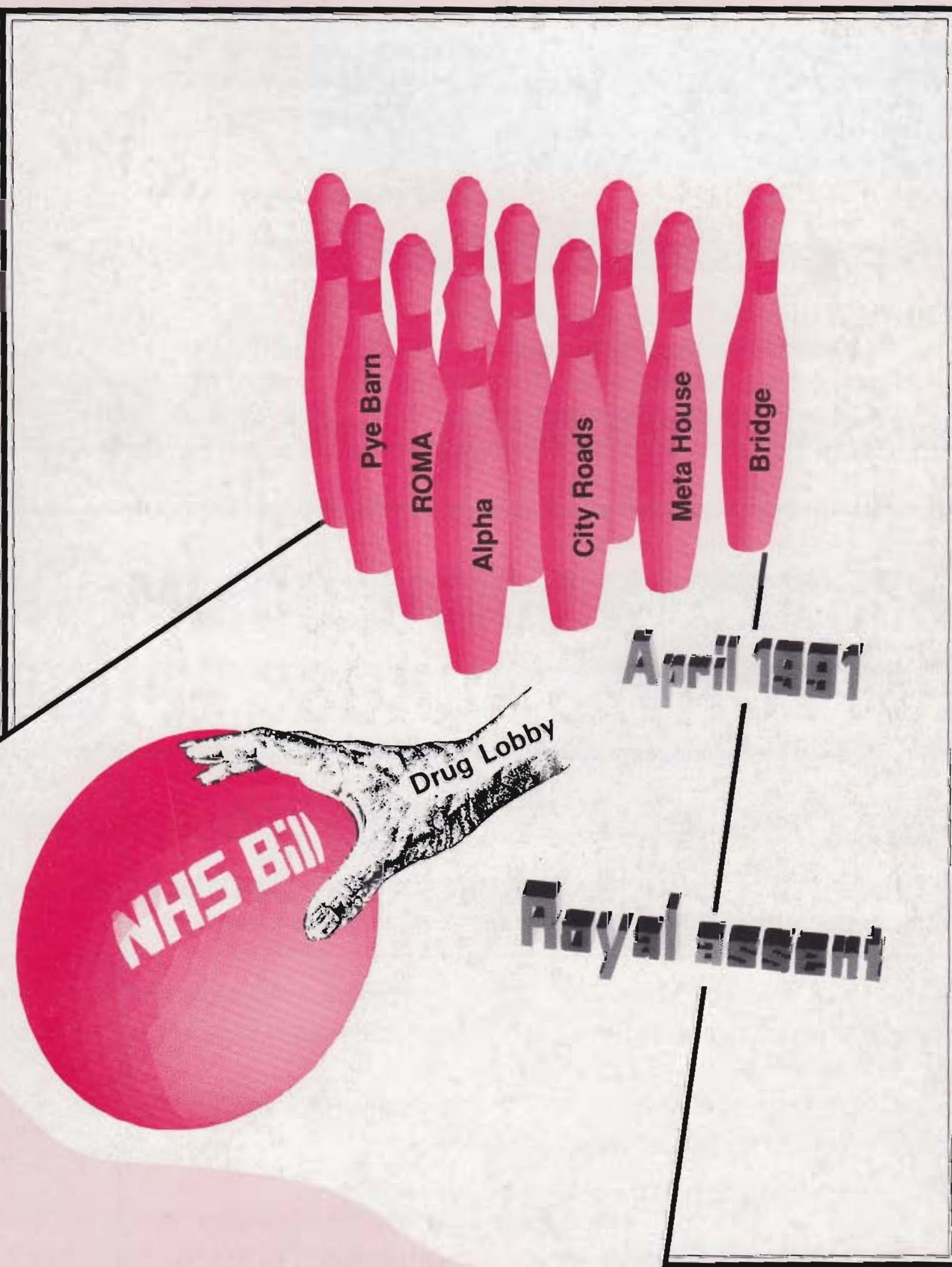
# DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN July/August 1990




Last minute reprieve possible for rehabs. See page 6

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# DRUGLINK

July/August 1990
Vol 5 issue 4
THE JOURNAL ON DRUG MISUSE IN BRITAIN

**DRUGLINK** is about 'disapproved' forms of drug use – seen legally, socially and/or medically as 'misuse'. **Druglink** does not aim to cover alcohol and tobacco use. **Druglink** is for all specialist and non-specialist workers and researchers involved in the response to drug misuse in Britain.

**ISDD** provides Britain's information service on the misuse of drugs and conducts research. **ISDD**'s reference library is unique in Britain and an important international resource. Services 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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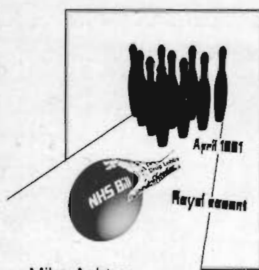

Mike Ashton

## World poverty and drugs

**In Imperial China (page 12) and in today's drug producer nations, the economic imperatives of poverty drive illegal drug production. The UN's increasingly forthright call for a change in the world economic order (page 14) throws down a challenge to the developed nations that dominate world trade.**

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**REVIEWS** — **19** — **Relapse and Addictive Behaviour** seems set to become the bible of relapse prevention for British drug workers.

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# Councils respond to Home Office teams

**At a meeting on 12 June the seven local authorities hosting the first wave of Home Office Drug Prevention Teams (see below) welcomed the money but were apprehensive at potential 'control' conflicts between local interests steering the teams' work and their Home Office managers.**

**The meeting was organised by the National Local Authority Forum on Drug Misuse. A Forum spokesman said there was concern at civil servants being "parachuted" in with little warning and little knowledge of existing networks, but general agreement that the Home Office team were "making the right noises" about flexibly responding to the local situation.**

**Home Office documents say the locally recruited advisory groups guiding the work of each drug prevention team may be a modified version of an existing committee. The problem is likely to be that existing committees are professionally based whereas Home Office guidelines call for parents, tenants, churches and businesses to be represented.**

**While the crack and cocaine focus still feature in Home Office paperwork, at the meeting officials described the initiative as a general Home Office contribution to reducing the demand for drugs.**

**n The teams will consist of 3-4 specially recruited Home Office staff, advised by a voluntary local advisory group. Their prime task will be to build community resistance to drug misuse by coordinating and generating local prevention efforts. The seven local authorities to host the first teams are Birmingham, Liverpool, Brighton and the London boroughs of Hackney, Lewisham, Southwark and Newham.**

**See *Druglink* 5(3) p.5 for more details.**

**Mixed messages...**

**...now water under the bridge**

# Shaky start for school drug tests

The movement to initiate random drug testing in sport is now being extended to schools via the human link of Dr Hugh McCollum, GP and medical adviser to the Lawn Tennis Association and to the Test and County Cricket Board.

Last year Dr McCollum established Drugs in Education to campaign for drug testing within schools, a non-charitable company with Dr McCollum and his wife as directors. So far his initiative has achieved considerable media interest but little in the way of concrete results.

Initially the campaign is being directed at private schools, one of which houses Dr McCollum's sons. In these schools testing could be undertaken without new legislation.

The longer term plan is that private schools will set an example for state schools to follow. On 22 May Labour MP Ray Powell introduced a private member's bill under the ten-minute rule to introduce drug testing in state schools two years this September.

Dr McCollum's company offers urine testing accompanied by an educational pack for pupils at a combined price of £25 a time. Testing will be random under parents' written consent; the pupil's refusal to take the test will be seen as an admission of guilt.

Justification for such a programme can be seen in the number of pupils expelled due to drug misuse. Experimentation with drugs, usually cannabis, is undoubtedly a fact of life in Britain's public schools.

