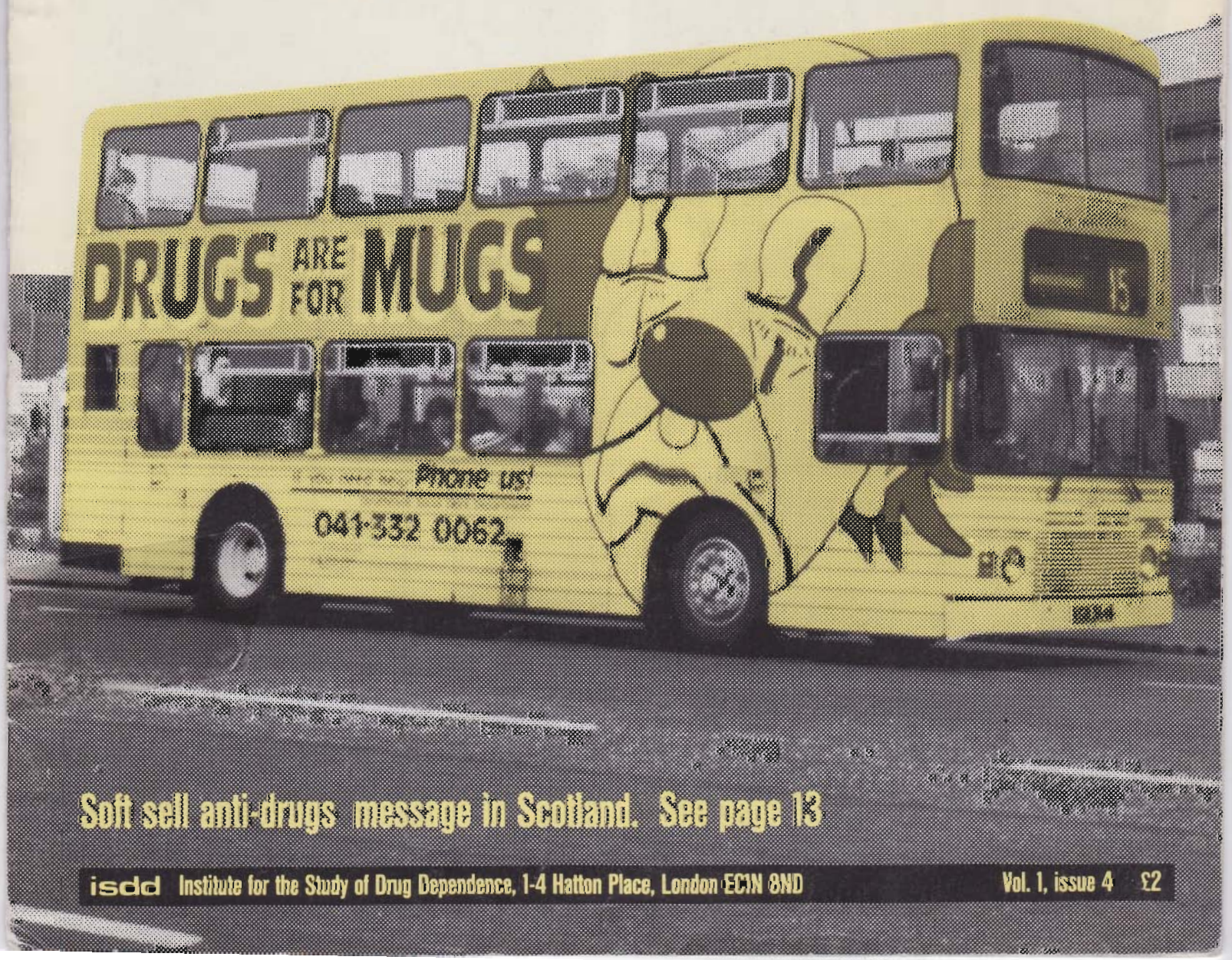
DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN November/December 1986



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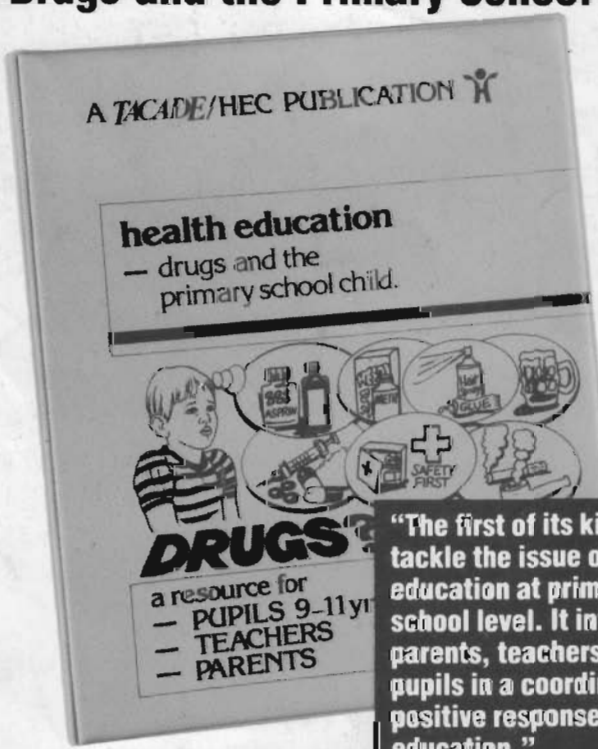

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● The newsletter is part of ISDD's Active Clearinghouse for liaison between Regional and Local Drug Research Projects, funded by the DHSS.

● Issue one was circulated to Health Authorities in 1985 and to the research projects listed in that issue.

● Issue two in 1986 updated the information by listing further research projects and presenting selected progress reports.

● There are plans for a conference for researchers to be held in 1987. Projects subscribing to ***Drug questions*** are eligible to apply for places.

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● There are currently 170 subscribers to ***Drug questions*** newsletter. If you are interested in subscribing contact ISDD for a subscription form.

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Issue three

● Issue three will be published in Spring/Summer 1987.

● If your drug research project was not included in issue one or two of ***Drug questions*** then please write in for a project description form to ensure that we have details for inclusion in issue three.

● Similarly, if your research was included in issue one or two but has now advanced, changed focus or yielded results, please write in for a form for inclusion in issue three.

● Contact Lorraine Lucas, ISDD, 1-4 Hatton Place, London EC1N 8ND, saying whether you need a *newsletter subscription form*, or *project description form*, or both.

DRUG QUESTIONS

DRUGLINK

November/December 1986
Vol. 1, issue 4
THE JOURNAL ON DRUG MISUSE IN BRITAIN

DRUGLINK is about 'disapproved' forms of drug use — seen legally, socially and/or medically as 'misuse'. **Druglink** does not aim to cover alcohol and tobacco use. **Druglink** is for specialist and non-specialist workers occupationally, professionally, or academically involved in responding to drug misuse in Britain. **Druglink** aims to inform, promote understanding and encourage debate.

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STAFF Editor: Mike Ashton ● Production: Jan Hodgman ● Additional reporting: Harry Shapiro ● Listings: John Witton ● Design & Print: Redesign, 9 London Lane, London E8 3PR. 01-533 2631. (J5513).

CONTRIBUTIONS **Druglink** welcomes letters and other contributions, including examples of interesting or effective practice in the response to drug misuse. Send contributions direct or phone Mike Ashton to discuss your ideas.

SUBSCRIPTIONS **Druglink** is published every two months. The subscription year is January to December. During the current year subscriptions can start from May (4 issues, £8); July (3 issues £6); September (2 issues, £4); or Nov (1 issue, £2). Send a further £12 to continue your subscription through 1987 (6 issues). Order forms available on request. Cheques payable to ISDD.

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

ISSN 0305-4349

Cover photo by Jackie Hodgman.
A Strathclyde local authority bus carries an anti-drugs message to the streets of Glasgow.

IN THIS ISSUE

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SEIZURE LAW DUE IN 1987

Assisting 'laundering' and paraphernalia sales now illegal

In line with international trends, the government has taken another significant step to increase penalties for drug trafficking. On 30 September the first stage of the Drug Trafficking Offences Act came into force and in the new year courts will be required to confiscate the proceeds of a convicted trafficker's entire drug trafficking career.

The Drug Trafficking Offences Act comes into effect in three stages.

● **Stage one** is already in force. As from 30 September it has been an offence to assist a trafficker to 'launder' the proceeds of the crime, eg, by investing the money in legal enterprises so it cannot be traced.

The prosecution will have to prove the accused *knew* they were dealing with a trafficker. It will also be a defence for the accused to show "on balance of probabilities" that they did not know or suspect the arrangement related to the proceeds of trafficking, or that it would assist the trafficker. The offence carries a maximum sentence of 14 years in prison.

Also in force are the provisions relating to the supply of drug "paraphernalia". Under the new Act, it will be an offence to supply (but *not* to possess) almost *any* article which may be used to take or prepare controlled drugs. Although aimed at the sale of 'cocaine kits', the law will apply to other articles, including pipes for smoking cannabis. Only the supply of syringes is exempt from the Act, to help prevent the spread of AIDS and hepatitis.

There is concern in some quarters that the new paraphernalia law is unworkable — in others, that it will be all too workable. The problem is that the prosecution have to prove the supplier actually *believed* (not just had reason to believe) the articles would be used to take drugs — a provision meant to protect, for example, the newsagent who innocently sells cigarette papers later used to roll a cannabis 'joint'. The maximum penalty is six months in prison and/or a £2000 fine.

Stage one of the Act also protects people who inform the police that funds or investments may be connected with drug trafficking. From 30 September this cannot be treated as breach of contract, a provision intended to encourage banks and other financial institutions to inform on 'suspicious customers'.

● **Stage two** of the Act, giving the police new powers to investigate the financial dealings of suspected traffickers (access to bank accounts, etc), may be implemented by late November. At this stage a third new criminal offence will make it illegal to prejudice a drugs investigation by tipping off the suspect, after police or customs have obtained or applied for the authority to demand disclosure of information. The maximum penalty will be five years on indictment and six months on summary conviction.

● **Only at stage three** will the main confiscation and restraint provisions of the Act come into force, rendering the assets of convicted dealers liable to confiscation. Stage three is expected to complete the implementation of the Act around the turn of the year.

The courts will be empowered to confiscate whatever can be realised from a convicted trafficker's assets or property up to the estimated value of their entire drug trafficking career. Where the offender's assets are insufficient, a prison sentence can be imposed on a sliding scale to a maximum of 10 years in default of a sum exceeding £1 million. Once somebody is accused of a trafficking offence, assets will be able to be frozen to prevent the defendant placing money, goods or property outside the jurisdiction of the court.

THE CONFISCATION and restraint provisions of the Act will apply only to England and Wales, though an English court's confiscation order will be enforceable in Scotland. Legislation to extend these parts of the Act to Scotland and Northern Ireland will be introduced "at the earliest opportunity". But this might not be the end of the story. At the recent Conservative Party Conference, the Home Secretary, Douglas Hurd, announced the government was considering widening the net of fiscal confiscation to include the proceeds of all crime, not just drugs.

See TALKING POINT for more on the Drug Trafficking Offences Act.

Ethnic origin of drug prisoners

For the first time Home Office statistics have given comprehensive information on the ethnic origins of prisoners received into custody, including those sentenced for drug offences. These show that the number of black people imprisoned for drug offences is disproportionate to their presence in the population (see table).

However, this apparent skew may be partly due to the fact that sentences of imprisonment are most likely to be imposed for smuggling offences. These can be expected to more often involve the nationals of foreign producer and transit countries, such as countries in Africa and the West Indies and Asia and the Middle East. Britain's report to the United Nations for 1983 showed that 14 per cent of convicted drug offenders were foreign nationals, the largest number from the Carribean (1060) and Nigeria (313). Only Eire with a large resident UK population came close, with 208 of its nationals convicted for drug offences.

