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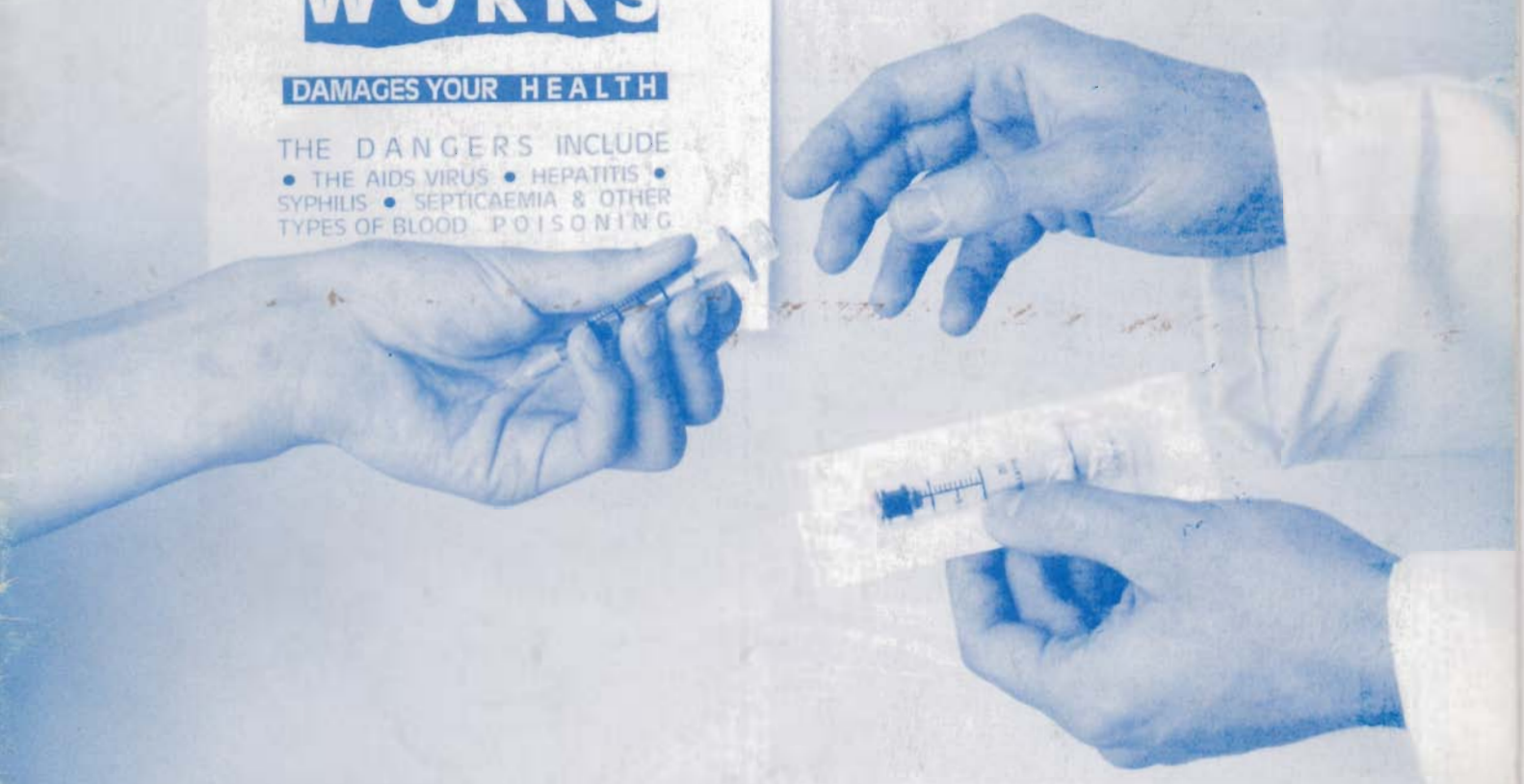

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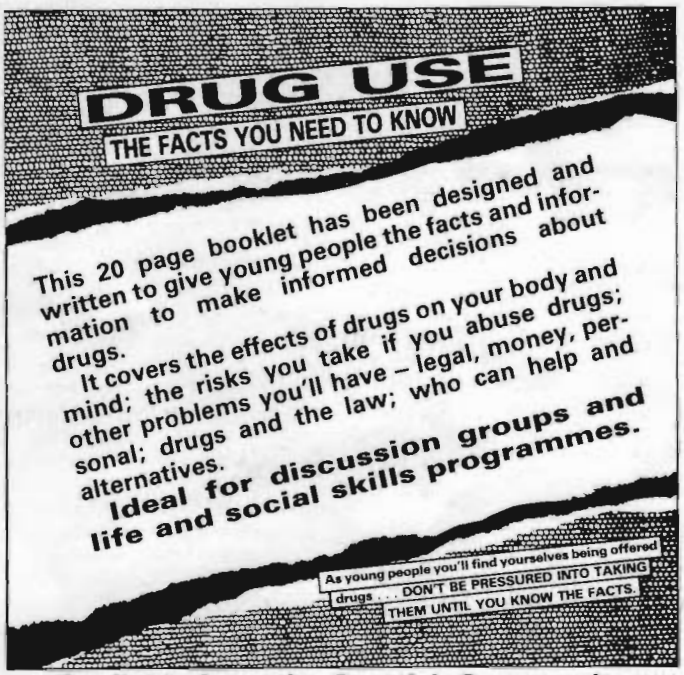

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DRUGLINK

September/October 1986

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THE JOURNAL ON DRUG MISUSE IN BRITAIN

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

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

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IN THIS ISSUE

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Research supports link between heroin use and crime

Research on heroin users, as different as the patients of Harley Street practitioners and residents of the most deprived areas of Merseyside, has lent support to the concern that the need to finance drug purchases can lead to revenue-raising crimes, such as burglary and theft.

IN ITS REPORT on *Heroin and crime*,[1] Liverpool University's Misuse of Drugs Research Project claims "conclusive" evidence that heroin use can accelerate or lead to acquisitive crime in young adults, presumably to help finance drug purchases.

A sample of 300 16-34 year-old Wirral residents convicted of serious crime in the first half of 1985 was found to include over 100 drug misusers known from earlier research.[2] Ninety-two of these were opiate misusers, almost invariably heroin. Half those convicted of burglary and three out of ten convicted of theft misused opiates, far higher than the general rate of known opiate misuse in the area.

One third of the drug using offenders were clear of convictions before age 16. With 16-17 the most common age for starting heroin use in the Wirral, the authors find it "hard to reach any other conclusion than that heroin dependency has led this group into regular offending for the first time". The remaining two-thirds appeared to accelerate their criminal activities after starting heroin use.

The Wirral research relied on agency and enforcement records rather than talking direct to drug users/offenders. When the sample's drug use actually started in relation to their criminal career, how much crime they committed but got away with, and the reasons they'd have given for committing crimes, are some of the consequent gaps in the findings that perhaps make the description "conclusive" ambitious.

MORE CIRCUMSPECT are the authors of a report on the *Impact of prescribing on the crimes of opioid users*.[3] Interviews with opiate dependents revealed some had stopped and others reduced their criminal activities after receiving a legal supply of opiates as part of their treatment. For instance, half the sample of patients at a Cambridge drug dependency unit offended frequently before receiving a prescription, but less than a quarter continued to do so after starting the treatment.

This reduction in crime was accompanied by less frequent resort to the illicit market, suggesting fewer crimes were committed because less money was needed to pay illicit market prices.

Much of the criminal behaviour that remained despite treatment was reportedly to raise money for goods or for personal use, rather than for drugs. In contrast over three-quarters of a sample of opioid users not receiving a legal supply, said they committed non-drug crime solely to finance drugtaking.

The authors cautiously conclude that more liberal opioid prescribing might reduce the overall level of addict crime, though some would continue offending to finance illicit drug purchases or for reasons unrelated to drug use.

The report offers limited support to the idea that the need to pay for opiates on the illicit market can elevate the level of revenue-raising crime. But samples were small and the response rate poor. As the researchers admit, much broader-based sampling would be required to substantiate the trends they'd observed.

1. Parker H., Newcombe R. and Bakx K. *Heroin and crime*. University of Liverpool, 1986. Available from Misuse of Drugs Research Project, Sub-department of Social Work Studies, University of Liverpool, L69 3BX, £3.00. (Cheques payable to University of Liverpool.)
2. Parker H., Bakx K. and Newcombe R. *Drug misuse in Wirral*. University of Liverpool, 1986. Available from Misuse of Drugs Research Project (address above), £3.50.
3. Bennett T. and Wright R. The impact of prescribing on the crimes of opioid users. *British Journal of Addiction*: 1986, *81* (2), p265-273.

Confusion among new drug education coordinators

As part of its contribution to the government's campaign against drug misuse, the Department of Education and Science has allocated £2 million during 1986/87 for the appointment of drug education coordinators within each of the English local education authorities.

The initiative was prompted by the success of a pilot project in the Wirral and the money, about £20,000 for each authority, has been allocated for two years. Welsh education authorities have received a similar allocation from the Welsh Office.

But what are the coordinators actually supposed to do? Prevention may be the "key" to combating drug misuse (as David Mellor has recently emphasised), but it is also a very imprecise concept. According to the government, coordinators will be expected to:

"Stimulate and coordinate action within the education service and collaboration with agencies or to take other action appropriate in the light of local circumstances aimed at combating drug misuse . . . The activities likely to be funded will include advice and support for schools, colleges, youth service workers and other staff; and the arrangement of suitable training for the authorities' staff."[1]

With such a wide-ranging brief the possibilities for varying interpretation and emphasis are legion, a point made by Adrian King, LEA coordinator for Berkshire, speaking at a recent National Children's Bureau seminar.

Many coordinators will be the only local authority staff with full-time responsibility for 'stamping out drug abuse' and, as Mr King was finding, this meant the labelling of the coordinator as the 'local drug expert'. He also recognised that local councillors, the education authority itself, local drug workers, head teachers, school governors and parents will have their own opinions as to what the coordinators should be doing and what is needed in their area.

These may or may not tally with government expectations even though that is where the money is coming from, or with the views of individual coordinators on drug issues and how best to approach them.

Some measure of the variations in the degree of commitment to the initiative is shown by the fact that a week before the DES-sponsored national conference for coordinators in September, some coordinators were not yet in post, though appointments were supposed to be made by 1 April.

WHAT SUPPORT and training can coordinators themselves expect once they start?

In the House of Commons last July, the Secretary of State for Education predictably replied this was the responsibility of each authority. But, again predictably, some authorities do not seem to be taking this responsibility on board. ISDD's contact with coordinators already in post suggests the experience of some at least is less than satisfactory. Shown an empty desk and told to 'get on and coordinate', they are not surprisingly feeling isolated and confused.

Coordinators in some areas have established good links with other local agencies like health education and health promotion units. But informal feedback indicates others are finding themselves embroiled in territorial conflicts between themselves, health education and personnel appointed using DHSS central funding initiative money in the nebulous areas of 'training' and 'co-ordination'.

Inevitably coordinators will be looking to the national conference in Southampton to help put some flesh on their job descriptions. At the very least there will be the chance for coordinators, some newly appointed, others in post for months, to exchange ideas and experiences.

1. *Tackling drug misuse*, rev. ed. London: Home Office, 1986, p18. Single copies free of charge from ISDD.

GPs may see 44,000 new opiate misusers a year

General practitioners in England and Wales may be seeing 44,000 new cases of opiate misuse a year; during a four week period in 1985, one in five GPs saw an opiate misuser.

These are some of the startling findings of a postal questionnaire survey of GPs by researchers at the Institute of Psychiatry's Addiction Research Unit, reported in a series of articles in the *British Medical Journal*.

Between May and August 1985, the researchers contacted a five per cent random sample of GPs in England and Wales. Nearly three-quarters of the GPs returned questionnaires reporting how many different patients they had seen over the past four weeks for problems associated with the misuse of heroin or other opiate drugs.[1]

The researchers estimate that one in five GPs had seen an opiate misuser during the four weeks but nearly half (46 per cent) had never come across the problem. A total of 329 misusers were seen. Allowing for non-response, the authors suggest all GPs in England and Wales may have seen 9,500 opiate misusers during the period.

Over a third of these patients were estimated to be consulting the GP for the first time about opiate problems. Assuming a similar picture at other times of the year, English and Welsh GPs may see some 44,000 new cases of opiate misuse in a year.

Nearly two-thirds of the new cases were seeking help with withdrawal and/or rehabilitation. From these figures it can be estimated that GPs see nearly 27,000 new cases of opiate misuse in a year where the patients present themselves as dependent on opiate drugs.

Another indication of the extent of GP involvement in the response to opiate misuse is the researchers' estimate that on average every GP in England and Wales will see two new cases a year.

In all the regional tables in the report, Mersey comes out 'worst', with the highest rates of GP contact with opiate misusers and the highest proportion of new cases, indicating continuing growth of an unusually extensive opiate problem.