Dr McCollum allies this fact to a familiar version of the 'escalation' theory. "We know that cannabis use can lead to a greater chance of using other drugs... a child who continues taking drugs must be removed from the school." He backs up this argument with US statistics on youth crack use and the threat of crack dealers at school gates.

Testing will be used both to pinpoint individual misusers and to deter others from misusing. Counter-arguments on civil liberties grounds are met head on by Dr McCollum. "If a child is suspected of using drugs he will be grilled, searched and possibly referred to the police... I would suggest to any libertarian that this would be far more detrimental to the child than a simple test."

Even as a deterrent and a tool for controlling drugtaking behaviour, the approach has critics. For Adrian King, Health Coordinator responsible for drug education in Berkshire, "there are two main questions: firstly, the infringement of an individual's rights; secondly, whether the pressure used to make one submit is fair and responsible... If the concern is purely behavioural, there is a large body of opinion which would doubt its effectiveness. I believe it would be more likely to alienate the very people it was claiming to help."

The Department of Education and Science are reluctant to comment until Ray Powell's bill is published, but a spokeswoman seemed unenthusiastic. "We have our own programme in place... These moves are to do with policing rather than education... The possibility of any private member's bill becoming law is slim due to the pressures on parliament."

Schools themselves, including Millfield which houses Dr McCollum's sons, are reacting with caution. After having approached more than 20, Dr McCollum says two schools have already taken on board his proposals but wish to remain anonymous. Marlborough school, where a ballot of parents recorded 85 per cent in favour of testing, is stalling until September.

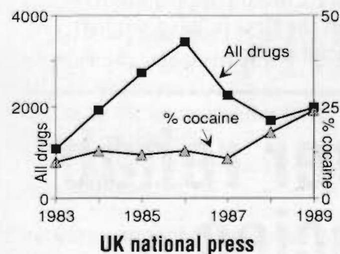
*Sun* readers were told that Ampleforth College was in favour of testing, but the paper later had to apologise for its misleadingly selective quotation from a letter to parents. What the *Sun* left out was that headmaster Father Milroy had told parents that compulsory testing would be "wholly unacceptable". The school is seeking legal advice.

Despite reticence in the schools, McCollum's smooth handling of the press has generated favourable coverage. His article in the *Daily Mail* (20 April 1990) made some sweeping claims: "I can confirm that such schemes have proved a highly effective deterrent to would-be drug abusers. The proof is that the governing bodies of both sports [tennis and cricket] can confidently pronounce them drug-free... The method we would use in schools is highly effective – 100 per cent accurate..."

**Steve Sampson**

■ **"Because uniformity in terminology is desirable when communicating prevention messages", editorial guidelines from the US health department's Office for Substance Abuse Prevention ban use of the terms 'recreational use' and 'responsible use', insisting that 'use' be substituted as "no drug use is recreational" and "there is risk associated with all use". "Since all illicit drugs are harmful" the guidelines disseminated last year also ban distinctions between 'hard' and 'soft' drugs.**

■ Nearly a quarter of all UK national press cuttings received by ISDD in 1989 singled out cocaine, double the average proportion for the rest of the '80s. At 483 cuttings, cocaine coverage was nearly four times the level afforded opiates. However, the national press's interest in drugs as a whole was below the levels of 1985-87.




**UK national press**

■ **Charges were dropped against a suspected cocaine dealer after he alleged a police informant had planted the drugs.[1] In June a crown court judge ruled that for a fair trial the informant would have to go into the witness box, but police decided to offer no evidence rather than expose the informer's identity. The collapse of the case could seriously hamper many drug prosecutions which rely heavily on evidence from informants.**

1. *Times*, 13 June 1990.

■ A study of some of the first British drug users to suffer HIV infection followed up 189 injectors identified at an Edinburgh general practice in 1980-5.[1] By 1987-8 nearly three-quarters had been tested for HIV and 64 per cent of these were known to be infected. Over 80 per cent of the group were still injecting drugs, though most less frequently. Among injectors identified since 1985, just 29 per cent of those tested were positive for HIV. The authors conclude that the epidemic spread of HIV in Edinburgh was over by 1984 but that the wave of resulting AIDS cases has yet to develop.

1. Skidmore C.A. *et al.* "After the epidemic: follow up study of HIV seroprevalence and changing patterns of drug use." *British Medical Journal*: 1990, *300*, p.219-23.

# Central funding 'critical' to drug services network

The major government funding initiative of the '80s succeeded in radically and perhaps irreversibly changing the landscape of drug services in England. The £17½ million government boost to drug services in England during 1983-89 supported almost half of all current drug services and was "critical" in adding a layer of community services to existing hospital and residential provision.

These are the conclusions of a three-year research project at Birkbeck College in London funded by the Department of Health, evaluating the department's Central Funding Initiative (CFI).

The initiative was the government's main response to the 1982 *Treatment and Rehabilitation* report from the Advisory Council on the Misuse of Drugs. Its objective was to supersede the hotchpotch of mostly London-based services left from the '60s with a comprehensive network capable of dealing with the spreading heroin and multi-drug problems of the '80s.

Government strategy was to bypass health and local authority resistance by directly funding individual projects in the form of three-year pump-priming grants. The crucial question was whether local funders would support projects once government cash dried up.

Susanne MacGregor and co-workers at Birkbeck found that by March 1990, 76 out of 100 CFI-funded services had achieved future funding after their three years on the government payroll, and just six had closed. But funding for the 36 non-statutory projects was distinctly insecure, sometimes requiring annual re-applications.

This success at keeping projects going was achieved mainly through government earmarking of health authority funds begun in 1986, when the first CFI grants were reaching their expiry date. Without this arm's length continuance of government funding, the third of today's drug projects pump-primed with CFI money may have faced cutback or closure as they competed for general health resources.

At the time of the *Treatment and Rehabilitation* report the key gap in service provision was in community services. "The total number of specialist street agencies, detached work projects and day centres in the whole of the United Kingdom does not exceed single figures", observed the Advisory Council.

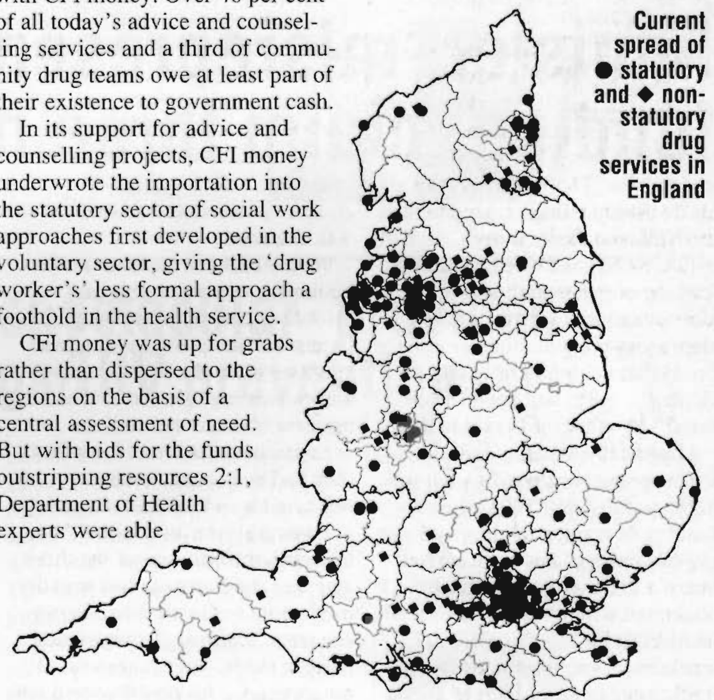
It was this deficiency that the CFI best remedied, with 56 per cent of the £17½ million going to community projects, supporting nearly 70 per cent of the staff paid with CFI money. Over 40 per cent of all today's advice and counselling services and a third of community drug teams owe at least part of their existence to government cash.