Welcome as they are, these latest statistics do not directly shed light on the ethnic origin of drug *users* in the UK, most of whom regardless of ethnic origin remain undetected or receive non-custodial sentences when they are. Increasing interest in the extent of drug problems among ethnic minorities in the UK (and the appropriateness of existing services for them) has yet to be informed by research.

Prisoners from different ethnic groups as a percentage of those under sentence for drugs offences 1 July 1984 to 31 March 1985, compared to percentage in the population 1984. England and Wales.

	Males		Females	
Ethnic origin	**% of population[1]**	**% of receptions**	**% of population[2]**	**%of receptions**
White	94	68	93	59
West Indian/ Guyanese or African	1	19	2	31
Indian, Pakistani, Bangladeshi	3	7	3	2
Chinese, Arab, mixed origin	1	3	1	2
Other	2	3	2	7
Total number = 100%	—	1910	—	238

1. Aged 14-64
2. Aged 14-54

Source: *The ethnic origin of prisoners: the prison population on 30 July and persons received, July 1984-March 1985.* Home Office Statistical Bulletin, June 1986.

COCAINE NOT YET A 'STREET' DRUG IN LONDON

Despite the recent rash of headlines about a "Tidal Wave Of Cocaine", fieldwork at the Drug Indicators Project shows cocaine has yet (if it ever does) to become a 'street' drug in London or a major cause of drug-related problems.

Concern about cocaine use in the UK and in Europe as a whole stems from developments across the Atlantic as much as from domestic trends. It is feared that expansion of cocaine production in South America is saturating the North American market, so further growth may occur in alternative markets such as Europe. There is also concern that the barrage of US reports about the destructive personal and social consequences of widespread use may be a foretaste of what could happen here.

● **Indicators of supply** and availability suggest that increased cocaine use has indeed occurred. In 1985 UK Customs seized almost 80kg — four times the average haul between 1978 and 1982. Some of this increase may reflect improved detection, but most is likely to be due to growing supply.

This conclusion is supported by a steady reduction in real price by about one third since 1979; by the relatively high purity (often 40-60 per cent at user level); and by some evidence of rising use (such as increasing arrests for possession, and observations of fieldworkers, drug users and police). Similar patterns, especially for seizures, are also seen in European countries such as France, Holland, Italy and Germany.

● **What of the fear** that increased availability will lead to serious medical, social and criminal consequences? Evidence for increased use comes largely from law enforcement sources. From information available on treatment, hospitalisation, deaths and so on, there do not appear to be large or rapidly growing numbers of people experiencing serious problems primarily associated with cocaine.

Similar discrepancies between enforcement and 'casualty' indicators are reported in Europe. There could be at least three reasons for this. It could be:

— because there are no special facilities for cocaine-related problems; or

— because there is a long time-lag between starting use and when a significant proportion of users lose control and become 'problem users'; or

— because most of the increase is in intermittent, recreational use that remains relatively free of problems (except the risk of arrest).

In London the evidence is that cocaine has become more widely used over recent years, but that, despite a modest fall in price, it is still an expensive luxury drug, and is still, in most cases, sniffed rather than smoked or injected and taken intermittently rather than regularly. It is rarely sold on the streets or in pubs.

More commonly, and to a greater extent than most drugs, cocaine is obtained through contacts, and it would need a marked change in distribution to make it a 'street' drug. This is partly to do with the consumers.

There appears to be a substantial 'upmarket' clientèle within advertising, journalism, popular entertainment, business, socialite circles and so on. There is also some evidence of working class cocaine use (for example, in the building trade, minicab, second-hand car and antiques businesses, boxing, snooker and weight-training circles) and more limited evidence of experimentation among adolescents.

However, amphetamine remains much more common, partly because of cost, partly because of cultural traditions, sometimes because it is preferred. Opiate users also use stimulants, often the cheaper amphetamines, though many regular heroin users sometimes buy cocaine as 'a treat'.

While some individuals do develop serious problems, especially financial, it seems that cocaine is not usually the primary drug among 'problem drug takers' and that serious 'problem cocaine use' is uncommon among cocaine users.

● **'Crack' has been** 'advertised' as if it were a completely new drug. This seems to be believed by many users. However, cocaine converted to cocaine base for smoking (of which crack is a form) is not new. We were aware of 'freebasing' (smoking) of cocaine in London around 1980/81. Although paraphernalia for both making and smoking freebase were openly on sale in parts of London, the practice remained uncommon.

The main difference with crack is the marketing — cocaine is sold converted to freebase, ready for smoking, and in small quantities, so that each unit appears cheap. However, because quantities are small and the effects short-lived, it is likely that crack works out more expensive than a gram of cocaine hydrochloride.

Over the past couple of months, there have been intermittent reports, from users, of crack being sold in inner London in £5 bags and £8 phials. It is not yet clear if it really is crack, though reports suggest that it is effective when smoked. Police report a few small seizures. At present there is little convincing evidence that crack is becoming established on the scale claimed in some American cities.

Of more interest, perhaps, is the fact that the media hype about crack has increased its attractiveness for people already involved in illicit drug use. Quite a few interviewed recently have expressed an interest in trying it after hearing so much about it.

WHETHER CRACK will become popular here is not clear. Not all drug fashions cross the Atlantic (ones that haven't include phencyclidine and 'designer drugs'). It is likely, however, that the availability and use of cocaine will continue to increase in the immediate future.

Richard Hartnoll and Robert Power
Drug Indicators Project

Funders to coordinate research

The main official funders of drug research in Britain have come together to develop a coordinated research strategy and find ways to forge a closer partnership between research and policy.

An exploratory phase of the Drug Research Initiative has been jointly funded by the Economic and Social Research Council (ESRC), Medical Research Council, Home Office, DHSS, and the Scottish Home and Health Department — the first time such a large group of bodies with funding responsibilities for drug research have been brought together.

The steering committee is chaired by Suzanne Reeve, secretary of the ESRC, and the scientific secretary is Dr Virginia Berridge. The focus is on the relation of research to policy and how the two could be brought into a more effective working relationship.

A number of papers have been written for the initiative setting out some of the research issues and Virginia Berridge has been talking to researchers and people in government with an interest in policy and research. She has also been investigating research at an international level, in particular the way in which drugs research is coordinated within Europe, and the influence tendencies in American research and policy are likely to have in Britain. The report on this preliminary stage is due by the end of the year.

There is, of course, no guarantee the report will lead to future action. A number of recent reports have made research recommendations on the misuse of drugs, notably the SSRC's *Research priorities in addiction*[1] and the reports on *Treatment and rehabilitation*[2] and *Prevention*[3] from the Advisory Council on the Misuse of Drugs. Despite this groundswell of feeling that there should be more research, the Commons Social Services Committee recently commented that "The main problem seems to be a lack of coordination and of general direction and an absence of research into, and evaluation of, past or present experience".[4]

Virginia Berridge can be contacted at the ESRC, 160 Great Portland Street, London W1N 7BA, phone 01-637 1499 ext. 260.

1. Social Science Research Council. *Research priorities in addiction*. SSRC, 1982.
2. Advisory Council on the Misuse of Drugs. *Treatment and rehabilitation*. HMSO, 1982.
3. Advisory Council on the Misuse of Drugs. *Prevention*. HMSO, 1984.
4. House of Commons Social Services Committee. *Misuse of drugs with special reference to the treatment and rehabilitation of misusers of hard drugs*. HMSO, 1985.

AIDS scare prompts policy re-think in Scotland

The AIDS scare has called current addiction treatment trends into question as supply of injection equipment and substitute drugs gains favour in the attempt to contain the spread of the virus.

Faced with patients who "cannot or will not abstain from misuse", a report on AIDS and drug injecting in Scotland[1] has recommended doctors exchange sterile needles and syringes for used ones to cut down on the sharing of injection equipment. Sharing 'works' is the main route for the spread of the HIV virus (cause of AIDS) between heterosexual drug users.

Services for drug users should, the report says, "be seen . . . as offering support and assistance rather than having the sole objective of stopping drug misuse" while "substitute prescribing is likely to be a necessary part of the means used to attract clients . . . and establish safer drug taking practices".

The committee which produced the report was set up by the Scottish Home and Health Department's chief medical officer, after studies revealed that as many as half the injecting drug users in Edinburgh may be infected with the virus — "considerably higher than that reported anywhere else in the United Kingdom and higher than in many places in Europe and the United States".

Why Edinburgh? According to the committee the Lothian police's policy of confiscating syringes and needles and discouraging their sale has contributed to extensive sharing, while "prevailing medical opposition to maintenance prescribing" and poor provision for drug users has deterred many from seeking medical help.

FORMER SCOTTISH Health Minister John Mackay likened issuing needles to addicts to offering prospective murderers "good weapons so that you'll murder them efficiently and quickly, and they won't suffer much . . . . heroin addiction is wrong . . . we ought not as a government, as a country, be encouraging it by giving people the means" (*Scotsman*, 3 September 1986).

A week later Mackay was re-shuffled to education. His successor, Lord Glenarthur, is less dismissive, but concerned that needle exchange "would have important implications for . . . tackling . . . drug misuse — to which . . . we must also . . . give high priority" (*Glasgow Evening Times*, 24 September 1986).

Elsewhere in the UK, fear of AIDS spreading from drug injectors to the general population (mainly via sexual contacts, including prostitution) appears to be effecting a conversion to previously condemned risk-reduction practices. In February, the Pharmaceutical Society lifted its disciplinary restriction on pharmacists selling syringes to drug misusers, and in September the Chief Medical Officer for England and Wales said the government (previously resistant) was "now actively considering" a needle exchange system.

EVEN IF POLITICAL and administrative leaders decree a syringe/needle exchange system, the troops needed to operate it may be reluctant to volunteer. The Scottish committee found voluntary drugs agencies "not willing, at present" to supply injection equipment and most GPs are reluctant to deal with misusers at all, let alone handle the added complications of an AIDS prevention programme. Many NHS drug dependence units will find it hard to accept supplying addicts the wherewithal to continue a practice staff are committed to ending, especially since injecting is the most dangerous form of drugtaking.

Pharmacists can already sell addicts needles and syringes at their own discretion and are being supplied anti-AIDS health education literature to go with them. But they cannot be expected to 'diagnose' whether their customer really is an injecting drug addict and are not equipped to dispose of potentially HIV-contaminated needles. Neither can they offer the health education counselling needed to make a needle exchange system work — if drug users continue to share their new needles and syringes, then AIDS too will continue to be shared.

Although the Scottish Committee on HIV Injection and Intravenous Drug Misuse produced its report in a matter of months, Lord Glenarthur has made it clear the government will not take "hasty decisions on issues which may conflict" — and the road from an eventual decision at the top to implementation at the base is littered with obstacles.

Meantime the Committee predicts that after three years latency one in ten infected with the virus will die every year. Even if the disease spreads no further, by the end of the decade they estimate this will result in 144 AIDS deaths a year among drug injectors in Scotland.

1. Scottish Committee on HIV Infection and Intravenous Drug Misuse. *HIV Infection in Scotland*. Scottish Home and Health Department, September 1986. Available from the Scottish Home and Health Department, £1.

See AIDS FILE for the full text of the Committee's recommendations.

Portsmouth local paper *The News* has revived the abstinence 'pledge' 1980s style. Young readers are being invited to sign an "anti-drugs pledge" to be witnessed by a responsible adult and sent to the paper which returns the certificate pictured above.

AIDS AND INJECTING

AIDS and injecting in ***Druglink***, volume 1 issue 3, pages 8-9, was based on work done by the SCODA AIDS Working Party and by Bill Nelles while at the Standing Conference on Drug Abuse. Bill Nelles is now at the Terrence Higgins Trust, Unit 10, 38 Mount Pleasant, London WC1N 3OP, phone 01-833 2971 (helpline), 01-278 3047 (office).