A second paper[2] reveals that two-thirds of the GPs in the sample referred their most recent opiate misuse patient to a hospital psychiatric service (either drug specialist or general). Relatively few referred the patient to non-medical social work or counselling services. A third prescribed opiates but only six per cent arranged urine tests to confirm that the patient was using opiates. A third of the patients (the ones the GP prescribed for?) were notified to the Home Office.

The research confirms the important role played by GPs in the response to opiate addiction in Britain already recorded in Home Office addiction notification statistics. But it also reveals the much more extensive and hitherto hidden involvement of GPs in treating literally tens of thousands of opiate misusers of which only a small proportion may have been notified to the Home Office.

A third paper is expected to cover GPs' views on issues of policy and practice in relation to drug misuse.

1. Glanz A. and Taylor C. Findings of a national survey of the role of general practitioners in the treatment of opiate misuse: extent of contact with opiate misusers. *British Medical Journal*: 1986, *293*, (6544), 16 August, p427-430.
2. Glanz A. Findings of a national survey of the role of general practitioners in the treatment of opiate misuse: dealing with the opiate misuser. *British Medical Journal*: 1986, *293* (6545), 23 August, p486-488.

Youth work training project

Youth workers' experience of and expertise in responding to drug-related issues goes largely unrecognised and undervalued in Britain. Yet in many ways, their knowledge exceeds that of allied professions.

But it is not just the level of experience; youth work has its own settings, history, problems and practices not recognised in the available materials. Most drug education and training materials have been designed with schools in mind. Others are designed for groups such as problem drug users, or friends or relatives who wish to help. Recent poster and mass media campaign material has been designed for young people. But very little material has been designed with youth work in mind.[1]

In October 1986, ISDD is beginning a project to bring together some of the experience of youth workers and to develop a package of materials for the Youth Service that reflects the needs of the field. The project will draw upon existing materials and identify gaps and needs in relation to drug-related issues in the youth work context, with the emphasis on training practitioners, rather than producing materials for use with, or by, young people.

The resulting package will probably have at least three important features.

► **Multi-level**. There will be different 'levels', corresponding to the needs of youth workers, part-time workers and youth officers. It *may* also contain material for young people, such as posters.

► **Broad scope**. It will address itself not only to ways of working with young people, but also to ways in which drug issues can become a focus for broader youth work issues between colleagues, between workers and management, and between the youth work service and other agencies.

► **Practical**. It will be issue-based, providing participative training and interactive self-study methods for working through the concerns of those working in the youth work field.

For the first four months of the project the emphasis will be on consultation with the field, including:

— discussions with workers with different degrees of experience of responding to drug-related issues in a youth work context, from those with little or no experience to some with extended and/or specialist experience. Small numbers of youth workers, youth officers and part-time workers will be seen individually and in small discussion groups.

— consultations with youth work and allied agencies (eg, advice projects with a youth clientele) and drugs agencies.

— possibly, a national postal survey of LEA policy and practice in England and Wales to find out about training provision and felt need, and to lay the basis for consultations around trial materials.

From early 1987 an outline of the training package will be agreed and sections of it written for trial. The package will be revised before finalisation in the Autumn, and will be available from ISDD.

● *Please contact the authors* in writing if you are involved in a youth work project working with issues around legal or illegal drugs, or can offer us advice based on experience of training youth work colleagues around these issues.

Christine James and Nicholas Dorn

Christine James, a Research Officer at ISDD, worked in community work before taking a qualification in health education. Nicholas Dorn is Assistant Director (Research) at ISDD. The DES has agreed in principle to fund the project.

1. In summer 1986 the National Youth Bureau began developing broadly-based health education materials for use in youth work, including drug-related issues.

Unique drug education package

Next month sees the launch of *Drugwise*, a drug education pack for secondary schools and colleges of further education. Funded by the Department of Education and Science and the Scottish Health Education Group (SHEG), *Drugwise* is the result of a 16-month project aimed at producing a comprehensive and innovative set of materials for teachers, tutors and young people aged between 14 and 18.

Coordinated by the Health Education Council, the pack is the result of a unique collaborative effort between ISDD, TACADE and Lifeskills Associates, three of Britain's leading drugs and education agencies.

This is the first drugs education pack to contain a curriculum guide outlining a range of opportunities for incorporating drug-related (not necessarily drug-focused) education into the curriculum. Recent drug education practice has been primarily aimed at personal, social and health education. While the guide covers these areas it also makes suggestions for working within subject-based and work-related education.

Anyone unaware of the possibilities of raising drug-related issues in say, history, science or even mathematics, will find many practical suggestions and lesson ideas based on contributions from teachers' existing good practice.

In addition the guide contains a section aimed at those whose coordinating role involves reviewing and planning the coverage of drug-related issues across the curriculum. The new LEA coordinators should find it particularly useful.

ISDD, who produced the curriculum guide, are just one of the agencies who have contributed their experience to *Drugwise*. The pack also contains student learning materials written by Lifeskills Associates and a training manual produced by TACADE (Teachers Advisory Centre for Alcohol and Drug Education).

Lifeskills Associates, who already have considerable experience producing material in the field of personal and social education, have applied their own skills-based approach to drug education. TACADE's training manual is designed to help teachers use the learning materials and provides detailed plans for staff development and parents' workshops in preparation for a *Drugwise* curriculum.

Drugwise will be available from ISDD, TACADE and Lifeskills Associates from early November, price £30.00 plus postage and packing.

Christine James and Parin Bahl

Christine James, a Research Officer at ISDD, and Parin Bahl, a District Health Education Officer in Newham, are two of the authors of the Curriculum Guide in the Drugwise *pack.*

WELCOME TO DRUGLINK, the journal on drug misuse in Britain.

Druglink is published every two months by the Institute for the Study of Drug Dependence, which houses Britain's national library on the misuse of drugs.

Like ISDD's library, **Druglink** is about 'socially disapproved' forms of drug use — seen legally (Misuse of Drugs Act), socially (eg, solvent sniffing) and/or medically as 'misuse'. **Druglink** does not aim to cover alcohol and tobacco use.

Druglink aims to inform, promote understanding and encourage debate.

Druglink's contents will include:

- **features** analysing issues and topics in depth drawing upon ISDD's unique library;
- **briefings** on subjects in need of clear, factual review;
- **news** of developments in a fast-moving and increasingly important area of British life;
- **platform** pages, opinions from people with something important, intriguing, or challenging to say;
- **practice notes** from those working with drug use or drug users to others grappling with similar problems — examples of effective practice and the mistakes made along the way;
- **talking points** — food for thought, new angles, surprising facts, insights and ideas;
- **letters** — your responses to **Druglink** and its contents, your chance to make a point or convey a finding to colleagues;
- **reviews** of books and audio-visuals plus listings of the latest publications received by ISDD's library.

Advisory teams aim to improve drug services

A new government initiative has been established to help promote appropriate service provision in the drugs field. The move is based on recommendations made by the Advisory Council on the Misuse of Drugs in 1982 and the House of Commons Social Services Committee in 1985.

The Drug Advisory Service (DAS) will operate along similar lines to, and under the auspices of, the NHS's Health Advisory Service (HAS). It will be serviced by the HAS secretariat funded by the DHSS, but report direct to the Secretary of State.

A letter to DAS members from the HAS secretariat said the objective of the service will be "to help facilitiate:

a) the promotion of liaison and coordination between the various agencies, professionals and local groups;

b) the assessment of the nature and extent of local drug misuse, existing services and preventive measures; and

c) the development of appropriate responses".

At an inaugural meeting on 3 July, DAS members started to work out how these objectives would be fulfilled. Like the HAS, the DAS will go into District Health Authorities either by invitation or because the DAS selects them as in need of special investigation to determine what provisions exist and whether these meet community needs.

DAS members will not be employed by the service; instead 80 people with a special interest in drug problems have been invited to serve on secondment from their respective agencies. They will be divided into 20 teams, comprising a doctor (probably a consultant), a senior nursing officer, a local authority social worker and a specialist drugs worker.

It is envisaged that each team will be sent into an area for one week to study service provision, discussing issues of concern with drug agencies, voluntary or parent groups, social services, probation and so on. They will take a further week to prepare a report for ministers.

The DAS is still feeling its way as to how the programme of visits will be carried out and monitored. The first two team visits arranged for this year to Oldham and Southend will not only report on the areas themselves, but also make recommendations for the conduct of future visits and the process of reporting back, so these teams will consist of people with a particularly high level of experience in the drugs field.

A spokesperson for the HAS/DAS secretariat said areas would be selected which provided models for good practice. Once reports on these areas were made public, it was hoped other District Health Authorities would invite a DAS team to examine service provision in their area, with a fiew to improving facilities for problem drug users and their families.

ALCOHOL AND DRUGS — UNSUITABLE ATTACHMENT?

Expanded funding for drugs agencies and the high level of political concern over drug problems have left alcohol agencies smarting over what they see as relative indifference to the much greater problem of alcohol abuse. Many have responded by changing their names and/or functions to incorporate drugs (and drug funding). Don Steele of Action on Alcohol Abuse looks at the options open to the alcohol agencies.

Don Steele

The social acceptability of alcohol means that, unlike other drugs, sanctions are not automatically applied. Neither is stigma attached to users except in cases where excess is evident. It is the consequences of drinking rather than the act itself which results in censure or social control.

The differences inherent in alcohol and illicit drug use were clearly demonstrated following the raising in 1918 of restrictions imposed by the 1915 Defence of the Realm Act. This Act not only prohibited the use of cocaine and other drugs but, at the same time, limited the availability of alcohol by introducing restricted opening hours as low as five and a half hours in some parts of the country.

After the war, two things happened. First, the restrictions on drugs were increased and the 'drug fiend' was born. There followed the Dangerous Drugs Act, administered by the Home Office, and the association between recreational drug use and criminality became institutionalised.

Meanwhile, there began a movement in exactly the opposite direction as far as alcohol was concerned. Restrictions imposed by the 1915 Act were at first ignored and then lifted. The Licensing Act of 1921 set the seal upon a movement toward liberalisation which continues to this day.

The 1961 Act matched with the 1964 elimination of retail price maintenance provided a drink entrepreneurs' charter. Outlets of all kinds could, and did, multiply. Between 1973 and 1983 the number of licensed premises increased from 109,782 to 137,031 (19 per cent).

The fact which emerges more clearly than any other is that since 1918 alcohol has become increasingly 'legal' and other recreational drugs have become 'illegal'.

TWO APPARENTLY independent but related developments are behind the alcohol agencies' desire for change:
— a realisation that far from being confined to a small, pathological group ('alcoholics'), alcohol related damage is experienced throughout the population to a greater or lesser degree;
— the rapid advance of illicit drug use and the unfettered legitimacy of a well-resourced (by comparison) government response.

Presented with these facts, alcohol agencies have two choices. First, it would be possible to recognise and build upon the realisation that their job in relation to alcohol is much bigger than they thought.

By concentrating upon the 'addicted minority' alcohol agencies could plug into — or take over — agencies serving illicit drug users

Their mission would be to the whole population and would include a broad spectrum ranging from advice on sensible drinking and associated behaviour to the advocacy of appropriate social and fiscal controls.

It is unlikely that any kind of populist, media-backed support would be generated by such a decision. On the contrary, unequivocal positions would have to be taken in relation to both government and the drinks trade.

ALTERNATIVELY, the alcohol agencies could re-invest their assets. Simply by concentrating upon the traditional 'addicted minority' they could, with justification, plug into — or take over — those agencies serving illicit drug users, if for no reason other than that both pathological minorities are frequently cross-addicted. This move would be attractive for a number of reasons.

► By becoming the 'same' as illicit drug agencies, additional financial resources would become available.

► Possibility of conflict with either government or the drinks industry would diminish because both are concerned with maintaining the myth of the 'pathological drinker' — the 'deviant minority' set apart from the 'normal' population.

► Areas of responsibility could be enlarged and salaries increased for what, on the surface, appeared perfectly legitimate and logical reasons. Such a fusion of activities might even increase respectability, gain peer acclaim and receive the accolade 'progressive'.

One thing is clear: a choice has to be made concerning which of these two expansionist paths is to be followed. It is impossible to move in both directions at the same time.

The truth is that the separation, institutionalised from 1918 onward, has set a great perceptual gulf between substances labelled 'legal' and 'illegal'. As Andrew Tyler has remarked:[1] "The reputation that a drug achieves rarely has much to do with its pharmacological reality but is a product of a culture's topical, often racially-linked, panics: or else the reputation is manufactured to serve an imperial or corporate interest".

In other words, permission and prohibition have a political purpose and the only link between illicit drugs and alcohol is at the point where the behaviour associated with the unrepresentative, addictive use of alcohol meets with the perception of illicit drugs as 'totally addictive'. It is the joining of a fragment with a whole; a marriage of dubious convenience.

Diversion from the dangers of alcohol toward illicit drug use is producing a distortion for which society will have to pay a high price

In considering the way forward, agencies would do well to weigh up both possible alternatives. The risks but undoubted potential social benefits attached to the first option might be taken into account. At the same time agencies should note the temporary nature of any advantage which might accrue from taking the second course.