In its support for advice and counselling projects, CFI money underwrote the importation into the statutory sector of social work approaches first developed in the voluntary sector, giving the 'drug worker's' less formal approach a foothold in the health service.

CFI money was up for grabs rather than dispersed to the regions on the basis of a central assessment of need. But with bids for the funds outstripping resources 2:1, Department of Health experts were able to selectively approve bids (and encourage applications from reticent authorities) in a way which "allowed firm central control over the design of services which developed nationally".

The report is generous in its praise of the civil servants who steered what it was feared would be an ad hoc distribution of resources, with money going to the areas that asked the hardest.

But how far this actually happened is still an open question. CFI funding ranged from nearly £3 per 15-34 year-old in Mersey down to a quarter of this in Oxford RHA, yet the earmarked health funding that followed the CFI was allocated evenly to regions in proportion to their 15-34 year-old populations. It's hard to see how both these very different funding patterns can have matched regional needs.



**Current spread of ● statutory and ◆ non-statutory drug services in England**

# Survey finds 550 drug services in England

**In the course of their research, the Birkbeck team established the most complete audit ever of drug services in England. They traced about 550 services principally involved in helping drug users, of which about a third were self-help groups and 41 catered solely for prescribed drug users.**

**Excluding these leaves 323 drug services with 1656 full time and 490 part time staff. These include 75 community drug teams – unknown before 1983 – and 135 advice and counselling services, all but 12 established in the '80s. Nearly half these community-based projects run syringe exchange schemes.**

**From being Britain's main response to addiction in the '60s and early '70s, hospital drug dependency units now account for just 10 per cent of all drug projects but 20 per cent of staff. Even in the statutory sector, hospital units have been overtaken by community drug teams, 60 per cent of which have their own prescribing capacity.**

☛ The Central Funding Initiative research report will shortly be published by ISDD.
To order your copy, contact Wil Baldwin at ISDD on 071-430 1991 for price and send cheque with order.

# Probation service makes harm reduction official policy

**Promotion of harm-reduction approaches with drug using clients is now official policy in the Inner London Probation Service (ILPS), breaking through the ideological barrier against criminal justice officers being seen to collude with continued offending in the form of illegal drug use.**

**The policy statement sent out in early June by ILPS's Chief Probation Officer also applies to alcohol misusers, building on the work of the service's innovative Demonstration Unit.**

**The unit was established in 1988 to identify best practice in probation work with alcohol or drug misusing clients. Its survey of inner London's probation officers conducted last year confirmed that the probation service is probably the caring profession in contact with the greatest number of problem drug users.**

**The survey indicated that probation officers were supervising 1829 clients believed to have a significant drug problem, 1278 of whom were out of prison, constituting a fifth of the service's community caseload. A further 821 clients were in trouble with alcohol but not using other drugs.**

**Heroin predominated involving 1136 clients, but at 438 cocaine use was surprisingly prevalent. A third were also misusing alcohol.**

**Only half the drug users were in contact with drug services and many that were had been referred by their probation officer. Nearly half the 1829 drug users admitted to injecting but less than a fifth of these were using a syringe exchange. These figures underline the importance of probation as an entry point into drug services, but the Demonstration Unit believes the absence of an explicit harm-reduction strategy in the criminal justice system seriously hampers work with drug users.**

**In a thoughtful presentation to April's Harm-Reduction conference in Liverpool, unit staff called for harm-reduction approaches to be an acknowledged element of a flexible probation response. They argued that the dominant abstinence philosophy gives clients little reason to disclose drug use and every incentive not to if the probation officer and the court treat illegal drug use as a breach of supervision. Without this disclosure neither the offender nor the public can be protected from the consequences of continued drug use.**

**But the fact that drug misuse is illegal and associated with other forms of offending makes departure from a purely abstentionist approach professionally risky for probation officers and other criminal justice personnel. In practice probation staff have exercised their wide discretion to encourage disclosure of drug use without taking clients back to court for re-offending.**

**But the greater visibility of harm-reduction resources (such as needle exchanges) and closer and more public oversight of probation work likely as a result of criminal justice reforms will restrict probation officers' scope for 'private' harm-reduction initiatives, argued Marilyn Bild and Paul Hayes in April. They concluded that the space for harm reduction must be re-opened by an official and open policy commitment, which up till then probation management had been unwilling to risk.**

**ILPS's initiative in issuing just such a policy may set an example for other services to follow. Many practise harm-reduction but Inner London appears to have been the first to have made it official policy.**

# Minister 'misrepresented' fears over rehab funding, claim three national agencies

On 14 June a crucial amendment to the NHS and Community Care Bill which could have safeguarded the funding of residential drug and alcohol services was withdrawn after a government minister told the Lords that voluntary drug and alcohol projects had been "reassured" by what she'd said to them.

Her statement dismissed widespread concern over what will happen after April 1991 when funding of residential drug and alcohol services has to be carved out of a general local authority allocation with no sums specifically earmarked for this purpose. The amendment sought to establish a transitional period of direct government funding until the Health Secretary was satisfied that other funds were available.

Astonished drug and alcohol field representatives from SCODA, Alcohol Concern and Turning Point rushed out a press release accusing Baroness Hooper of having "misrepresented" their position. The Baroness's statement followed a question from Lord Ennals asking whether she'd consulted the organisations supporting the amendment.

SCODA, Alcohol Concern and Turning Point – its joint supporters – say they have consistently expressed concern that wholesale closures could follow unless the bill was amended.

As the national representative bodies for voluntary drug and alcohol agencies and the single largest service-provider, the three agencies were at a loss to know who was being referred to when the minister claimed that "all the organisations that I met intimated they had been considerably reassured by what I had to say".

Dianne Hayter of Alcohol Concern, the only one of the three agencies the Baroness had actually met, wrote to the minister saying she was "alarmed, dismayed and bewildered by your statement... In our meetings, Alcohol Concern has never expressed anything other than the deepest anxiety over the future survival of residential projects".

Just a week before the amendment was debated, SCODA's Residential Services Forum had issued a press release warning of "wholesale closure" of residential drug services unless their funding was earmarked under the NHS and Community Care Bill.

Turning Point predicts that 75 per cent of their 20 or so residential drug and alcohol projects could close within nine months of the NHS and Community Care Act coming into force. They have calculated that over the two years' implementation period £26 million would be needed to replace Department of Social Security payments currently made to alcohol and drug rehab residents.

With no statutory responsibilities for these client groups, all the major agencies are convinced local authorities will prioritise their statutory duties to care for the elderly, the handicapped and children, leaving services for the 'undeserving addicted' to cut back or close.

Exactly this kind of consideration led the Government to make provision for earmarking community care funding for the mentally ill. On 14 May Baroness Hooper explained this was because local authorities "have not been able to give as much priority" to the mentally ill as to other groups.

Refusing to extend earmarking to funds for drug and alcohol dependents, the minister said it was inconsistent for the Government to aim to make local authorities more accountable to their electorates and at the same time "determine from the centre how resources should be deployed".

After this statement the original attempt to get drug and alcohol funding singled out was withdrawn, to be introduced in amended form on 14 June. Though again withdrawn, there is still a possibility of its being reintroduced at the third reading of the bill or when the bill goes to the Commons (see below).