End of an era at Home Office Inspectorate

On September 29, an era in the administration of British drug policy ended — 'Bing' Spear retired (early!) after 34 years in the Home Office Drugs Branch Inspectorate.

Although he did not become Chief Inspector until 1978 he exerted an important influence on the style of the British response to drug addiction from the beginning of the 1960s. He did not invent the 'British system' (and denies there is such a thing), but his combination of meticulous information-gathering in the service of the law together with a humane and caring response to the individual addict (or reprobate doctor) typified what people took the 'British system' to be.

Stories of Bing's approachability abound; in the late '60s, when most of our two or three thousand addicts were to be found in London's West End, he was reputed to know all of them personally — certainly they did not hesitate to ring him up to complain if they felt they were being unfairly dealt with by a drug clinic.

Bing has already published several key papers on the epidemiology of drug use in Britain. We hear that he is hoping to devote some of his time to writing the recent history of the administration of British drug policy — which will go some way towards consoling us all for the gaping hole his departure has left.

Jasper Woodcock
ISDD Director.

ATTACK ON DEALERS STRETCHES BRITISH JUSTICE

The editors of the Criminal Law Review identify three "supposed principles" of English justice reversed by the Drug Trafficking Offences Act now trickling into effect.

Criminal Law Review

In July this year the Drug Trafficking Offences Act received the Royal Assent. Its provisions will be brought into force as and when the detailed Rules of Court which are necessary for its implementation are prepared. The main thrust of the Act is to introduce a new mandatory procedure where a person appears before the Crown Court to be sentenced in respect of one or more drug trafficking offences.

Before and in addition to passing whatever sentence the court thinks appropriate, the court is required to determine whether the offender has benefited from drug trafficking by receiving any payment or other reward for it. If so, the court must then make a confiscation order. The amount of the order will be the sum assessed as the proceeds of the offender's entire drug trafficking career, not just the offence(s) on this occasion.

In the assessment, the court is empowered to assume that all the trafficker's current property, and everything owned in the previous six years, is or represents the proceeds of drug trafficking unless it is shown otherwise; the order should not exceed the trafficker's current assets (plus certain property transferred to others); a receiver may be appointed to recover the property confiscated, and the Act provides lengthy periods of imprisonment for non-payment.

The Act is a powerful response to an activity which is widely regarded as a grave social evil, but the complex and unusually far-reaching requirements placed upon the Crown Court may make heavy demands on the court's time and interpretive skills.

Among the Act's other provisions are three new offences. One is a 'laundering' offence, aimed at persons who facilitate another's retention, control or investment of the proceeds of drug trafficking. There are various special defences, framed so as to require the defendant to establish his innocence on one of these grounds after the prosecution has established the elements of the offence itself. The maximum penalty is 14 years' imprisonment.

Another offence is committed by a person who, knowing or suspecting or having reasonable grounds to suspect that an investigation into drug trafficking is taking place, makes any disclosure which is likely to prejudice the investigation. Again the special defences place the burden of proof on the defendant; the maximum penalty is five years' imprisonment.

There is also a new offence, which becomes section 9A of the Misuse of Drugs Act 1971, of selling cocaine kits or other drug paraphernalia, for which the maximum penalty is six months' imprisonment.

It is worth pointing out that among the supposed principles of English criminal justice which suffer reversals in this Act are the presumption of innocence, the principle of *mens rea*[1] for serious offences, and the principle that offenders should be dealt with only for the offence(s) before the court.

Of course there is wide agreement that drug trafficking constitutes such a grave social menace that stronger measures are called for, and it is not suggested that tears should be shed for traffickers who find themselves in the grip of this legislation. Nonetheless, it is important to be conscious of what is being done and why. □

1. The principle of *mens rea* requires criminal intention or knowledge of wrongdoing before conviction for serious offences.

First published as an editorial in the *Criminal Law Review*, September 1986, pages 577-8, published in London by Sweet & Maxwell Ltd.

See NEWS AND REPORTS for more on the Drug Trafficking Offences Act.

HARM-REDUCTION — WHOSE LIFE IS IT ANYWAY?

The AIDS scare has drawn harm-reduction in from the 'irresponsible' fringe to the 'acceptable' centre of the debate on drug policy. Harry Shapiro of ISDD asks — why the sudden change?

Harry Shapiro

Currently there is serious discussion within medical circles about the provision of sterile syringes to addicts in an attempt to prevent the spread of AIDS and hepatitis B through the sharing of needles. Although at first reluctant to countenance such a move, the government appears to be responding to a veritable barrage of pleas to ease access to syringes — "not in any way to encourage drug-taking but to avoid adding to the misery of drug victims" (*Reading Evening Post*, 2 May 1986).

Speaking to the conference of the Pharmaceutical Society (whose members may have to supply the syringes), the government's Chief Medical Officer reported that his political masters were "actively considering" such a move (*Daily Telegraph*, 26 September 1986). Free syringe supply, by anybody's definition, is 'harm-' or 'risk-reduction'; the recognition that:

— a particular method or kind of drug use is especially harmful;

— it is unrealistic to believe that drug use as such can be reduced sufficiently to eliminate this risk; and so therefore

— a strategy should be adopted which aims to reduce the potential harm rather than (or as well as) stopping the drug use.

But the concept of harm-reduction is nothing new. In 1980, ISDD published *Teaching about a volatile situation*, a leaflet designed for health educators based on a harm-reduction strategy for solvent misuse. This recognised that if young people want to misuse solvents, there is precious little that any parent or teacher can do about it, however hard that might be to swallow. The aim was quite simply to help minimise the number of young deaths through solvent misuse.

However, the media and others (to whom the leaflet was *not* directed) did not see it in that light, and the document was widely condemned as 'a guide to safe sniffing', 'a glue sniffers' charter' and so on.

Another leaflet on risk-reduction for drug users has been in existence for some time, but the RHA to which it was presented has been painfully slow in making it generally available in the region. It is still only 'on trial' in a very small area. This *could* be an example of an RHA working at top speed, or perhaps they are concerned about what has always been considered a political hot potato.

So what has happened? Why have the proposals to supply syringes to addicts not been universally slammed as giving a green light to intravenous drug use on the NHS?

If solvent misusers do not take steps to reduce the most harmful aspects of their involvement with solvents, they run the risk of death. If the worst happens, the misuser will die and their family and friends will suffer: but neither the death nor the suffering is contagious — the public at large can rest easy.

The drug user with AIDS is a very different character; a potential threat to the non-using majority in any community — not through the old stereotypical concept of addiction as a contagious disease, but a disease carrier in a very real sense.

Could it be that what at first sight appears an altruistic attempt to protect the health of drug users, is really little more than enlightened self-interest?

The message to health educators seems clear — don't give people the necessary information to reduce the dangers of taking drugs because that could be construed as approval. Unless, of course, by *not* doing so, you and me are put at risk. □

SCOTTISH PROPOSALS

"I am personally and on principle against it", said the former Scottish Health Minister about issuing needles and syringes to addicts. But a committee set up by his Chief Medical Officer was about to recommend just that. AIDS FILE brings you their radical recommendations — plus news from New York, where the entrepreneurs of the illicit drugs market have stepped in with their own 'free needles' offer as the authorities consider relaxing legal restrictions.

Prevention of spread of HIV infection: approach to individual injecting drug misusers

The following recommendations should be implemented as a matter of urgency.

► Injecting drug misusers who cannot or will not abstain from misuse must be educated in safer drugtaking practices. It is of the utmost importance that those who continue to inject are persuaded to use clean equipment and never to share it. Clean equipment should therefore not be denied to those who cannot be dissuaded from injection. In this connection authorities should be reminded that threat to life of the spread of HIV infection is greater than that of drug misuse. On balance, the prevention of spread should take priority over any perceived risk of increased drug misuse.

► Practitioners should be informed that it may be an appropriate part of the management of individual patients, in the interests of limiting the spread of infection, to issue needles and syringes and that this should be done on a one-for-one exchange basis for a needle and syringe. This should be linked with a simple reminder to practitioners that tests for drugs in the urine which can be used in the surgery are available and with the warning that any drugs which were being given to the patient could be crushed up and injected. Testing for HIV antibodies, with appropriate pre-counselling should be offered to those who are given this equipment.

► Substitution prescription should be considered for those patients for whom it is judged that it will assist in reducing or stopping injection. It should also be considered as a means of establishing and maintaining effective contact with injecting drug misusers.

► All drug misusers must be given advice on 'safe sex' with particular emphasis on the use of condoms. Family planning advice should be readily available, linked to counselling about the grave risk to an infant born to infected parents.

Organisation of preventive measures to contain the spread of HIV infection

► Health boards should identify an appropriate individual to be responsible for coordinating action in connection with the AIDS epidemic, including both the prevention of infection and provision for the management of clinical disease, and who would relate to a person carrying these responsibilities at national level.

► Health boards should re-examine all the provisions in their area for dealing with the drug misuse problem to ensure that these services are adequate to meet the additional problem of HIV spread. This will include the use of outreach workers to contact the very large proportion of intravenous drug misusers who have not yet been identified and the effective marketing of health education and counselling and may require expansion of specialist facilities within the health service in the management of drug dependency problems.

AIDS = acquired immune deficiency syndrome. An invariably fatal syndrome of diseases resulting from damage to the immune system caused by infection with the HIV virus.

Immune system = body systems responsible for maintaining resistance to disease.

HIV virus = human immunodeficiency virus. Formerly known as the HTLV III virus and sometimes called the 'AIDS virus'. In Britain about one in ten people infected with the HIV virus develop AIDS and a larger proportion (about one in three) develop less serious illnesses.

HIV antibody = the antibody produced by the body in response to the HIV virus. Tests for HIV infection rely on detecting the presence of this antibody. Absence of the antibody does not necessarily mean the individual is clear of infection.

► A clinician should be identified in each Health Board with overall responsibility for drug misuse problems including support for the non-statutory drug misuse agencies and also to provide advice to Boards in relation to further service requirements. In the larger Health Boards, especially those with existing substantial drug misuse problems, new appointments will be necessary to cover this task.

► The Committee wishes to emphasise the extent to which reliance is now placed on the non-statutory drug agencies in the attack on the drug misuse problem in Scotland and recommends that urgent steps be taken to ensure that sufficient extra funding is made available to permit these agencies to cope with the additional workload required to control spread of HIV infection in injecting drug misusers.

► Additionally the Committee recommends that, with the impending hand-over of management of the non-statutory drug agencies from the Scottish Home and Health Department (SHHD) to Health Boards, appropriate steps be taken urgently to provide security of tenure for key staff in these bodies to avoid loss of personnel and decline in morale. In this connection the Committee welcomed the Minister's recent announcement that "those who are working in this difficult field should (therefore) be assured that there will be support funds for worthwhile projects and initiatives for some years to come" but emphasised the long term nature of the problem.

► The Committee recommends that the responsibilities of the general practitioner be re-emphasised in regard to the treatment and prevention of drug misuse and related HIV problems. Health Boards should provide active encouragement to general practitioners to deal with patients with drug problems and should ensure that adequate sources of advice and opportunities for referral of patients are made available to them.

► There should be established one or more resource centres based in existing clinical units which have experience in clinical care of HIV infection and in counselling. The centre(s) should provide a scientific and clinical database on HIV infection and be able to provide a consultation service to health care and other workers including those in the drug misuse field.

► An extensive programme of educational workshops, seminars, etc, on HIV related problems should be established and effectively marketed. These should specifically be aimed at health care and other staffs who may encounter such problems in their work. The Scottish Health Education Group (SHEG) should provide training materials for these educational workshops.

► SHEG should provide a range of health education materials related to HIV infection and drug misuse. The Committee identified an urgent need for the rapid provision of low cost materials using all appropriate media designed to communicate effectively with drug misusers and to meet particular local needs, eg, geographical and client-related.