Overall, one fact emerges quite clearly: the diversion of attention from the pervasive dangers of rising alcohol consumption in the general population toward an exaggerated perception of the dangers of marginal illicit drug use is producing a distortion for which society will have to pay a high price by the end of the century.

1. *New Statesman*, vol. 3, no. 2867, 7 March 1986, page 21.

First published in *Alcohol Concern*, May/June 1986, vol.2, no.9. This publication also included contributions from other alcohol agencies on the same topic.

Don Steele is the Director of Action on Alcohol Abuse (AAA). He believes there is so much unfinished business in relation to the abuse of alcohol that alcohol agencies should concentrate on that problem and not allow themselves to be diverted by the temporary attractions of addiction funds.

AAA was set up in 1983 by a conference of the Royal Medical Colleges to campaign for sensible attitudes to drinking backed by controls on alcohol availability. AAA is at Livingstone House, 11 Carteret Street, London SW1H 9DL, phone 01-222 3454.

AIDS AND INJECTING

AIDS FILE will bring *Druglink* readers British and world literature on the single most serious health threat to drug users. First is Dave Turner's call for drug agencies to practice risk-reduction to save lives. We also see how such practices — including new syringes for old — have been working in Amsterdam.

David Turner

Professionals have many ideas for schemes meant to offer some protection against HIV infection and AIDS to those at greatest risk. There is, however, a major dilemma: measures which might limit the spread of the HIV virus in injecting drug users are in conflict with current good practice in the treatment of drug misuse.

For instance, shortage of needles and syringes is a factor in sharing injection equipment, but good treatment practice is seen as not prescribing injectable drugs and the means of injecting them.

Again, if the goal of treatment is seen as abstinence then drugs should not be prescribed as part of that treatment, but controlling the spread of infection may require prescribing oral substitute drugs for those not yet ready for abstinence or a rehabilitation programme.

The conflict is profound and challenging. Which approach should have priority? Limiting the spread of the virus, to which injecting drug users appear one of the most susceptible groups with a high mortality rate from infection? Or treating drug misuse, telling those at risk that the choice is theirs, but that injecting and sharing injection equipment can lead to and spread infection and result in AIDS, as well as other serious consequences?

This brief paper attempts to present some of the problems, to provide an update on a number of prevention initiatives, and to offer food for thought.

Infection increasing

The incidence of HIV infection in drug users appears to be slowly increasing. Although some areas are showing much higher levels of infection than others, the virus is present in all parts of the country.

Drug-free rehabilitation communities are admitting residents from all parts of the country who are later found to be infected. The last published estimate of HIV prevalence in drug users from the Public Health Laboratory Service, based on limited sampling and excluding areas of Scotland, shows a five to six per cent level of antibody-positive returns.

In 1985 much of the attention was focused on parts of Scotland where drug users had been screened for antibodies. Whether this screening was done with adequate pre- and post-test support is open to debate, but the results were of considerable importance.

Many cases of infection were detected in Edinburgh and Dundee, with some in Glasgow. Even assuming *no* rise in the number of drug misusers infected, it must be conservatively estimated that some 40-50 young drug users in Scotland alone will be suffering from AIDS within the next two to three years. Given that infection is almost certain to spread for some time, the numbers may well be higher.

The situation may be far more serious than has previously been believed in other areas outside Scotland. It is often difficult to reach injecting drug users at risk and to obtain the necessary support facilities for antibody screening. In consequence, the information base in these areas is likely to be substantially less than that in areas where screening has been undertaken for some time.

David Turner is the coordinator of the Standing Conference on Drug Abuse, the national representative body for non-statutory agencies providing advice, counselling and rehabilitation to drug users.

Role of treatment centres

Drug treatment centres in the United Kingdom now recognise the need to act quickly to reduce risk and to prevent the spread of infection. However, they have a number of difficulties.

The services they offer to injecting drug users are often perceived by those drug users as not worth pursuing. Clinics may still be some distance away and may have waiting lists which prevent the drug user getting attention until several weeks after the initial approach. Some will not prescribe substitute drugs while most will not prescribe drugs in injectable form.

It is essential that no risk-reduction option is rejected out of hand because it conflicts with abstinence.

Many professionals believe that this new and potentially lethal threat of HIV infection makes it all the more important to induce those at risk to make contact with agencies and treatment centres. They are, however, divided on how this should be achieved.

Some argue that offering substitute drugs to be taken by mouth is a strong inducement to drug injectors to stop their primary AIDS-risk behaviour (unless they are also homosexual) — the using and sharing of injection equipment. Others argue they are in the business of helping people to get off drugs, not of providing drugs which help perpetuate drug dependence.

Yet others argue that where infection is spreading rapidly but is not yet endemic among drug users, the provision of injectable drugs with injection equipment, or at least easier access to injection equipment, is a method of prevention which is well worth trying.

The need to fund large-scale programmes to counsel drug users and offer the antibody test was widely recognised at a recent meeting held at the Public Health Laboratory Service in London. No plans have yet been made to accomplish this. It is unrealistic to expect the sexually transmitted disease clinics to continue provision of counselling and testing for injecting drug users, especially in Metropolitan areas: services designed for drug users will have to become involved.

Preventing spread

So the difficulties in preventing spread of infection are considerable. Although currently injecting drug users who share injection equipment are most at risk of becoming infected or infecting others, those who have injected in the past may already be infected. They risk infecting others through intercourse and are a potent group for spreading infection more widely into the population generally believed not to be at risk.

Prevention has two goals: first, to limit the spread of infection among the most at-risk groups, namely those injecting drugs and sharing equipment; second, to limit the spread of infection from drug users to the general population through counselling and advice about safe sexual practices.

Motivating those who are drug dependent to understand that there are alterna-

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.

tives to continued drug use is usually a long and involved task. Abstinence may be the ultimate goal, but it is rarely achieved quickly and harm-reduction as part of the process leading to abstinence is an essential element in any treatment intervention.

With HIV infection now such a real threat, can we allow ourselves the luxury of refusing to deal with drug users except from a position of saying 'Abstinence is the only goal and everything we do will be designed to achieve this as speedily as possible, whether or not you are ready to accept it'?

More resources *are* needed. Many drug users who seek help with their drug problem cannot be accepted into treatment or rehabilitation because services are full. But there is also a need to develop existing treatment services which can counsel drug users, advise them on risk-reduction in drug use and sexual behaviour, offer alternatives to continued dangerous injecting practices and, if necessary, offer injectable drugs and the means of injecting them.

The use of drugs is not going to suddenly cease because of society's disapproval. Drug use, particularly by injection, is an unsafe activity — especially when someone who knows little about drugs and the dangers associated with injecting chooses to experiment indiscriminately — but we cannot afford to ignore the facts. It is essential that no risk-reduction option is rejected out of hand because it appears to conflict with a service's stated goal of abstinence.

Our own feelings and attitudes to drug use can cloud our judgment when it comes to devising strategies to beat the AIDS virus.

A range of options might be considered. For instance:
— providing health education about infection and the risks associated with injection;
— working with local pharmacists so that risk-reduction literature was provided to anyone buying needles and syringes;
— arranging with a pharmacist that s/he would sell needles and syringes to someone referred by a drug agency;
— providing needles and syringes on a new-for-old exchange basis.

In any risk-reduction package, it is important to counsel about safe sex activities and the package might include providing or making arrangements for the supply of condoms.

The tests of any intervention should be:
► Has the drug user ceased sharing injection equipment?
► Is s/he aware of the risks involved in sharing injection equipment?
► Are his/her drug using friends aware of these risks?
► Has s/he ceased taking drugs by injection?
► Has the drug user become more controlled in his/her drug use?
► Has abstinence from drug use become a goal for the drug user?

These tests are not incompatible with the goals of drug treatment, but they do challenge the limited alternatives offered by many drug services.

It is understandable that the idea of supplying or arranging the supply of needles and syringes or of prescribing substitute drugs may be unpalatable and seen as in conflict with good treatment practices.

However, is it not better to have uninfected drug users who may survive their addiction than to have infected drug users who may not? To combat the spread of AIDS a much greater range of options needs to be available to drug users, attracting them into treatment rather than deterring or excluding them.

Based on 'HTLV III infection and AIDS in injecting drug users: report from the Standing Conference on Drug Abuse' in: *Proceedings of the AIDS Conference 1986*, Peter Jones *ed*, Newcastle upon Tyne: Intercept, 1986, pages 249-253. Full conference proceedings available from Intercept, P.O. Box 2, Ponteland, Newcastle upon Tyne, NE20 9EB.

PREVENTING AIDS IN AMSTERDAM

Amsterdam has taken three measures to prevent the spread of human immunodeficiency virus (HIV) among drug addicts — a publicity campaign; an exchange system for syringes and needles; and the distribution of condoms among addicted prostitutes.

In the publicity campaign leaflets are being distributed and meetings are held to inform workers in the drug field and addicts themselves about AIDS.

Among drug addicts HIV is mainly transmitted by sharing of contaminated needles and syringes,[1] so the provision of sterile equipment might slow the spread of the virus in this group. To avoid increasing danger that people might inadvertently prick themselves with carelessly discarded syringes and needles, a strict exchange system was adopted. This was introduced in Amsterdam in 1984, organised by the Municipal Health Service in cooperation with the Association of Drug Addicts ('junkies' union'): addicts receive a sterile syringe and needle free of charge when they return a used syringe and needle.

Studies from Africa strongly suggest that HIV can be transmitted by heterosexual contact and that prostitutes and their male customers in Africa should be regarded as at high risk of AIDS.[2,3] Thus in western countries prostitutes who use intravenous drugs could be a link in the spread of HIV to the general population. The Municipal Health Service now provides free condoms to addicted prostitutes.

These measures need to be viewed in the context of Amsterdam's approach to the drug problem. Because the results of drug-free treatment were disappointing and few addicts were being reached, Amsterdam revised its policy in the late 1970s towards a more pragmatic, non-moralistic approach. The principle is: that if it is impossible to cure a drug addict one should at least try to create a situation that greatly reduces the risk that the addict harms himself or his environment.

Besides drug-free treatment programmes and resocialisation projects, much emphasis is put on getting in touch with addicts through streetwork, medical assistance to arrested addicts, special attention to those admitted to general hospitals, and an outreaching 'low threshold' methadone programme (like 'methadone by bus project').

Once in contact, we persuade the drug addict to stabilise their addiction and life-style by regular methadone use and less involvement in illegal drugs, by regular medical check-ups, and by attention to his or her social circumstances (housing, money, and 'normal' social relationships).

Although it is early days, the effort to contact as many drug addicts as possible seems to be successful. In 1985, 60-80 per cent of the city's drug addicts were in touch with the Amsterdam helping system. The AIDS publicity campaign could therefore be reaching a substantial proportion of the target group.

In 1985 some 100,000 syringes and needles were provided in the exchange system and there has been no evidence of an increase in 'needlestick' accidents among the general population. Nor has the fear that this approach would encourage drug addicts to inject and not become involved in treatment come true so far. The number of addicts who use intravenous drugs did not increase in 1985 (25-30 per cent inject, 70-75 per cent inhale heroin or 'chase the dragon'). Therapeutic programmes report that more clients than ever are being motivated to enter treatment. The number of drug addicts in Amsterdam has stabilised over the past few years at 7000-8000.

In Amsterdam only two AIDS cases have been diagnosed among drug addicts. When sera taken from drug addicts at the end of 1983 and the beginning of 1984 were tested for HIV antibodies (R.A.C. and J. Goudsmit, unpublished), five (3.4 per cent) of those from 145 addicts entering a methadone programme and 12 (23 per cent) of those from 52 addicted prostitutes were positive.

In December 1985 a large epidemiological study began. The prevalence, incidence, and risk factors of HIV infection among drug addicts in Amsterdam are being studied and the influence of the preventive measures now adopted will be assessed.

E.C. Buning, R.A. Coutinho, G.H.A. van Brussel, G.W. van Santen and A.W. van Zadelhoff
Municipal Health Service, 1000 HE Amsterdam, Netherlands.

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First published in *The Lancet*, 21 June 1986, page 1435.

TRENDS IN DRUG ENFORCEMENT

Many whose jobs involve defending the welfare of drug using clients have feared that the crackdown on 'pushers' will trickle down the scale to drug users. Release's recent survey of solicitors indicates this is exactly what's happening, but with wide geographical variations.

Jane Goodsir

Over the past few years there have been a series of major initiatives within the criminal justice system to respond to a perceived 'drugs menace'.

In each policing area, drug squads have been set up, regardless of local views about the scale and nature of illegal drug use in the area. In some big cities, bids for increased funding have been made for additional officers to combat drug trafficking. In many forces, police have mounted publicity campaigns on drugs — and have been under some pressure to come up with results.

In the courts, a series of judicial decisions has established deterrence as the key policy. Courts continue to rely substantially on information from police about drug use. In our adversarial legal system, this has its dangers. Sometimes it has appeared there is a cosy understanding between the police and the courts, with police evidence on drug use largely untested. This trend may be set to continue under the terms of the Drug Trafficking Offences Act.