■ The only concrete reassurance the Government has so far been able to give residential drug and alcohol services is a commitment to explicitly include these in official guidance to local authorities on their responsibility to provide community care.

Attempts to amend the NHS and Community Care Bill to give legal force to this requirement for England and Wales were resisted on the grounds that reference to "illness" and "disability" in the bill covers all potential client groups. The argument was that being explicit about which groups were included might imply others were excluded.

■ **Just as *Druglink* was going to press a Department of Health official confirmed that the Government intended to introduce its own amendment to ring fence community care money for drug and alcohol services. This unexpected concession could give residential services the protection they need from adverse funding decisions by local authorities. The amendment is due on 27 June but may be delayed to the end of the month.**

■ **The Crown Prosecution Service (CPS) will not prosecute drug workers distributing sterile water ampoules to drug injectors as part of syringe exchange schemes. Under a 1986 amendment to the Misuse of Drugs Act, supply of drug "paraphernalia" other than needles and syringes is an offence, but a local CPS office has written to Drug Concern (Barnet) saying it "would not be in the public interest" to prosecute in these circumstances. This ruling applies only to the Barnet area but the prosecutor said he would be "very surprised" if other areas didn't take the same line.**

■ A letter to the *Pharmaceutical Journal*[1] says that the new gel-filled temazepam capsules meant to prevent the contents being injected pose "only a minor inconvenience" to injectors. The contents are water soluble and the gel is easily transformed into a free flowing liquid by warming to 40°C. The letter from two hospital pharmacists appeared alongside a Wyeth pharmaceuticals ad claiming the new capsules were "abuse resistant".

1. Griffiths S.J. *et al. Pharmaceutical Journal*: 9 June 1990, p.675.

■ **A new report on training from the Advisory Council on the Misuse of Drugs calls for a national drugs training development agency.[1] James Kay who chaired the working group behind the report says its key recommendations concern the need for planning committees and agency management to invest in training as a crucial element in service development. "None of the recommendations of the Advisory Council's AIDS reports can be properly implemented without a root and branch rethink of the role of training", says Mr Kay. Although with them since November, the Government have yet to respond to the report.**

**1. Advisory Council on the Misuse of Drugs. *Problem drug use: a review of training*. HMSO 1990. Copies from HMSO, £5.50.**

■ In June the Health and Safety Executive published a booklet which aims to help employers establish a drug policy (including encouragement for staff with drug problems to come forward for treatment) and to inform employers of safety risks associated with drug misuse.[1] On drug screening the booklet says there may be a case for its introduction for highly safety sensitive posts.

1. HSE. *Drug abuse at work: a guide to employers*. HSE, 1990. Copies from HSE, 1 Chepstow Place, London W2 4TF, phone 071-243 6000.

# Crack a 'standard commodity' in major English cities

A Home Office memo dated 23 March acknowledges that "increased police attention" to crack has raised the seizure rate, but concludes that crack has now become "a standard commodity" in major cities in England. Provisional statistics for 1989 show police cocaine seizures nearly doubling to a record 113kg while for the second year running heroin seizures fell, totalling just 16kg compared to 45kg in 1987.

But the statistics give little evidence of major crack manufacturing operations in Britain. Despite large cocaine seizures, the 138 police seizures of crack last year netted less than a quarter of a kilogram. Nearly three-quarters of all crack seizures weighed less than a gram, the equivalent of about five rocks of the drug.

In the first five months of this year, police have already exceeded last year's crack haul in their 97 seizures.

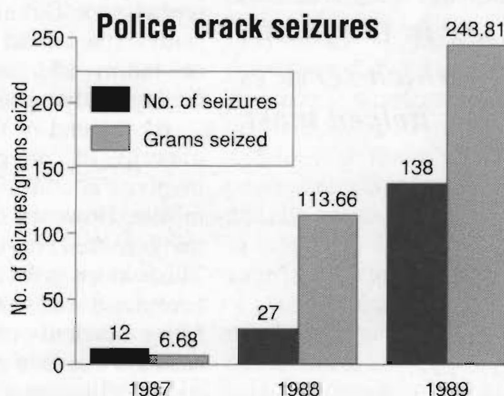
In London, which last year accounted for a third of the crack seized, 75-80 per cent of crack trafficking suspects arrested by the 'crack squad' were people of Jamaican origin present illegally in Britain. In south and west London the squad say 'illegal Jamaicans' have cornered the retail crack market. Lesser crack busts involve people who transform cocaine into crack for their own use or for friends rather than as a business proposition.

In purity terms, crack currently has a major advantage over its stimulant rivals. In the first quarter of 1990 purity of street cocaine was at its lowest for five years at 50 per cent, while crack was over 90 per cent pure, matching the purity of cocaine at importation.

Amphetamine purity fell to a new low, with samples now containing 90-97 per cent impurities. Purchasers of amphetamine powder are usually spending most of their money on common or garden (and totally legal) caffeine.

In 1989 police amphetamine seizures totalled 89kg, less than cocaine for the first time in at least ten years. Just over 9kg was methylamphetamine, the injectable 'speed' of the '60s, practically absent from seizure statistics throughout the '80s.

Although due to the discovery of a single major lab, this blip in the statistics has brought the first real sign that illicitly manufactured methylamphetamine and perhaps its smokable derivative 'ice' may be on their way into the British drug market.




**Despite the increase, crack seizures accounted for just one eighth of one per cent of the quantity of stimulants seized by police in 1989**

# Multi-media 'spectacular' provides model for drugs/HIV prevention

Throbbing beat, slide-shows, the heat, the sweat... no, it's not the latest rave, it's Too Hot to Handle. If you're looking for an effective model of drugs/HIV prevention among young people, this innovative multi-agency approach may provide a useful basis for future work.

Too Hot to Handle was an initiative to use community development and peer education to develop a high profile for HIV/AIDS issues among young people in the London borough of Hackney. Devised and coordinated by Cultural Partnerships, a local arts and media organisation, and funded by Hackney Council, it was designed as a framework for use elsewhere.

The project was guided by a steering group with members from the council, ILEA Youth Service, the local health authority, and the voluntary sector – including a drug project.

Over a three-month period ending in May, Cultural Partnerships employed health and sex education workshops to work with about 45 young people, dealing with issues such as safer sex, drug injecting, and confidence amid peer pressure.

During this period some of the young people produced *Too Hot to Handle – a Magazine for and by Young People in Hackney. Their View of Sex, Drugs and AIDS*, and a series of slides.

These activities culminated in three performances of a multi-media show – a heady mix of music, sketches, 'commercial breaks', slides and The Hot Quiz. Ragga (reggae rap) numbers, futuristic drama, satire, the game show and audience participation were just some of the media on the menu.

Questions of fear, prejudice, relationships and safer sex were covered in a highly entertaining and often graphic way, with the responsibility for HIV placed squarely on the shoulders of us all.

For more about Too Hot to Handle, contact Cultural Partnerships on 071-254 8217.

**Sheila Henderson**
*ISDD Research Unit*

**A page from the *Too Hot to Handle* magazine**

# PARENTS SELF-HELP IN MERSEY

***Parents devastated by heroin use in the family speak about which services helped most.***

**Research among parents of heroin users found a high degree of shock and distress. Parents felt the probation service was most help as it included them in its work with their child. Family support groups were used only by a minority. Exclusion of parents from the work of client-centred drug agencies and differences in approach have led to a split which will need to be healed if local prevention schemes are to succeed.**


## Howard Parker & Loraine Donnelly

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THE MERSEY REGION has been deeply affected by heroin use. A conservative estimate would be that the region has hosted at least 12,000 regular or dependent users in recent years. This article reports briefly on a study of the impact of 'problem' heroin use on family life, and particularly on the feelings and responses of parents of users.