► The Committee recommends that it should be a high priority for the Scottish Education Department to ensure that in-

These recommendations have been reprinted from HIV infection in Scotland, *the report of the Scottish Committee on HIV Infection and Intravenous Drug Misuse, published by the Scottish Home and Health Department in September 1986. The full report is available for £1 from the Department at St Andrew's House, Edinburgh EH1 0AU.*

formation about AIDS and the transmission of HIV by needle sharing and by sexual contact should be built into the health education provided in schools.

► Police policies in relation to individual drug misusers should be reviewed to ensure so far as possible that they do not prejudice the infection control measures recommended.

Epidemiological surveillance of HIV infection

► Comprehensive and effective epidemiological surveillance should be undertaken by the Communicable Diseases (Scotland) Unit. The Director should be asked as a matter of urgency to advise the Chief Medical Officer on further steps to improve the surveillance programme indicating the resources required.

► The objectives of surveillance should include:

— the establishment of arrangements with laboratories in Scotland to provide regular reports of antibody testing containing sufficient data for continuing epidemiological assessment;

— the complete reporting of all cases of AIDS in Scotland and (in so far as it is possible) of other HIV related clinical conditions;

— the design and implementation of serial point-prevalence studies to monitor spread of HIV infection;

— maintenance of an up-to-date information service on national and international epidemiological trends in HIV infection.

Epidemiological surveillance of the injecting drug misuse problem

► Studies should be commissioned by SHHD on the following aspects:

— the continuing assessment of the extent of drug misuse in Scotland and in particular an attempt to assess the numbers of presently unidentified drug misusers. Such studies have already been undertaken by the Standing Conference on Drug Abuse in Glasgow and Edinburgh (commissioned by SHHD) and should be re-instituted;

— comparative studies in a number of UK centres aimed at clarifying local factors which may contribute to the spread of HIV infection in injecting drug misusers. Factors studied should include injecting practices, availability of equipment, police activity and sentencing policies;

— prospective studies to elucidate further the natural history of HIV infection in various groups of intravenous drug misusers, their contacts and their offspring.

Forecasting and resource requirements

► Studies should be undertaken to establish, on the basis of the currently available data, the likely increase in the infected population and the likely incidence rate of clinical AIDS and other HIV-related conditions including opportunistic infections.

► Estimates should be developed of the likely resource requirements for the clinical care of these patients.

Public concern

► The problem of HIV infection and AIDS should be put into perspective by sustained educational efforts to dispel fears of casual spread of the disease. Public health education campaigns should however emphasise the known methods of transmission and in particular the risk of casual sex, to avoid complacency, especially over heterosexual transmission of HIV. □

See NEWS AND REPORTS for more on AIDS policy in Scotland.

The message is getting across. Fear of AIDS spreading has brought people as disparate as the drug dealers of New York and official committees in Scotland together in the attempt to supply clean 'works' to addicts.

FREE NEEDLES OFFER ATTRACTS CUSTOM IN NEW YORK

In New York, public health authorities are currently considering the lifting of some of the legal restrictions[1] on the availability of sterile needles as a way of preventing AIDS. Whether intravenous drug users would use readily available sterile needles is one of the important issues in their considerations. We report here on two recent developments involving 'free' needles that are a response to the AIDS epidemic among intravenous drug users in New York City.

The Street Research Unit of the New York State Division of Substance Abuse Services, which is composed primarily of ex-addicts, has been monitoring street-drug activity in New York City for the past decade. Since the spring of 1985, they have observed two types of 'free' sterile needles in the city.

The first type involves a modified 'two-for-one' sale. Some needle sellers are now including an extra needle with the sale of a complete syringe and needle (the packages are stapled together). A new syringe with needle typically sells for $2 in New York City, but this complete syringe with an extra needle sells for only $2.50. The 'extra point' can be used immediately if the first needle becomes clogged when a drug user is preparing to inject. Because it is just before injection that a drug user is most likely to be experiencing withdrawal or craving symptoms and is therefore most likely to use whatever needle is available, the availability of a spare 'point' at this particular time may be an important way of keeping a drug user from using someone else's needle.

The other source of 'free' needles is drug dealers who have been observed to include a 'free' needle and syringe with sales of $25 and $50 bags of heroin, although this practice does not appear to be as widespread in the city as the 'extra point' sales described above. These two 'free needle' marketing tactics indicate an increased demand for clean needles among intravenous drug users in New York City and an effort by present suppliers to meet that increased demand.

These observations are consistent with our previous findings of an increased use of sterile needles among intravenous drug users, and they strengthen the argument that a meaningful reduction in the risk of AIDS is possible in this group. □

Don C. Des Jarlais PhD, William Hopkins MA
New York State Division of Substance Abuse Services

1. In New York hypodermic needles are only available on prescription.

First published in the *New England Journal of Medicine*: 5 December 1985, *313* (23), page 1476.

THE RISE AND FALL OF

In the '60s it was the sometimes amphetamine-aided mods and rockers clashes that outraged the nation for a few years before interest faded. Similarly a moral panic over solvents spread throughout the UK from the mid-'70s and apparently faded in the '80s, leaving a legacy of damaging misconceptions. 'Shocking' punk sniffers and 'shocked' adults joined in mutual provocation, raising the temperature of public reaction and making sniffing a prime element in punk's stock of shock-tactics. Richard Ives explains how this unlikely alliance elevated glue sniffing to public drug concern number one.

Richard Ives

"Societies appear to be subject, every now and then, to periods of moral panic. A condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests; its nature is presented in a stylised and stereotypical fashion by the mass media; the moral barricades are manned by editors, bishops, politicians and other right-thinking people; socially accredited experts pronounce their diagnoses and solutions; ways of coping are evolved or (more often) resorted to; the condition then disappears, submerges or deteriorates . . . Sometimes the object of the panic is quite novel and other times it is something which has been in existence long enough, but suddenly appears in the limelight."
— Stanley Cohen, *Folk devils and moral panics*.

BEFORE THE 'solvents problem' waxed and then waned in the media and among the public, a similar cycle had been completed with respect to the young 'deviants' of the '60s.

In his book *Folk devils and moral panics*,[1] Stanley Cohen used material gathered from the public response to the mods-and-rockers' clashes of the mid-1960s to develop a theory of 'moral panic' as a response to emerging threats to society's values and interests.

Media reports of various seaside incidents portrayed the fairly homogeneous mass of young people as polarised into these rival gangs, encouraging their polarisation in reality. Public panic came to be out of all proportion to the size of the problem. Young people of all descriptions were turned back from seaside resorts on Bank Holiday weekends, and the fines and other punishments imposed were disproportionate to the relatively minor offences committed.

Coverage of these events encouraged people, including young people themselves, to see mods and rockers in opposition to one another, attracting more young people to the resorts on Bank Holiday weekends and giving a new shape to their presence there: they were 'looking for trouble' instead of 'doing nothing'.

Adult opinion was outraged by this apparently new phenomenon, and many and various causes and solutions were postulated. These were often extremely punitive and included, among others, forcing mods to smash up their own scooters with hammers.

Richard Ives is a development officer at the National Children's Bureau, currently working on a DHSS-funded project looking at responses to solvent misuse and assisting in developing treatment and prevention strategies. He can be contacted at the NCB, 8 Wakley Street, London ECIV 7QE, phone 01-278 9441.

Eventually the moral panic died away. What stopped it? From the point of view of the public and mass media, it was largely a waning of interest. The mod phenomenon had developed before receiving widespread public attention and the disturbances continued after reporting of them had ceased. Mods and rockers as folk devils were replaced by other new and newsworthy youth phenomena — notably drugs, student militancy, hippies and football hooligans.

For adults and punks alike, sniffing became a potent sign of punk's deviant image.

The rise and fall of the 'glue sniffer' can be looked at in similar terms. Glue sniffing was born as a social phenomenon in Britain in the late 1970s. Although not at first the perogative of any particular youth subculture, sniffing was adopted by punks (and later by skinheads) because public perceptions of sniffing fitted in with what punk subculture 'had to say'.

Punk was opposed to consumption and to adults' solutions to problems. Political allegiance, if any, was to anarchy — a political form most opposed to all conventional solutions to structural problems, and significantly the one best suited to shock adults. As a response to youth unemployment and renewed threats of nuclear extinction, its slogan was 'no future'.

Dick Hebdige's notion that "subcultures are constructed, however obliquely, out of headlines"[2] gives an important clue to the origins of the punk movement. By presenting themselves as degenerate, punks were dramatising Britain's highly publicised decline. Punk was a spectacle. It became important to members of the subculture itself, as much as for adults outside it, for punk to be oppositional to adult concerns. As a result, these aspects of punk subculture became 'amplified'.

● **Glue equals punk, OK?:** Panic over glue was part of the panic about punk: the link in the public's mind between punk and glue was so strong that non-punk glue sniffing was assimilated to the root of the panic — the punk-glue axis.

Media presentations of sniffing associated with punk reinforced the adult public's image of sniffing, but were often at odds with younger people's awareness that sniffing was not a punk preserve. There was a period in the early 1980s when many adults assumed any 'punkily' dressed youngster must be a sniffer, and anyone discovered sniffing must be a punk. This inaccurate coupling eventually broke down in the face of reality, especially when skinheads adopted equally visible sniffing.

Non-punks sniffed solvents for a variety of reasons. For some it was a cheap intoxicant, for others availability was crucial. The perceived risk involved — overstated again and again in the media and by parents and professionals — provided an attractive dare encouraging some to give it a try.

Parents who caught their child sniffing immediately associated this behaviour with

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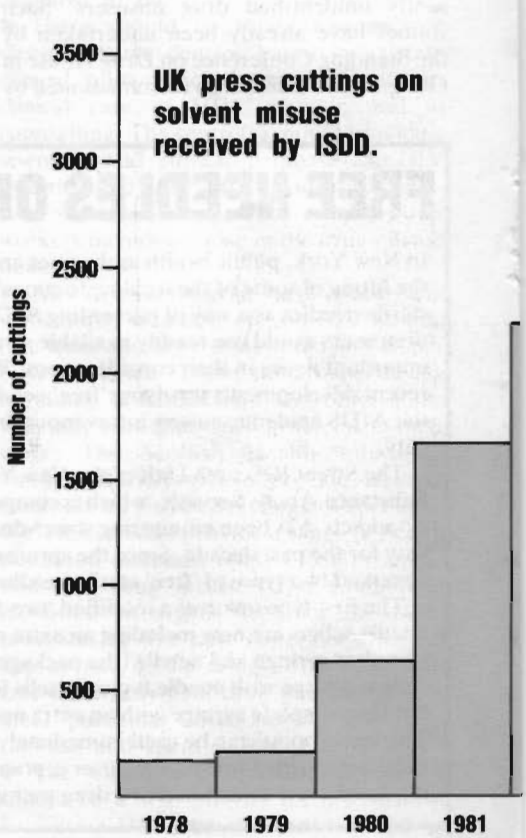


THE SOLVENTS PANIC

their image of punk. Their child was either a punk or an insipient punk, or had been encouraged, or even forced, to sniff by punks. (This last explanation was sometimes eagerly seized upon by beleaguered children to explain their behaviour to angry parents.) In its formative period, the moral panic over solvent sniffing was a response to this (as adults saw it) extreme expression of punk negativity.

Why glue sniffing?

By using household products as intoxicants, punks were certainly giving objects and events fresh meaning by re-assembling them in novel ways, one definition of the creation of a 'style'.[3] But from the start there must have been something about these objects that fitted punk's self-image.

For many years, experimental sniffing (and sometimes a bit more than experimental) had been fairly random individual and small group behaviour. Sniffing was taken up by a few punks, probably at first as a cheap 'high'. Adults who saw them were outraged, hostile, and often concerned: sniffing became a 'problem'.

