicators of opiate use in different districts and compared these maps with levels of unemployment and social deprivation: "the similarity [was] unmistakeable. Quite clearly the majority of identified opiate users come from the poorer areas of the city." Closer scrutiny of one area of multiple deprivation revealed a high rate of heroin injecting in the 17-25 years age group, among whom unemployment approached 40 per cent. Opinion in the area (as in other areas) was that unemployment is the "root cause" of increased drug problems.

The author suggests a sense of futility in young people living in areas of high unemployment, may mean they are more willing to seek immediate gratification without thought for the future. Coupled with ease of access to heroin and the drug's seductive psychological effects, the result may be the high levels of regular heroin use observed in the study.

A strikingly similar picture emerges from a report on *Drug misuse in Wirral*[2] by researchers from the University of Liverpool. In this area too, known heroin users tended to be in their late teens or early twenties and over 80 per cent were unemployed. Again the areas of deprivation and heroin misuse overlapped. "The highest rates of heroin use were found in the larger townships or estates with the highest unemployment rates. The majority of [heroin] users come from Wirral's most deprived areas." In one of these areas, over eight per cent of 16-24 year olds were known to have used heroin in 1984/5.

Still the authors stop short of claiming their work proves unemployment helps cause heroin use. Exceptions to the 'high unemployment = high heroin use' rule are explained in terms of the relative availability of heroin and proximity to deprived areas of high heroin use.

A team of researchers from Middlesex polytechnic has taken a look at heroin use in the North as a whole. Their report *Young people and heroin use in the North of England*[3] targeted ten neighbourhoods in Manchester, Merseyside and South Yorkshire where "a specific heroin network was at its highest density". Because of the research already going on there, Wirral was excluded. Nevertheless a comparison with 1981 census statistics on unemployment and other measures showed "how heroin misuse and social deprivation tend to gather together in tight geographical proximity" — the pattern observed in Glasgow and Wirral.

Further north in the Lothian region of Scotland around Edinburgh, 1000 15- and 16-year-olds from five secondary schools were questionnaired about their drug use. This initial survey was due in 1979-80. More than three years later, aged 19-20 and now out of school, most of the previous respondents were asked about their drug use again. Over a quarter had used illicit drugs, though opiates had been used by only a very small minority. The average number of illicit drugs ever used was significantly higher among the 12 per cent who were unemployed, yet three years earlier their drug use had been virtually indistinguishable from the remainder.

In their book, *Alcohol, drugs, and school leavers*[4], the authors are cautious in their interpretations. But what they have been able to do is eliminate the possibility that drug use in school led to later unemployment.

The Scottish Home and Health Department issued a statement to coincide with the book's publication, insisting there was no *established* causal link between unemployment and drug abuse (*Scotsman*, 7 November 1985). Limitations in the available research and examples such as Northern Ireland — with high unemployment but no real heroin problem — shows this statement is correct. But the fact it was issued indicates how politically sensitive is the suggestion that the economic and social policies of the government currently running Britain's first mass media anti-heroin campaign, may have helped cause the heroin problem in the first place. The research was not capable of proving the reverse — that unemployment led to drug use — but this remains a possible explanation of the findings.

1. Haw S. *Drug problems in Greater Glasgow*. Glasgow: SCODA, 1985. Available from SCODA, same address as ISDD.
2. Parker H *et al. Drug misuse in Wirral*. University of Liverpool, 1986. Available from the authors at the University of Liverpool.
3. Pearson G. *et al. Young people and heroin use in the North of England*. Middlesex Polytechnic, 1985.
4. Plant M. *et al. Alcohol, drugs, and school-leavers*. London: Tavistock, 1985.

Tranquillisers controlled but possession legal

From 1 April 1986, 33 of the benzodiazepine group of drugs were controlled under the Misuse of Drugs Act. Among them are the most frequently prescribed drugs in Britain, including tranquillisers and sleeping pills such as:

- ▶ diazepam, trade names Valium, etc, prescribed 7.85 million times in Great Britain in 1981;
- ▶ nitrazepam, trade names Mogadon, etc, over 8.2 million prescriptions in 1981;
- ▶ chlordiazepoxide, trade names Librium, etc;
- ▶ lorazepam, trade names Ativan, etc.

In England in 1983, pharmacists dispensed 23.3 million prescriptions for all benzodiazepines.

The legislation is intended to bring the UK into line with the United Nations Convention on Psychotropic Substances, an international drug control agreement to which Britain is a signatory. In February 1984 the UN voted to control the 33 benzodiazepines under the Psychotropic Convention. To ratify (ie, implement) the Convention, Britain had to duplicate the UN's move in its domestic legislation, hence the new law.

Benzodiazepines are in a schedule to the Convention which requires only minimal controls. These drugs are already prescription-only medicines under Britain's Medicines Act, which makes supply other than by prescription an offence. To bring them under the Misuse of Drugs Act, the British government created a new set of custom-made controls which do little to alter the existing situation, and put them in class C, the class of drugs with the lowest maximum penalties.

It is still not illegal to possess benzodiazepine tranquillisers in the form of a medicinal product, even without a prescription, nor to administer them to someone else as directed by a doctor or dentist. But unauthorised administration or supply are now offences under the Misuse of Drugs Act, with a maximum penalty for supply of three months plus £500 fine at a magistrates court, or five years plus unlimited fine at a Crown Court. The same maximum penalties apply to allowing the illegal supply of tranquillisers on premises you occupy or manage. Pharmacy and medical practice are practically unaffected by the new controls.

Technical changes impose record-keeping requirements on manufacturers, importers and exporters. There is now an obligation on the UK to prevent the export of tranquillisers to countries which have banned their import, assuming those countries are party to the UN Convention.

It was partly because of these requirements on licit traders and manufacturers that the UK opposed the international control of most of the 33 tranquillisers. Avoidance of trading restrictions was also behind the pharmaceutical industry's opposition to international controls on some of its most profitable commodities. The controls give developing countries in particular a means of preventing or restricting the distribution and marketing of imported benzodiazepines and thus exercising control over the activities of powerful private pharmaceutical interests.

With the benzodiazepines under Misuse of Drugs Act controls, the UK is now able to meet all its obligations under the UN Convention on Psychotropic Substances. The instrument of ratification was deposited at the UN on 24 March 1986 and the UK becomes party to the Convention on 22 June 1986.

The 33 benzodiazepines controlled in Schedule 4 to the Misuse of Drugs Regulations 1985 are: alprazolam, bromazepam, camazepam, chlordiazepoxide, clobazam, clonazepam, clorazepic acid, clotiazepam, cloxazolam, delorazepam, diazepam, estazolam, ethyl loflazepate, fludiazepam, flunitrazepam, flurazepam, halazepam, haloxazolam, ketazolam, loprazolam, lorazepam, lormetazepam, medazepam, nimetazepam, nitrazepam, nordazepam, oxazepam, oxazolam, pinazepam, prazepam, temazepam, tetrazepam, triazolam.

Drug Trafficking Offences Bill could backfire

The Drug Trafficking Offences Bill continues to progress through Parliament without real debate over many of its provisions. The Bill, if passed, will enable courts to confiscate money and goods accumulated in the five years before conviction of any defendant convicted of a trafficking offence.

In the present atmosphere, it appears that draconian legislation with far-reaching consequences for the entire criminal justice system can be nodded through, provided such legislation is associated with drug dealers. Already, some provisions echoing the Drug Trafficking Offences Bill have appeared in the Criminal Justice Bill.

Many criminal lawyers are convinced that the proposed legislation will affect small-time user-dealers, as well as the relatively small number of defendants who appear on major trafficking charges. The consequences of being convicted of any drugs offence involving supply are going to be so appalling that, at Release, we fear there will be an increase in the number of people entering 'not guilty' pleas at Crown Court, creating additional court costs.

The most troubling aspect of the Bill is the proposal to act on "a written statement, which, in the opinion of the person making it, is the value of the proceeds of drugs trafficking by the defendant". (s2.2) Inevitably, such statements are going to be made by CID officers. Statements by police officers on matters relating to drugs are often unreliable and ill-informed. For the first time in criminal procedure, such statements made after conviction will give police a direct influence on sentencing levels.

In a recent case I dealt with, an officer arrested a man in possession of just under four ounces of very impure amphetamine. It was clear that supply to a number of people was about to take place. The officer in charge of the case offered a statement running to 11 pages venturing an expert opinion on the behaviour of an 'average' addict. He maintained the defendant had been buying at least 16 ounces at a time, though there was no evidence to support anything other than one transaction involving four ounces. At one stage, he informed the jury that an average addict using an average dose of amphetamine daily would die after nine months.

The defendant would have pleaded 'guilty' if the evidence had dealt with only the four ounces of amphetamine, saving four days jury trial. He had been working as a self-employed odd-job man. Some of his work was done for cash, and some involved proper receipts and invoices. He had a house, a mortgage, a wife, and a young baby.

Under the proposed legislation, the courts might have relied on the police officer's 'expert' assessment of the scale of drug dealing over the previous five years, with no additional evidence, to confiscate any sums of money or goods paid for by way of unreceipted income. In my view, having looked at his account books, it was impossible to assess what the legitimate income of the defendant had been, so almost all his income would have been regarded as suspect, and his wife and child would probably have had their house sold over their heads.

Over and over again, in advising defendants facing drug charges at Release we find police pitching the significance and scale of drugs cases too high, and defendants whose cases could have been disposed of quickly and quietly plead 'not guilty' as a result. Raising the stakes for defendants by way of additional forfeiture procedures at the discretion of police officers, is going to mean that people facing trafficking charges have much less to lose by pleading 'not guilty'. The result? A substantial increase in contested cases with all the attendant court and legal costs.

Jane Goodsir
Release Co-ordinator

MISUSE OF DRUGS ACT

ISDD Information Service

This year UK drugs law received its biggest shakeup since the Misuse of Drugs Act 1971 came into effect in 1973. From 1 April 1986 the most frequently prescribed drugs in Britain — the benzodiazepine tranquillisers — became subject to the Act, under a new tailor-made set of controls.

At the same time the regulations detailing permitted uses of other controlled drugs were reorganised: anyone who previously knew what schedules 1, 2, 3 and 4 were all about, will now have to re-learn their regulations.

Earlier changes had increased penalties and brought the (still frequently prescribed) barbiturates under control. Time, then, for a fresh look at Britain's revamped drug law.

First we describe what the Misuse of Drugs Act aims to do and the main prohibitions it establishes to achieve these aims. Then explore the regulations classifying drugs according to the extent to which they are excused from these prohibitions. To complicate matters, 'controlled' drugs (shorthand for drugs controlled under the Misuse of Drugs Act) are divided up in a different way to set maximum penalties for offences involving them.

Tables 1, 2, 3 and 4 are explained in the text. Together they outline the Misuse of Drugs Act as it currently stands, concentrating on those features that most affect the general public (as opposed to the doctor, pharmacist, pharmaceutical industry, etc). Those involved in Misuse of Drugs Act prosecutions will need much more detailed guidance, of the kind that can be obtained from Release (01-603 8654) or from text books that cover case law as well as the statutes.

Aims and prohibitions

In its own words, the Misuse of Drugs Act aims to prevent the unauthorised use ('misuse') of "drugs which are being or appear . . . likely to be misused and of which the misuse is having or appears ... capable of having harmful effects sufficient to constitute a social problem ...". It is also the way the UK fulfills its obligation to control drugs in accordance with international agreements. To the man or woman in the street, the Misuse of Drugs Act is the law which makes it illegal to use (sic) a wide range of drugs without a prescription drugs like heroin, cocaine, LSD, cannabis, amphetamines.

The Act begins by defining the things it is illegal to do with the drugs it controls. Surprisingly (except for prepared opium) these prohibited activities do *not* include using the drugs. But they do include:

— possession (ie, just having the drug);

— possession with the intention of supplying the drug to another person;

— production (including cultivation);

— supply or offer to supply to another person (including giving, selling, sharing, bartering, etc);

— import or export;

— allowing premises you occupy or manage to be used for supplying or offering to supply drugs.

Possession, the first of these offences, is penalised less severely than the rest. Except for the last in the list, these more serious offences are known as 'trafficking' offences.

Exemptions

Most controlled drugs have medical uses, others may be of scientific interest, so the Act allows the government to authorise possession, supply, production and import or export of drugs to meet medical or scientific needs. These exemptions to the general prohibitions are in the form of 'regulations' made under the Act. It is these regulations that have recently been reorganised and extended to accommodate the benzodiazepine tranquillisers. (The new regulations are available from HMSO — ask for Statutory Instrument 1985 number 2066, *The Misuse of Drugs Regulations 1985*. They can also be consulted in ISDD's library.)

Schedule 1

The Misuse of Drugs Regulations now divide controlled drugs into five schedules (see *table 1*). Drugs in schedule 1 are the most stringently controlled. These drugs (such as LSD and cannabis) are not authorised for medical use and can only be supplied, possessed or administered in accordance with a Home Office licence. Such licences are issued only for research or other special purposes. Outside these rare exceptions there are no circumstances in which possessing, supplying, producing, etc, these drugs is permitted. Doctors cannot prescribe them nor pharmacists dispense them. This is the closest British law comes to absolute prohibition.