By the end of the 1980s, only a small minority of 'affected' parents remained involved in collective action about heroin misuse. However, between 1982 and 1985, things looked very different on Merseyside. This was when the incidence (new cases) of heroin use was in a steep epidemic climb. Many hundreds of families found themselves in a state of great shock, summarised by words like 'shattered' or 'devastated', on discovering their son or daughter was dependent on heroin and caught up in an associated lifestyle.

Given the early lack of official responses and help, large numbers of *ad hoc* parents' groups formed. Most can be described as family support groups (FSGs). Several dozen groups and networks of concerned parents came and went. Some felt they'd achieved their goal of "getting something done", but most collapsed, with members feeling deprived of success or help.

Oral histories, taken from key members of about a dozen of these defunct groups, highlighted recurring difficulties such as inadequate funds and facilities, no regular venue for meetings and, in retrospect, a lack of appropriate managerial and organisational skills to sustain the group. The stigma of being a 'heroin family', particularly in aspiring, status-conscious neighbourhoods, also seems to have prevented parents attending semi-public groups.

There is a view, particularly among drug professionals, that that was that – as one article put it, the "rise and fall of family support groups".[1] Certainly in the north-west of England, this is too simple a verdict, partly because it is inaccurate and also because, as we will show, it endorses too narrow a view of professional practice.

There remain at least eight surviving groups in the region: a couple have become fairly closed groups of parents who offer mutual support, a couple struggle on, and a few have become strong and durable agencies with staff, permanent premises and a wide range of services. Furthermore, new groups continue to form. There are also about a dozen 'advice point' centres or networks run by parents of users. These very local, low-key services include telephone counselling and help with transport.

However, a mismatch is apparent between the few hundreds of parents involved in grassroots self-help, and the many thousands affected in the Mersey region.

## Self-help under-resourced

One component of our research involved interviewing 40 families who were 'coping' with heroin using children but who were *not* currently involved in a support group. This could obviously not be a random sample and parents were contacted using a wide range of sources and 'grapevines'.

The concept of a user's drug career is now widely accepted. Our research identified a parallel career pattern among parents, refering principally to women as mothers and family maintainers.

The first phase often involves growing concern about a teenage child's moods and behaviour, and perhaps about their secrecy about where they are or where they are going. That their child is a heroin user was most often revealed by a sibling, although theft from the home or a visit from the police also regularly conveyed the bad news.

The discovery had a dramatic, often traumatic effect on family life. Deceit and theft from the home added to the confusion as long-standing trust was broken. A range of coping strategies had to be employed, ranging from expulsion to house arrest.

Twenty-two of the 40 families we interviewed were themselves on the receiving end of theft. Thirty sets of parents discovered, in due course, that their offspring were involved in drug-related crimes outside the home, primarily shoplifting.

Geraldine Spence

**Getting organised – it's what family support groups need to do to survive, but few are given the resources or help they require.**

This, in turn, led to another phase for parents – hassle with the police, courts and prison. With daily habits leading to daily crime, risk of apprehension for users is high. Repeated prosecutions led to remands in prison, to probation orders and to custody.

Throughout this period, usually years, parents struggle from one crisis to the next. For some, the difficult admission that they only found peace of mind when their son was in custody was strange comfort.

One commonly cited side-effect of their child's heroin lifestyle, particularly on the municipal estates around Liverpool, concerned local drug dealers. The dealer's 'visiting card', to remind the family of unpaid debts, was often left: heavy phone calls, threats and broken windows all served the purpose. Again, it was often mothers who appeared to feel the pressure most.

While sharing common threads, family reactions to all this varied considerably. Some fell apart, others found greater inner resolve. Some sought formal help, others found support in family groups. An intriguing response, found several times, involved mothers 'giving up on' their own user children, yet committing themselves to working with other similar users through a community project.

The pattern of formal help-seeking by parents in the 40 families interviewed is outlined in the table. GPs, most often contacted, proved largely unhelpful.

The surprise success has to be the probation service. Almost certainly the initial contact was related to a court hearing involving their offspring. However, parents generally found probation officers particularly helpful. The reasons for this are important. Parents felt the officer included them in the process of supervision. Parents felt listened to. They realised they were not 'abnormal' or unique failures as parents.

## Professional exclusion

Parents judged helping agencies on the degree to which they were included in tackling their own child's drug problem. It follows that those agencies which insisted on a confidential practitioner-client relationship, or which appeared to condone drugtaking, were viewed negatively.

This largely explains the mixed responses to drug dependency units and even to 'user-friendly' drugs agencies in the region. Ironically, most family support groups have not satisfied 'ordinary' parents either. Their poor organisation and insularity has meant that even parents brave enough to attend a group have not felt included or empowered.

The indigenous parents' movement has not achieved its potential of becoming a magnet for the enormous unmet need in affected families and neighbourhoods. One reason for this is that, despite the rhetoric, such grassroots developments have received negligible support and funding from central and local government alike. Residents in poorer neighbourhoods, without economic and educational power, may lack the ability to empower themselves and so help and support each other effectively.

Another reason for under-achievement revolves around the parents' ideological commitment to a drug-free community. The reality of 'practising' such beliefs in the face of the continued easy availability of illicit drugs, the spread of HIV, and what is now the endemic presence of determined long-term users, produces perpetual collective ambivalence.

A psychological struggle, both within the parents movement and against the 'new professionals' with their harm-reductionist strategies, has diverted too much energy. In consequence, far too many 'ordinary' parents are left stranded and unhelped, caught between the insularity of some family support groups and inadvertent exclusion by most user-focused drug agencies.

Moderation and mediation is required on both sides. Family support groups need to adapt and be more flexible, so could benefit from knowledge, skills and resources held in professional settings. Drugs and social agencies need to have regard for the emotional pain so many parents suffer and the cost of fractured family relationships on parents and users.

The Government's chosen route to 'demand reduction' appears to rest on coordinating localised responses. Parents' groups are clearly already *in situ* and committed to prevention. The level of cooperation and liaison between them and more pragmatic drugs agencies may well determine the success or failure of local demand reduction schemes. ■

1. Dorn N. *et al.* "The rise and fall of family support groups." *Druglink*: 1988, 3(1), p.8-11.

## Parents' voices

**"Their dad went berserk and wanted to throw them out. Me and him had lots of rows. I was more protective towards them, he wanted to beat them up and throw them onto the streets."**

**"We have to lock everything up. If it's not nailed down he will take it and sell it for drugs. There's no trust in our house any more, it's caused a lot of unhappiness and pain."**

**"My son's probation officer has been most helpful. He is a good listener and takes time to explain things to me. At first I knew nothing about drugs and heroin in particular. He helped me to understand and realise my son wasn't going to die because of his addiction."**

## Awareness of and perceived helpfulness of various drugs and related services

| | Drug agency[1] | GP | Electro-acupuncture[2] | FSG | Probation office | Police | Other | None |
|---|---|---|---|---|---|---|---|---|
| Aware of agency | 32 | 39 | 30 | 31 | 25 | 6 | 2 | 1 |
| Agency approached | 20 | 37 | 5 | 10 | 18 | 2 | 1 | 1 |
| Agency parents found most useful | 5 | 6 | 3 | 1 | 14 | 0 | 0 | 6 |
| Agency parents found least useful | 10 | 19 | 0 | 7 | 0 | 4 | 0 | 0 |

1. Voluntary agencies and hospital clinics. 2. Bio-Physical Medicine Clinic.

Based on interviews with 40 sets of parents of heroin users not involved in family support groups. Multiple responses encouraged. See text for details.