Because sniffing was singled out for adult repulsion, punks came to see sniffing as useful 'oppositional behaviour', and adult emphasis on 'sniffing kills' resonated well with the punk theme of 'no future'. For adults and punks alike, sniffing became a potent sign of punk's deviant image, arousing yet higher collective emotions spilling over into outrage against anything (such as the innocent scented rubbers) seen as encouraging sniffing.

> The hallucinations experienced by many solvent users helped provide a sense of shared 'communion' among the small group of sniffers.[4] At the same time these mystic experiences helped mark out the sniffer as someone special in a society where individuality is often not recognised. Hallucinations also offered youngsters scope to control a small part of their world. Sniffers report exerting considerable control over the course of their experiences and groups have reported that they can collectively control jointly experienced hallucinations. Hallucinations often have themes of power, of flying or swooping over territory — taking 'symbolic possession' of it.

Sniffing was both a useful and a practical part of punk 'sign-language' for several reasons.

► Sniffing was visible drugtaking which (being legal) could take place on the street, fitting well with punk's *emphasis on street life* and making it easy to *shock adults* by sniffing in front of them.

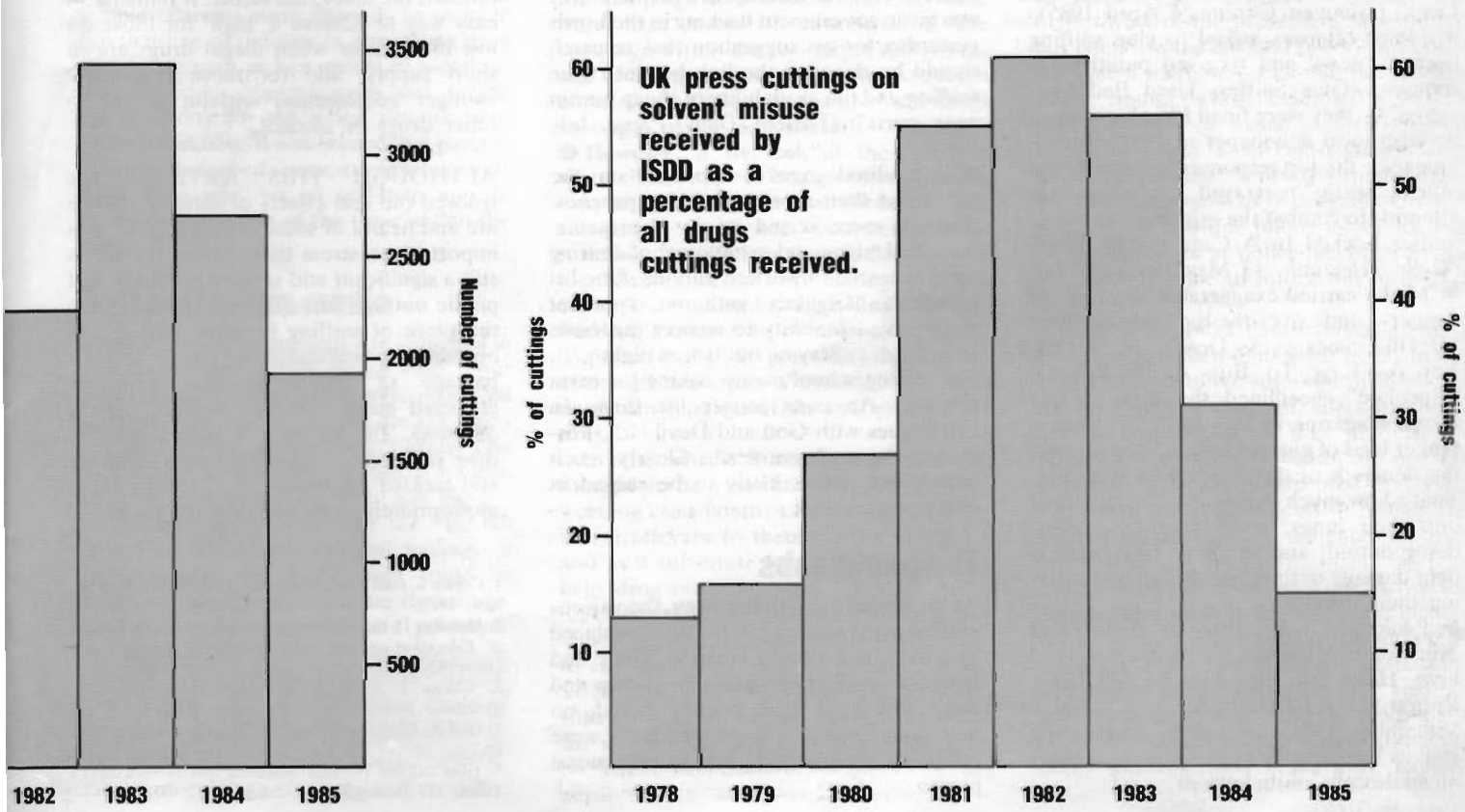
► Sniffing provided a swift 'high', fitting in with the value punks placed on *immediacy*. This same emphasis on immediacy called for a drug that was not only cheap but easily and widely available — not one (like illegal drugs) that required forethought to obtain and might be in short supply. Solvents fitted the requirement.

► Use of a readily available consumer product to achieve intoxication strengthened punk's statement about its *relationship to consumer society*. Punks saw themselves as outcasts from consumer society and rejected consumerist values. Sniffing transmuted the products offered by society for practical, unglamorous purposes into items of illicit pleasure.

► The objects of sniffing could be used to provide hallucinatory experiences which *distinguished* the sniffer from adults and from other young people, and could even perform a *sacramental* role. These experiences could also be used to give at least the illusion of *control* and *power*, which sniffers actually lacked (see box for details).

► *Disgust* is one of the most noticeable features of adult reaction to solvent sniffing, perhaps due to the confusion of consumer categories. If familiar household products are not used for their manufacturer-ordained purpose, then nothing is sacred. If glues can become intoxicants, what can be done with a packet of Persil! This disturbing dissonance made ▷

...y 'the solvent sniffer' rose and fell in the British press.



glue sniffing a particularly effective way for punk to shake up the adult 'establishment'.

► To most adults today sniffing from a plastic bag is a dramatically different way of becoming intoxicated, although in the last century snuff-taking and the inhalation of nitrous oxide or ether were all fairly common. So sniffing served to emphasise the *difference* between members of the subculture and the rest of humanity.

► Solvents are an effective way of becoming '*completely out of it*', often for considerable periods of time, a potentially desirable prospect for unemployed youngsters with time to kill.

► Sniffing solvents can be *dangerous*, an attraction to many people. And the more adults told young people that 'sniffing kills', for some youngsters, the more attractive it became.

Moral panic develops

The constantly changing elements of punk style were partly a response to the internal demands of the subculture and of the individuals who composed it. But changes were also due to the response of adults. Much of that response was visible through newspaper reports. In the constant interplay between public concern and media response, the media reflected and wrote large society's concerns, providing a graphic record of the development of the moral panic over sniffing.

Accredited experts appeared on the scene and their most frightening prognostications were seized upon by the media.

► Glue deaths became material for lurid front page stories in both local and national newspapers: "Glue Trip Punk In Death Leap" (*Islington Gazette*, 4 April 1985).

► Minor offences linked to glue sniffing became 'news' and received punitive responses: "Glue Sniffers Used Bad Language" — they were fined £25 plus costs (a Scottish local newspaper in 1984). Meantime over-the-top responses by parents and others were portrayed as desperate attempts to combat the grip of glue: "Glue Sniffer Locked In A Cage For A Year" (*Daily Telegraph*, 13 May 1985).

► Media carried exaggerated warnings of dangers and over-the-top descriptions: "Death Games — As Deadly As Heroin, Yet As Easy To Buy As A Bar Of Chocolate", headlined the *News of the World* magazine in July 1984: "It takes a tanker load of glue a week to keep up with the demands of the children in Wiltshire. That's how much they sniff . . . gulping it into their lungs, wrecking their bodies, doing untold, and in many cases permanent damage to their health and endangering their lives".

► Panic was heightened by discovering ever younger sniffers — "Mohican Aged Five. Head Says Boy Has Sniffed Glue. Robert Was A Skinhead At Three" (*Sun*, 6 September 1984) — and by implicating glue as the primary cause of various kinds of adolescent misbehaviour.

"After a sniffing session, glue gets into people's hair. This started the spikey hair fashion, and it was under the anaesthetic effects of glue that punks were able to put safety pins through their noses and ears", says the commentary to this slide from a set on glue sniffing.[5]

► Deviant images of sniffers were presented. A poster advertising a Scottish solvent helpline counter-productively depicted an evil-looking sniffer and press photos featured sniffers with their eyes blanked out, like criminals required to hide their identity.

► Media campaigns reported and promoted many and various calls for legislation, some claiming success with the passing of the Intoxicating Substances Supply Act of 1985.

► Sniffing was linked to up-and-coming moral panics: "Glue And Heroin Link Feared . . . the Bishop of Norwich . . . was given government backing in the Lords yesterday for his suggestion that research should be done on the link between glue sniffing and the availability of cheap heroin near ports" (*Eastern Daily Press*, July 1984).

► Accredited experts appeared on the scene and their most frightening prognostications were seized on by the media. So-called 'signs and symptoms' of sniffing were repeated to worried parents. One list included: "Giggling with no apparent reason . . . Inability to answer questions sensibly . . . Staying out late at night . . . Not buying school meals, asking for extra money." An even longer list threw in "Dialogues with God and Devil . . . Possession by evil entities". Clearly, such 'symptoms' are as likely to be caused in other ways.

The panic ebbs

As the panic began to die away, the various unthinking reactions tended to be replaced by a more questioning attitude. There had been too much crying wolf, the papers and those who read them became bored, no new angles could be found and there were other more newsworthy and current moral panics.

Youth culture, too, moved on and developed new concerns. Society was and is left with a 'mopping-up exercise', to inform those still confused about the problem, and ensure young sniffers are helped to stop and that other young people do not start.

Concern and outrage about solvent misuse not only 'amplified' sniffing's role in punk subculture, but can also encourage experimentation by other young people. As punk died out, some members of the new generations of young people took up sniffing. To some, it became a useful metaphor which emphasised the role of the outcast, the loner, the reject. It remains an easy way to achieve a 'high' for those on low incomes or when illegal drugs are in short supply, and for those (especially younger adolescents) without access to other drugs or alcohol.

ALTHOUGH THIS ARTICLE has ignored the real effects of solvents on the life and health of some young people, it is important to stress that solvent misuse is still a significant and serious problem. But public outrage served merely to reinforce the place of sniffing in punk culture and obscure any real damaging effects under a barrage of hyperbole that probably attracted more potential sniffers than it deterred. The lesson is a general one — drug problems need to be taken seriously and tackled appropriately. Tackling them appropriately does not involve panic. □

1. Cohen S. *Folk devils and moral panic*. MacGibbon & Kee, 1972.
2. Hebdige D. Subculture: image and noise. *In* Dale *et al. Education and the state*, Volume II, Falmer/Open University, 1981.
3. Clarke J. Style. *In* Hall S. and Jefferson T. *Resistance through ritual*. Hutchinson, 1976.
4. Hall K. Crossing the divide. *Youth in Society*: 1984, 96.
5. *Glue sniffing (volatile substance abuse)* by Camera Talks, 197 Botley Road, Oxford OX2 0HE.

SOFT SELL-HARD CELL

Prevention policy in Scotland is both 'softer' and 'harder' than in England and Wales. The mass media campaign is softer, focusing on social issues and positive lifestyles rather than on the effects of heroin. But drug enforcement in Scotland is hard-line, some say 'hysterical'. Liz Jagger describes Scotland's 'soft sell/hard cell' approach to prevention.