Schedule 5

At the other end of the scale is schedule 5, listing preparations of drugs considered to pose minimal risk of abuse. Some of these dilute, small-dose, non-injectable preparations are allowed to be sold over-the-counter at a pharmacy without a prescription, and all may be possessed by anyone with impunity. But once bought they cannot legally be supplied to another person, a restriction that is probably ignored more often than it is enforced. Among these schedule 5 preparations are some well-known cough medicines, anti-diarrhoea agents and mild painkillers.

Schedules 2, 3 and 4

Between the extremes of schedules 1 and 5 are schedules 2, 3 and 4, including the vast majority of controlled drugs. These drugs are available for medical use, but can only be supplied or administered in accordance with a prescription or other authority. Here we find heroin, a drug that can still legally be prescribed by any doctor to any patient for the treatment of physical disease or injury.

It is illegal to possess drugs in schedules 2 and 3 without a prescription or other authority; but so long as they are in the form of a medicinal product, the benzodiazepine tranquillisers in schedule 4 *can* legally be possessed, even *without* a prescription. So it is an offence for Mr X to give (ie, 'supply') Ms Y some of the Valium his doctor prescribed him, but Ms Y would be in the clear as she merely possessed the drug.

Penalties and classes

Drugs divided in the Regulations to define what counts as an offence, are divided up *differently* in the Act itself, according to the maximum penalties for these offences.

Class A drugs are thought to be the most harmful when misused, so the penalties are the highest; then comes class B and finally class C, with the least potential for harm and the lowest maximum penalties. In injectable form, drugs listed in class B count as class A.

Within each class, penalties are highest for 'trafficking' offences, less high for possession. Although maximum penalties are severe, they can only be imposed by a judge in a Crown court, where contested cases are tried by jury. Magistrates must either satisfy themselves with the limited penalties available to them or refer the case to a Crown court. Hence the distinction in *table 2* between maximum penalties on 'indictment' (ie, in a Crown court) or after 'summary' trial (ie, in a magistrates court).

The 2x2x3 matrix of maximum penalties, depending on the class of the drug, the seriousness of the offence, and the court trying the offence, is reflected in *table 2*.

Controlled drugs

Table 3 shows in general terms which types of drugs are in which schedule to the Regulations, and which class of the Act. *Table 4* is meant to help readers identify the control regimes (ie, schedules 1-5) and maximum penalties (ie, classes A, B and C) attaching to particular drugs. It is by no means a full list of drugs controlled under the Misuse of Drugs Act. For a full list, consult the new regulations.

Table 1 Misuse of Drugs Regulations[1]

	Drugs in schedule 1	2	3	4	5
Available to the general public on . . .					
Unrestricted sale	NO	NO	NO	NO	NO
Sale at pharmacies without a prescription	NO	NO	NO	NO	YES
Prescription	NO	YES	YES	YES	YES
Anyone can legally . . .					
Possess without a prescription or other authority	NO	NO	NO	YES[2]	YES
Import or export without a licence	NO	NO	NO	YES	YES
Administer to another person without special authority[3]	NO	YES	YES	YES	YES
		But only as directed by a doctor or dentist			

For all controlled drugs (schedules 1, 2, 3, 4 and 5) it is illegal to:
— supply, offer to supply, or possess intending to supply them to another person;
— allow supply or offers of supply on premises you occupy or manage;
— produce by cultivation, manufacture or any other method.

1. The regulations also give detailed instructions to manufacturers, suppliers, doctors and pharmacists regarding records, labelling, the writing of prescriptions, etc. This table outlines only those provisions that most affect the general public. For more detailed guidance turn to the Regulations or phone the Home Office Drugs Branch (01-213 4247).
2. But only in the form of a medicinal product.
3. In the Regulations, administration is distinct from supply. So, for instance, a mother may administer a dose of kaolin and morphine (a schedule 5 controlled drug) to her child without authorisation, but could commit an offence of supply if she gave the bottle to her husband.

Table 2 Maximum penalties

Offence	Type of trial	Class of Misuse of Drugs Act A	B[4]	C
Possession	Summary[2]	6 months + £2000 fine	3 months +£500 fine	3 months +£200 fine
	Indictment[3]	7 years + unlimited fine	5 years + unlimited fine	2 years + unlimited fine
'Trafficking'[1]	Summary[2]	6 months + £2000 fine	6 months + £2000 fine	3 months +£500 fine
	Indictment[3]	Life + unlimited fine	14 years + unlimited fine	5 years + unlimited fine

1. Includes supply, offer to supply, production, import and export. The same penalties apply to allowing premises to be used for supply. Unauthorised import or export are prohibited by the Misuse of Drugs Act but offences under the Customs and Excise Management Act, so fines on summary conviction can reach three times the value of the goods seized.
2. That is, when tried before a magistrates court.
3. That is, when tried before a Crown court.
4. Any class B drug in injectable form is treated as a class A drug.

Table 3 Main types of controlled drugs by schedule and class

Schedule	Class of Misuse of Drugs Act A	B	C
1	Active ingredients of cannabis Hallucinogens Raw opium Coca leaf	Cannabis and cannabis resin	
2	Strong opiates and opioids (heroin, morphine, etc) Cocaine Phencyclidine (PCP)	Strong stimulants (amphetamine, methylphenidate, etc) Weaker opiates and opioids (codeine, etc) Methaqualone and mecloqualone	Dextropropoxyphene
3		Pentazocine Barbiturates	Weaker stimulants (diethylpropion, phentermine, etc) Some sedatives and hypnotics (eg, meprobamate)
4			Benzodiazepine tranquillisers
5[2]	Preparations containing opium, morphine, certain opioids, and cocaine	Non-injectable preparations containing codeine and other weak opiates and opioids	Preparations containing dextropropoxyphene to be taken by mouth

1. Any class B drug in injectable form is treated as a class A drug.
2. Includes dilute and/or small dose preparations of certain of the drugs listed in schedule 2.

Table 4 A selected directory of controlled drugs

Class	Schedule	Drug
B	2	Amphetamine
B	3	Amylobarbitone (Amytal)
B	3	Barbiturates
C	4	Benzodiazepines
B	3	Butobarbitone (Soneryl)
B	1	Cannabis and cannabis resin
C	4	Chlordiazepoxide (Librium)
A	2 & 5	Cocaine
B	2 & 5	Codeine (Actifed, Phensedyl)
B	2	Dexamphetamine (Dexedrine)
A	2	Dextromoramide (Palfium)
C	2 & 5	Dextropropoxyphene (Distalgesic)
C	4	Diazepam (Valium)
C	3	Diethylpropion (Tenuate)
B	2 & 5	Dihydrocodeine (DF 118)
A	2	Dipipanone (Diconal)
A	2	Fentanyl
C	4	Flurazepam (Dalmane)
B	2	Glutethimide
A	2	Heroin
A	2	Levomethorphan
A	2	Levomoramide
C	4	Lorazepam (Ativan)
A	1	LSD, lysergamide
C	3	Meprobamate (Equanil)
A	2	Methadone (Physeptone)
B	2	Methaqualone
B	2	Methylamphetamine
B	2	Methylphenidate (Ritalin)
A	2 & 5	Morphine
C	4	Nitrazepam (Mogadon)
A	2 & 5	Opium, medicinal
A	1	Opium, raw
C	4	Oxazepam (Serenid)
B	3	Pentazocine (Fortral)
B	3	Pentobarbitone (Nembutal)
A	2	Pethidine (Pamergan)
B	2	Phenmetrazine
C	3	Phentermine
A	1	Psilocin and related compounds, found in Liberty Cap mushrooms
B	3	Quinalbarbitone (Seconal)
C	4	Temazepam (Euhypnos)
C	4	Triazolam (Halcion)

Drugs are listed in alphabetical order of their non-proprietary name. Common trade (or proprietary) names of those marketed for medical use in the UK are given in brackets.

PRACTICE NOTES

DRUGS: A FAMILY PROBLEM?

Having returned to work in an NHS drug dependency clinic after working in a family-based psychiatric service, I was naturally interested in the relevance of working with problem drug users in a family context.

My first impression was that for those clients who attend a drug clinic, there is nearly always a family member involved, even if the person is living on his/her own. However, what is striking is that in some families problematic drug use can continue or stop without affecting family dynamics, except in the most superficial of ways. The implication is that simply because a family is heavily involved with a problem drug user, family work is not always indicated, and can sometimes be more harmful than beneficial.

The second point is that there seem to be two types of family problems and that both these 'types' require distinct interventions, both in terms of therapy and in terms of prescribing.

The first type is where the drug user becomes a problem drug user *because* of a pathological family system. Like the work of family therapists with schizophrenia, it seems that because of faults within a family, one member presents with a mental illness. My experience is that similar types of families and individuals now find themselves being referred to drug clinics, with the 'problem' individual not being schizophrenic or mentally ill, but a problem drug user. (My impression is that this type of referral has increased since the government anti-heroin advertising campaign.)

The second type is one where, because of long-term drug use by one member, relationships within the family have started to revolve around that individual's drug use. It may be that parents are making allowances and arrangements (such as supplying money) which facilitate continued drug use by their adolescent son or daughter. Here the normal exercise of parental authority has been turned into a collusive relationship.

Problem family

In the first type, the problem that needs to be resolved first is the pattern of family relationships that is producing the problematic drug use. In one family I dealt with, the individual identified as having a drug problem stopped using drugs and left the family, only for his younger brother to start using drugs. In this case, simply helping one family member with his drug use was insufficient, because the conditions creating the 'diagnosis' of problem drug use were only going to produce further symptoms.

In such cases the prescribing of heroin substitutes such as methadone has little to do with solving the basic problem. In fact prescribing is secondary, and detoxification attempts will be 'sabotaged' by other family members, until the family has been able to resolve the basic differences which are creating the pressures that cause problem drug use.

Once the family intervention has been made, then a successful detoxification programme can be planned. However, even in these cases, methadone prescription can be a useful tool for engaging both problem drug users and their families.

Problem drug use

The second pattern starts from the opposite perspective. Since the drug use has become the central feature of family life, until it is either controlled or discontinued, it is not possible to look at the family patterns that have been created by the drug use. But it is surprising how many people, including myself, attempt to resolve family conflict while drug use still dominates this type of family.

In one family I dealt with all four members were using heroin, though only two were clinic patients. At our first meeting with them as a family, they were interested in when they'd get a prescription, whilst the therapist attempted straightaway to tackle relationships within the family. After one more meeting like this, one family member stopped coming to the clinic and the family as a unit was lost to further therapeutic intervention. If priority had been given to stabilising drug use before dealing with underlying relationships, then a more lasting and beneficial therapeutic intervention might have resulted.

Of course, life is not always as simple in practice as it is in theory. Recent experience suggests that some families are so problematic that it is not clear where one pattern started and another finished, or even if there is any continuity between the two. Eliminating problem drug use as the focus of family interaction may merely reveal further family problems, and it may be unclear whether these were caused by or caused the drug use, or were unrelated.

As a rule, the first type of family tends to present, at least at my drug clinic, as an adolescent or young adult, often accompanied by another family member, usually a parent, while the second type is a person in their 20s or early 30s, who come on their own.

Tom Aldridge
Social Worker, University College Hospital Drug Dependency Unit

***Practice Notes** will provide a regular opportunity for 'grassroots' workers to pass on lessons learnt from experiences in working with drug use or drug users.*

TALKING POINT from ISDD's library collection

Heroin-related crime — all bad?

"Probably the most important implication of chapter 12, however, lies in the jarring realisation that, from a purely economic standpoint, heroin-abuser criminality [in New York] is not all bad. In fact, although crime victims sustain important economic losses (not to mention non-economic considerations, such as fear of crime, anger, frustration), more persons gain than lose.

On an annual basis, the average heroin abuser probably committed about 25 crimes (robbery, burglary, and larceny) against individual victims who would complain to police. But he also committed an additional 75 non-drug crimes without clear victims (mainly shoplifting for resale, burglaries of abandoned buildings, and larcenies considered as losses by victims). The merchandise stolen during these shopliftings, other larcenies, and burglaries are purchased by many low-income neighbourhood residents at a relatively substantial discount. In addition, the heroin abuser supplied valued services (eg, sex or three-card-monte games) to 60 other persons.

The victims involved suffered economic losses of about $14,000, and the heroin abusers received about $5,800 in cash income. The purchasers of the stolen merchandise thus received a net gain of $8,200 worth of products with a higher economic value than they could afford."

Johnson B.D., Goldstein P.J., Preble E. *et al, Taking care of business: the economics of crime by heroin abusers.* Lexington, Mass: Lexington, 1985. xxi, 278 pages.

HEROIN IN BRITAIN

In this briefing, ISDD's information service pulls together what's known about heroin and its non-medical use in Britain, and highlights some of the issues involved in the UK's response to this use. *Heroin: ISDD drug notes 1* is also available from ISDD as a leaflet. The *Drug notes* series is intended to cover all the major drugs or drug groups misused in Britain. *Druglink* will feature these leaflets as they become available. See back page for further details.