Release is researching the attitudes of both police officers and magistrates towards drug cases. Relying on information provided by solicitors in criminal practices, our research indicates a wide disparity of practices by both police officers and the courts in different areas of the country.

Police and enforcement

Officers of different ranks appear to have different attitudes towards drug use. Senior officers speaking to the media say that they are interested in arresting traffickers, not users. Were this policy being carried through, one might expect the number of offences involving simple possession of drugs to be in relatively sharp decline, with perhaps an increase in the percentage of adult defendants cautioned. This would appear particularly appropriate following Home Office encouragement on the use of the caution.

In some areas — Leicester is an example — police have directed alcoholics who have been picked up to 'drying out' units. Such work is not undertaken in relation to drugs offenders, and it remains clear that the police are concerned with enforcement even when trivial offences have been committed.

Statistics show that cautions for drugs offences have increased from 254 in 1981 to 2140 in 1984. However, nearly all these cautions were given for offences involving possession of small amounts of cannabis. Looking at reports in individual policing areas, it is clear that use of the caution for petty offences is unusual. In some areas, however — Avon, Devon and Cornwall, West Yorkshire — cannabis users are often cautioned. Use of the caution in heroin and cocaine cases does not, so far as we are aware, take place.

● **Quality v quantity:** If the statistics are to be believed, the police are having major successes in catching traffickers. But police continue to influence decisions concerning the prosecution of cases, despite the introduction of the Police and Criminal Evidence Act, where decisions on prosecutions were to be made by an independent authority. In most cases, police remain responsible for drawing up charges at the conclusion of a criminal investigation.

Prosecutions are based on the possibility that a small quantity of drugs can be divided and sold in minute quantities.

Police influence on charges at different levels of seriousness may mean the statistics for 'major' trafficking convictions are inflated.

In our experience, questionable decisions are made about the prosecution of certain offences, particularly possession with intent to supply, a trafficking offence subject to the same maximum penalties as actual supply. Shored up by verbal admissions in police stations and police statements on drug use, these cases are often bitterly contested.

Police perceptions of 'suppliable' quantities have changed recently. Increasing numbers of prosecutions are based on the theoretical possibility that a small quantity of drugs can be divided again and sold in minute quantities.

In our research, we found some cities where defendants who might have been charged with simple possession of say one gram of heroin five years ago, would these days be charged with a supplying offence. This despite the fact that purity levels of heroin are decreasing, and the smoking of heroin (which needs more heroin than injecting for the same effect) is more common, so users may now possess less pure substances in larger quantities.

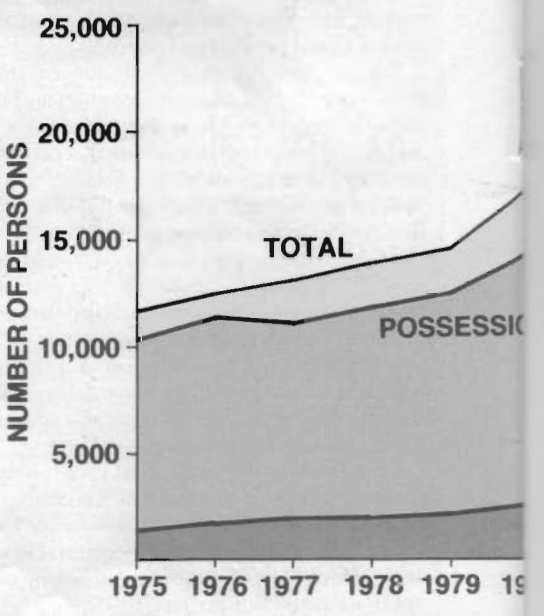
Despite the statistics, the number of *major* trafficking convictions relating to drugs in class A — the most serious — of the Misuse of Drugs Act is surprisingly small.

● **Street policing:** One might expect that over the years, police operations would have become more sophisticated. 'Stop and search' — the police's authority to stop and search people on reasonable suspicion of possessing drugs — is notoriously unpopular, and has been related to some recent public order incidents which might have deterred police from relying on these powers on an operational, rather than individual, basis.

Instead we found many areas where large numbers of drug arrests had occurred in a series of 'purges', with defendants appearing in batches on minor charges, following indiscriminate raids on housing estates, clubs and other obvious targets. These unfocused operations were often favoured in preference to longer term criminal investigations.

Telephone 'hot lines' have been set up in some towns, with police responding to tip-offs from the public that are often anonymous. There are obvious dangers in relying on unchecked and potentially malicious information. There is also the problem that low-level user-dealers are often easily identified by potential callers, while

Persons found guilty of or caut



Despite attempts to concentrate enforcement e drug convictions are still for possession.

Jane Goodsir is the director of Release, the national agency providing a drugs and legal advice and information service, including a 24-hour emergency phoneline (01-603 8654). Release can be contacted on 01-377 5905 on weekdays between 10am and 6pm.

major suppliers are not.

Police are having occasional successes, we conclude, but the priority in practice has remained the policing of drug use, with some ordinary drugs users now unjustifiably promoted to 'trafficking' status.

Courts and sentencing

Courts dealing with drugs offenders are bound by the rules and precedents of the criminal legal system. Drugs offences cannot be taken in isolation. Under English law, the courts have a duty to examine the individual circumstances of the offender, and look at the case in context, as well as taking account of public policy.

On the basis of information received from defending solicitors, it seems the defendant's circumstances are often disregarded by courts dealing with drugs cases, in a manner that would not be acceptable in offences such as theft, or even offences involving violence. We found a clear tariff operated in almost all courts at every level, regardless of individual circumstances.

However, the level of the tariff varied from area to area.

● **Minor heroin offences:** Looking at the way different courts dealt with heroin offences, we found that in rural areas, where the courts saw fewer cases, it remains popular to fine heroin users.

In large cities, where they may be 'case-hardened', we had the impression that courts attempt different approaches. Some investigate treatment or supervision options as a matter of routine. Others always reject supervision, and some courts sentence heroin users to imprisonment, whatever the circumstances. Some magistrates and judges see prison as a forcible detoxification facility.

Heroin users face prejudice in relation to bail decisions, as well as sentence. The reasoning behind most bail refusals is dubious to say the least.

Some courts remand heroin users in custody despite clear indications that bail is appropriate, on the basis that an admitted addict is going to commit further offences. This has occurred in cases where it has seemed likely that a non-custodial sentence will eventually be passed. Magistrates often see bail refusal as an opportunity to 'cure' the addict by quick detoxification. (Bail provisions were modified in 1976 precisely *because* magistrates were misusing their powers to grant bail, particularly where social enquiry reports were being prepared.)

We found many areas where large numbers of drug arrests had occurred in a series of 'purges', following indiscriminate raids.

Stipendiary (salaried) magistrates often appear harsher than lay magistrates, who will sometimes take a long-term view on rehabilitation. Certain lay benches seem inclined to ignore deterrent policies, and appear better informed than judges and stipendiary magistrates about the nature and treatment of drug use.

● **Cannabis and amphetamines:** Defendants on cannabis possession charges normally face a tariff that ranges according to area from a £25 fine to £200 fine plus costs on a first offence. Some courts give conditional discharges. Usually, the only factor influencing the penalty is the number of previous convictions. A millionaire and a social security claimant might appear on similar charges and be fined similar sums.

There is a great deal of confusion over amphetamine sulphate. Some courts seem inclined to deal with it as if it were a class A drug. Others view it more leniently than cannabis. We noted extreme variations in sentence in relation to both serious charges and simple possession.

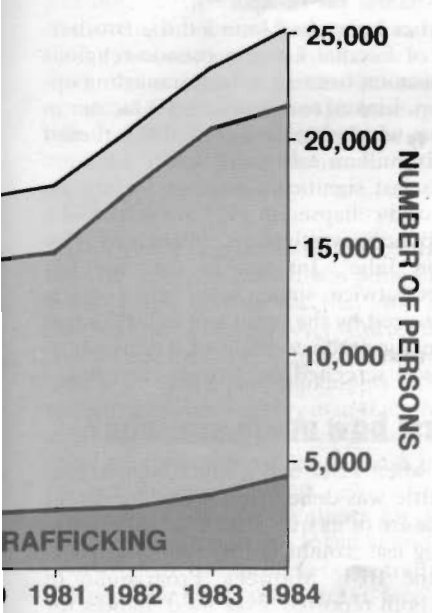
Only a minority of courts sentence amphetamine offenders at the *same* level as they would cannabis users — and this, after all, would appear to be the logical option, given that both drugs are in class B of the Misuse of Drugs Act. No court appeared to consider the possibility of imposing an order that would facilitate rehabilitation.

IN LOOKING at the treatment of drugs offenders by the police and the courts, the most disturbing factor is the absence of information. There appears to be little organised training for those dealing with drugs offenders and little information available on the effects of different drugs. Instead, there is a naive reliance on police information about the illegal drugs market and lifestyles of drug users.

Illegal drug use is an issue about which many people feel strongly. It's possible to say almost anything about it and be taken seriously, in a situation where research can be ignored and little training is made available. Many of the views confidently put forward by police, judges and magistrates are appallingly misguided. We need to make information available to those responsible for administering the criminal justice system, and, in return, we need more information on how the courts deal with different types of cases.

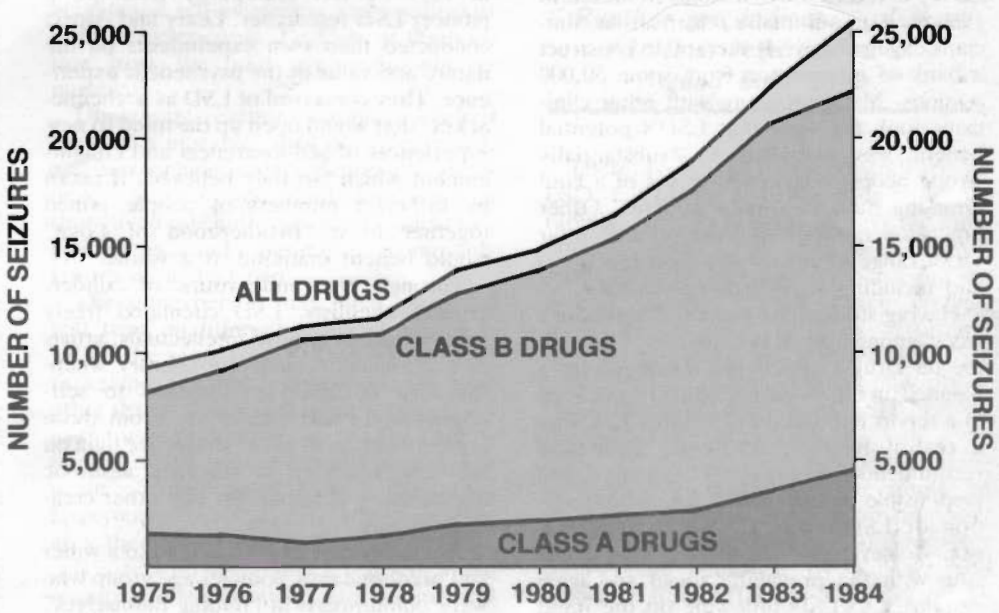
This article is based on the interim findings of Release's 1986 telephone-questionnaire survey of solicitors on their national referral list. The list probably includes the majority of UK solicitors interested and experienced in acting for those accused of drug offences. A full report is being prepared and will be made available by Release.

ned for drug offences, UK



rt on traffickers, the majority of

Police seizures of controlled drugs, UK



Heroin may be the main concern but the vast majority of police drug seizures involve cannabis and other class B drugs.

LSD USE IN BRITAIN

The second of the *ISDD drug notes* series to be reprinted in *Druglink* covers LSD, the most frequently used hallucinogen in Britain, a drug whose doses are measured in micrograms but whose effects are often described in cosmic terms. We attempt to summarise the facts.

ISDD Information Service

LSD (d-lysergic acid diethylamide) was discovered in 1938 by Albert Hofmann then employed as a chemist at Sandoz Pharmaceuticals in Geneva. The drug was synthesised in the course of a systematic attempt to prepare new therapeutic drugs from ergot, a parasitic fungus found growing naturally on rye and other grasses.

Disappointing preliminary tests on animals meant that further work was shelved until in 1943 "a feeling that it would be worthwhile to carry out more profound studies" led Hofmann to prepare a fresh quantity. During these later tests, Hofmann unwittingly ingested the minute amount necessary to trigger the first LSD 'trip'.

Suspecting LSD as the cause of his bewildering experience, Hofmann began a series of experiments on himself and colleagues. Confirmation was swift; in the sense of the amount of drug needed to produce an effect, Hofmann had stumbled on one of the most potent drugs ever discovered.

● **LSD was made available** by Sandoz and later (in the UK) by SPOFA of Czechoslovakia to supply a growing research and clinical market throughout the fifties and early sixties. Beginning as early as 1950 in America and 1953 in the UK, LSD was used extensively in the psychotherapeutic treatment of alcohol and drug addiction for those with disturbed personalities and with terminally ill patients to alleviate pain and help them cope with facing death. LSD was valued for its ability to deliver what one writer has recently called "a big bang" to the memory of a repressed neurotic releasing a stream of buried recollections and supressed responses.