Liz Jagger

In 1984 the government instructed the Scottish Health Education Group (SHEG) to devise and develop a publicity campaign against drugtaking. £350,000 was allocated — less than 1p per head of population. In the time-honoured way of politics, the announcement of the campaign was followed by widespread criticism in the Scottish press from various 'experts' working in drugs and related disciplines.

Reservations were also expressed within SHEG itself: the Director, Stanley Mitchell, stressed that before being instructed by the government, the Group had had no intention of mounting such a campaign. He indicated that SHEG's approach would be low-key, integrating what they wanted to say about drugs within their overall current campaign promoting positive health.

So at the outset Scotland rejected a high profile, 'scare tactics' campaign, in favour of an approach aimed at getting young people to think positively about their lifestyles. The major divergence from the campaign in England and Wales is that Scotland has not mounted a specifically anti-*heroin* campaign, emphasising the extreme medical consequences of drugtaking, but rather placed this practice in a much broader social context.

The primary target group for the campaign was to be teenagers between the ages of 13-20 years who were not using drugs or who might be at risk of trying them. Because of perceived differing interests and lifestyles, the group was further split into two sub-groups — 13-16 year olds and 17-20 year olds.

The third target group identified by SHEG were the parents of these young people. Parents were thought to provide the first line of defence in preventing drug use, being seen as key agents of socialisation, exerting control over and taking responsibility for the moral development of their children. It was argued that parents needed "balanced, accurate information" both as a stimulus to self-help and to promote discussion of the topic within the family.

Soft sell in the media

The mass media campaign was launched in two stages, the first in March 1985. Four pop video TV commercials were produced using slogans borrowed from the US Army — "Be All You Can Be" and "Choose Life Not Drugs" — and from North American preventive material — "Just Say No".

The message conveyed by the "Be All You Can Be" video was that feelings of independence and self-esteem could be achieved through sources other than drugs. Groups of young people were portrayed fashionably dressed going to discos, driving around in cars and playing a variety of sports.

"Choose Life Not Drugs" was based on a decision-making model. Four situations were presented encompassing the conventionally assumed social determinants of drug use, such as family conflict and peer-group pressure. The commercial showed how these potentially negative situations could be resolved positively. Imaginative video work with contrasting monochrome and colour photography was used to enhance the message.

Liz Jagger is a research worker at the West Lothian Drugs Education Project, 47 Adelaide Street, Craigshill, Livingston, West Lothian, EH54 5HQ, phone 0506 30225/6.

One in three of those thought most at risk saw the campaign as irrelevant and a substitute for real action.

Research to evaluate the first stage of the campaign was carried out by SHEG's own research unit at Strathclyde University. 635 respondents were interviewed, but how representative this sample was is unclear, since the sampling techniques are not specified in the report.

The Unit claimed their findings showed the campaign had been a success; there were high levels of awareness of the campaign within the two target sub-groups and there appeared to be no confusion about the positive and negative anti-drugs messages of the commercials.

● **However, if we look** at these results more closely, a less benign interpretation can be made. While two-thirds of each sub-sample saw the commercials as reaching "people like them", this level of identification decreased among working class and unemployed young people. Further, a quarter of all respondents (and 35 per cent of 17-20 year olds) thought the campaign was "just a pretence . . . not doing anything about the real problem of drugs".

In other words, one in three of the group thought to be most at risk (unemployed, working class youth) saw the campaign as both irrelevant to their life circumstances and as a substitute for any real action to help drug users.

A fifth of all respondents also felt it was "just another campaign telling people how to run their lives" and 30 per cent of the 17-20 year olds felt it was "out of touch with reality". A similar number expressed the view that such a campaign might even be counter-productive, encouraging experimentation with drugs.

These findings seriously call into question the usefulness of a campaign aimed at the majority of young people, who are unlikely ever to use drugs, and which was regarded as irrelevant by many of those deemed most at risk. The 'equal opportunities' model of life portrayed in the commercials fails to take into account the realities of the depressed social environment many young people find themselves in — access to discos and sporting facilities usually costs money.

Further, the magazine insert *Family matters* intended to promote discussion between parents and young people, is filled with stereotyped images of happy families — images which neither take into account the fact that many young people involved in drugtaking are without this kind of family support, nor statistics showing high levels of divorce, child abuse and wife-battering.

However, these criticisms do not seem to have registered with the policy makers; SHEG have recently been promised a further £300,000 to mount another campaign.

Hard cell in the courts

In Scotland, as elsewhere in Britain, the main thrust of the preventive programme has been toward law and order. In February 1986 it was announced that the Scottish Crime Squad, whose caseload is 70 per cent drugs-related, would get an additional 21 officers and a specialist drugs wing would be formed. Seven out of the eight Scottish forces now have drugs squads and recently a *Drugsline* phone-in service has been established at police headquarters to encourage people to inform on suspected dealers.

One of the most controversial aspects, however, has been sentencing policy in the courts. The punitive response of the Scottish judiciary to drug offenders has been described as nothing less than "hysterical". Although up-to-date statistics are not yet available, it is widely accepted that 1985 was the worst year in Scottish history for the imposition of heavy sentences on drug offenders.

At the end of 1984 the Lord Advocate directed that all drug dealing cases, including those involving cannabis, should go to the High Court to circumvent restrictions on sentencing in the lower courts. In 1985 more than 240 drugs cases were brought before the Scottish High Court and sentences totalling 1000 years were handed out. ▷

A study (by Steve Woolman at the University of Edinburgh) of cases reported in the *Scotsman* in the first four months of 1985, suggested that offences involving the supply of heroin frequently attracted sentences of six years imprisonment. Five cases involving the supply of cannabis resulted in two sentences of seven years, and one each of five, four and three years.

While the author allows this was an unrepresentative sample biased towards more serious offences, nevertheless it was indicative of a worrying trend. People appeared to be receiving very heavy sentences when, had they been on trial in England, they might have expected at worst a short prison sentence. A letter to the *Scotsman* (29 March 1985) reported an instance where a man had got four years for possessing cannabis and his appeal against the severity of his sentence was refused.

Unlike their English counterparts, the Scottish courts have always rejected an explicit tariff system, preferring a more individualised approach to sentencing and, in the process, protecting the independence of the judiciary. In the sentencing guidelines applied by English courts, the supply of cannabis cases described above would have fallen into the bracket of between one and four years imprisonment. It appears that cannabis offenders in Scotland have been caught in the judicial backlash against heroin.

● **Legal and welfare workers** in Scotland spoken to recently, raised various issues of concern. One mentioned by several was a possible shift in the type of charge preferred, from simple possession to the more serious possession with intent to supply.

In Scotland the decision on whether to prosecute and on the charges to be brought lies solely with the Procurators Fiscal. But police reports seem extremely influential, particularly in drug cases where Fiscals feel themselves relatively ignorant and the police more knowledgeable.

Until quite recently police were thought to use a 'rule of thumb' guide to decide whether a person was dealing or not; if someone had more than half a gram of heroin, for example, the police would argue they must be dealing since this exceeded a 'normal' day's supply. Rules such as these fail to take account of differing levels of consumption or the fact that people might buy more than one day's supply at a time. Police also influenced judicial proceedings by greatly inflating the street value of some drugs.

1985 was the worst year in Scottish history for the imposition of heavy sentences on drug offenders.

However, since the beginning of 1986 observers have detected a gradual move towards a more moderate and sophisticated approach by both the police and the judiciary. The Crown Office itself is now prepared to call for psychiatric and medical reports instead of leaving this to the defence; police are more informed about drugs in general, making distinctions between different levels of dealing and accepting that amounts used can vary; and agreements reached between the police and some lawyers have resulted in more realistic and consistent estimates of street prices. In a recent case a deferred sentence had been passed on a man in possession of three grams of heroin — a situation which would not have obtained earlier.

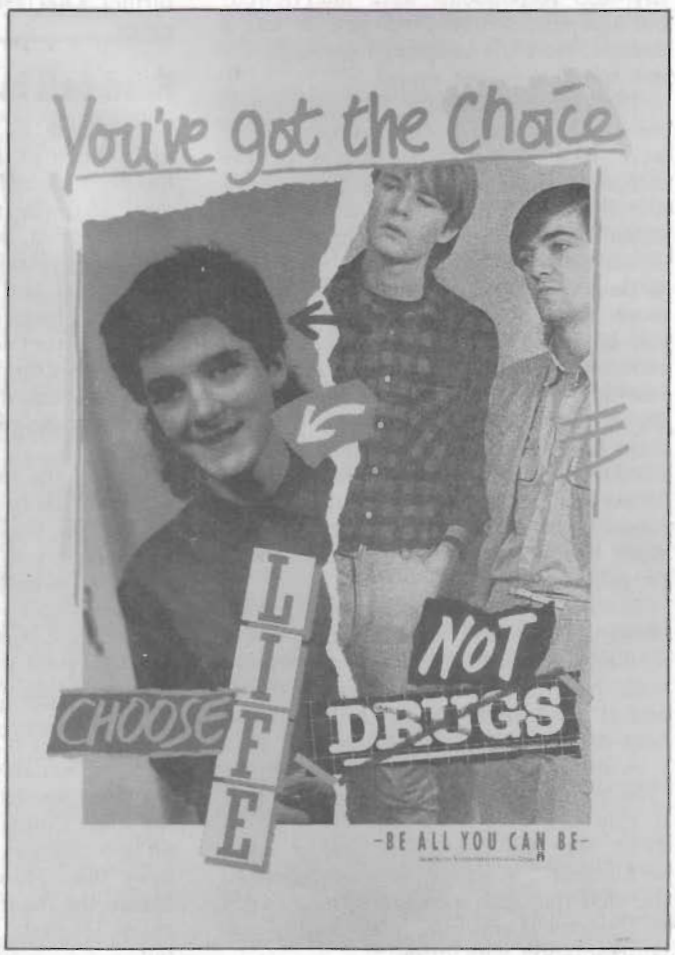
● **This trend to moderation** was most frequently attributed to the judiciary's realisation of the futility of sending the small-time user-dealer to prison again and again. Others have suggested it might be due more to overcrowding in Scottish jails. In March 1986, a record 5,797 people were held in Scottish prisons. Although no accurate statistics are available as yet, it is widely accepted that this figure is attributable to an increase in the number of people serving long prison sentences, many drug-related.

One other indication of a more moderate approach is the refusal of the Scottish Parole Board to adhere rigidly to government guidelines stating that parole should be refused to all prisoners serving five years or more for violent and/or drug-related crimes.

In various localities attempts have been made to operate schemes diverting drugs offenders from prison to rehabilitation. One scheme in operation in Edinburgh for the last 18 months has run up against difficulties in its implementation: some community drugs projects have refused to cooperate with the 'conditions of attendance', feeling the element of compulsion is inconsistent with their role, and some Fiscals remain unwilling to waive their right to prosecute.

However, some issues of general concern remain. One major issue is the automatic refusal of bail to alleged drug dealers. In effect, this means the judiciary are prepared to suspend the presumption of innocence, and sentence to an automatic three and a half months in custody anyone the police and Crown choose to charge with supplying drugs. In so doing they have created a new category of crime not susceptible to bail, a measure usually restricted to murder and treason.

'Be all you can be', 'Choose life not drugs', says SHEG's anti-drugs campaign. But happy families and alternative pursuits may be in short supply in deprivation black spots.



DESPITE SOME MORE optimistic trends this year, there is little room for complacency in Scotland.

▶ The low-key and more socially oriented approach of the media campaign in Scotland is generally considered an improvement on that developed in England and Wales, but it may have failed to reach those most 'at risk' of drug use and been counter-productive among the majority of youngsters who would never have taken drugs anyway.

▶ One of the two projects in Scotland specifically funded for prevention sees a demand at a grass-roots level for information about drugs and their effects and ways of minimising harm for those 'at risk' or already using drugs — a group ignored by the mass media campaigns.