Heroin is one of a group of drugs (the 'opiates') derived from the opium poppy with generally similar effects, notably the ability to reduce pain and anxiety. As well as being prescribed as pain-killers, opiates are used medically to treat coughs and diarrhoea. Opium is the dried 'milk' of the opium poppy. It contains morphine and codeine, both effective pain-killers, and from morphine it is not difficult to produce heroin which in pure form is a white fluffy powder with twice the potency of morphine.

In the nineteenth century opiates were a popular 'cure-all' and could be bought without prescription from grocers and other shops in the UK. Despite this free market, the level of abuse and health damage from opiates was relatively limited. However, opiates were a major cause of poisoning deaths and there were fears that the industrial working class might be using opiates as an intoxicant rather than a medicine. Doctors and pharmacists also wished for a monopoly on prescribing opiates for their own professional and economic interests, so in 1868 opiate sales were restricted to pharmacies. After the First World War, Britain implemented an international agreement and prohibited non-medical use of opium and opiates. Nevertheless, Britain has never denied that opiates, including heroin, could be prescribed to addicts who could not cope without the drug.

> "Yoo goo into druggist's shop o' market-day, into Cambridge, and you'll see the little boxes, doozens and doozens, a' ready on the counter; and never a venman's wife goo by, but what calls in for her pennord o' elevation, to last her out the week. Oh! ho! ho! Well, it keeps women-folk quiet, it do; and its mortal good agin ago' (ague) 'pains'."
> "But what is it?"
> "Opium, bor' alive, opium!"
> C Kingsley. *Alton Locke*. 1850.

This 'system', relying heavily on the doctor's discretion, worked well until the sixties when a group of younger addicts[1] emerged who recycled surplus heroin obtained from a few GPs. As a result, addiction spread and in 1968 all but a few specialist doctors were prohibited from prescribing heroin for addiction and hospital addiction treatment clinics were established. Not necessarily as a result, the mid-seventies saw the beginnings of a significant black market in imported illicitly manufactured heroin. Now nearly all the heroin misused in Britain comes illegally from abroad rather than from doctors.

A number of synthetic opiates (or opioids) are manufactured as pain-killers. These include pethidine (often used in childbirth), dipipanone (Diconal) and methadone (Physeptone), the drug often prescribed for opiate addiction. For simplicity the term opiates is used here to refer both to drugs derived from the opium poppy and to these synthetic substitutes. Drugs used in medicine may be sold under a number of trade names.

How opiates can be taken

To produce an effect opiates must be absorbed into the bloodstream. Most opiates, including heroin, are only poorly absorbed from the stomach after swallowing. Heroin is much more effective if it is sniffed, smoked or injected, so misusers will generally use these methods rather than 'waste' the drug by swallowing it. When sniffed, heroin is absorbed into the bloodstream in the nose. When smoked the heroin smoke is drawn into the lungs and very quickly enters the bloodstream. 'Chasing the dragon' is a way of smoking heroin by heating the powder and inhaling the fumes through a small tube. Heroin can be injected directly into the bloodstream through a vein; as with smoking the effects are practically immediate and also stronger, as none of the drug is 'lost' before entering the bloodstream.

Compared to other opiates, heroin is effective, acts quickly, is easy to dissolve in water for injection, and causes fewer side-effects like vomiting, facts which partly account for its relative popularity. Methadone is a synthetic opiate that (unlike most opiates) is effective when swallowed.

The law

Heroin and other opiates are controlled under the Misuse of Drugs Act, making it illegal to possess them or to supply them to other people without a prescription. The Act also bans unauthorised production, import or export. It is also an offence to allow premises to be used for producing or supplying these drugs.

The Misuse of Drugs Act divides drugs up into classes A, B and C. Maximum penalties are most severe for class A, least severe for class C.

'Trafficking' offences (producing or smuggling drugs, supply or intent to supply to other people) are more severely penalised than possession of drugs for personal use.

Heroin is in class A, where the maximum sentence for trafficking offences is life imprisonment plus fine; for possession, 7 years imprisonment plus fine.

Morphine, opium, methadone, dipipanone, and pethidine also appear in class A of the Act. Codeine and dihydrocodeine (DF118) are in class B. Dextropropoxyphene (Distalgesic, etc) is in class C. Some very dilute mixtures of codeine, morphine or opium (used as cough medicines or to treat diarrhoea) are exempt from most of the restrictions and can be bought over the counter from pharmacies. These include Actifed, Phensedyl. codeine linctus (all with codeine), Gee's Linctus, Collis Browne's mixture (opium) and kaolin and morphine mixture.

> Cigarette smoking is unquestionably more damaging to the human body than heroin.
> — Dr Vincent Dole in E Brecher. *Licit and illicit drugs*. Little Brown & Co, 1972.
>
> It was much easier to quit heroin than cigarettes.
> — Ex-addict, *New York Times*, 1971.

In practice relatively few offenders receive the maximum penalties allowed for in the Misuse of Drugs Act. In 1984, 40 per cent of those convicted of heroin offences were sentenced to immediate imprisonment, most of them for 2 years or less. Fines for heroin offences were usually between £20–£100.

Only specially licensed doctors can prescribe heroin or dipipanone for anything other than physical illness. This means most doctors cannot prescribe these drugs as a way of dealing with addiction. Apart from this, all opiates can be prescribed for their normal therapeutic uses. For instance, heroin is not uncommonly prescribed in Britain for the relief of severe pain in the terminally ill.

Users; how many and who?

Although licensed doctors can still prescribe heroin to addicts, most choose not to, so very little prescribed heroin reaches the illicit market. On the other hand, an illicit market in imported heroin has developed and in 1984 over 312 kilos of heroin were seized by British Customs. Since the late 1970s this smuggled heroin has become more and more easily available in Britain, and more people are using it and becoming dependent.

In 1983/4, illicit heroin was selling to users for about £60-80/gram, with sometimes wide regional variations. Relative to inflation, the price has halved since 1978. On average an addict might use ¼gm or more each day. More and cheaper heroin, coupled with the fact that heroin users and dealers no longer form subcultures separate from the wider society, mean that the drug is presently fairly easy to obtain.

Today, heroin on the illicit market in Britain originates largely from the Indian Sub-continent, though some still comes from SE Asia. At street level it is likely to have been diluted (or adulterated) with a

variety of powders of similar appearance, commonly lactose, glucose or mannitol (a laxative), but also chalk dust, caffeine, quinine, vitamin C and talcum powder. Recently heroin sold to users in Britain has been about 30-60% pure, the remaining 40-70% consisting of these various additives. Compared, say, with the USA, these purity levels are remarkably high.

Doctors must notify the Home Office of any opiate addicts they see in their practice[2]. During 1984 nearly 12,500 persons were notified. It is generally accepted that the number of people using opiates on a heavy and regular basis (approx. daily) is several times (perhaps five times) the number notified to the Home Office. Notified addicts generally inject and are very heavy users, but

Interviewer: Why did you try heroin again, if you got sick from it the first time?
Addict 1: Cause I liked, you know, like the high.
Interviewer: You said you got sick?
Addict 1: I got sick, but I got loaded. Got bombed . . . You get sick at the stomach, you know, but when you're loaded, you just don't care [You] just sit there nodding. [If you] feel sick, you just go, come back, and nod some more.
Addict 2: Well, I know one broad in particular. She begged me to give her . . . a shot, and she got deathly sick. And that was the last time she used it.
Interviewer: Did she say anything about it?
Addict 2: She said, if that's the way it is, she didn't want anything to do with it.

— W E McAuliffe. *A second look at first effects.* J. Drug Issues, 1975.

intermittent or 'recreational' use of heroin has developed amongst people in their late teens, the drug being sniffed or smoked rather than injected. Half the addicts first notified in 1984 were aged under 25.

Although spreading, the available surveys do not suggest that opiate use is yet widespread in the general population, with commonly 1 per cent or less of young people admitting any heroin use at all. Nevertheless in some areas (eg, deprived inner-city areas or amongst some well-off groups) recreational heroin smoking or sniffing may be quite common. For those who continue their use, injecting may become the preferred method.

In times of difficulty it is not unusual for heroin users to resort to other opiates, to sedatives, or to drinking large quantities of opiate-based cough medicines available without prescription from pharmacies; some people restrict their opiate misuse to these preparations.

Effects of using heroin

Opiates are effective painkillers, but they also produce a number of other physical effects. Like sedatives they depress the activity of the nervous system, slowing down breathing and heart-rate and suppressing the cough reflex. Opiates also increase the size of certain blood vessels (giving a feeling of warmth) and depress bowel activity (resulting in a tendency to constipation).

Rather than blocking the sensation of pain, heroin and other opiates make pain more tolerable by reducing the sufferer's emotional reactions to it, so although still felt the pain seems to matter less. More generally opiates cushion the user from the psychological impact of not just pain, but also hunger, discomfort, fear and anxiety. This relief from suffering is also experienced by many people as a positive feeling of well-being, contentment and happiness – a sense of being 'wrapped up in cotton wool'.

Even at doses sufficient to produce these feelings, the user is still capable of functioning adequately – s/he can, if necessary, think, talk and act coherently. At higher doses sedation takes over and the user becomes drowsy. Excessive doses produce stupor and coma, and possible death from respiratory failure. Overdose death is unlikely unless there are aggravating factors – other depressant drugs used at the same time (eg, alcohol), loss of tolerance (see below) or a dose of unexpected strength. There can also be fatal reactions to impurities injected with the heroin. With the uncertain contents and strength of 'street heroin', dangerous reactions of this kind can never be entirely ruled out.

The initial experience of heroin is not always pleasant. Especially after injecting there can be nausea and vomiting alongside or instead of pleasurable feelings. These unpleasant reactions fade with repeated use.

When injected into a vein, all the heroin is usually injected directly into the bloodstream at one go. This can intensify the initial effects into an almost immediate, short-lived burst of extremely pleasurable feelings, often described as a 'rush'. Other ways of taking heroin give less intense feelings, though after smoking the effects are also practically immediate.

And the consequences?

Tolerance refers to the way the body usually adapts to the repeated presence of a drug, meaning that more must be taken to produce the same effects. Tolerance develops to opiates such that someone attempting to repeat their initial experiences must increase the dose and/or change their method of administration. Injection into a vein maximises the effects of a given amount of heroin and produces a much more intense, immediate experience. So as tolerance develops (and perhaps as money runs short), there may be a tendency to move from sniffing or smoking heroin to injecting.

If the user is unable to step up the dose to overcome tolerance (eg, due to shortage of money or supplies), a point will be reached at which this dose will fail to recreate the desired effects. Even *if* the user is able to continue increasing the dosage eventually the same will happen – the person will be using the drug just to feel normal and avoid withdrawal effects. Tolerance also develops to the respiratory-depressant effects of opiates. This means that gradually increasing the dose does not in itself increase the risk of death through overdose. However, fatal overdoses can happen when opiate users take their usual dose after a break during which tolerance has faded.

After as little as several weeks on high, frequent doses of heroin, sudden withdrawal results in differing degrees of discomfort some compare to a bad bout of influenza. The effects start 8-12 hours after the last 'fix' and include aches, tremor, sweating and chills, sneezing and yawning and muscular spasms. Withdrawal effects fade in 7-10 days, but feelings of weakness and loss of well-being can last for several months. Abrupt opiate withdrawal is rarely life-threatening and is considerably less dangerous than withdrawal from alcohol or barbiturates.

Fear of withdrawal effects can be a strong inducement to continue using heroin (physical dependence). But even after these effects have faded many addicts go back to heroin. For this reason it is generally accepted that physical dependence is not as significant as the strong psychological dependence that can develop to the effects of heroin *and* the lifestyle of being a regular heroin user.

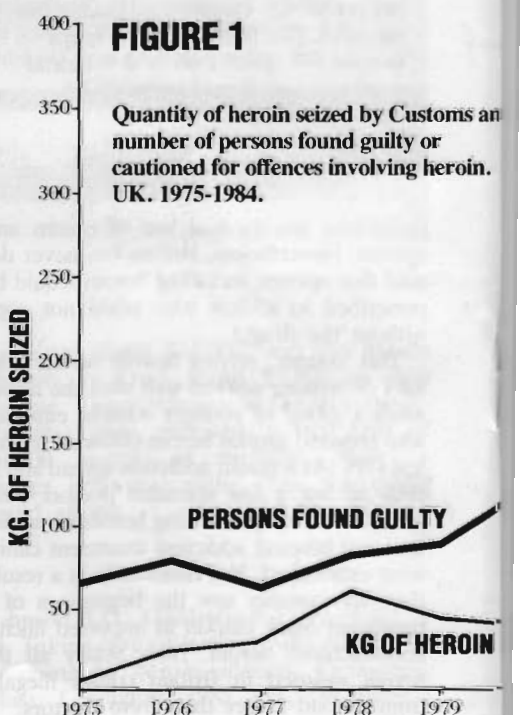
To be a regular heroin user is often to be drawn into a relatively tight community where relationships develop and then revolve around the daily, structured routine of buying, dealing, using and sharing heroin. As far as daily life is concerned, a purpose exists where possibly none did before, however negatively this purpose may be viewed by family and non-drug using friends. To stand any chance of remaining abstinent, the regular heroin user may have to reconstruct his/her life around non-drug activities and relationships, having first concluded that the reasons for continuing to use heroin are outweighed by the reasons for coming off.