Medical opinion remained divided on the efficacy (and to a lesser extent) the safety of LSD psychotherapy. A major UK survey conducted by Nicholas Malleson in 1968 used questionnaire returns from clinicians engaged in LSD therapy to construct a bank of information from some 50,000 sessions. Malleson along with other clinicians took the view that LSD's potential benefit was restricted to "substantially strong people whose neurosis is of a kind dimming their enjoyment of life". Other practitioners reported successes with a far wider range of personality disorders up to and including recalcitrant psychosis.

Having studied the results of Malleson's work among others, the Advisory Committee on Drug Dependence (later Advisory Council on the Misuse of Drugs) concluded in a report published in 1970 that LSD had a real if limited therapeutic value and recommended licensing of "approved and responsible practitioners" for a continuation of LSD's clinical and experimental use. However, the Committee were out of step with the prevailing social and legal responses to LSD following on the rapid rise of non-medical use by young people. Placed under the drug laws in 1966 both in Britain and America, therapeutic prescribing of LSD had virtually ceased by 1968.

LSD's 'big bang' capabilities also attracted the US military and intelligence services as a potential brainwashing/truth drug weapon. These tests were eventually abandoned in the sixties, but ironically, in the process some of America's most prestigious universities and hospitals had played host as test centres using volunteer students and graduate assistants. One such hospital was attached to Harvard University. Students and academics began feeding back their experiences which attracted the attention of two Harvard psychologists, Timothy Leary and Richard Alpert.

> "Last Friday, April 16, 1943, I was forced to interrupt my work in the laboratory in the middle of the afternoon and proceed home, being affected by a remarkable restlessness, combined with a slight dizziness. At home I lay down and sank into a not unpleasant intoxicated-like condition, characterised by an extremely stimulated imagination. In a dreamlike state, with eyes closed, I perceived an uninterrupted stream of fantastic pictures, extraordinary shapes with intense ka'eidoscopic play of colours. After some two hours the condition faded away."
>
> Albert Hofmann. *LSD; my problem child.* McGraw-Hill, 1980.

The term 'psychedelic' was first coined in 1957 by Dr. Humphrey Osmond, a pioneer LSD researcher. Leary and Alpert conducted their own experiments on the nature and value of the psychedelic experience. They conceived of LSD as a 'chemical key' that would open up the mind to new experiences of self-awareness and enlightenment which (so they believed) if taken by sufficient numbers of people joined together in a "Brotherhood of Love" would benefit mankind as a whole.

Through the endeavours of 'underground' chemists, LSD circulated freely among student groups, intellectuals, artists and musicians around the country where the idea of LSD as a means to self-improvement had caught on. From those groups came most of the subjective data on the drug's ability to sensitise aesthetic appreciation of music, art and other creative pursuits.

Inevitably, use of LSD spread to a wider and predominantly younger age group who were uninterested in "finding themselves" — they simply liked using LSD.

Whatever their ideological bases, the spokesmen and distributors of LSD for non-medical use met with a ferocious public reaction which eventually induced Sandoz to withdraw from the clinical market in 1966-67 in turn helping to shut down further research into LSD's therapeutic applications.

Even those in favour of its continuing and more widespread medical use were violently opposed to any encouragement of LSD's use by untrained personnel in uncontrolled situations, arguing that the incidence of adverse reactions was likely to be greatly increased in these circumstances, and that, in the absence of readily available medical care, these reactions might have serious consequences for the individual's health.

Others claimed that in the light of its possible impact on physical health, any long term use of LSD, medical or otherwise, was foolhardy. Consequences envisaged ranged from brain damage, deformed babies, psychosis, homicide, suicide, to a frequently mistaken belief in one's ability to fly. Some of these dangers were real; others simply without foundation (see below), but publicity over these concerns served to catapult LSD to the status of a first division media 'horror' drug, much as cannabis had been in the thirties and phencyclidine (angel dust; PCP) became in the seventies.

● **During the seventies** interest in LSD diminished considerably as the supporting 'hippy' ideology lost credibility and the 'alternative' communities on both sides of the Atlantic broke up.

Earlier Leary had founded the Brotherhood of Eternal Love, a pseudo-religious organisation fronting a drug-smuggling operation. Linked to it was an LSD factory in Britain which between 1970-1973 turned out six million tablets of LSD.

This last significant attempt to turn on the world collapsed in 1977 at the end of a long police investigation codenamed 'Operation Julie'. Interest in the case has surfaced twice since; once when assets were seized by the court and in 1985 when a dramatic reconstruction of the investigation was screened on British television.

Users: how many and who?

Even when LSD had a much higher profile, little was done to establish the extent and nature of its use. Two national surveys of drug use, conducted by OPCS in 1969, and the BBC Midweek Programme in 1973, both reported 'ever used' figures for LSD at around 650,000 people or one per cent of the population.

In 1982 National Opinion Polls (in a

survey for the *Daily Mail*) interviewed 1326 people aged between 15-21 where a three per cent ever-used figure for LSD was recorded while in 1985, the *News of the World* commissioned Audience Research to conduct a further national survey of a representative sample of those aged between 16-34. In this survey eight per cent said they had been to parties where LSD had been taken while four per cent said they had tried the drug themselves. Extrapolated nationally, this would again reveal an 'ever-used' figure for LSD of around 650,000 people.

● **One possible indicator** of continuing (if not necessarily rising) demand is the identification of new LSD designs appearing on the market in recent years. LSD is most usually distributed as microdots on paper carrying distinct designs. The most frequently encountered designs are currently Toadstool, Red Hearts and ET. Palm Trees, LSD 100 and Pink Panther are new designs on the market. These 'fun' designs are indicative of the way LSD is nowadays regarded as a 'good time' drug.

Two examples demonstrate the broad church of LSD users. The first shows that LSD remains a favoured drug among those attending events previously associated with the 'alternative' society. The Sheffield branch of the 'Legalise Cannabis Campaign' conducted an 'intended use' survey at the Stonehenge and Glastonbury Festivals in 1984. This revealed that 41 per cent and 30 per cent of respective festival-goers would be using LSD. Only cannabis was a more favoured drug.

By contrast, LSD is also prevalent among groups for whom hippy ideology is anathema. The *Sunday Times* magazine (23 October 1985) published an article entitled "All Dressed Up and Nowhere to Go" focussing on Britain's unemployed. One punk remarked "I was taking acid twice a week and it was making me go crazy". The article continued "most punks are just on LSD or Speed which they take at night-clubs because it is so good with the music."

Research from the Drug Indicators Project suggests that use of LSD will continue to expand, but it is unlikely to attract more than a minority interest in relation to other illicit drugs such as cannabis, amphetamines and heroin, although among a limited section of the population its use may continue to be fairly common.

The law

LSD was first subject to special controls in the UK, when in 1966 it was added to the list of drugs covered by the 1964 Drugs (Prevention of Misuse) Act. Currently it is controlled as a Class A drug under the 1971 Misuse of Drugs Act, making its unauthorised possession, supply, manufacture, import, etc, criminal offences attracting the same maximum penalties as those involving heroin among others.

Maximum custodial sentence for possession of a class A drug is seven years: those convicted of the more serious trafficking offences involving these drugs face up to life imprisonment.

Lysergamide (lysergic acid amide) used in the manufacture of LSD, and a constituent of psychoactive varieties of Morning Glory seeds, is also a class A drug.

In 1979 there were 216 seizures of LSD with 208 persons being found guilty or cautioned for LSD-related offences. This represented the lowest point in a downward trend starting in 1971. However, by 1984, the figures had risen to 629 and 558 respectively.

Effects of using LSD

LSD will 'work' in doses as small as 25 micrograms (or 25 millionths of a gram) although the average dose for a full blown psychedelic experience is 100-150 micrograms.

A trip begins about half an hour to one hour after taking LSD, peaks after two to six hours and fades out after about 12 hours, depending on the dose and having progressed through several phases.

Exactly what happens when a drug is taken is often determined by what the user expects will happen and the situation in which the drug is used (eg, alone or with a group of trusted friends etc).

Leary conceived of LSD as a 'chemical key' that would open up the mind to new experiences of self-awareness and enlightenment.

Users often report visual effects such as intensified colours, distorted shapes and sizes, and movement in stationary objects. Distortions of hearing occur, as do changes in sense of time and place. Generally the user knows these effects to be unreal. True hallucinations are relatively rare.

Physical effects are so slight (eg, dilation of pupils, slight rise in body temperature, goosebumps) compared with psychological or emotional effects that they are of little importance.

● **Emotional reactions vary,** but include heightened self-awareness and mystical or ecstatic experiences. Feelings of dissociation from the body are commonly reported.

Unpleasant reactions are more likely if the user is unstable, anxious or depressed, and may include anxiety, depression, dizziness, disorientation, and sometimes a short-lived psychotic episode including hallucinations and paranoia, commonly known as a 'bad trip'.

The same person may have good and bad 'trips' on different occasions, and even within the same trip. But whilst the LSD experience is variable compared with most other drugs, it is also relatively more open to the user's intentions and to the suggestions of others. Hence friendly reassurance is an effective antidote to a bad trip. Experienced users steer the trip toward the area they wish to experience or explore.

It is difficult to combine a trip with a task requiring concentration, and driving will almost certainly be impaired. Suicides or deaths due to LSD-induced beliefs or perceptions, though much publicised, are rare. Fatal overdose was unreported in the literature until as recently as 1985. In the case reported, from the Metropolitan Police Forensic Science Laboratory, twice the amount ever found at post-mortem was detected in the subject's body with no other drug present.

And the consequences?

There are no known physical dangers attributable to long term LSD use. In particular there is no reliable evidence that LSD causes brain damage or damage to future children. Adverse psychological effects are possible after one trip, but are more common in regular users.

● **Prolonged serious adverse** psychological reactions are rare, but have been reported. These can be psychotic in nature and generally occur among those with existing or latent mental illness, most commonly after repeated LSD use, when LSD has perhaps acted as 'the final straw'. No case of LSD producing psychosis of this nature in a previously well balanced individual has been established.

According to DHSS mental hospital admission statistics for the 1979-1984 period, LSD was implicated as the main factor for admission in 61 males and 17 females and a further 21 males and 11 females where LSD use was diagnosed as an underlying or associated factor.

A number of LSD users report a short-lived vivid reliving of a past trip without use of the drug known as a 'flashback'. Part of LSD's media portfolio as a horror drug were claims that users could have flashbacks lasting days or even weeks. In truth an LSD flashback (which can occur up to months after using the drug) normally only lasts a few minutes and is rarely dangerous although it can leave the person feeling anxious, disoriented or distressed. Flashbacks are most likely to happen in situations reminiscent of past LSD experiences or sometimes when a past user is smoking cannabis.

'Fun designs such as Pink Panther are indicative of how LSD is regarded as a 'good time' drug.

There is no physical dependence to LSD, but tolerance to the drug builds up rapidly. After 24 hours to achieve the same effect a much larger dose is necessary. After three to four days of increasing the dosage, a limit is reached whereby no dose would be effective. A break of around three days would be required for LSD 'sensitivity' to return. A small minority of those who have ever used LSD become psychologically dependent.

The effects and consequences of taking hallucinogenic mushrooms are similar to those of LSD. For more information see/read the pamphlet *Hallucinogenic Mushrooms* published by Release and available from ISDD at 80p.

LSD: ISDD drug notes 2 is available from ISDD at £0.50 plus £0.20 p&p.

AN EXPERIENCE IN THE USE OF VOLUNTEERS

NO FREE LUNCHES

Using volunteers to staff drugs advice and information lines may seem attractive to small, under-funded projects. But even with meticulous planning, things can go wrong. Andy Malinowski shares the experiences that led him to drop volunteers and look for more paid staff instead.

Andy Malinowski

Druglink, Swindon's new drug advisory centre, was set up in June 1985. The immediate task was to develop a community-based advice and counselling service. Funding was only sufficient to employ one full-time Project Leader and a part-time Administrative Assistant, so recruiting and training of volunteers to help staff the project was to be one of the first duties of the Project Leader.

It was decided to enlist the help of our local Voluntary Service Centre. They agreed to carry out the initial recruiting and together we selected candidates to go on to a training programme. I drew up a list of the qualities I expected volunteers to possess, eg, to be non-directive in style, to agree with Druglink's philosophy, to be a good listener. The nine volunteers interviewed were all accepted for the two-part training programme.

I found myself apologising for lack of calls. Worse, they began to lose touch with their initial training.

The first part of the training programme (two days and six evenings) was designed to equip volunteers to competently give advice and information on drug-related issues, and to refer callers to other agencies when necessary. The two days comprised a basic drug briefing followed by a day on good practice. The six evenings looked at issues related to working for a voluntary agency, the legal and medical context of drug use, national and local resources, and the emotions, techniques and methods involved in advice and information giving.