▶ The number of drugs cases coming before the courts is not decreasing. Unless viable alternatives to custody are made available which also take account of the special problems of the user-dealer, the prison population is likely to continue to increase, helping neither the imprisoned drug user, nor the public whose money supports their repeated imprisonment. □

A CAUSE FOR WHOSE CONCERN?

DRUGS CRIME AND VIOLENCE

Who, if anyone, needs to worry about drug-related violence? The person on the street, shopkeepers, governments — or drug users themselves? Fieldwork experience in London and a review of the international research literature throws up some unexpected answers.

Robert Power

Any illegal activity, such as the supply and use of illicit drugs, involves varying degrees of criminal behaviour. Concern about associated violence, not in a small part fuelled by sensationalist journalism, is inevitable. In September 1986, the *Daily Express* quoted Metropolitan Police Commissioner Sir Kenneth Newman's prophecy that: "Violence to people on the street could well fall as the need to finance addiction waned. And some of the more perverted crimes such as rape, torture and murder would fall as people breathe a drug-free atmosphere."

To unravel the link between drugs and violence, and to lay to rest some of the myths, three questions need to be addressed.

- ▶ Do illicit drugs *in themselves* incite violence, and in particular violent crimes?
- ▶ What types of crimes do drug takers commit, and what is the associated level of violence?
- ▶ What is the 'arena' of drug-related violence and which groups are its victims?

Do drugs cause violence?

The answer to this question, with one or two qualifications, is no.[1,2] The most common drugs of abuse are strong nervous system depressants valued for their euphoria-inducing and tranquillising effects rather than as aids to aggression (though it's well-known that depressants such as alcohol can release violence through their disinhibitory effects).

Even in the case of hallucinogenic drugs (such as LSD and phencyclidine or PCP), or amphetamines and other stimulants, there is no convincing evidence for a direct link between pharmacological effects and violent crime.

Hallucinogenic drugs do cause bizarre behaviour, which sometimes leads to violence; but this is sporadic and seemingly random, rather than a predictable effect of the drug, and does not result in aggressive crimes, planned and carried out against the person.

● **Amphetamines:** The case regarding stimulants, especially amphetamines — is more complicated. Until the mid-1970s, research tended to conclude amphetamines were a direct cause of violent behaviour.[3] However, this early research has been criticised for concentrating on clinical observations of small numbers of amphetamine users who had exhibited violent behaviour.[4]

Since then, studies have tended to move away from the clinical setting and out on to the streets. The consequence has been to give greater prominence to the mediating effects of personality and context, thereby highlighting the importance of individual differences in reactions to amphetamine.[5] Taking this point of view one step further, it has been stressed that the link between narcotics and violence has largely been generated by political leaders (and one might add the media) rather than by social and biological scientists.

At another level, common wisdom among regular drug users warns against the erratic and aggressive behaviour of 'speed-freaks' and 'barb-heads'. However, such behaviour is unpredictable, often dependent on the situation, and cannot simplistically be attributed to the effects of the drugs themselves.

Are drug users violent?

The short answer to this question is — no more than anyone else. Drug dependence, and the protracted process of procuring expensive illicit drugs, means that for many drug users crime is the only way to gain sufficient income to meet their needs. But most crime committed by regular drug users is non-violent crime against property (predominantly theft), perpetrated in order to support a drug habit.

Adulterated drug deals, 'rip-offs' and robberies, desperation and greed, are all potential scenarios for violence.

A whole body of research points to the fact that drug users are more likely to be involved in revenue-raising property crime rather than crime against the person.[6]. One US study from the mid-'70s found that drug users, particularly those dependent on heroin, were more inclined to property crimes, whereas non-drug using criminals were more likely to be involved in crimes of violence against the person.

More recently, 75 per cent of crimes (such as shoplifting for resale and burglaries of abandoned buildings) committed by a sample of heroin users in New York were found to have had no clear victims.[7]

Another US study has made a direct link between the price of illicit drugs and the level of property crime, concluding that a one dollar increase in the price of heroin caused the drug user to commit crimes that would net an extra 30 cents.

Not that drugs and crime are never related. It has been said that criminal enterprises in the USA have a tradition of violence; it would be odd if drug-related crime were a total exception. In Britain, where an equivalent culture of violence is not prevalent, the level of violent crime among drug users is low.

● **Home Office statistics** for opiate addicts first notified in 1979 to 1981 show that 42 per cent were first convicted for theft, 19 per cent for drugs, and 18 per cent for burglary.[8] Among the convicted population in general, these figures are 60 per cent, two per cent, and 11 per cent respectively.

The proportion of convictions for burglary and theft (the crimes more likely to be associated with violence) among addicts declined over the period just before, and up to two years after, notification. Indeed, the level of violent crime remained lower, at around six per cent of the crimes addicts were convicted of, than the equivalent figure of 12 per cent for the general convicted population. As the Home Office statistics point out: "the involvement of notified addicts in violent crime appeared to be small and stable".[9]

Fieldwork at the Drug Indicators Project among 'addicts' not notified to the Home Office, gives no reason to suspect that the situation is any different for this group, where fraud, shoplifting and theft are the main forms of street-level crime.

IT IS IMPORTANT to make the point that people dependent on illicit drugs come from all walks of life — not all resort to non-drug crime to support their habits. At one end of the scale celebrities like Boy George can maintain a reported eight gram a day (£640) heroin habit from their legitimate earnings. Others hold down a variety of jobs, live on the dole, and bring up families, without becoming involved in fund-raising crime. Yet others get involved in small-scale dealing, or 'serving' to friends, to support their drug dependency.

American research in the 1970s showed that the percentage of dependent drug users resorting to crime as their primary means of support, ranged from a low of about 30 per cent (among white females) to ▷

Robert Power is a research officer at the Drug Indicators Project, currently working on a study of help-seeking among regular drug users.

a high of 80 per cent (among black males).[10] Later research confirmed the lower levels of criminal activity among women drug users.

Who suffers?

Again, there is a short answer: violence takes place largely between drug users and drug dealers themselves, though this is not the whole story.

At one level, the violent exploits of internationally organised criminal syndicates in the drugs trade, such as the Mafia and the Triads, are legend. The upsurge of cocaine trafficking and the value of the 'narcolire' has meant high stakes are involved. Dramatic machine-gun shoot-outs between importers and distributors on the streets of New York and South Florida, and violent incidents between cocaine dealers in London, have made gripping news.[11]

Such extremes of violence are very much contained within the trafficking world itself, where high rewards and strict codes of conduct mean fierce economic competition, and cursory penalties for misconduct.

At another level, a link can be made with 'terrorist' acts, with both left- and right-wing groups involved in the sale of drugs for revenue to buy arms. The IRA, the Red Brigade, and Basque separatists in ETA, plus a range of neo-nazi groups, have all been implicated in trafficking in heroin or cannabis for arms.

At one end of the political spectrum, drugs and arms trading have created links between European fascists and Lebanese Phalangists. At the other, Turkish left-wing groups were found to be exchanging heroin for guns in the Bulgarian capital, Sofia.

In 1982, Omega 7, the anti-Castro organisation, were responsible for a series of bombings in the USA. After finding 40 pounds of marijuana in the flat of one of its members, the FBI concluded that drug trafficking was helping to finance the group's armoury.[12] In this convoluted way, another chain in the link between drugs and violence can be made.

However, it is between and among drug users themselves that violence more directly related to drugs tends to take place. The daily round of 'scoring' and 'dealing', which fills much of a regular drug user's time, is the arena in which most violence occurs. Adulterated drug deals, 'rip-offs' and robberies, desperation and greed, are all potential scenarios for violence.

A description of the amphetamine scene in San Francisco makes a point that has general application:

"Most of the criminality is directed towards other members of the drug scene . . . Most of the violence . . . results from an interaction among drug effect, lack of social controls within the subculture, and a variety of economic factors, including the way the market place is sustained by the individual users."[13]

● **Not only do drug users** face violence from fellow users and participants in the illicit drugs market: they are also vulnerable to abuse from other sources. Operating to a large extent outside the protection of the law, isolated and unprotected drug users are easy prey for other criminal groups, who are safe in the knowledge that their activities will not be reported to the police.

Isolated and unprotected drug users are easy prey for other criminal groups.

Such predatory violence has been common on the London drug scene for some years, but has reached frightening proportions in recent months (see box for an example). Even when criminals threatening drug users are charged and imprisoned, other groups are all too ready to take their place, so the harassment and violence continues.

In recent years, drug users have been accused of being responsible, not only for the increase in crime and the promotion of drug use among the young, but also for outbreaks of serious unrest, such as the Handsworth riot.

Encouraged by dramatic newspaper headlines and media stereotypes, it is no surprise that public opinion is firmly set against this group of people and 'vigilante' groups have been active on estates in several cities. For example, in Dublin, suspected 'pushers' were threatened with eviction; others were harassed by chanting crowds.[14] More recently, well-publicised anonymous phone lines have given residents in many areas of the UK the chance to identify suspected dealers.

NO ONE WANTS a drugs problem on their own doorstep. Harassment and intimidation, often based on prejudice and misinformation, are no answer. Persecuting drug users and even burning down a rehabilitation centre[15] does nothing to help problems of dependence; neither does it further our understanding of a social issue of serious and worrying proportions.

I have hoped to show that the link between drug users and dealers, violence, crime, drugs and the public, is complex. It is neither clear-cut in terms of causation, nor undirectional in effect. □

Fieldwork experience at the Drug Indicators Project has confirmed that a group of non-drug using criminals have been identifying, threatening, and robbing drug dependent women, who more often than not are living on their own with small children. Out of economic necessity, these women have turned to small-scale dealing to maintain their drug habits and support their families. Pinpointed as particularly vulnerable, they have been systematically threatened by the gang until drugs and money are handed over. Shotguns have been pointed into babies' prams, knives pressed to small children's throats, and bottles of acid held over their heads. That no serious injury has occurred is due to the fact that the women concerned have always given over whatever drugs or money were in their possession.[16]

SUMMARY

► Drugs do not of themselves cause violent criminal behaviour. Drug effects may raise or lower resistance to violent behaviour, but personality, situation and culture remain critical determinants.
► The vast majority of drug-related crime is against property, accomplished to support a dependence upon expensive (and sometimes elusive) illicit drugs.
► Very few regular, dependent, drug users relish petty crime; nor are they proud of it.
► Violent acts are perpetrated by drug users — but so are they by every sector of society. Some will kill for a £10 bag of heroin or a 'line' of cocaine. Others will kill for the price of a taxi fare or on the result of a football match.
► Most violence directly associated with drugs and drug dealing takes place between and among dealers and users themselves.
► However, there is an indirect link between violence and drugs, both with respect to international 'terrorism' and organised syndicated crime.
► People dependent on illicit drugs are sometimes on the receiving end of intimidation and violence from the public they are supposed to threaten.

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THE MEANING OF ADDICTION: COMPULSIVE EXPERIENCE AND ITS INTERPRETATION. Stanton Peele. Lexington, Mass.: Lexington, 1985. 203 pages.

The main purpose of *The meaning of addiction* is 'to create a framework for understanding addictive behaviour . . . [and to] construct a model of the relationship among cultural, social, psychological, pharmacological, and other components". To succeed in these endeavours would be a truly impressive achievement, and it would be harsh to judge Peele's book too strictly by these lofty aspirations.

My own feelings about the book are mixed. I am sympathetic to many of the points that Peele makes and have criticised many of the same misconceptions. I also greatly enjoyed reading the book. It is not at all hard going and offers many fascinating nuggets of information (eg, that Jellinek's 1946 specification of the phases of the alcoholism disease process was based upon 98 questionnaires returned from a mailing to 1600 Alcoholics Anonymous members).