Physical consequences

The physical effects of long-term heroin use are rarely serious in themselves. They include chronic constipation and menstrual irregularity. At higher doses chronic sedation can occur, but at moderate doses addicts can function normally. Women generally remain

FIGURE 1

Quantity of heroin seized by Customs and number of persons found guilty or cautioned for offences involving heroin. UK. 1975-1984.



fertile despite taking large doses of heroin, and pregnancy is possible. Diarrhoea during withdrawal may make the contraceptive pill ineffective.

However, the consequence of injecting opiates and of a drug-using lifestyle can be serious. Among regular injectors, there is commonly physical damage or infection associated with poor hygiene and the injection of adulterants. These include hepatitis, AIDS (through the sharing of needles), inflammation and obstruction of veins (which may lead to superficial veins being 'used up' as the user searches for healthy veins to inject), heart disease, lung disorder (as adulterants clog blood vessels in the lung).

Whether they inject or not, opiate addicts suffer from a high incidence of lung disease (especially pneumonia), caused by repeated drug-induced respiratory depression and decreased resistance to infection. Reduced appetite and apathy can contribute to disease caused by poor nutrition, self neglect and bad housing. Repeated heroin sniffing may cause nasal damage.

On the other hand, because opiates, in themselves, are relatively safe drugs, addicts in receipt of heroin or methadone on prescription and who maintain a stable, hygienic lifestyle can be indistinguishable from non-drug users and suffer no serious physical damage.

Opiate use during pregnancy results on average in smaller babies who may suffer severe withdrawal symptoms after birth. These can usually be managed with supportive therapy (which may or may not involve giving the baby drugs), until the withdrawal syndrome has run its course, but can be fatal in the absence of medical care. Opiate withdrawal during pregnancy can also result in foetal death, so the preferred option is usually to maintain the mother (and therefore the foetus) on low doses of opiates until birth. Appropriate pre-natal medical care can minimise risks to both mother and baby.

Issues in Britain's response to heroin

Stopping the supply

Heroin is a drug primarily smuggled into Britain from illegal production centres overseas. The upsurge in heroin use has focussed attention on the extent to which overseas nations can (or can be persuaded or helped) to clampdown on illicit opium cultivation and heroin production within their borders.

Recent British initiatives have concentrated on Pakistan, the country from which 80% of the heroin smuggled into Britain is said to originate. Several million pounds have been given to assist Pakistan in the eradication of opium poppy fields or to help encourage peasant farmers to replace opium with licit crops ('crop substitution').[3]

The government recognises that these efforts may only meet with limited success (opium tends to be grown in lawless, inaccessible frontier regions), and that even if they were successful, heroin production may simply shift elsewhere. Critics of this approach add that the licit global economic order perpetuates the disadvantaged position of Third World primary producer nations (opium growing nations included), encouraging the production of relatively lucrative illicit crops.

It is also suggested that political objectives sometimes encourage less than wholehearted opposition to heroin producing or trafficking groups. One recent example of this dilemma has arisen in Soviet-controlled Afghanistan, where the 'rebels' have stepped up their heroin production. To call upon the Soviet government to eradicate this development would amount to asking them to extend their control over the Western-supported Afghan opposition groups.

Other enforcement measures have attempted to make cost-effective use of resources (and minimise inconvenience to the public) by strengthening the drugs intelligence gathering/investigating capacity of Customs and police, rather than massively extending spot-searches at ports of entry or on the street.

Increased penalties

Recently the maximum penalty for trafficking in class A drugs (the category in the Misuse of Drugs Act which includes heroin) has been increased to life imprisonment. The government intends to introduce legislation permitting courts to freeze the assets of suspected drug traffickers and (on conviction) effectively confiscate assets or income that the defence is unable to show were not the proceeds of drug trafficking. These measures, though not aimed exclusively at heroin, have certainly been prompted by the increase in heroin smuggling and use.

Overprescribing doctors now supply only a small part of the opiates available on the illicit market. Nevertheless further measures to restrict prescribing have been taken (the restricting of dipipanone prescribing for addiction to licensed doctors) or proposed (the extension of similar restrictions to all opiates, a proposal recently rejected by the government).

Further controls are justified partly by the increasing involvement of private doctors in addiction treatment, by the physical damage caused by addicts injecting ground-up tablets obtained from doctors, and by fears that success in preventing illicit importation of heroin might be counteracted by increased pressure on doctors to supply opiates on prescription. But further controls over family doctors' prescribing to addicts have also been criticised as unnecessary infringements of clinical freedom and a likely deterrent to the involvement of GPs in addiction treatment.

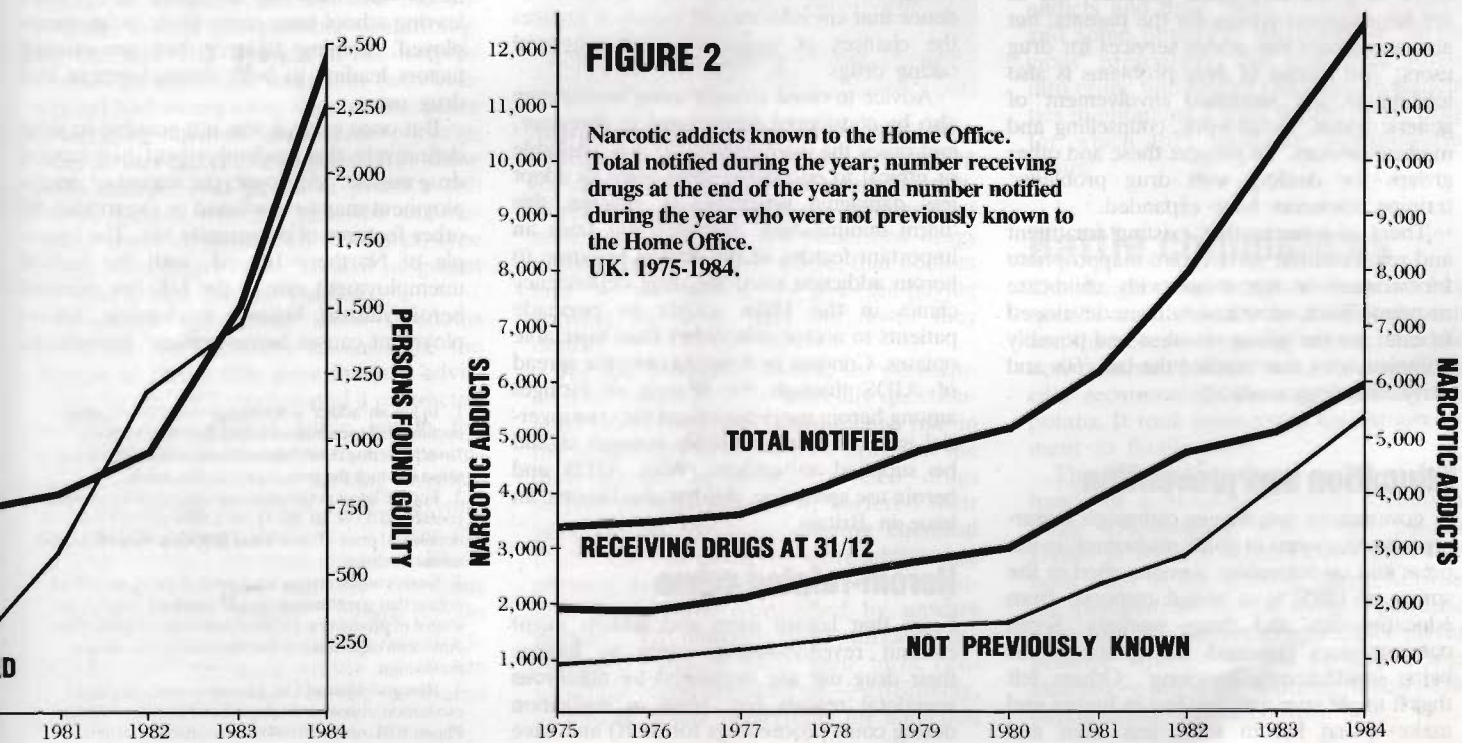


FIGURE 2

Narcotic addicts known to the Home Office. Total notified during the year; number receiving drugs at the end of the year; and number notified during the year who were not previously known to the Home Office. UK. 1975-1984.

Health and welfare responses

The NHS hospital drug dependency clinics established in the late '60s have continued to provide largely outpatient treatment to opiate addicts. This may involve counselling, psychological therapy and social work assistance, but the most contentious area has been the extent to which opiate drugs should be prescribed to remove the addict's need to resort to illicit supplies. This 'maintenance therapy', though still practised, has generally been abandoned in favour of 'fixed-term' prescription regimes usually lasting no more than six months.

Few doctors will prescribe opiates in injectable form to addicts. Most prefer methadone mixture, a non-injectable formulation taken as a drink. Doctors outside the clinics can still prescribe methadone (or any opiate other than heroin or dipipanone) for addiction, but are generally unwilling to take on addict patients. Nevertheless pressure on the relatively few clinics is such that general practitioners have come to rival the hospitals as a treatment resource. This development is also attributed partly to more restrictive prescribing policies in the clinics. It may also be a reflection of the fact that opiate addiction has spread to younger and less deviant groups who tend to remain settled in their local communities.

It is likely that about four-fifths of opiate dependents are not in treatment at any given time. These and other heroin users may receive help from voluntary sector day centres, advice, counselling and social work services specialising in drug problems. Such centres may take the major role in supporting and rehabilitating their clients, or may refer them to clinics or to one of the residential rehabilitation houses, where drug dependents who have ceased drug use stay for up to 18 months to reconstruct their personal and social life.

With the increasing spread of drug problems (particularly heroin-related problems) amongst young people, volunteer services based on parental concern have become more of a feature. These generally act as self-help support groups for the parents, but also sometimes run advice services for drug users. The spread of drug problems is also leading to the increased involvement of generic youth, social work, counselling and medical services. To prepare these and other groups for dealing with drug problems, training resources have expanded.

There is concern that existing treatment and rehabilitation services are inappropriate for women or for those with child-care responsibilities, most having been developed to cater for the young, rootless and possibly homeless men that typified the late '60s and early '70s drug scene.

Education and prevention

A government anti-heroin campaign featuring advertisements in youth magazines, in the press and on television, was launched in the spring of 1985, to a mixed response from educationalists and drugs workers. Some commentators criticised the campaign for being insufficiently 'shocking'. Others felt that it might stimulate interest in heroin and make taking heroin seem less alien and unthinkable ('normalise' heroin use). There were also fears that the adverts' portrayal of inevitable dependence and physical deterioration after taking heroin might provide unfortunate 'role models' for those youngsters it failed to deter from trying the drug.

A small-scale evaluation of the campaign's impact queried how far any such campaign could succeed in areas of marked deprivation where heroin use is widespread and familiar, and expressed concern that in other areas it might help to reduce the audience's 'instinctive' repulsion for heroin and for injecting. A subsequent 'before and after' quantitative evaluation found that the campaign had probably 'firmed up' young people's existing anti-heroin attitudes and led to a greater awareness of health risks of heroin use. There was no evidence of decreased heroin use.[4]

Less controversially, the upsurge in heroin use has stimulated educational initiatives including videos and teaching packs for use with young people in schools, youth training and other youth-work settings. One favoured objective is to give youngsters the social skills to refuse drug offers from their peers, an approach which recognises that friends of the same age are the usual source of drugs for young people.

> Boils and abscesses plague the skin; gnawing pains rack the body. Nerves snap; vicious twitching develops. Imaginary and fantastic fears blight the mind and sometimes complete insanity results. Often times, too, death comes — much too early in life . . . Such is the torment of being a drug addict; such is the plague of being one of the walking dead.
> — US Supreme Court, 1962.

At the same time as modern education packages are being developed, more traditional materials based on 'shock-tactics' have been revived or produced, and are also widely favoured despite criticism from health educationalists. There is no compelling evidence that any educational approach reduces the chances of young people in general taking drugs.

Advice to those already using heroin may also be considered educational in character, and raises the issue of how far it is advisable or ethical to encourage drug users to adopt less damaging practices. In practice this 'harm minimisation' approach has been an important feature of the British response to heroin addiction since the drug dependency clinics in the 1970s sought to persuade patients to accept oral rather than injectable opiates. Concern in America over the spread of AIDS through the sharing of syringes among heroin users has raised the controversial issue of whether sterile syringes should be supplied to addicts. With AIDS and heroin use spreading, this has also become an issue in Britain.

Heroin-related crime

Fears that heroin users and addicts might commit revenue-raising crime to finance their drug use are supported by numerous anecdotal reports (eg, pleas in mitigation during court proceedings for theft) and have gained credibility from research in the deprived areas of Glasgow, where the majority of users interviewed stole to support their habit.

However, it is impossible to say whether these crimes might not have been committed in any event, if only to finance the purchase of alcohol, tobacco or other consumer goods. Studies abroad have found that drug use may lead to crime, that the reverse may be the case (as the proceeds of crime are spent on drugs), or that both crime and drug use may be caused by a third factor.

It should be remembered that only a proportion of heroin users need (as opposed to choose) to turn to non-drug crime — occasional users and those with sufficient resources can support themselves by legal means, whilst more regular but less affluent users may be able to manage from the proceeds of small-scale dealing in drugs.