# PRESCRIBING HEROIN: DOES IT WORK?

***Thirteen years ago, this was the first published account of what remains the world's only randomised test of injectable heroin prescribing.***

**A study in 1972-76 randomly allocated heroin addicts seeking a heroin prescription into two groups, one prescribed injectable heroin, the other only oral methadone. Twelve months later many more of the heroin group were still in treatment but more were injecting and using heavily, though there was less crime. The methadone group tended to polarise into 'very good' or 'very bad' outcomes in terms of drug use and criminality.**

**Martin Mitcheson & Richard Hartnoll**

*At the time of the study, Martin Mitcheson was consultant psychiatrist in charge of University College Hospital drug dependency unit in London and Richard Hartnoll was an independent assessor on the study.*

IN DETERMINING the treatment of any one individual there are a number of conflicts liable to arise. Most patients presenting to treatment clinics ask for a maintenance prescription. The staff may take one of a number of decisions.

They may accept that the addict will inevitably continue to take drugs and that for their sake and/or for society's – which would suffer if the drug trade and drug use became more criminalised – it is acceptable to provide a long-term maintenance supply. They may determine that in the long term they may be able to influence this person to stop taking drugs, but that in the short term the patient's commitment to drugtaking is such that a temporary prescription is acceptable. They may decide – although the patient is indeed currently taking drugs – that he or she is at a point of crisis and that a refusal to prescribe drugs may be followed by a period of abstinence, whereas a steady prescription would confirm the patient in their addiction.

Another area of conflict arises because most patients associate with each other in a loosely connected drug using subculture, and the treatment offered to any one patient is usually made known to others outside of the clinic. Thus precedents may be set, limiting the clinic's ability to respond individually to cases.

These conflicts together with the conflict between the clinic's responsibility to individual patients and to society in general, do not admit of any simple resolution. A controlled trial carried out at University College Hospital provides certain information as to the consequences for individual behaviour, and thus some of the consequences for society, when a group of patients are either offered maintenance treatment with injectable heroin (HM), or refused this but offered methadone to be taken by mouth as methadone mixture (OM). Allocation to treatment regimes was on a random basis.

Approximately one third of the patients presenting to the hospital between February 1972 and February 1975 were considered suitable for the trial, the basic criteria being that:

- the patient should be demanding maintenance with injectable heroin; and
- the clinic accepted that the person was indeed so addicted that it was reasonable to consider this treatment.

Random allocation to oral methadone or injectable heroin was satisfactory in terms of most intake variables except that there were tendencies for the heroin group at intake to be more often in full time employment and less likely to have committed acquisitive offences over the previous month. Records were maintained both by the clinic and by an independent research worker. All patients were followed up outside of the clinic by the independent research worker for a period of 12 months whether or not they maintained their contact with the clinic.

All but 4 per cent of the patients were followed up to 12 months, and some anecdotal information was available for the remainder. The main outcomes of the trial are summarised below.

## Heroin: less abstinence but less crime

The heroin group were generally more likely to have continued regular use of heroin than the group who were refused heroin from the clinic. In the twelfth month of the follow-up, 10 per cent of those prescribed heroin but 32 per cent of those prescribed methadone were consuming on average less than 5mg of opiates daily. Also at this time, 90 per cent of the heroin group but just 57 per cent of the methadone group were injecting regularly.

During the final three-month period, 5 per cent of HM voluntarily abstained from injecting for at least 31 days compared to 30 per cent of OM; and a further 12 per cent of the heroin group abstained for between three and 30 days compared to 28 per cent offered methadone. All these differences were statistically significant. However, there was no difference between the two groups in terms of their consumption of non-opiate drugs such as barbiturates, tranquillisers

and amphetamines.

On the other hand, refusal to prescribe heroin tends to be associated with a higher conviction rate. During the year of the trial, 50 per cent of HM and 70 per cent of OM were convicted of a crime (approaching statistical significance).

Similarly, more of the heroin group were dependent on crime as a major source of income during the last month of the trial. This difference was statistically significant. However, if the initial slight tendency for the HM group to be more dependent on crime was taken into consideration, statistical significance was not maintained, though there was still a trend.

## Denying heroin polarises outcomes

On various assessments of involvement with the drug subculture, time spent in the company of other drug users, etc, most of the heroin group maintained some contact with other drug users, but there was some reduction in the number categorised as having the most intensive contact.

On the other hand, denying heroin and offering oral methadone instead tended to polarise patients towards high or low categories: more maintained a high involvement, but a considerable proportion broke off all contact with other drug users. Similarly with the use of illegal drugs, most of those prescribed heroin continued with some illegal drug use, but the methadone group tended to polarise towards more intensive purchase in the illegal market, or to cease illegal drug use entirely.

The most statistically significant result was continued clinic attendance. At 12 months, 76 per cent of those offered heroin and 29 per cent of those refused it were attending the clinic regularly. This reflected the receipt of a prescription, with 74 per cent of HM and 29 per cent of OM in receipt of a prescription at the 12 month follow-up. There was no difference between the two groups in terms of employment, health, or death rate.

## A question of priorities

Overall, prescribing heroin can be seen as maintaining the status quo, with most patients continuing to inject heroin regularly. Prescribing heroin is not associated with an improvement in social functioning or a reduction in consumption of illegal drugs, as is sometimes claimed. It may reduce the degree of involvement in criminal activity, especially in terms of arrests and conviction rates.

Refusal to prescribe heroin and offering oral methadone instead, constitutes a more confrontational response by the clinic and results in a higher abstinence rate. But this treatment is less acceptable to the client and the clinic fails to maintain regular contact with the group who continue to use illicit drugs, most of whom are fairly heavily dependent on criminal activity to support their drugtaking. Our findings suggest that that this group of persistent drug users come from particularly disadvantaged backgrounds in terms of social class, parental loss and incomplete education.

This research does not, therefore, provide a simple answer as to the success of the traditional British policy of offering maintenance with injectable drugs to heroin addicts. Rather, it highlights the conflict between different outcomes, none of which are ideal. Thus future decisions regarding treatment or control of addicts can ultimately only be resolved on the basis of ethical, social and political decisions.

These depend upon the relative importance given to the goal of abstinence and the achievement of a lifestyle free of involvement with the drug scene; the weight given to the client's request for a drug which, in the short term, will ameliorate his or her situation; the values which one places upon the consequences of someone continuing to support an illegal drug habit with the risk of chronic intermittent incarceration; and whether society can and will tolerate the continued (almost always minor in the United Kingdom) criminal activity of the persistent drug user.

It seems that refusal of heroin to confirmed addicts is more therapeutic, in terms of discouraging continued drug use, but leaves a group heavily involved in drugs outside of clinical control. This prospect might be considered undesirable to society, both because of the criminal activities of this group and because they form the basis of a potentially expanding illicit drug culture.

On the other hand, the implications of maintaining addicts with heroin include the prospect of a steadily accumulating clinic population of chronic heroin addicts who are rather less criminally involved and who buy illicit drugs in smaller quantities.

One ends up with a decision which requires clinical, ethical and political judgments, depending partly on the extent to which treatment should be concerned with the interests of individual patients or of society as a whole.