Associated with part one training was an accreditation procedure, dependent on the extent of a volunteer's experience of advice and information giving. Volunteers would be considered 'accredited' once they had successfully dealt with 20 referrals, or had worked at the project satisfactorily for three months, whichever was the longer. The idea was to provide time to supervise and assess each volunteer, and to enable them to accumulate valuable experience.

An optional part two of the training programme was designed to enable volunteers to go beyond information/advice giving to offer counselling and support to people with drug-related problems. Counselling and support requests would not be carried out by a volunteer until the completion of part two training. In the event, none of the first batch of volunteers completed part two.

Volunteers were given a clear job description and job contract and each volunteer received a resource pack of relevant booklets.

Seven of the volunteers completed the first part of their training and elected to go on to the three months accreditation procedure. But because of their commitments and personal circumstances, they were able to give only a limited amount of time to the project. Each volunteer was on duty for one three-hour shift per week, during which they dealt with advice and information calls under my supervision as part of the accreditation procedure.

At the outset there was no way of telling how many calls Druglink would receive. Still, the system worked satisfactorily for the first eight to ten weeks. However, it became evident that while I was busy developing other aspects of the project, the volunteers were becoming increasingly disillusioned by the lack of calls during their three-hour stint. After three months, some volunteers had only received seven or eight referrals.

Their enthusiasm began to wane, while my concern for them rose. I found myself apologising for the lack of calls. Worse, they began to lose touch with their initial training. Confidence levels fell and in some instances information-giving was incomplete, meaning I had to devote more time to supervision and support. During the second three months, the number of calls increased, but not enough to counteract the problems.

Although the seven volunteers were at different levels of development and sophistication during their training, I was hoping that, through their experience of telephone advice and information giving and personal supervision, they would reach a minimum standard of competence. However, due to the situation — not due to their personal abilities — this only happened in varying degrees.

The problems were such that I decided to stop using volunteers in such a central role, though perhaps in the future we will use them in a more peripheral and complimentary way, depending on the staffing needs of the project. Our experiences have led us to seek funding for an extra project worker.

OUR EXPERIENCE with volunteers has brought to light a number of points.

- ► The accreditation process was lengthy and time-consuming, especially for a project with only one and a half paid staff.
- ► Timing the introduction of volunteers is important in order to avoid a situation where there is little work for them to do.
- ► The number of volunteers needs to match with the project's workload.

Although able to give only a small amount of time, volunteers need to be trained almost to the level of full-time staff.

What our experiences highlight most is a dilemma that will be common to many small provincial projects thinking of taking on volunteers. Although usually able to give only a small amount of time to a project, volunteers need to be trained almost to the level of full-time staff to ensure the quality of their contribution.

But lack of regular, frequent opportunities to put the training into effect and develop it through experience can mean their training atrophies and the need for supervision rises.

In the end, the balance of benefits and losses may tip — as it did for Druglink — to the point where both parties are better off terminating the arrangement.

Andy Malinowski is Project Leader of Druglink (no relation to the present journal), one of the 'new wave' of provincial drug advisory centres supported by the government's central funding initiative. Druglink is at 174 Victoria Road, Swindon, Wiltshire, SN1 3DF, phone 0793 610133.

DRUG USE IN EUROPE

Richard Hartnoll places Britain's drug problems in the context of recent trends and current patterns in Europe. The message is — we are not alone.

Richard Hartnoll

Illicit drug use emerged as a social phenomenon among young people across Europe during the late 1960s and early 1970s. This was most marked in the northwestern countries while in southern and eastern Europe, drug use was largely restricted to small social groups.

In France, West Germany, the Netherlands, Denmark and the United Kingdom, the main drugs were cannabis and, to a lesser extent, LSD. Such use was associated with the rapid changes in youth cultures gathering momentum throughout the 1960s.

Among working class youth in England and Germany, and especially in Sweden, the pattern was different. There, amphetamines were the preferred drug, though in Sweden, unlike other countries, they were injected.

Within these broader patterns of drug use, small heroin using subcultures emerged, mainly in large cities in the northwestern European countries (for example, Amsterdam, Berlin, Copenhagen, London, Paris). Only in London did this occur in the context of excessive prescribing of heroin.

Over the 1970s, drug use continued to grow in much of Europe, though, as in England, there was a general perception that the 'drug crisis' of the late 1960s had passed.

The two most important general trends since the mid-1970s have been:
— the emergence of illicit drug use in European countries such as Italy, Spain, Poland and Greece with relatively little previous experience of such use;
— a substantial increase in the availability and use of heroin, especially in the second half of the 1970s.

Heroin through Europe

Until 1976/77, the increase in heroin use primarily involved heroin originating from southeastern Asia, but thereafter, heroin from southwestern Asia became increasingly significant.

Within this broad trend, there were national variations that to some extent reflected links with the two major sources of production, SE and SW Asia.

For instance, in West Germany, the supply of SW Asian heroin rose sharply from around 1976/77 on the basis of previous routes for importing morphine base from Turkey. In the UK, SW Asian heroin did not become significant until 1978/79, associated with the influx of refugees following the fall of the Shah of Iran.

In both countries, however, increase in illicit heroin use was preceded by an apparently steady growth in the use of synthetic heroin-type drugs (opioids), often with drugs such as barbiturates.

In contrast to Germany, heroin markets in the Netherlands, France and the UK, prior to the arrival of heroin from SW Asia, were dominated by the SE Asian product. In all three countries, there were strong pre-existing cultural and economic links to SE Asia. In Italy, increased use of heroin of SE Asian origin was observed in 1973/74, but rapid escalation did not take place until 1978/79, when SW Asian and Sicilian heroin became widely available.

Many countries will be faced with much higher levels of drug use than a decade ago.

BY NO MEANS all variations in levels of heroin use can be explained by supply. Factors specific to internal national situations are also likely to be important, though it is not easy to specify what these factors are.

In Sweden, the primary pattern of 'problematic' drug use continues to be the intravenous use of stimulants. In Poland, the major concern is home produced heroin prepared by users themselves from poppy straw (obtained from poppies grown legitimately for their seeds). In Yugoslavia, although there has been some increase in heroin use, the major drug used by addicts in treatment is trihexyphenidyl (used to treat Parkinson's disease).

AFTER OPIATES and opioids, the main drugs causing concern are the stimulants, such as amphetamines and cocaine. It appears that in some countries (eg, Germany, UK, Sweden), they are also, after cannabis, the most widely used illegal drugs. Several countries (for example, France, the Netherlands, West Germany, Italy, Sweden) have noted a recent increase in cocaine seizures. However, there is no clear evidence of 'epidemic' use, nor of increased demand on services due to cocaine-related problems.

Since the second half of the 1970s, several countries, including France, West Germany and the UK, have reported increased use of solvents and other volatile inhalants (glue, butane, etc). In all countries, the phenomenon is largely restricted to 12 to 16 year-old boys.

In countries such as West Germany, Ireland, and the UK, use of barbiturates by young people presented a problem in the 1970s. These have become less significant, partly due to increased availability of heroin, partly due to reduced prescribing. Likewise, LSD does not appear to be as significant as in the early 1970s, though in some countries there is evidence of increased use (France, UK, the Netherlands).

Current drug patterns

It is not possible to make direct comparisons between countries in terms of the 'true' prevalence of drug use. This is partly because few even approximate estimates exist, and partly because different definitions are used.

In many countries, greatest concern is expressed about young drug users. However, the age range of the people involved, including new users, is wider than it was ten or 15 years ago, especially in areas with a longer history of drug use. Thus in Amsterdam, Paris, London, Berlin and Stockholm, significant proportions of drug users are in their thirties. All countries indicate a predominance of males.

Social characteristics of drug users vary considerably. In Sweden, intravenous drug use is concentrated in the working class or in traditional criminal groups. In the Netherlands, as in West Germany and France, it is more widely spread among the population, with higher levels among certain minority groups. In contrast, in the UK drug use except cannabis, has generally been much rarer among minority groups though this may now be changing.

While in some countries it appears that the most serious patterns of drug use are concentrated in the more deprived inner city areas, it is not yet possible to draw firm conclusions regarding the relationship of economic and social factors to changing patterns of drug use.

In countries which experienced 'epidemics' of heroin use in the mid- to late 1970s, it appears that the increase in new users (incidence) is slowing down. This is clearest in regard to cities such as Berlin, London, Dublin, and Amsterdam. But even if the situation is stabilising, many countries will continue to be faced with much higher levels of drug use than a decade ago.

It has been suggested (for example in Italy and the UK) that drug use in the 1980s should no longer be characterised as an 'oppositional' phenomenon on the margins of society. Rather, it may now be viewed as more 'normalised', part of the everyday context within which 'ordinary' people, especially young people, live.

Richard Hartnoll is coordinator of the Drug Indicators Project (DIP). For several years he has participated in the Expert Epidemiology Working Party of the Pompidou Group in the Council of Europe. The Group was set up to encourage European cooperation over drug use and trafficking. DIP is at Birkbeck College, 16 Gower Street, London WC1, phone 01-580 6622, and welcomes enquiries about their research.

FOCUS ON
AMPHETAMINES

Once a drug of public concern as the '60s mods went 'speeding' on scooters and at all-night parties, the amphetamines have recently been overshadowed by more newsworthy drug problems. But amphetamines are still widely misused — even if politicians and media prefer the 'glamour' of cocaine.

Harry Shapiro

Amphetamines are stimulants capable of giving a 'lift' lasting three to four hours. Feelings of exhilaration, confidence and alertness and the temporary elimination of fatigue are what the user looks for, but these are 'paid for' by after-effects including hunger, fatigue, and sometimes depression.

Frequent repetition to maintain the 'high' can result in irritability, anxiety and paranoid feelings. In extreme cases these can develop into a psychotic episode. At such times the overwrought user can be a danger to themselves and others.

The attractions of amphetamines make psychological dependence a problem, but even after heavy use there is no physical withdrawal 'sickness' of a kind that might need medical attention. Amphetamines can be injected, eaten or smoked, but are most commonly sniffed or 'snorted' up the nose and absorbed into the bloodstream via nasal membranes.

These drugs were once widely prescribed for the treatment of obesity and depression, accounting for two and a half per cent of all NHS prescriptions in 1961. Recreational use by teenage 'mods' led to the control of amphetamines in 1964. By the end of the '60s, voluntary prescribing restrictions by GPs had greatly reduced the amount of the drugs in legal circulation. Amphetamines on the illicit market were the product of theft or continued excessive prescribing.

'Speed'[1] enjoyed a subcultural renaissance in the late '70s among punks and among youngsters on the Northern Soul dance circuit re-enacting the all-night music club sessions of the '60s.

Seizures rise sharply

Latter-day amphetamine is almost entirely the product of illicit laboratories in the UK or abroad, particularly in the Netherlands.

The home product is largely amphetamine sulphate, an off-white or pink powder retailing at a modest £10-£12 per gram, but generally less than 20 per cent pure. 'Sulphate' is relatively easy and cheap to make. There are indications from some parts of the country that Hells Angel-style gangs are involved in its distribution.

Harry Shapiro is responsible for developing ISDD's publications and for the distribution of the 75 publications currently available through ISDD.

There has been a sharp rise in amphetamine seizures since 1980 when just over 5kg were seized in the UK. In 1985 the Customs service alone intercepted 28kg of amphetamines, compared to less than 20kg in the previous year and less than 10kg in each of the first three years of the '80s. Illicit imports now probably account for the bulk of British supplies.

Almost every police drug squad in the country has reported a very significant increase in the availability of amphetamine. Seizures in some areas have reached the proportions of cannabis and several forces regard amphetamine as their number one concern. Illicit amphetamine laboratories are said to be evolving throughout the country and 15 were discovered by the authorities in 1985.

The amphetamine "threat" was singled out by the National Drugs Intelligence Unit's new head when speaking to the Association of Chief Police Officers' conference in June. His concern that amphetamine use might lead to cocaine use was echoed in the *Economist* (21 June 1986), but is so far unsubstantiated.

Two recent national surveys by commercial polling agencies found the prevalence of amphetamine use was second only to that of cannabis among young people. A 1982 survey of 15-21 year-olds found five per cent had ever used amphetamines, while in 1985, four per cent of the 16-34 year-olds polled admitted amphetamine use.

Almost every drug squad in the country has reported a very significant increase in the availability of amphetamine.

Thirty per cent of respondents to the BBC *Drugwatch* questionnaire survey (a self-selected, *not* representative sample) were taking amphetamines regularly. More interestingly, the majority of amphetamine users said their drug use had on balance had a negative effect on their lives, while the reverse was the case for cannabis users.

The widespread prevalence of amphetamines is confirmed by contact with drugs workers and reports received into the ISDD library over the past two years detailing local incidence of drug use in areas as diverse as the East Anglian countryside and the industrial North.

The specialist in community medicine for West Suffolk commented in a report that heroin use was not widespread in the county but regarding amphetamine use, it was necessary to take "a more serious view", amphetamines being "readily available in many pubs in all areas of the county".