To sum up, whilst it is undoubtedly true that many individuals are led into crime by their involvement with heroin, it is unclear how far the overall level of non-drug crime has been affected by the spread of heroin.

Unemployment

Recent political debate over where the 'blame' lies for increased heroin use in Britain has concentrated on the extent to which unemployment and poverty may be a factor, young people turning to heroin to cope with boredom and the lack of prospects or alternative pursuits.

What is clear is that nationally heroin use and unemployment appear to have increased more or less in parallel and that studies of young heroin users find a higher than expected rate of unemployment. Recent British studies have strongly suggested that behind this correlation lies a causal link, with unemployment and deprivation helping to cause misuse of whatever drugs are available on the illicit market.

One study found that from an apparently 'normal' sample of teenage school children, those who went on to misuse drugs after leaving school were more likely to be unemployed, helping to rule out pre-existing factors leading to both unemployment and drug use.

But once again it was not possible to state definitively that unemployment had caused drug misuse. Moreover, the impact of unemployment may be mediated or overridden by other features of community life. The example of Northern Ireland, with the highest unemployment rate in the UK but minimal heroin misuse, belies a mechanistic 'unemployment causes heroin misuse' hypothesis.

1. In law an 'addict' is defined as someone who has become so dependent on a drug that they have an "overpowering desire" to continue its use. This is the sense in which the term is used in this article.
2. For the latest notification and enforcement statistics contact ISDD or ask the Home Office (01-213 3388) for details and price of their latest statistical bulletin on the misuse of drugs.
3. Some commentators have posited the more radical notion that governments should purchase crops at the source of production for later destruction although the American experience is that this merely encourages production.
4. Research Bureau Ltd. *Heroin misuse campaign evaluation: report of findings.* London: RBL, 1986. Phone RBL on 01-480 9600 for availability details.

DOCTORS AT WAR

Should doctors be allowed to prescribe whatever drugs in whatever quantities they think best for addict patients? Or should the government ban all but the 'experts' from the minefield of prescribing addictive drugs to drug addicts? It's an issue that has recently riven parts of the medical profession into bitterly opposed camps. In the first half of a two-part article, Mike Ashton from ISDD's library looks at the arguments, the events and the evidence.

Mike Ashton

Two recent full-page articles in the national press explored the case for legally 'maintaining' addicts on opiate-type[1] drugs (*Guardian*, 12 March 1986; *Observer*, 16 March 1986). As in the '60s, controversy surrounds the idea that providing a cheap, legal supply of heroin or heroin-substitutes on prescription can help some heroin addicts live stable, productive lives *and* undercut the illicit market. Behind this is the argument about whether doctors should be *allowed* to prescribe in this manner. It's an argument that reaches to the heart of the British response to opiate addiction – the so-called 'British system'.

Long the envy of liberal-minded observers across the Atlantic, the distinctive element of this system (and the reason why many deny there *is* a system) is that each doctor can treat their addict patients as they see fit, with minimal interference from the authorities. For 60 years the range of acceptable treatments open to any doctor in Britain has included long-term opiate prescribing if withdrawal was impractical or inadvisable. Because the aim is to keep the addict on an even keel rather than to attempt a cure, this practice is known as 'maintenance' prescribing.

Legislation enacted in the late 1960s and in the 1971 Misuse of Drugs Act eliminated heroin itself from most doctors' addiction treatment armoury and allowed the authorities to stop 'irresponsible' prescribing. By the mid '70s, opinion in the hospital centres for addiction treatment (and elsewhere) had swung away from maintenance prescribing towards short-term prescription of non-injectable opiates. But these legal changes and trends in practice still leave doctors free to prescribe maintenance doses of almost all the opiate-type drugs according to their clinical judgment of what's best for the patient.

Proposals to curtail these freedoms made by the Advisory Council on the Misuse of Drugs (the government's advisory body) in 1982 precipitated a protracted and sometimes bitter battle within the medical profession, one with serious implications for everyone seeking medical help for opiate addiction, and everyone involved in helping them find it. How the 'British system' survived its close shave with the legislators, but the freedoms (some would say, abuses) it entails remain in the balance, is the subject of our story. In this issue we trace events up to the government's response to the proposed curbs.

Curbs recommended

In its 1982 *Treatment and rehabilitation* report, the Advisory Council on the Misuse of Drugs took a hard line on prescribing to addicts.[2] They observed more addicts were turning to GPs and private doctors rather than the specialist hospital-based drug dependency clinics. Through inexperience and lack of expert advice, some of these 'independent' doctors in addiction (a term coined to distinguish them from hospital doctors) were guilty of 'injudicious' prescribing. There was also a strong suggestion that private prescribing for addicts was morally and ethically undesirable — an allusion to the concern that addicts may need to sell prescribed drugs to pay medical fees or, worse, that doctors may be too willing to give fee-paying patients the drugs and the doses they desire.

> ► **Extend licensing**
> Only doctors licensed by the government should be allowed to prescribe any opiate-type drug for the treatment of addiction.
>
> ► **Enforce guidelines**
> As a condition of obtaining (and maintaining) a licence, doctors would have to adhere to certain of the "guidelines" to be contained in an "authoritative statement of good practice" in the treatment of addiction.
>
> ► **Supervise 'independent' doctors?**
> The guidelines would stipulate that non-hospital doctors should operate in "close liaison" with the nearest hospital specialist, possibly amounting to supervision by the specialist. This in particular may be made a condition of obtaining a licence.
>
> Advisory Council on the Misuse of Drugs. *Treatment and rehabilitation report*. 1982

For the Advisory Council, the consequence of 'injudicious' or 'ethically questionable' prescribing was a significant rise in the availability of prescribed drugs on the illicit market, as addicts 'recycled' drugs surplus to requirements or bartered their prescriptions for more alluring chemical treats. The end result was more addicts and physical damage from injection of unsuitable preparations prescribed by unwary doctors. To counter these threats, the Advisory Council made their most controversial recommendations — effectively, an end to opiate prescribing for addiction unless the doctor accepted national treatment guidelines and/or local supervision by a more 'experienced' practitioner[3] (see box for details).

It took little imagination to see the Advisory Council's recommendations as an attempt to legislate the non-hospital doctor out of addiction treatment, unless they toed the line laid down by the clinic psychiatrist — an unprecedented restriction on the autonomy of the GP. As one GP later put it, the grandly-titled 'independent' doctors treating addicts might become little more than "clinical assistants to their local psychiatrist".

If doctors outside the clinics were to toe the clinic's line, what was this likely to be? Each clinic sets their own policy, but the Advisory Council recognised that most clinic doctors had turned away from long-term prescribing. The dominant treatment in the clinics now probably involves a 'fixed-term' prescription reducing to zero over up to six months. A significant number prefer not to prescribe opiates at all, while those that practice maintenance prescribing usually supply only non-injectable (and therefore, for the addict, less attractive) drugs to be taken by mouth.[4] The Advisory Council also observed that in some areas GPs were prepared to prescribe more liberally, in direct conflict with the clinic psychiatrist — with predictable results on their relative pulling power among the local addict population.

Extending clinic policies beyond the hospitals would have seen the legislated erosion of most doctors' remaining clinical freedom in addiction treatment, and, in many areas, the practical restriction of the treatment available to strictly enforced, short-term, non-injectable withdrawal regimes. At the receiving end would be the addicts and drug users — some supplied and some physically damaged by 'injudicious' prescribing, but also some forced into crime and health risks due to difficulties in obtaining a legal supply of the drugs for which they have an "overpowering desire".[5]

Battle commences

The heightening temper of the debate outside and inside the medical profession, and the potentially major impact on addiction treatment, made the Advisory Council's recommendations an unusually hot potato. It took three years for the government to finally reply.

The Council's proposals ended up in the hands of a Medical Working Group on Drug Dependence announced by the DHSS in 1983. It included members from both sides of the growing divide between the psychiatrists in the drug dependency units and the doctors in general or private practice who — if the proposals were enacted — might be required to accept the psychiatrists' advice/control.

'Good practice' guidelines

After just six months of meetings in the first half of 1984, the Group were able to compose the "authoritative statement of good practice" called for by the Advisory Council. As the *Guidelines of good clinical practice in the treatment of drug misuse*[6] these were later sent to "every hospital doctor and general medical practitioner" in Britain (though many profess not to have received them).

The *Guidelines* emphasised drug-free treatment and withdrawal regimes of up to six months duration, for which it gave detailed guidance. Nowhere was longer term prescribing recommended, even for the stable, chronic addicts for whom in earlier days it had been considered appropriate. Instead a few cautionary lines warned maintenance prescribing should never be initiated by general practitioners and undertaken only by, or in conjunction with, an experienced specialist.

But this was the only place where GPs were told they should work with the specialists (see box for details). Even so, at least one member of the Group later came out against the document and an indignant letter to the *British Medical Journal* from a Scottish psychiatric consultant complained at the Group's presuming to be able to lay down guidelines for others to follow. But critical comments in the medical press were few.

Now the Group had to tackle the crunch issue. Guidelines, after all, can be 'adapted' by doctors who remain in possession of their clinical freedom. But prohibiting unlicensed doctors from prescribing any opiate for addiction would have the force of law, and could be used to turn 'guidelines' into rules.

Licensed to prescribe?

In 1968 it became necessary for a doctor to hold a special Home Office licence before they could prescribe heroin or cocaine in the treatment of addiction. Licences were (and still are) given to only a few hundred doctors, almost all working in hospital clinics. Not until 1984 was another drug — dipipanone (Diconal) — similarly restricted on the Advisory Council's urgent recommendation, after evidence of serious physical damage from its abuse by injection.

Both moves met remarkably little medical opposition, perhaps partly because doctors still had a wide range of opiate-type drugs with which to attract and treat addict patients. But the proposal now before the Medical Working Group would leave the vast majority of British doctors unable to prescribe any opiate-type drug for addiction.

Without an opiate 'scrip' to look forward to, addicts might no longer think a visit to the doctor worth the time, effort and the risk involved.[7] Doctors already reluctant to accept addict patients could embrace their unlicensed state as a further excuse for refusing treatment of any kind; the remainder might read increased legal and professional restrictions as a warning not to get involved. Net result — a potentially drastic reduction in the availability of medical care to addicts.

On the plus side the proposals could have meant a virtual end to unsupervised addiction treatment by profit-minded private physicians and inexperienced family doctors, and provide a much more direct means of preventing or eliminating 'injudicious' prescribing.

The issue irreconcilably split the Medical Working Group. Its recommendation to the Minister went in two parts. A majority were for extending licensing to all opiate-type drugs except oral methadone, a non-injectable liquid favoured by the clinics and recommended in the *Guidelines*, but relatively unattractive to addicts. To prescribe other opiates for addiction, GPs might have to obtain a licence committing them to have regard to the *Guidelines*.

A dissenting minority opposed extended licensing, "primarily because they considered that it would discourage some GPs from treating drug misusers".[8]

Temper

On both sides of the argument, feelings ran high. Speaking to a conference in 1983 a London clinic doctor admitted: "I would certainly find it very difficult to keep my temper in a discussion with some members of my profession" — he was referring to private doctors "abusing their legal rights" by prescribing excessively to addicts.

Later that year two more London clinic psychiatrists published a research article uncompromisingly titled "Unacceptable face of private practice: prescription of controlled drugs to addicts".[9] One of the authors served for a time on the Medical Working Group and is known to have been in correspondence with the General Medical Council concerning the behaviour of another member of the group, a private practitioner and president of the Association of Independent Doctors in Addiction. This latter doctor had recently been prone to publicise her trenchant criticism of the competence and relevance of the NHS clinics (eg, "Have Drug Clinics Failed", *Sunday Times*, 27 February 1983).

► "All doctors have a responsibility to provide care for both the general health needs of drug misusers and their drug related problems."

► "The aim of treatment should be to deal with problems related to his or her drug misuse and eventually to achieve a drug-free life."

► "Doctors are advised not to undertake long-term prescription of opioids [natural and synthetic opiates] unless in consultation and conjunction with a specialist in a drug treatment unit or elsewhere who has experience of this approach."

► "We strongly recommend that the general practitioner should explain clearly and sympathetically at the first interview [with a drug misusing patient] that treatment ... will certainly not involve long-term maintenance prescribing."

Medical Working Group on Drug Dependence. *Guidelines of good clinical practice in the treatment of drug misuse*. 1984

Exasperated by this "ever-present but highly local controversy" between clinics and private doctors in London, Dr Banks, a provincial GP on the Medical Working Group, nevertheless had strong words to say about the Advisory Council's proposals. Extended licensing would, he said, be a "quite revolutionary step . . . forcing a major section of the medical profession to become clinical assistants to their local psychiatrist . . . whether or not they agree with his policies or judgment, and whether or not they have more experience and perhaps a sounder clinical basis for their treatment."

"please, please tell Mr Mellor that if one brings in licensing now any flicker of interest among GPs may be snuffed out"

His campaign within the Medical Working Group culminated in a last minute plea to Norman Fowler: ". . . please, please tell Mr Mellor [minister in charge of coordinating drugs policy] . . . that if one brings in licensing now ... any flicker of interest among general practitioners may be diminished if not snuffed out ...".