Theoretically it should be possible to determine which patient may benefit from either style of treatment, but individual patients certainly change in their capacity to respond, and once an injectable prescription has been initiated there is very considerable resistance to alteration. In addition, the drug subculture inevitably results in a rapid sharing of information regarding clinic policies, so the treatment offered to one patient is inevitably reflected in the expectations of others. ■

## In retrospect

**One of the authors reassesses the contemporary significance of their unique test of prescribing injectable heroin to heroin addicts.**

When this research was reported to drug clinic workers in 1977, it was with a very clear health warning that it did *not* provide a clear answer to what treatment was best. We did, however, suggest it provided valuable information as to the consequences of choosing different policies – choices that were painful and must be based on ethical as much as clinical considerations. Sadly, the response of many was to use this as a directive to change policy rather than as a basis for rational discussion.

What is the relevance of this research now? I suggest by far the most important implication is the duty on those who advocate a particular treatment to specify the goals and ascertain to what extent these goals are achieved. It should be noted that at a time when HIV was not a risk (but hepatitis and septicaemia were) the prescription of injectable drugs did *not* result in an improvement in health. Indeed, those prescribed heroin were more likely to require inpatient hospital treatment for a complication of drugtaking than those refused such a prescription. It should also be noted that, by comparison with the independent assessors, the clinical staff recorded a progressively over-optimistic view of their patients' progress over the year, and that this was particularly marked for those prescribed injectable heroin.

Many changes, including the risk of HIV transmission, have occurred in the drug scene between 1976 and 1990, but theorising pedagogues still abound.

Sadly, the capacity of project workers to evaluate their programmes with a rational assessment of their effects rather than to listen to unproven ideologies has changed very little.

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## Sources

This article is based on the authors' presentation in December 1977 to the University of Cambridge Institute of Criminology Cropwood Round-Table Conference. It was published in *Problems of Drug Abuse in Britain* (D.J. West *ed*, Cambridge University, 1978). Academic publication of the study was in the *Archives of General Psychiatry*: 1980, *37*, p.877-884, when Richard Hartnoll was the first author.

# PROHIBITION: THE CHINESE EXPERIENCE

***Imperial China's drug war battled uphill against powerful traffickers and booming demand – with familiar results.***

**Opium problems in nineteenth-century China have been cited as illustrative of the evils of legalising drugs, but are more illustrative of the effects of a ban which lacked popular support and faced powerful traffickers feeding a significant demand. Lack of official control of the market led to widespread corruption and banditry. Later, underdevelopment and political instability underpinned China's growing home production.**

## Richard Newman

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RECENT PROPOSALS for the legalisation of drugs have revived interest in the experience of countries where drugs were widely available in the past. Foremost among these is China, the world's largest producer and consumer of opium in the late nineteenth and early twentieth centuries.

Opium was so widely available that the impression has arisen that its trade and consumption was legal, leading to the argument that China's addiction problem illustrates what could happen if drugs were legalised today. In fact, both trade and use were illegal. This article argues that prohibition of opium in China was mostly ineffective and had many harmful consequences, and that addiction was, in any case, less widespread than generally supposed.

The first of a long line of anti-opium edicts was issued by the Chinese emperor in 1729.[1] The main penalties fell upon dealers; smokers and importers – whose trade was in its infancy – were relatively lightly punished. By the 1790s both pipe smoking and the import trade had increased enormously and new prohibitionist edicts were issued.

In 1813 all of these measures were intensified in the aftermath of a scandal about opium-taking by eunuchs of the imperial palace. With China's domestic opium production reaching significant proportions, in 1830 heavy penalties were imposed on growers, refiners and conniving village headmen: poppies were to be rooted up, lands confiscated and annual affidavits supplied by officials to confirm their districts were clear.

The most detailed and intrusive measures against opium were taken in 1839. An attempt was made to stamp out demand for the drug completely in order to facilitate Lin Tse-hsu's campaign against foreign imports in Canton. A set of 39 regulations prescribed death for importing, selling or smoking opium or keeping an opium den. Even more draconian measures, some falling upon whole families, were laid down in 1850, although in practice this was when arrests and prosecutions dwindled. Anti-opium measures were not seriously revived until 1906 when, in a very different political climate, they were dramatically successful, at least for a time.

The willingness of the Chinese population to comply with its government's wishes – even more, the willingness of the ruling elite to cooperate positively with officialdom – determined the success or failure of these campaigns. In southern China in 1839, opium smoking was too widely accepted as a normal part of social behaviour for Lin's campaign to have much more than a superficial effect. In 1906, with opium eradication symbolic of wider currents of reform and nationalism, it was easier to win genuine support for imperial policy.

## Economic imperatives

The growth of opium-related problems in nineteenth-century China is an instructive example of what can happen when a persistent supply and an insistent demand are coupled with ineffective suppression.

Up to the 1830s the problem was created largely by foreign suppliers – Dutch and Portuguese at first, British later. Imports of Indian opium into China were essential to balance China tea exports to Britain, which provided almost all the profits of the East India Company as well as a large slice of British government revenue arising from the import duty on tea. Equally important, and much less controllable, were the private merchants in India and Canton who saw the opium trade as a means of repatriating their fortunes to Britain.

The government of India, which maintained an official monopoly on opium production in its own territories, soon found that opium sales were one of its main sources of income. So powerful were the economic motives behind the triangular trade between India, China and Britain that heavy pressure to maintain sales in China was inevitable. Opium exports from India doubled in the 1830s, despite the measures which the Chinese authorities were taking against the drug.

During this phase of the trade southern

**Estimates of opium addiction in nineteenth-century China range up to 15 million, but ignore the drug's widespread social and medical uses. Addiction as such probably only involved a few per cent of the population, but attempts to curb opium smoking caused serious social and economic dislocation.**

Hulton Picture Company

China began to suffer some of the economic and social repercussions that have accompanied the illicit drug trade in more recent times. The currency came under strain as opium imports passed the level needed to balance exports and began to suck out silver bullion, and smuggling became integral to commercial life.

Opium was officially contraband. Ships carrying it were forbidden to sail up the Pearl River to Canton, so clippers from India transferred their opium to vessels moored in the estuary, beyond effective customs supervision. These floating markets, their decks piled with balls of opium and ingots of silver, unloaded consignments of the drug into fast rowing boats which ran the opium ashore under the eyes of compliant district officials. Bribery, already a recognised source of income for Chinese bureaucrats, was inflated to enormous sums by the opium trade, and the military forces around the coast were widely corrupted.[3]

Lin's crackdown in Canton simply drove the opium depot from the estuary out to Hong Kong, and the selling points to even more distant ports and estuaries. Pirates infested the coastal waters and bandits preyed upon the land routes that took opium into the interior. After the Opium War of 1839-42, when the British presence at sea was greatly strengthened, the pirates moved inland up the navigable rivers, adding significantly to the violence and rebellion that swept central China in the 1850s.

Meanwhile the opium trade continued in an official twilight. The Treaty of Nanking (1842) set up five treaty ports where foreigners could lease land and trade under consular protection, but opium was excluded from the agreement and its sale and distribution took place on receiving ships moored discreetly away from the ports.[4] Half China's foreign trade was in a commodity which Chinese officials would not recognise and British officials could not prohibit.

Opium did not appear in the customs schedules until 1858. Thereafter the Chinese seem to have taken the view that import might as well be allowed into the open so it could be taxed and smuggling reduced, while laws against possession and consumption by Chinese citizens remained.

Only in this period, which coincided with the decline in prosecutions for drug offences, did the treatment of opium in China even begin to approach de facto legalisation. By then, however, the damaging consequences of ineffective suppression were already apparent: networks of illegal supply had been created, opium use was widespread south of the Yangtze and the bureaucratic system had been undermined.