Wessex RHA covers the rural areas of Wiltshire, Dorset and Hampshire. In these areas too, amphetamines along with cannabis were "widely used throughout the region". Sussex's chief constable has recently reported a "noticeable" increase in the misuse of amphetamines imported largely from Holland: "It is a comparatively cheap drug . . . and is therefore attractive to younger drug users."

Not surprisingly, 'speed' is also easy to obtain in urban areas like Halifax. The report on a Calderdale area solvent and drug misuse survey stated that "heavy use of amphetamines could prove to be a major problem in this area". In London in 1985, arrests for amphetamine offences were up by 58 per cent.

More injection

Drugs workers in several areas profess to being far more concerned about amphetamine use among young people than heroin. This is partly explained by the following comment from a recent drug survey in Southwark, South London: "many [young people] stick to amphetamines in the misguided belief that they are not addictive . . . the same people steer clear of heroin and cocaine".

It has become generally accepted that one of the reasons for the rise in the popularity of heroin among young people was the realisation that the drug could be smoked or sniffed ('snorted') rather than injected. Where heroin is smoked rather than injected, it appears amphetamine tends to be sniffed, smoked or eaten, but where heroin injection dominates then amphetamine too is injected.

Most amphetamine sulphate is sniffed, but injection has become more common. Those who inject tend to be in the older age groups (25 plus). However, some drug workers are concerned that where amphetamine sulphate is the drug of choice, it is being injected by those younger age groups who were supposed to abhor using needles.

One possible consequence of amphetamine injection may be an increase in the reported incidence of amphetamine rather than heroin-related infective hepatitis, a liver disease that can be spread by the sharing of needles. Such outbreaks have been noted in South Wales, Cardiff and Hull. A trend to amphetamine injection must be worrying, given the greater prevalence of amphetamine over heroin use.

1. 'Speed' is one of the few enduring and widely understood slang terms in the drugs field. Sometimes used to refer specifically to methylamphetamine (a particularly potent variant), it refers here to the amphetamines as a group.

WHAT ABOUT DRUGS? Angela Cotton. Slough: Foulsham, 1986. 34 pages. £1.75.

This 34-page glossy publication has arrived on the market at an opportune moment. Many teachers would agree there is a shortage of good, cheap, up-to-date written material for school pupils, and Foulsham are obviously aiming to fill the gap. The booklet's magazine-style format is visually stimulating, liberally studded with black and white photographs.

The booklet deals with legal and illegal drugs, and looks at the pleasures as well as the problems associated with drug use. However, like the photographs, it is written in black and white — simplistic, low on facts and high on emotion. The result could well be called the 'agony and ecstasy' approach to drug education.

Many questionable statements are made. The term 'addict' is used indiscriminately to describe users of all drugs, and at one point it is stated that some people become addicted the first time they use heroin.

Great emphasis is placed on the horrors of heroin withdrawal. Three pages are devoted to explaining this in gory detail: "Filthy, unshaven, dishevelled, befouled by his own vomit and faeces, the addict at this stage presents an almost subhuman appearance". Visual back-up is provided by numerous pictures of needles and of drug users at various stages of degradation, many of whom appear to be living in squats.

Some of the material's 'shock-horror' approach is compounded by the high moral and judgmental tone used throughout. References are constantly made to the 'weak' and 'selfish' person who takes drugs: "It is not often the strong who take drugs — it's the weaker ones to whom they offer strength".

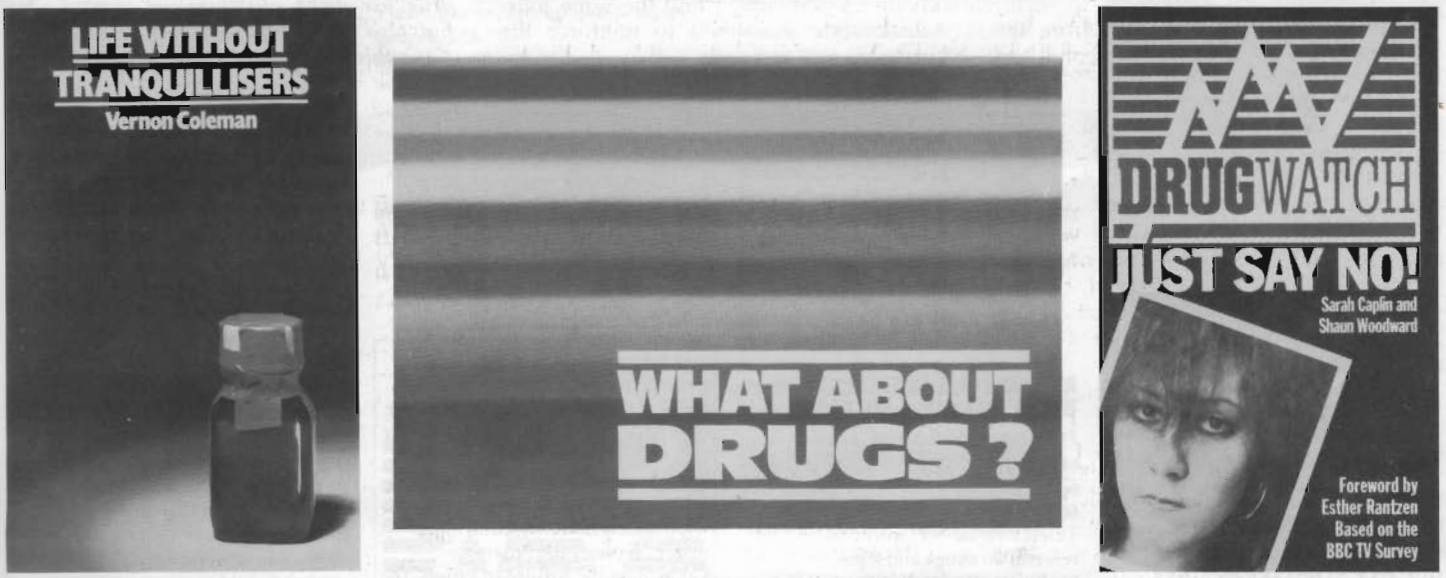
The booklet relies heavily on case studies of drug users which, although making for an interesting read, are not in themselves of great educational value. No suggestions are given for how the material could be used with young people, although there are questions at the end of some of the case studies, presumably intended as points for discussion.

The publishers claim the booklet could also be used as a reference resource for teachers, but far more comprehensive information is available in free leaflets.

What about drugs serves to reinforce the stereotypical image of drug users: used with young people, it could be positively harmful. Unfortunately, many teachers may find the material tempting as it is short, easily accessible and could be fitted into a couple of sessions. Our advice would be to resist temptation, and hopefully some enterprising author will come up with a good alternative.

Jan Barcroft and Chris James

Jan Barcroft is Drug Coordinator for Waltham Forest. Chris James is a Research Officer with ISDD.



LIFE WITHOUT TRANQUILLISERS. Vernon Coleman. London: Judy Piatkus, 1985. 153 pages. £6.95

According to the dust jacket, Vernon Coleman trained as a doctor and practised as a GP for 10 years. He is now a full-time author. Of necessity, presumably, Dr Coleman needs to write successful books directed towards the general public and on matters of general concern such as tranquilliser use. His contentions and advice should be sound, sensible and sober. Does Dr Coleman attain these ideals in this book?

The book is engagingly written in a racy style, although certain tricks of writing such as repeated questions are more appropriate in advertising copy than in an educational book. The ten years as a GP do show in some places, however, with some assertions made *de haut en bas*.

Some of these assertions are breathtakingly sweeping, for example: "From the conclusive evidence available it is now quite clear that no one taking any benzodiazepine should be allowed to drive or ride any sort of vehicle". In the reviewer's opinion, not only is the evidence not conclusive, but there is very little evidence anyway.

Another example of overstatement concerns the reviewer's own work on benzodiazepines and brain damage. I was careful to point out that our data from a pilot study suggested some association between long-term benzodiazepine usage and neuroradiological changes. Dr Coleman uses the ambiguous phrasing "brain scans done on a small group of patients who had been taking diazepam for a number of years had produced evidence suggesting that their brains had been damaged". The dust jacket does not pussyfoot around: "these drugs . . . can cause brain damage". Remember, he is writing for the general public, not for specialists versed in the nuances of scientific writing.

Perhaps the most astonishing and exceptional statements concern the relative dangers of tranquilliser use and cigarette smoking. He reiterates his opinion that "doctors would serve some anxious patients better if they gave them prescriptions for filter cigarettes rather than benzodiazepines". Perhaps Dr Coleman should spend a month doing a locum GP job in an industrial city in the winter!

Are there any good sections? The two best are an entertaining account of the seven stressful forces — guilt, boredom, vanity, frustration, ambition, fear and lust — and the section dealing with alternatives to tranquillisers. The section on withdrawing from tranquillisers is less satisfactory as it does not address problems such as prolonged reactions and the onset of depressive illnesses. The case histories at the end do not ring true, presumably because of editing to maintain confidentiality.

All in all, one is left feeling that a talented communicator like Dr Coleman has diluted his argument by overstating his case and selecting his evidence. One applauds his ends, one is less happy about his means.

Malcolm Lader

Malcolm Lader is Professor of Clinical Psychopharmacology at the Institute of Psychiatry, University of London, and has researched for over 25 years on the topic of benzodiazepines. More recently he has been closely involved in the description of normal dose benzodiazepine dependence.

DRUGWATCH: JUST SAY NO. Sara Caplin and Shaun Woodward. London: Corgi, 1986. 144 pages. £1.95.

Another TV spin-off, *Drugwatch: just say no* has hit the bookstalls with the ambitious claim to be the "most extensive study ever undertaken in Britain on drug abuse". Unfortunately, it fails to live up to the hype.

The book is based on the 1985 survey of drug users and their families, first reported in the TV special of the same name. They appealed for drug users to complete their questionnaires on *That's Life* and through articles in *Mirror* group newspapers.

These appeals came in the context of an anti-drugs 'crusade', which must have put off most 'recreational' users, especially of cannabis — just 24 out of over 1000 drug using respondents had limited their illegal drug use to cannabis only. Nevertheless, the sample included a wide range of 'problem' drug users and, provided it is regarded as such, it is a useful source of information.

The most startling omissions from the survey (and programme) were alcohol and tobacco use. The survey did, however, look at patterns of drug use, initiation, and ways of giving up. One section looked at social policy, but the options listed failed to include any 'liberal' measures, such as legal reform or maintenance prescribing, though these were suggested by respondents.

Over half the drug using respondents claimed to have ceased use. Half had used heroin, and most were multi-drug users. Those whose drug of choice was cannabis comprised only a third of the sample.

Results showed heroin and amphetamine had an overwhelmingly detrimental effect on users' lives, though a clear majority (59-63 per cent) of cannabis users felt the effect on their lives to have been more positive than negative.

Given these findings, the selection of quotations and case histories seems unbalanced, particularly for cannabis users, where the quotations come from the minority who reported negative effects. All the quotations seemed to have been 'creatively' sub-edited into the same journalistic style, no doubt to reinforce the "just say no" message.

The lengths to which the authors will go to make their political point is illustrated by their claim (on the back cover) that the results show cannabis to be the "gateway" to drug abuse. The trouble is that over 40 per cent of their respondents started by using *other* illegal drugs. Reefer madness rules OK!

Such an unbalanced presentation does the survey an injustice. The authors, clearly not professional academic researchers, also failed to include such elementary data as exact response rates and sample sizes.

The best section is the advice on getting help from John Strang and David Turner. Another valuable section is the appendix, where most of the actual results are listed — without the hype!

Though flawed, *Drugwatch: just say no* nevertheless represents an essential read.

Matthew Atha

Matthew Atha is a research psychologist at Birmingham University, studying illicit drug use using questionnaire surveys. He has also been coordinator of the Legalise Cannabis Campaign.

NATIONAL ORGANISATIONS

A short list of some organisations offering a service on a national basis to those working in the drugs field.

INSTITUTE FOR THE STUDY OF DRUG DEPENDENCE (ISDD). 1-4 Hatton Place, London EC1N 8ND. 01-430 1991.
Britain's national library and information service on the misuse of drugs and drug dependence. Research and development unit currently working on producing youth work training materials and examining responses of families and neighbourhoods to heroin problems. Publications production and distribution. **Druglink** journal.

The place to go for background reading, references, for reviews, leaflets, booklets, and books and for information about drugs and drug use in Britain.

STANDING CONFERENCE ON DRUG ABUSE (SCODA). 1-4 Hatton Place, London EC1N 8ND. 01-430 2341.
A representative membership organisation open to non-statutory organisations and individuals working in the drugs field. Associate membership available to workers in statutory agencies. Aims to coordinate activities of non-statutory drugs agencies and improve contact between all types of organisations in the field. Directory of drug help agencies (*Drug problems: where to get help*), other publications and *SCODA Newsletter*.

The place for advice on referrals, on the assessment of the level of drug problems in an area, the development of services, and the organisation and funding of drugs agencies.