Government decides

Among the majority for extended licensing were some of the biggest names in addiction treatment in Britain. General practitioners themselves (through the General Medical Services Committee of the BMA) had accepted the need for further restrictions on their right to prescribe. In contrast the medical forces against licensing appeared weak. With them were the civil servants at the Home Office and the DHSS, the former anxious to retain Britain's traditional flexibility and moderation in the treatment of addiction, both departments concerned about the practicalities of monitoring and enforcing extended controls.

Aided by the civil servants, the minority carried the day. In its response to yet another call for more prescribing restrictions, the government observed that prescribing of the drugs causing concern had decreased of its own accord, so "any advantage ... from extension of licensing restrictions would be slight, and would ... be outweighed by the risk that at least some GPs would be discouraged from treating drug misusers".[10] The decision was not to extend licensing restrictions but to "monitor prescribing trends ... so that, should the situation alter, further action can be speedily considered".[11]

Battle continues

As one doctor put it, defending the *Guidelines* against a rare attack in the medical press, "Guidelines are not rules, and any individual doctor can extract from them whatever he thinks is appropriate to his patients and his practice". After the government's refusal to legislate on prescribing, these malleable words of advice were the only extra safeguard standing between the doctors and their addict patients. ►

HELPING DRUG USERS. SOCIAL WORK, ADVICE GIVING, REFERRAL AND TRAINING SERVICES OF THREE LONDON 'STREET AGENCIES'. Nicholas Dorn and Nigel South. London: Gower, 1985. xi, 229 pages. £14.50

Many years ago, whilst living in Scotland, I attended the auction of a small hill croft. The crofter himself had died of cancer at the 'back end' of a bitterly hard winter. Now with the beginnings of a bleak and unpromising spring his few remaining effects had been brought out on to the green before the croft and neatly labelled with lot numbers. I left some hours later with two broody hens, a fifteen pound axe and a lasting feeling of embarrassment at seeing the private belongings of a neighbour laid out for public gaze and scrutiny.

Some of that discomfort made an unwelcome return whilst reading *Helping drug users*. There is after all something vaguely disconcerting about the sight of colleagues in non-residential services (many of whom I have known well) laid open for public examination and critical analysis. Whatever criticisms I might have of the book are tempered by my respect for the staff of the three agencies examined, for their frankness in discussing the issues, and for the sensitivity of the authors in relaying them.

The book is an in-depth examination by ISDD's research unit of three London 'street agencies' (Hungerford Drug Project, Community Drug Project and the Blenheim Project), set against a changing and often unpredictable drug subculture from the late 1960s to the (almost) present time.

The views of the consumers of drug treatment services (and other social work agencies) are rarely held up for serious consideration. This book was a welcome change. I would, however, have appreciated a more detailed examination of the contradictions between some statements made by the 'customers' and the philosophy and aspirations of the staff.

Among staff there was, for example, a widespread desire to move towards advocacy and consultation (". . . if someone's got problems, then we co-ordinate other people sorting them out . . .", Blenheim staff member). Yet the drug users interviewed make it clear that, for them, the street agencies have a special quality which wasn't on offer/possible with other services: "The help I've gained has been a hundred times better than the drug dependency unit . . ."; "I felt I was more on the same wave-length with them than I would with a GP . . .". Here, perhaps, is a warning that a balance will always have to be struck between direct and indirect service provision. An agency which spends all its time on drugs issues will always be 'better at it' than one which doesn't.

Again, a drug user commented on detached work: "I don't think they make any contact whatsoever really because people are just not interested". The authors' comment that "detached work does make contact with some people, as it did with Keith himself", was hardly a substitute for the sort of informed debate that I would have liked to see in the light of such a serious and stark rebuttal of staff perceptions.

In Chapter 3, one customer remarks, "I've been coming here for a long time. I've never wanted to do anything up until about the last three weeks . . .". This lightning conversion theory seems popular with the workers too. One Hungerford staff member claims, "when that time comes, when this unmotivated person, maybe for a split second in their life, maybe about half a day, but they all of a sudden become motivated . . .".

Belief in 'motivation' as an unpredictable, mystical force which takes over the heart without warning may be comforting for the customer, but collusion in this belief by drug workers encourages the user to avoid a potentially painful but useful examination of the lessons to be learnt from previous drug-free episodes.

What is heartening about *Helping drug users* is the emergence within the consumer feedback of a common pattern of approaches to abstinence, belying this 'road to Damascus' concept of motivation. Most of those interviewed had undertaken a series of 'dress rehearsals' for abstinence, the duration of which was determined by a wide range of attendant circumstances, including their own belief in the effectiveness and appropriateness of the service they were offered. The street agencies were invaluable in helping them come to terms with these issues and refine/improve them for a future attempt.

Helping drug users is an extremely useful examination of the development of non-residential services under the constraints of inadequate and insecure funding. The relationships with residential services (rehabs) is touched upon but could have been explored in greater depth. Many of the developments within street agencies stemmed from their position as the 'poor relatives' of the drug field. It was the rehabs who had the rewards of seeing the clients change and grow, they were the ones who won the thanks of successful abstainers and — what's more — they never had to deal with customers "pissing in the broom cupboard" (page 159).

Book reviews inevitably concentrate on what appears to be missing/inadequate/wrong. I should point out therefore that this is an immensely helpful and optimistic book which will be of great interest to non drug-specific agencies in planning and implementing their response to drug users.

One final grouse. I couldn't help but chuckle at: "In the following pages . . . we . . . remain firmly in the vernacular". Taking the authors at their word, I subjected the book to Gunning's *Frequency of Gobbledygook* readability test. It scored 52. This makes it harder to read than the *Guardian* (39), *Tit Bits* (28) and the application form for an 'Access' card (49).

Rowdy Yates

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Available from ISDD. Add 15% p&p.

BIG DEAL: THE POLITICS OF THE ILLICIT DRUGS BUSINESS. Anthony Henman, Roger Lewis, Tim Malyon *et al.* London: Pluto Press, 1985. £4.50. 211 pages.

It's not often that we come across a book that is a breath of fresh air for our thinking about drug problems. Much of academic debate and policy comment has been caught up in the interminable focus on drug users (why do they do it?) and services (what can we do to prevent or treat them?). In itself, a laudable focus that

► *continued from page 14*

To some it would appear that clinical freedom and the availability of medical care for addicts had been preserved from the encroachments of a power-hungry elite; to others, that the inexperienced, incompetent and immoral among the medical profession had been given the green light to continue creating havoc on the streets and in addicts' veins through their virtually unfettered prescription pads.

But the outcome is not quite so clear cut. The powerful tide of medical opinion that wants prescribing more tightly controlled still has two weapons available to it. First is the medical profession's own disciplinary committee, run by the General Medical Council; second, the Misuse of Drugs Act tribunals, organised by the Home Office. Not quite the 'big bang' of blanket licensing, these mechanisms are nevertheless quite capable of eliminating the individual 'injudicious' prescriber.

In the next issue of *Druglink* we see how these mechanisms have been oiled-up and put to use, creating more controversy as the leader of the 'independent' doctors felt the weight of the GMC's disapproval.

1. Strictly speaking 'opiates' are drugs derived from the opium poppy, whilst 'opioids' are synthetic drugs with similar effects. In this article the term 'opiate' or 'opiate-type drug' is used to refer to all drugs with opiate effects, whether opiates or opioids.
2. *Treatment and rehabilitation. Report of the Advisory Council on the Misuse of Drugs.* London: HMSO, 1982. Available from ISDD at £3.95 + 15 per cent p&p.
3. A letter sent to the Advisory Council in 1981 (signed by a long list of drugs workers including the later chair of the Advisory Council itself) called for extended licensing and said "a condition of the licence could be that the doctor works in close consultation with or under the supervision of the nearest appropriate specialist facilities...".
4. Smart C. Drug dependence units in England and Wales. The results of a national survey. *Drug and Alcohol Dependence*: 1985, *15* (12), p. 131-44.
5. Misuse of Drugs Act regulations give this definition of addiction: "... a person shall be regarded as being addicted to a drug if, and only if, he has as a result of repeated administration become so dependent upon the drug that he has an overpowering desire for the administration of it to be continued."
6. 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.
7. Drug users fear notification to the Home Office but don't realise that the doctor's prescription could 'shop' them to the police.
8. DHSS, DES, Home Office, MSC. *Government response to the fourth report from the Social Services Committee, session 1984-5.* December 1985.
9. Bewley T. and Ghodse A.H., Unacceptable face of private practice: prescription of controlled drugs to addicts. *British Medical Journal*, 11 June 1983.
10. DHSS, DES, Home Office, MSC, *op cit.*
11. DHSS response to Medical Working Group, 9 December 1985.

deals with real people with real problems. But there is another level of analysis that receives much less attention, possibly because it seems further removed from the practical day-to-day problems of drug users and agency life.

It is this other level that is dealt with in the essays in this book. The authors share a concern to understand drug problems at the level of the politics and economics of the international trade in drugs. Rather than put the blame on wicked dealers, ignorant victims, or ruthless producers in faraway countries, the authors seek to understand the international and national conditions that facilitate the production. importation and consumption of drugs.

Three of the chapters deal with the political economy of drugs. Lewis looks at the "Global heroin economy", Malyon at cannabis, and Henman at cocaine. All writers indicate the economic importance of drug production for poor countries, and provide important insights into the structure of the international market and its relation to world and local economics and politics. O'Bryan gives us an essay on youth 'style' in clothes, behaviour and drugs, suggesting that patterns of heroin use in London are no longer necessarily based on a rejection of 'mainstream' society. Ettore looks at women, psychotropic drugs and the drug industry.

What is missing is a sense of our options for the future. Lewis suggests that altering the pattern of economic dependence that promotes drug production would entail altering the entire world economic system. Until that happens, is the drug trade here to stay or are there viable, short-term, strategies? Most of us, caught up in the day-to-day round of work, give little time to these issues. But they are profoundly linked to the everyday problems that we meet. We need far more debate about policy options for the future. This book makes us think about these larger issues.

Gerry Stimson

Gerry Stimson researches and writes on drug issues. He is Principal Lecturer in Sociology at Goldsmiths' College, and is on the Advisory Council on the Misuse of Drugs.

Available from ISDD. Add 15% for p&p.

STREET DRUGS. Andrew Tyler. Sevenoaks, Kent: New English Library, 1986. 342 pages. £3.50

The reality of Britain's drug scene from cannabis and cocaine to extra-strength lager, is that hundreds of thousands of people are involved in experimental or even regular drug taking because they enjoy it. Most will come to no harm. But as many drugs workers will tell you, the Great British Public find truths about drugs and drugtaking most unpalatable.

For the majority, 'information' about drugs comes from the popular press. And the press know their readers: they want to read about playground pushers and junkie babies, jet-setting drug 'barons' and tales of personal misery. Apart from blatant scaremongering, much of the material on drugs plays safe. It is written by those who have no affinity with British youth culture. *Street drugs* is a brave and unique book. The author does not have a string of letters after his name; what he does have is a wealth of experience as a journalist working for popular periodicals like *New Musical Express*, writing for that section of the younger population (under 30) who make up the bulk of Britain's drug users.

Street drugs is unique for two reasons. First, because Tyler 'tells it like it is'. The correct antidote to press hysteria is not the naive apologia for drug use beloved of the underground press in the sixties, or the glossy *Penthouse* style of drug promotion found in America's *High Times*, but well-researched, balanced information. "Some people manage to engage in non-threatening recreational use [of heroin] for years, but it is also true that virtually every addict started out believing s/he could boss the drug", gives an indication of what I mean.

The uniqueness of the book also lies in the fact that the author has combined a thorough review of reputable published sources with his own investigations of the drug scene. There is plenty of valuable 'street information', much of it already known to drugs workers, who never have the time to write up their knowledge for publication.Tyler includes alcohol, tobacco, caffeine and tranquillisers in his definition of 'street drugs', devoting a chapter per drug covering health effects and consequences, prevalence, patterns of use and treatment together with sections on the political and economic setting of the drug in society. Despite the 'encyclopaedic' layout, the engaging style in which *Street drugs* is written lends itself to reading cover to cover — which I did.

Criticisms? The book is referenced, but a bibliography would have been useful. The appendix of helping agencies at the back has no indication of what they do and the address of the one I work for is wrong. Good as it is, the publisher's blurb dubbing *Street drugs* a "definitive guide" goes too far, an hyperbole compounded by the absence of a recommended list of further reading.

Harry Shapiro

Harry Shapiro is the Information Officer at ISDD responsible for the library's publications.

Available from ISDD. Add 15% p&p.

KICK HEROIN: A GUIDE FOR THOSE CONCERNED WITH ADDICTS. Liz Cutland. London: Sky Books, 1985. 112 pages. £3.95

OFF THE HOOK: COPING WITH ADDICTION. Helen Bethune. London: Methuen, 1985. 113 pages. £2.95

Both these books are addressed to abstinent adults and parents having to cope with compulsive drug use; the drug users are defined as their young sons, daughters or friends.

Both counsellors, using metaphors like cancer and diabetes, contend that casual drug use leads to the 'disease' of dependence. They argue that the 'cure' for this illness lies in the family's refusing further collusive succouring of the sick member. S/he is then forced to seek 'treatment'.