However, I had reservations. I was occasionally unsure whether real issues were being addressed or whether arguments were being set up for the express purpose (and undoubted pleasure) of knocking them down again.

For instance, the book begins with the assertion that "the conventional concept of addiction . . . derives more from magic than science". Great! Good, lively, provocative stuff. But this assertion is illustrated by the statement that the conventional concept sees all aspects of addictive disorders as attributable to a single biological process. If this is so, then Peele is surely right to go for the jugular. But where are all of these conventional people who believe this? There are undoubtedly a few dinosaurs in the field who have not yet noticed that social and cognitive factors are important — but probably not very many.

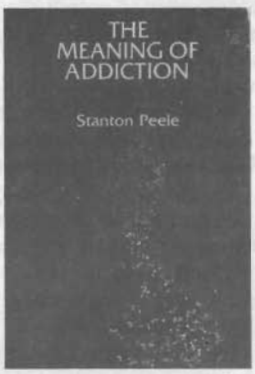
Nor was I entirely comfortable with the apparent dismissal of availability as a determinant of use and dependence. "The idea that people incur the costs of alcoholism simply because they have more alcohol available to them makes little sense." This is a point of view, but a lot depends upon what one reads into the word "simply". It does, however, contradict a great weight of evidence to the contrary which Peele does not properly consider.

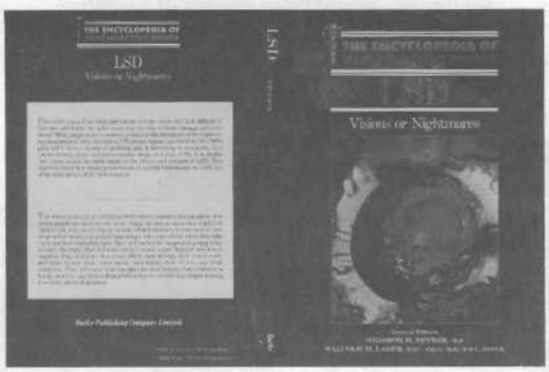
But I would not wish to dwell upon my reservations. The book offers much to anyone prepared to listen to what the author has to say. There is lots of interesting material relating to the commonalities that underly the addictions, a category that is extended to include not just those that involve chemicals, but also behaviour such as gambling, eating, jogging, love and aggression. Others have also brought together these sorts of behaviour in an apparent synthesis, about which Peele remarks: "this new theoretical synthesis is less than meets the eye: it recycles discredited notions while including piecemeal modifications".

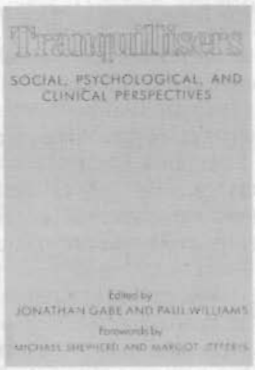
The essence of Peele's thesis is that people become addicted to *experiences*. Such experiences are potent modifiers of mood and sensation, and although these may have some basis in pharmacology and physiology, they take their ultimate form from cultural and individual constructions and interpretations of experience.

Michael Gossop

Dr Michael Gossop is a psychologist, and is Director of Research at the Drug Dependence Unit of The Bethlem Royal and The Maudsley Hospital. He is the author of Living with drugs.







LSD: VISIONS OR NIGHTMARES. Michael E. Trulson. London: Burke, 1985. 121 pages. £7.95 hardback, £4.50 paperback.

Possibly one of the most surprising aspects of the work done by the Drugs Education and Advice Project this summer was the amount of hallucinogenic drug use we came across among young people, and further, the difference in how it is used and regarded in comparison to 20 years ago.

So I was delighted to be told of this *book, which specifically targets "young* adults, particularly those who find themselves caught up in the abuse of psychoactive drugs", as well as parents and others working with young people. Sadly, it does nothing of the kind, but is instead a strange mixture of coffee-table glossy, *Rolling Stone* nostalgia, and scaremongering, with the odd piece of useful information to be found if you are prepared to persevere.

The book is extensively illustrated. However, the bulk of the pictures are of Leary, Ginsberg and other sixties alumni, together with anguished parents and concert bills for the Fillmore. What this has to do with British hallucinogenic drug use in 1986 escapes me and, I suspect, would do likewise for most of the targeted readership. Although the book claims to have been edited for a British market, the naturally occurring hallucinogen psilocybin is only mentioned in an American context, and there is no mention of any of the other hallucinogens found in plants or fungi which grow in this country.

More damaging than any of this, however, is the way that unproven, dated research has been drawn upon to suggest conclusions about the link between hallucinogenic drug use and various psychoses. *There are no footnotes or source references.* Although the author sometimes admits there is no empirical evidence to support some of the claims made, he elects to blame this on lack of adequate research, rather than lack of proof following extensive research.

From the emphasis given to flashbacks in this book, you could be forgiven for concluding that they are almost an inevitability after even one trip. Again, there is no conclusive written or empirical evidence to back this up, and thus the book will be further discredited in the eyes of readers with personal experience of hallucinogenic drugs.

In sharp contrast to this dwelling on flashbacks and other toxic effects, there are just two pages devoted to practical ways of helping people experiencing a bad time on hallucinogenic drugs, over a half of which is taken up by case studies. In short, it advises "seeking professional help". Examples of ways of working with hallucinogenic drug "addicts" include jogging, bio-feedback, meditation and psychotherapy. Not enormously relevant suggestions for the average recreational or experimental drug user, let alone drugs worker or concerned parent.

In conclusion, it is hard to take this book seriously. I suppose it may conceivably further deter people who would never have experimented with hallucinogenic drugs anyway, but it is unlikely that it can be anything but a laughing stock to the majority of young users. Unfortunately, there will be a small percentage of people, particularly parents, who will respond to and be panicked by its alarmist and scaremongering tactics. It is a matter of urgency that something sensible and user-friendly is written on this subject.

Clare Tickell

Clare Tickell is the coordinator of the Drugs Education and Advice Project, which has provided an information/crisis intervention service at pop festivals this summer.

TRANQUILLISERS: SOCIAL, PSYCHOLOGICAL, AND CLINICAL PERSPECTIVES. Jonathan Gabe and Paul Williams, *eds*. London: Tavistock, 1986. xv, 31 pages. £25.

This book is a collection of 16 papers on various aspects of tranquilliser use. What is most noticeable about it, is that 12 of the papers have been published previously between 1975 and 1984, as journal articles. Hence, the majority of this book will already be familiar to anyone conversant with the research on benzodiazepine prescribing and dependence.

The book does, however, offer some occasional new insights. It begins with a previously unpublished historical perspective on benzodiazepine use and the growing concern about these drugs in recent years. The advantage of a sociological perspective (which this chapter provides) is to explain that this concern is not just a function of new medical findings, but also of changing social trends, ranging from a shift towards the valuation of self reliance in society, to an increasing enthusiasm for alternative medicines.

Parts two and three of the book are headed "Long Term Tranquilliser Use" and "Influences on Tranquilliser Use" respectively, although papers in both sections examine factors which determine tranquilliser use. The notable feature of these two sections is the introduction to part two, which contains one of the few critical appraisals of Lader *et al*'s studies of benzodiazepine withdrawal. This rightly points out that Lader's studies were conducted with highly selected samples and with subject numbers no greater than 40. Further methodological improvements are required before we can confidently talk of a physical dependence syndrome for the benzodiazepines.

Part four of the book contains three papers under the heading "Alternatives to Tranquilliser Use". A major shortcoming is that not one paper on the effectiveness of psychological treatments in relation to tranquilliser use was included.

Part five examines the meaning of tranquilliser use. The findings from these papers are significant with regard to their clinical implications. They indicate that tranquillisers serve important social and psychological functions for the people that consume them, and that these functions are not simply dependent on the chemical effects of the drugs. Attempts to withdraw people from these drugs without taking account of such issues, are likely to be beset with difficulties.

This book offers very little new to those familiar with the literature in this field. Others may well find they can obtain access to most of the articles in this book at much less than the £25 being asked. For this reason the book is rather disappointing, and we still await a standard text on benzodiazepines which properly reviews the field and assesses the empirical literature from an objective point of view.

Paul Grantham

Paul Grantham is senior clinical psychologist at Bolton General Hospital and chairs the Benzodiazepine Interest Group (see LISTINGS for the Group's newsletter).

LETTERS to the editor

School drug education — give it a try

With reference to Les Kay's article on prevention in the July/August edition of ***Druglink***, I suggest that before drug education programmes based on knowledge, attitudes, decision-making skills and improved self-esteem within a PSE programme are scrapped, these approaches should *actually* be tried out.

Many teachers and some health education and advisory staff, particularly when under pressure from head teachers, parents, LEAs and the government, revert to shock-horror or mild horror methods. This is seen in the use of experts — either those working with problem drug users or former problem drug users themselves. Often both start from the position of problem drug use and convey a personalised shock-horror message.

Most pupils are not problem drug users, many are not users. Education programmes need to recognise this fact. Young people need clear, unbiased information about all drugs, not just illegal ones but also prescribed drugs and 'everyday' drugs including alcohol, tobacco and caffeine. They need an opportunity to explore this information, discuss their attitudes and expose for themselves the hypocrisy with which they are surrounded. These are the aspects of drug education which should be part of a PSE programme.

Decision-making skills and resisting peer group pressure should be taught as part of any life-skills component, as they relate to other areas of life, as well as drug use. If young people use these skills to reject our messages, then we must respect this choice.

It is at *this* point that harm-reduction strategies would logically fit. Any teacher who *started* from the assumption that some pupils would use or did use illegal drugs, and so gave advice on harm-reducing strategies, would be in danger of a severe reprimand.

In most schools the less controversial approach of information-giving, discussion of attitudes to drug use and promotion of healthy alternatives to drug use, has yet to be tried. If it is to be tried, then teachers need help. This help should consist of suitable materials for the teacher and student, plus in-service training to enable teachers to become familiar with new materials and gain confidence in the informal teaching methods which using these involve. Such methods need to be seen by staff and pupils as a valid use of time, and staff need to accept that this type of activity will be more noisy than traditional lessons.

If schools worked in this way to promote "positive outcomes such as a healthy lifestyle", then the community-based, harm-reduction strategies advocated by Les Kay, would have more chance of success. Abandoning schools drug education programmes would reduce the chance of these approaches of being successful. Both approaches are necessary and each complements the other.

Madeleine M. Savage

Health education officer, Wigan.

Alcoholics and addicts don't mix

I write to contribute to the debate addressed in Don Steele's article in the September/October issue of ***Druglink***. My concern is with the clinical implications of a merger between alcohol and drug projects.

I see the arguments here as pitched at one level. For convenience sake, let us call it the 'macroscopic' level. That is, the inevitable need to obtain funding to support and develop alcohol/drug agencies. At a different level we need to ask: having obtained funding to establish a dependency project serving both alcohol and drug addicts, what are the implications for the users of these resources?

Evidence exists that alcoholics look down on drug addicts, and vice versa.[1] From personal experience it has not been practicable to keep a mixed group of alcoholics and drug addicts together through a five-week group programme. The drug addicts could not identify with the experiences of the alcoholics, and the alcoholics could not see why not. After all, they have always needed the odd sleeping pill to assure themselves of a good night's sleep!

The outcome was inevitable! The drug addicts left before finishing the programme. A programme of this nature is likely to be seen as alcohol-biased and correspondingly attract clients only from the alcoholic population. A reverse form is imaginable. That is, a programme seen as drug-biased and attracting only drug addicts, even though it is established for both groups.

We should not fight for funding to the exclusion of the welfare of the clients for whom these services are provided. If service planners must merge the financial management of alcohol and drug services, let them go ahead, but be cautioned about running programmes for a mixed group of alcoholics and drug addicts together.

Noble Kumawu

Drug Advisory Service, Haringey, north London.

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