RELEASE LEGAL EMERGENCY AND DRUGS SERVICE. (RELEASE).
169 Commercial Street, London E1 6BW. 01-377 5905 weekdays 10am-6pm. 24-hour emergency phone 01-603 8654.
Telephone advice, information and referral on drugs and legal problems. Personal callers by appointment. Maintains national list of solicitors interested and experienced in defending those accused of drug offences. 24-hour emergency phone staffed by solicitors and other volunteers offers immediate advice to those arrested for drugs and other offences or faced with a drug-related crisis.

The place for up-to-date information and advice on drugs law in theory and practice and for a national overview of drug use in Britain.

DRUG ADVISORY SERVICE. Sutherland House, 29-37 Brighton Road, Sutton, Surrey SM2 5AN. 01-642 6421.
Organised under the auspices of the NHS Health Advisory Service. Consists of 80 people experienced in the drugs field seconded from their agencies to form teams to visit local areas to help assess drug problems and advise on the development of appropriate responses. DAS reports are expected to publicise existing good practice as well as help rectify deficiencies.

HOME OFFICE DRUGS BRANCH. 50 Queen Anne's Gate, London SW1H 9AT. 01-213 3000.
Maintains the index of opiate/cocaine addicts notified by doctors. Doctors can ring to check on the past history of drug misuse and treatment of addict patients and to check if they are currently receiving notifiable drugs. Can also advise on the content and operation of drug laws, particularly as they affect doctors, pharmacists and others legitimately handling controlled drugs. Services the Advisory Council on the Misuse of Drugs, the government's advisory body on drug law and on drugs issues generally.

NATIONAL DRUG TRAINERS' FORUM. c/o SCODA, 1-4 Hatton Place, London EC1N 8ND. 01-430 2341.
Membership organisation for individuals for whom training in the drugs field forms a substantial part of their workload. Aims to facilitate the sharing of ideas, experiences, methods and materials among drug trainers and (in the longer term) to set up a drugs training resource bank and help promote new training programmes.

ASSOCIATION OF NURSES IN SUBSTANCE ABUSE. Contact James Kennedy, National Coordinator, c/o The Alcohol Problem Advisory Service, National Temperance Hospital, Hampstead Road, London NW1 2LT. 01-387 8354.
Membership organisation for nurses working in the fields of drugs and/or alcohol. Aims to act as a professional organisation to develop awareness of drug and alcohol problems in nursing and to improve nursing skills in this area.

TACADE. Incorporates Health Education Development Unit and Teachers' Advisory Council on Alcohol and Drug Education. Head office: 3rd Floor, Furness House, Trafford Road, Salford, M5 2XJ, 061-848 0351. Southern office: 202 Holdenhurst Road, Bournemouth, BH8 8AZ, 0202 295874.
Publications, training and information for teachers and others involved in educating young people about alcohol and drugs. Responsible for the *Free to choose* education pack. Triannual newsletter *Monitor*. Also advice on counselling young people and for parents.

PUBLICATIONS

Materials listed below are books or reports unless indicated otherwise. All are available for reference in ISDD's library. For a free listing, send a copy of your new publication/audio-visual material to ISDD's library. Inclusion cannot be guaranteed.

General

► DRUGS: AN INFORMATION PACK. Board for Social Responsibility, General Synod of the Church of England and the Churches Council on Alcohol and Drugs, 1986. Pack of leaflets and booklets. £1.95.
Information pack aimed at adults wanting to find out more about drug misuse and as aids to starting to consider drug issues, particularly from a christian point of view. *Available from Church House Bookshop, Great Smith Street, London SW1P 3BN.*

► **DRUGS: USES, EFFECTS AND ABUSE. Metropolitan Police Central Drug Squad, 1986. Wall Chart. £6.85 inc p&p.**
Intended to assist police, community workers and other agencies to recognise drugs which may be abused. Consists of colour pictures of drugs plus table of effects, law, etc.
Available from Central Drugs Squad, Room 1633, New Scotland Yard, London SW1.

Treatment

► **COMMITMENT TO CHANGE: A STUDY OF ALPHA HOUSE, A REHABILITATION UNIT FOR DRUG MISUSERS. Jackie Powell, Diane McGoldrick and Robin Lovelock. Portsmouth: Social Services Research and Intelligence Unit, 1986. vi, 281 pages. £5.25.**
A study of the structure and operation of the Alpha House therapeutic community, featuring interviews with present and past residents and staff.
Available from Bronwen Cook, Secretary, SSRIU, School of Social and Historical Studies, Portsmouth Polytechnic, Milldam, Burnaby Road, Portsmouth, PO1 3AS.

► **TURNING POINT NEWS. Newspaper. 3 issues per year.**
Newspaper of Turning Point, the national charity operating various drug and/or alcohol counselling and rehabilitation services. First issue Spring 1986.
For availability contact Gladeana McMahon, Turning Point, 9-12 Long Lane, London EC1A 9HA, phone 01-606 3947.

Medical

► **PHYSICIANS' HANDBOOK FOR MEDICAL MANAGEMENT OF ALCOHOL- AND DRUG-RELATED PROBLEMS. Paul Devenyi and Sarah J. Saunders, *comps, eds.* Toronto: Addiction Research Foundation and Ontario Medical Association, 1986. vii, 75 pages. 5 Canadian dollars.**
A pocket-sized handbook on the recognition and early management of alcohol and drug-related problems: arranged for quick reference.
Available from Addiction Research Foundation, 33 Russell Street, Toronto, Ontario M5S 2S1, Canada.

► **SHARING NEEDLES AND WORKS . . . Standing Conference on Drug Abuse (SCODA), 1986. Poster. Free.**
"Sharing needles and works damages your health. The dangers include: the AIDS virus; hepatitis; syphilis; septicaemia and other types of blood poisoning" — advice to drug users from the national representative body for drug agencies.
Available from SCODA, 1-4 Hatton Place, London EC1N 8ND.

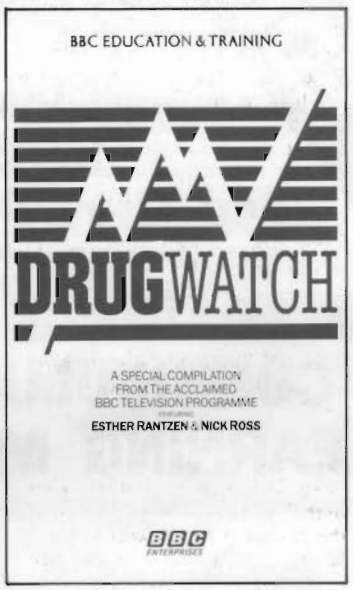
AIDS

► **PROCEEDINGS OF THE AIDS CONFERENCE 1986 NEWCASTLE UPON TYNE UK. Peter Jones, *ed.* Ponteland: Intercept, 1986. xvi, 272 pages. £12.50.**
Up-to-date information on AIDS for health care workers. Includes a discussion of AIDS and the injecting drug user.
Available through bookshops.

► **TACKLING THE SPREAD OF THE AIDS VIRUS: OPTIONS FOR DRUG AGENCIES. Standing Conference on Drug Abuse, 1986. Leaflet. Free.**
Aims to help drug agencies develop policies to contain the spread of the AIDS virus. To be read in conjunction with *Facts about AIDS for drug workers* (£0.20 from SCODA). See also *Sharing needles* ... poster under **Medical**.
Available from SCODA, 1-4 Hatton Place, London EC1N 8ND.

Education

► **DRUGWATCH PACK. BBC Education and Training, 1986. Video, poster, record, publications, badges. £28.75.**
Includes a 58 min. video compiled from the TV programmes of the same name, said to be suitable for adults and secondary school pupils. Also teachers' notes and directory of helping agencies. The theme is 'Just Say No'.
Available from BBC Enterprises Ltd, Education and Training Sales, Woodlands, 80 Wood Lane, London W12 0TT.



► **YOUNG PEOPLE AND HEROIN USE IN THE NORTH OF ENGLAND. Geoffrey Pearson, Mark Gilman and Shirley McIver. Health Education Council, 1986. 60 pages.**
Report on a six-month investigation into the patterns and prevalence of heroin use and the response of the statutory and voluntary agencies. Featuring interviews with drugtakers, the report provides first-hand accounts of heroin using careers and a discussion of appropriate health education strategies based on this information.
Available from Health Education Council, 75 New Oxford St., London WC1H 1AH.

Solvents

► **GLUE SNIFFING AND SOLVENT ABUSE. Denis J. O'Connor. Boys' and Girls' Welfare Society, 1986. 112 pages. £5.55.**
Practical guide on all aspects of solvent abuse with an emphasis on the problems it causes for families and communities and how to manage and treat solvent-related problems.
Available from Boys' and Girls' Welfare Society, 57a Schools Hill, Cheadle, Cheshire SK8 1JE.

► **INFORMATION PACK: SNIFFING SOLVENTS AND VOLATILE SUBSTANCE ABUSE. Re-Solv. Stone: Re-Solv, 1986. 23 pages. £1.75**

SOLVENT ABUSE: THE SOCIAL WORK CONTRIBUTION. Mike Laxton. Stone: Resolv, 1985. 17 pages. £1.75.
Publications from Re-Solv, the national charity dealing with all aspects of solvent and volatile substance abuse with an emphasis on prevention and reduction of use.
Available from Re-Solv, St Mary's Chambers, 19 Station Rd., Stone, Staffs. ST15 8JP.

► **RE-SOLV NEWSLETTER. Biannual newsletter of The Society for the Prevention of Solvent and Volatile Substance Abuse.**
Intended for the Re-Solv membership in local authorities and the solvents, glue and aerosol industry, but other interested parties can apply.
Available from Re-Solv, St Mary's Chambers, 19 Station Rd., Stone, Staffs. ST15 8JP.

Tranquillisers

► **COMING OFF TRANQUILLIZERS. Shirley Trickett. Wellingborough: Thorsons, 1986. 110 pages. £1.99.**
A new version of the step-by-step guide to withdrawal from tranquillisers with new illustrations and an expanded further reading list.
Available from ISDD. Add 15% p&p.

► **TRANQUILLISERS: SOCIAL, PSYCHOLOGICAL AND CLINICAL PERSPECTIVES. Jonathan Gabe and Paul Williams, *eds.* London: Tavistock, 1986. xv, 311 pages. £25.**
Adopts a multidisciplinary approach to tranquilliser use and places it in a social context. Includes epidemiological and sociological accounts of the history of tranquilliser use, an exploration of the factors that influence their use and the social meaning of tranquilliser use.
Available through bookshops.

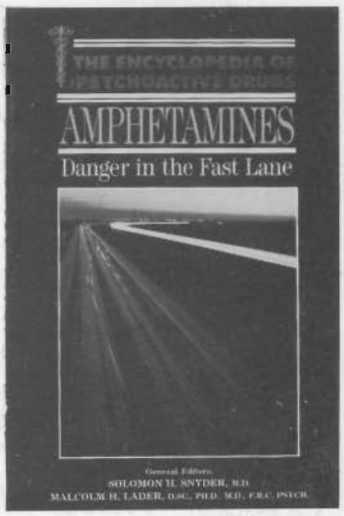
Other drugs

► **NICOTINE: AN OLD-FASHIONED ADDICTION. Jack E. Henningfield. 125 pages.**

LSD: VISIONS OR NIGHTMARES. Michael E. Trulson. 121 pages.

MARIJUANA: ITS EFFECTS ON MIND AND BODY. Miriam Cohen. 109 pages.

AMPHETAMINES: DANGER IN THE FAST LANE. Scott E. Lucas. 101 pages.
All published in London by Burke in 1985 at £7.95 hardback, £4.50 paperback.
First four in a projected 25-volume *Encyclopedia of psychoactive drugs* aimed at a young adult audience. Each volume has brief information on history, effects, hazards, chemistry, legal status, myths and social impact, and many illustrations.
Available through bookshops



COURSES

► **DRUG EDUCATION COORDINATORS. TACADE. 4-6 Nov; 8-10 Dec, 1986.**
Two courses designed specifically for the new LEA drug education coordinators aiming to enhance their skills in working with teachers.
Further details available from TACADE, 3rd Floor, Furness House, Trafford Road, Salford, M5 2XJ, phone: 061-848 0351.

► **TRAINING COURSES: ANNUAL PROGRAMME. Drug Concern (Barnet). Various dates from Sept 1986 — June 1987.**
A series of courses for generic workers ranging from residential weekends to a one week accredited course organised by Barnet's drugs advice and counselling service.
Programme and application forms from Drug Concern (Barnet), Woodlands, Colindale Hospital Grounds, Colindale Avenue, London NW9 5HG. Free to workers within Barnet. Otherwise £10 per half-day, non-residential.

► **TARGETING YOUNG PEOPLE AT RISK OF DRUG MISUSE. Kaleidoscope Youth and Community Project. 20-25 Oct; 17-21 Nov; 8-12 Dec 1986.**
Three separate one week multi-disciplinary courses for professional workers organised by a youth project with 18 years' experience of dealing with young people and drugs.
Enquiries and application forms from Kaleidoscope, 40-46 Cromwell Rd., Kingston-upon-Thames, Surrey, KT2 6RE, phone 01-549 2681. £125 non-residential.

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