Reference to the treatments available is surprisingly restricted. Bethune's index lists merely Narcotics Anonymous and Families Anonymous. These are support groups promoting total abstinence and having close links with the 'Minnesota method' centres. Cutland's suggestion that these centres — she works for one — are the *only* agencies that can help drug users is misinformation, and her description of their regimes is vague.

Case-history presentation reinforces the authors' insistence that 'tough love' will propel the sufferer towards recovery. Support and sympathy which has the effect of 'enabling' drug use to continue is disastrous. Cutland implies that 'Valerie's' addict-son might not have died had she attended Families Anonymous meetings.

They believe it impossible to attain controlled use of drugs. All are toxins, poisoning hapless victims whose systems are particularly vulnerable to the addiction 'virus'.

The reassuring tones of both writers contradict their hysteria about psychoactive substances. Bethune's litany of inevitable consequences includes: death, jailing, insanity, brain and organic damage and sterility — these last three from marijuana. "Surviving" solvent abusers are said to become "sad cabbages".

However, the authors are perceptive about relationships. Cutland writes with insight about parental addiction to the child's dependent state. Bethune's chapters on painful emotions and parental misbehaviour are excellent. Her discussion of adult responses like nagging and resentment, her suggestions for improving family dynamics, are both practical and inspiring.

Yet, these writers' passionately sincere advocacy of the 'Minnesota method' is also propaganda for the private sector.

There are, obviously, some good regimes in the fee-charging centres practising the 'Twelve Steps' to recovery associated with the 'Minnesota method' and Narcotics and Families Anonymous. Waiting lists are shorter and their non-judgmental approach to addiction may mean clients are treated with more sympathy and respect than in some projects that do not charge fees or in traditional drug clinics. Narcotics and Families Anonymous provide valuable support for ex-clients and their families.

But there is nothing in these books or in the written texts of the 'Minnesota method' that could not be found somewhere in the existing NHS or voluntary projects. Good practice in these includes encouraging clients to take responsibility, challenge denial, participate in group life, and support each other. The difference is that these are free, whereas charges in the private sector range from £450-£2000 a week, though 'Minnesota method' centres are not the most expensive, and some NHS assisted places are available.

Lorraine Hewitt

Lorraine Hewitt is the North West Regional Liaison Officer of the Standing Conference on Drug Abuse.

Druglink listings feature

FOCUS ON DRUGS

A list of audio-visual materials available in Britain

Concern over drugs has brought a new wave of home-grown audio-visual materials, including government-backed videos available free of charge. This special *Druglink* listings feature brings readers up to date with the new materia and lists the old ones that may still be relevant.

Inclusion does not constitute a recommendation by ISDD. Potential users are strongly advised to view materials in advance before showing to the intended audience.

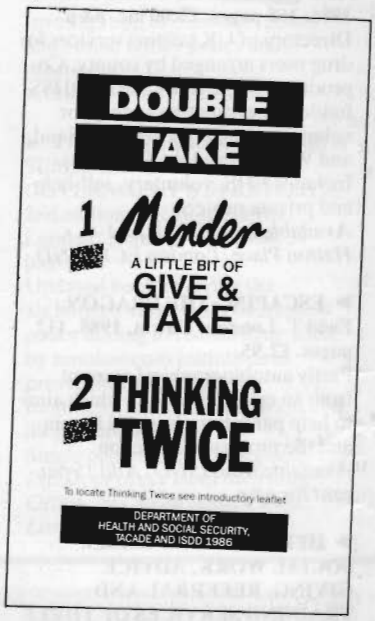
Materials have been selected on the basis either of being viewed by ISDD staff or entries in distributors' catalogues. Allocation to sections is also based on the distributors' catalogues. Where there is any doubt, the film has been assigned to the General category. Items marked ☆ may be viewed by appointment at ISDD.

For young people

► BETTER DEAD . . . THEN AND NOW☆ 1972/1985
First produced in 1972 and features young addicts talking about their use of drugs. Graphic sequences of users injecting. Followed up by **Better dead '85**, a reflection by one of the original group of addicts on his drug using career. Accompanied by teacher/presenter notes.
Available from: Project Icarus, Raglan House, 4 Clarence Parade, Southsea, Hants. PO5 3NW. Tel: 0705 827460
To buy: £75 + VAT (VHS format)
To hire: £10 for 2 weeks
Reduction and purchase price by negotiation (normally 50%) for parents groups, youth groups or similar bodies engaged in drug education.

► CHASING THE BANDWAGON☆ 1985
Produced by the YMCA and starring Lenny Henry. Complete with teaching materials and posters, the film aims to stimulate discussion on decision making over whether or not to take drugs.
Available from: CFL Vision, Chalfont Grove, Narcot Lane, Gerrards Cross, Bucks. Tel: 02407 4433
To buy: £80 + VAT (VHS)
To hire: £16

► DOUBLE TAKE☆ 1986
A drug education package aimed primarily at the 13-15 age range. Comprises:
A Little Bit of Give and Take — a three-part trigger video featuring Dennis Waterman and George Cole with teacher materials by TACADE.
Thinking Twice continues on the same video with material on decision making for young people and accompanying documentation all by ISDD.
Available from: ISDD
To buy: £31 (VHS). Extra sets of printed teaching materials for each film cost £5 each.
Available free to secondary schools



on application to CFL Vision (see above)

► HEALTH EDUCATION DRUGS AND THE PRIMARY SCHOOL CHILD☆ 1986
A health education pack divided into modules using slides and printed teaching materials. Originally produced by the Wirral Health Education Unit and now being revised by TACADE for national distribution.
Available Summer 1986. Contact TACADE. Tel: 061-848 0351

► JUNKIE☆ Three self-contained films on different aspects of heroin addiction. With notes for the teacher presenter.
Available from: Project Icarus (see above).
To buy: £85 + VAT (VHS)
To hire: £10 for 2 weeks
Contact Project Icarus for special discounts.

► KIDS STUFF☆
Centred largely on the circumstances surrounding the death of one glue sniffer.
Available from: Project Icarus (see above).
To buy: £60 + VAT
To hire: £10 for 2 weeks
Contact Project Icarus for special discounts.

► NOT TO BE SNIFFED AT☆ 1985
Originally shown as a BBC Schools programme, the film looks at why young people sniff solvents, the effects of sniffing and the dangers.
Available from: BBC Enterprises Ltd, Education and Training Sales, Woodlands, Wood Lane, London W12
To buy: £85 + VAT

► PREVENTION OF SOLVENT ABUSE☆
Video and audiotape aimed at the younger groups in secondary schools. Pack includes teachers notes, work cards and other background information.
Available from: The Robertson Centre, 16 Glasgow Road, Paisley, PA1 3QG. Tel: 041-887 3726
To buy: £32 incl. VAT

► SELF DESTRUCTION☆ 1985
Prevention video depicting the early drug career of a young heroin user.
Available from: Phil Cooper, "Drug Aid", 23 Chadwick Street, Bolton, BL2 1JN
To buy: £23 plus a contribution to postage.

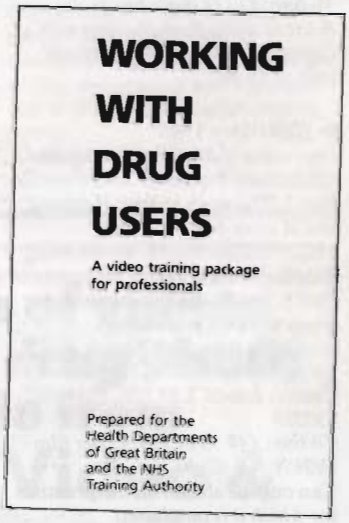
In-service training

► D MEN☆ 1985
The pack consists of a video tape, training exercises and tutor briefing notes. Designed to be used either as part of a longer training course or as a 'stand alone' seminar on the issue of problem drug use and the mythologies surrounding it.
Available from: North West Regional Drug Training Unit, Kenyon Ward, Prestwich Hospital, Bury New Road, Manchester, M25 7BL. Tel: 061-798 0919
To buy: £31
To hire: £6 on 10 day approval

► ILLUSIONS☆
Training film for professionals, focussing on intervention options with young solvent misusers.
Available from: CFL Vision (see above)
To buy: £45 + VAT (VHS)
To hire: Free of charge

► SOLVENT MISUSE: A TRAINING MANUAL FOR PROFESSIONALS☆
Produced by the Health Education Council and comprising: a manual, audio cassette, slides and overhead transparencies.
Available from: Michael Benn Associates, P.O. Box 5, Wetherby, Yorkshire. Tel: 0937 844524
To buy: £25 plus p&p.

► UNDERSTANDING PROBLEM DRUG USE 1986
Shows the different ways in which all drugs can be used, describes the problems which can be associated with drug use and explores the range of responses available. Supported by literature pack and tutor briefing notes.
Available from: North West Regional Drug Training Unit (see above)
To buy: £30 + £1 p&p
To hire/preview: £6 + £1 p&p



► WORKING WITH DRUG USERS☆ 1986
Training pack to use with those who come into contact with drug users in their day-to-day work. Materials include: 12 video modules contained on one video lasting 2 hours 45 minutes and full back-up printed materials for tutors and course participants.
Available from: CFL Vision (see above)
To buy: £45
To hire: Free of charge, but the video cannot be hired on its own without the course notes which cost £15. Those who become subsequent buyers get £10 off the price of the video.

General viewing

Better dead ... then and now, **Junkie** and **Kids stuff**, plus:

► AN EASY PILL TO SWALLOW 1979
Valium — a number of women describe how it feels to be dependent on this drug, and how they would like to be free of it. A

continued page 18 ►

► *continued from page 17*

doctor explains how prescribing it can often be a substitute for real help such as counselling, and a girl tests doctors by going with a made-up story of slight depression and getting prescriptions with no difficulty at all. National Film Board of Canada.
Available from: Concord Films, 201 Felixstowe Road, Ipswich, Suffolk, IP3 9BJ. Tel: 0473 76012/715754
To buy: £50 + VAT + p&p (VHS)
To hire: £10 (1 day's hire)

► **GALE IS DEAD 1970**
Gale became a drug addict, and died by an overdose at the age of 19. This attractive and intelligent girl had to go into local authority care when six months old, and had been in 14 institutions in her short and hopeless life. The BBC *Man Alive* programme asks if Gale need have died, and tries to show that there may be other Gales it is not too late to help.
Available from: Concord Films (see above).
To buy: No details given
To hire: £12 (1 day's hire)
A set of slides from the film with a commentary is available for sale only at £8.60.

► **HEROIN☆ 1985**
One video featuring a three-part series from Yorkshire TV:
Part 1: The story of Paul Ackland, son of actor Joss Ackland
Part 2: Studio discussion involving sociologist Jock Young and parents
Part 3: Studio discussion involving drugs workers and exusers.
Available from: Jeff Foster, N.T. Sales, Yorkshire TV, Television Centre, Leeds, LS3 1JS. Tel: 0582 438283
To buy: £44.95 or £19.95 per film (VHS)
Can only be shown on the premises for which it is purchased.

► **THE HEROIN BARONS 1983**
Granada *World In Action* programme examining the illicit trade in Britain.
Available from: Concord Films (see above)
To buy: £190 + VAT + p&p (VHS)
To hire: £9.80 (1 day's hire)

► **IN A DIFFERENT WORLD GLUE SNIFFING☆ 1981**
Tyne Tees Television film on the life of one 20-year-old glue sniffer.
Available from: Concord Films (see above)
To buy: £45 + VAT + p&p (VHS)
To hire: £11 (1 day's hire)

► **ON THE GLUE☆ 1976**
Thames Television film about the dangers of solvent misuse, interviews with those who have stopped and a bereaved father.
Available from: Concord Films (see above).
To buy: £50 + VAT + p&p (VHS)
To hire: £9.80 (1 day's hire)

All publications and audio-visual materials listed below are available for reference in ISDD's library. For a free listing, send a copy of your new publication/audio-visual material to ISDD's library. Courses, conferences and other events also listed free of charge — send details to the editor. Inclusion cannot be guaranteed.

COURSES

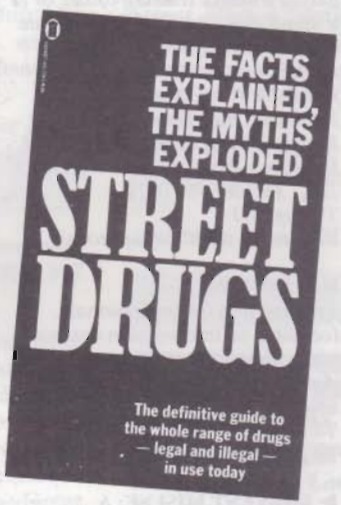
► **WORKING WITH COUPLES AND FAMILIES WITH ALCOHOL/DRUG PROBLEMS. Alcohol Interventions Training Unit, University of Kent. 1-5 Sept. 1986.**
Internal dynamics of drug-problem families and various types of family intervention. For those with experience of working with such families.
Application form from: School of Continuing Education, Rutherford College, University of Kent, Canterbury, Kent CT2 7NX or phone Gail Jones, 0227 66822 ext 691.

► **DRUG PROBLEMS; RECOGNITION, ASSESSMENT AND INTERVENTION. Alcohol Interventions Training Unit, University of Kent. 1-5 Sept. 1986.**
Introductory, multi-disciplinary course for those with little or no previous experience of working with problem drug users.
Application form from: as above.

BOOKS

General

► **HEROIN: CHASING THE DRAGON. Picardie J., Wade D. Harmondsworth: Penguin, 1985. 121 pages. £2.50.**
An 'investigative report' by two *Sunday Times* journalists on Britain's heroin problem and responses of enforcement and welfare agencies.
Available through bookshops.



► **STREET DRUGS. Tyler A. Sevenoaks: New English Library, 1986. £3.50.**
Popular reference book allocating a chapter to each of the main drugs abused, misused or overused in Britain. History, cultures of use, effects and problems.
Available from ISDD. Add 15 per cent for p&p.

Help and Advice

► **BOTTLING IT UP. Curran V., Golombok S. London: Faber and Faber, 1985. 160 pages. £3.25.**
From two psychologists at London's Institute of Psychiatry. Investigates why twice as many women as men take tranquillisers, then gives practical advice on taking and stopping tranquillisers.
Available through bookshops.

► **DRUG PROBLEMS: WHERE TO GET HELP. BBC Drugwatch and Standing Conference on Drug Abuse. London: BBC and SCODA, 1986. 155 pages. £2.00 inc. p&p.**
Directory of UK helping services for drug users arranged by county. Co-produced by SCODA — the DHSS-funded co-ordinating agency for voluntary drug projects in England and Wales — and the BBC. Includes NHS, voluntary, self-help and private projects.
Available from SCODA, 1-4 Hatton Place, London EC1N 8ND.

► **ESCAPING THE DRAGON. Field T. London: Unwin, 1985. 112 pages. £2.95.**
Partly autobiographical account from an ex-heroin addict which aims to help parents understand heroin and the process of addiction.
Available from ISDD. Add 15 per cent for p&p.

► **HELPING DRUG USERS: SOCIAL WORK, ADVICE GIVING, REFERRAL AND TRAINING SERVICES OF THREE LONDON 'STREET AGENCIES'. Dorn N., South N. Aldershot: Gower, 1985. 229 pages. £14.50.**
From ISDD's research unit. Describes the social work, advice giving, referral and training services of three London 'street agencies' specialising in drugs.
Available from ISDD. Add 15 per cent for p&p.

► **HOOKED? NET: THE NEW APPROACH TO DRUG CARE. Patterson M. London: Faber and Faber, 1986. 280 pages. £4.95.**
NET — neuro-electric therapy — is claimed to relieve acute withdrawal symptoms and prevent longer-lasting symptoms. A small portable 'black box' delivers an electric current behind the ears, said to stimulate natural recovery processes.
Available through bookshops.

► **HOW TO GET OFF DRUGS. Mothner I., Weitz A. Harmondsworth: Penguin, 1986. 304 pages. £3.95.**
Anglicised edition of a 1984 US publication. How to assess the severity of your drug problem and overcome it using personal resources and helping agencies. Includes legal and illegal drugs and medicines.
Available through bookshops.

► **KICK HEROIN: A GUIDE FOR THOSE CONCERNED WITH ADDICTS. Cutland L. London: Sky Books, 1985. 112 pages. £3.95.**
By a counsellor at one of the private addiction treatment services operating the 'Minnesota model'. Advice for the addict's family and an exposition of a philosophy of addiction and treatment becoming more influential in Britain.
Available through bookshops.

► **LIFE WITHOUT TRANQUILLISERS. Coleman V. London: Piatkus, 1985. 153 pages. £6.95.**
By an ex-GP and popular medical author/broadcaster. Covers anxiety, problems and dangers of tranquillisers, how to stop taking the pills and find other ways to cope. The author believes tranquillisers can cause more harm than tobacco.
Available through bookshops.

Prevention

► **DRUG USE: THE FACTS YOU NEED TO KNOW. Youth Enquiry Service (Strathclyde Resource Unit) and Youth Information Resource Unit (Scottish Community Education Council), 1985. Leaflet. £0.30.**
Colourful leaflet meant to bring home the dangers of drugs to young people.
Available from SCEC, Atholl House, 2 Canning Street, Edinburgh EH3 8EG.

► **HEALTH EDUCATION DRUGS AND THE PRIMARY SCHOOL CHILD: A RESOURCE FOR PUPILS 9-11, TEACHERS, PARENTS. Wirral Health Education Unit. Wirral: WHA, 1985.**
A health education pack divided into modules for pupils, parents and teachers. The aim is to raise awareness of drugs and drug dangers and help prevent future problems. Consists of slides, notes, and sheets for copying and distributing to parents.
Phone TACADE for price and availability, 061 848 0351, or write to TACADE, 3rd Floor, Furness House, Port of Manchester M5 2XA.

► **LOCAL EDUCATION AUTHORITY POLICIES AND PRACTICES ON DRUG MISUSE AND DRUGS EDUCATION. Hodgson. A. Slough: National Foundation for Educational Research, 1985. 42 pages plus appendices, mimeo. £3.00 inc. p&p.**
Research report of a questionnaire survey of LEAs in England and Wales. The research was commissioned by the D.E.S.
Available from: Ann Hodgson, NFER, The Mere, Upton Park, Slough, Berkshire SL1 2DQ.

► **THE USE OF DRUGS. Ward B. London: Macdonald, 1985. 64 pages. £5.50.**
One in the "Debates" series for older secondary school pupils aiming to present the facts and the arguments, leaving the pupil to decide. Covers legal and illegal drugs and medicines.
Available through bookshops.

Policy and law

► **MISUSE OF DRUGS. Bucknell P., Ghodse H. London: Waterlow, 1986. xxix, 410 pages. £35.00.**
A barrister and drug dependency unit psychiatrist combine to produce a reference work on drugs law (including case law) up to October 1985, plus the effects of controlled drugs and forms of treatment.
Available through bookshops.

► **MISUSE OF DRUGS WITH SPECIAL REFERENCE TO THE TREATMENT AND REHABILITATION OF MISUSERS OF HARD DRUGS. Fourth report of the Social Services Committee, session 1984-1985. Together with proceedings and minutes of evidence. UK House of Commons Social Services Committee. London: HMSO, 1985. lxiii, 189 pages. £11.20.**
Wide-ranging investigation of the current state of addiction treatment in Britain plus recommendations.
Available from HMSO.

► **MISUSE OF HARD DRUGS. First report from the Home Affairs Committee, session 1985-86. Together with the proceedings of the Committee minutes of evidence and an appendix. UK House of Commons Home Affairs Committee. London: HMSO, 1986. xv, 159 pages. £10.70.**

Investigation of Customs, police and Home Office policy and practice.
Available from HMSO.

► **TACKLING DRUG MISUSE: A SUMMARY OF THE GOVERNMENT'S STRATEGY. 2nd edition. UK Home Office. London: Home Office, 1986. 39 pages.**
Updated booklet giving the authorised version of government policy aiming to reduce drug abuse by simultaneous initiatives in prevention, enforcement, treatment, and control of legal and illegal supplies.
Single copies free of charge from ISDD, or order from the Home Office, 50 Queen Anne's Gate, London SW1H 9AT.

Trafficking

► **BIG DEAL: THE POLITICS OF THE ILLICIT DRUGS BUSINESS. Henman A., Lewis R., Malyon T.,*et al*. London: Pluto Press, 1986. 211 pages. £4.50.**
The global heroin economy, drugs in young subcultures, the cannabis commodity market, pharmaceuticals and passivity, cocaine politics in Latin America, a collection of 'alternative' perspectives on drugs issues.
Available from ISDD. Add 15 per cent for p&p.

► **THE FIX. Freemantle B. London: Michael Joseph, 1985. 303 pages. £10.95.**
An ex-foreign editor of a national paper investigates the global illegal drugs production and distribution business. Also chapters on the history and pattern of drug misuse in Britain.
Available through bookshops.

Epidemiology

► **DRUG MISUSE IN WIRRAL. A study of 1800 problem drug users known to official agencies. The first report of the Misuse of Drugs Research Project to the Wirral Drug Abuse Committee. Parker H., Bakx K., Newcombe R. Liverpool: University of Liverpool, 1986. 144 pages, mimeo. £3.50 inc. p&p.**
The extent and nature of drug misuse in a part of Britain known as 'smack city'. Documents widespread heroin smoking, most commonly among young unemployed from deprived areas.
Available from Misuse of Drugs Research Project, Sub-Department of Social Work Studies, University of Liverpool, Liverpool L69 3BX.

► **DRUG PROBLEMS: ASSESSING LOCAL NEEDS. A practical manual for assessing the nature and extent of problematic drug use in a community. Hartnoll R., Daviaud E., Lewis R., Mitcheson M. London: Drug Indicators Project, 1985. £5.00.**
Detailed guidance from the Drug Indicators Project whose work has provided the generally accepted basis for assessing the extent of opiate dependence in Britain.
Available from ISDD. Add 15% p&p.

► **DRUG PROBLEMS IN GREATER GLASGOW. Haw S. Glasgow: SCODA, 1985. £5 inc. postage.**
Report of a SCODA fieldwork survey. Systematic study of resources and the extent and nature of drug use in a city with reputedly one of the worst drug problems in Britain.
Available from SCODA, 1-4 Hatton Place, London EC1N 8ND.

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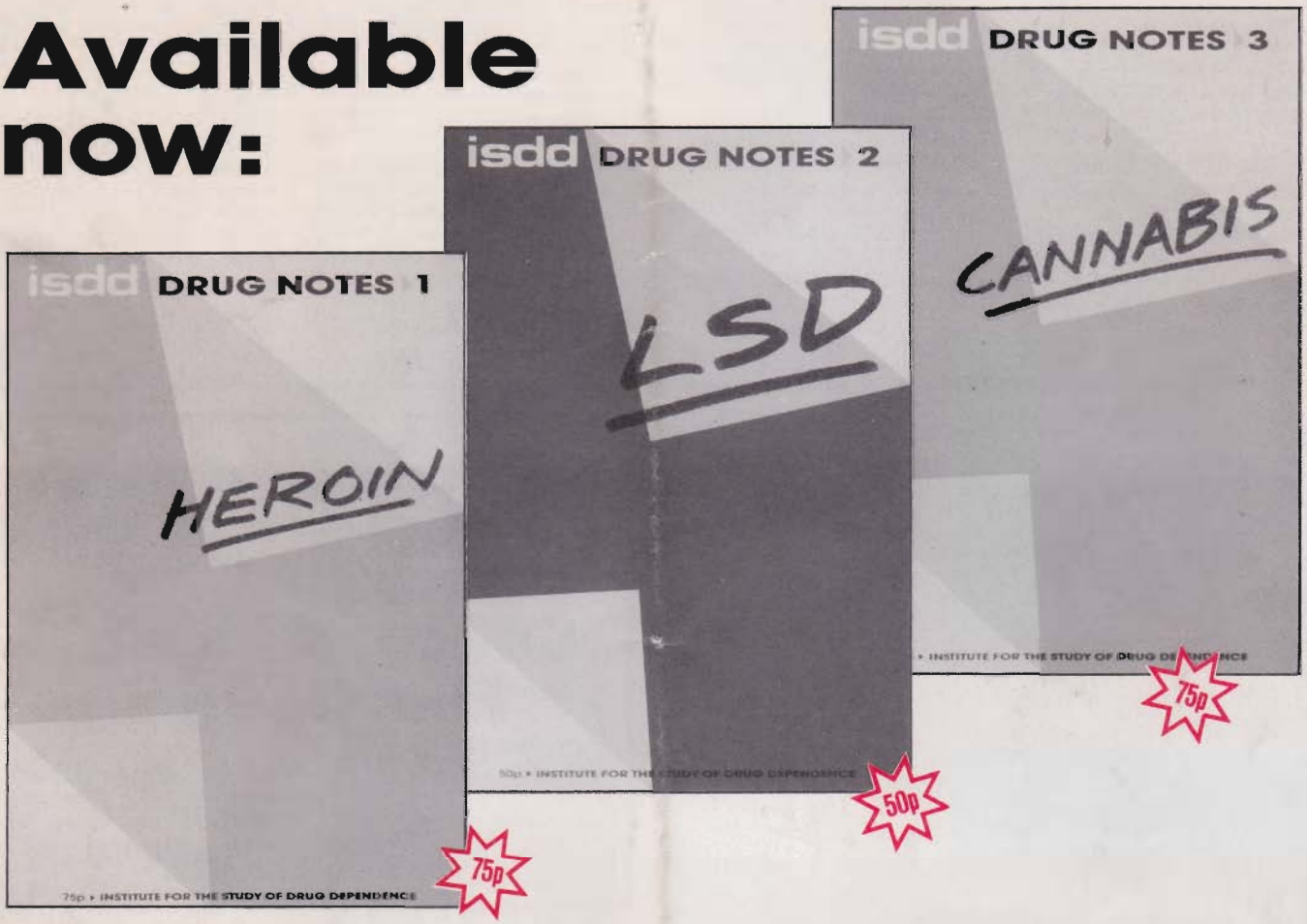

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