## China grows its own

After 1860 it was the Chinese themselves who played the major part in the production and distribution of opium, the most appropriate cash crop for many peasants. In Szechwan, for example, poppies could be grown in winter, leaving the summer harvest for food grains; in Yunnan, the backward state of communications meant opium was virtually the only cash crop that could be got to market.[5] Being light but high in value, opium was an ideal commodity for casual porterage.

All over China, the production and distribution of opium became taxable activities. It was a time when rebels and local militias sought funds to fight each other, and when provinces became increasingly independent of Peking and embarked on their own modernisation programmes. Opium was too valuable a source of revenue for moral scruples to stand in the way of its exploitation.

By 1906 nearly a third of some provincial budgets came from opium taxes. The twin evils of rural underdevelopment and political instability, which provide a fertile environment for illicit drug production in many parts of the modern world, have their parallels in imperial China.

## An addicted population?

The impact of the opium trade on the Chinese population was the subject of much adverse comment at the time, giving rise to the modern assumption that the nineteenth-century Chinese were uniquely drug-addicted. Such an assumption ought not to be made without careful consideration of the evidence.

Attempts to calculate levels of addiction have taken the total quantity of opium available and divided this by the amount required to sustain a heavy smoking habit. On this basis, estimates of the number of addicts have ranged between 2.8 million and 12.5 million for the 1830s, while Jonathan Spence has estimated that there were 15 million addicts in 1890.[6]

These numbers seem large, but represent between 1.5 and 6.8 per cent of the population of the provinces mainly affected in the 1830s, or 3.7 per cent of the national population in 1890.

Probably these calculations underestimate the amount of opium on the market, but, on the other hand, they do not make consistent use of the rudimentary definition of addiction on which they claim to be based, and the assumption is that opium was consumed solely by addicts.

This was clearly not the case. Opium was used in a variety of ceremonial and social situations: merchants often set the seal on a business arrangement by taking a pipe of opium together, and smoking was also a common accompaniment to gentry hospitality. Another important role for opium was as a folk medicine.

Since a large proportion of the available opium must have been consumed by these moderate users, full-scale non-medical addiction must have been much more limited than estimates suggest. Compared with the 23 million Americans (9.7 per cent of the population) believed to have recently consumed an illegal substance in 1985, it may even be doubted whether imperial China deserves its reputation as the most drug-ridden society in modern history.[7] ■


1. Spence J. "Opium Smoking in Ch'ing China." In: *Conflict and control in Late Imperial China*. F. Wakeman *et al ed.* University of California, 1975, p.143-173.
2. Chang H. *Commissioner Lin and the Opium War*. New York: Norton, 1970.
Waley A. *The Opium War through Chinese eyes*. London: Allen and Unwin, 1958.
3. Waley op cit, p.24-26.
4. Fairbank J.K. *Trade and diplomacy on the China coast*. Harvard University, 1953.
5. Adshead S.A.M. "The opium trade in Szechwan 1881 to 1911." *Journal of Southeast Asian History*: 1966, 2, p.97.
Report by Acting Consul C.A.W. Rose, 9 June 1910. In: G.B. Foreign Office. *The opium trade 1910-1941*. Wilmington: Scholarly Resources, 1974, *1*, p.28-34.
6. Spence op cit, p.154.
Chung T. *China and the Brave New World*. Bombay: Allied, 1978, p.146.
Chang op cit, p.34-35.
7. Bennett W.J. *National drug control strategy*. US White House, 1989, p.2.

# ILLICIT DRUGS AND THE WORLD ECONOMY

***Why a world economy that gives us cheap coffee also gives us cocaine.***

**The rapid decline in raw commodity prices and accumulation of foreign debt in developing countries in the 1980s lies behind the escalating illicit drug production and trafficking activities in some of those countries. Examples are given of the economic pressures behind coca cultivation in Latin America and heroin production in Asia. The conclusion is that global economic reform is essential to the elimination of illicit trafficking.**

## UN Information Service

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TWO OF THE economic trends that shaped the world in the 1980s were the rapid decline in the prices of raw commodities such as minerals and agricultural goods, and an accumulation of external debt among many of the developing nations. The pincer action of these two forces tore apart the development plans of scores of countries and brought on, for the first time in the post-World War II era, continent-wide increases in poverty.

It also ushered in another major trend of the 1980s: the worldwide traffic in illicit drugs became a dominating world industry, with net sales greater than those of petroleum and exceeded only by the international arms trade. According to an estimate in *Fortune* magazine, drug trafficking is now a $500-billion-per-year business.

These bellwethers of the world economy in the 1980s – debt, falling commodity prices, poverty and drug trafficking – are interconnected and mutually reinforcing. The decline of prices for commodities like sugar (by 64 per cent), coffee (30 per cent), cotton (32 per cent) and wheat (17 per cent) between 1980 and 1988 motivated farmers to turn to cash crops like the coca bush and the opium poppy to avoid economic ruin.

At the national level, export of illicit drugs often took up the slack in foreign exchange depleted by falling prices for agricultural goods as well as for minerals, including tin (down by 57 per cent in the 1980–1988 period), lead (28 per cent), crude oil (53 per cent) and iron ore (17 per cent).

The situation was especially desperate in nations burdened with external debt, which needed to be serviced with scarce foreign exchange. Indebtedness and declining revenues from export commodities brought on internal budgetary deficits for many countries, and debt-repayment guidelines demanded reduced spending in the public sector.

Under these conditions, attempts to stem drug trafficking through strengthened law enforcement or increased social services were effectively crippled. Programmes for replacing illicit cultivation with food crops or other legitimate cash crops, which had achieved some success during the 1970s, suffered in the 1980s due to falling prices for agricultural commodities. As farmers turned away from food crops, the need for imported foodstuffs increased, further weakening currency reserves and bringing about greater dependence on foreign exchange inputs from drugs.

The constituent elements of the illicit drug economy are found in highest concentration in the western hemisphere. Latin American and Caribbean nations were hurt badly by plummeting prices for coffee, sugar, tin and petrol, among others. Their combined foreign debt will reach $420 billion in 1990, greater than that of any other region in the world.

In the mean time, the burgeoning United States market for illicit drugs was close at hand. Estimates put its size at from $50 billion to $100 billion a year. Cocaine from South America holds the lion's share of the market, but Mexico, Central America and the Caribbean islands are involved as transit points for cocaine traffic, as well as the production of cannabis. Cultivation of opium poppies for heroin also takes place in Mexico.

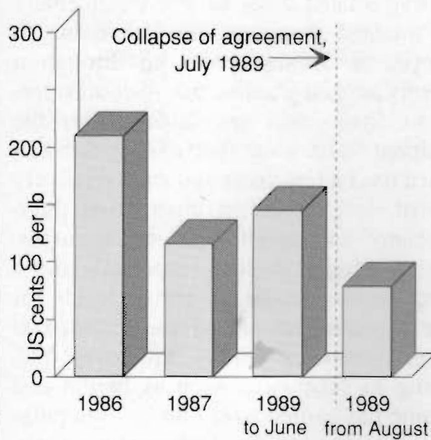
## Coca dollars and banks

According to press reports, suitcases filled with $50 and $100 bills are turned in routinely at bank windows for conversion to pesos in the Colombian city of Medellin, home to the largest of the cocaine cartels.

Peruvian banks maintain busy branches in frontier hamlets of the Upper Huallaga Valley, where the most extensive cultivation of coca bushes in the world is carried out. An informal currency exchange market is run on Ocona Street, in the capital city of Lima, where $3 million change hands daily.

A similar situation prevails in Bolivia. A 1986 report by economist Samuel Doria Medina found that four-fifths of the exchanges in Bolivia's 'parallel' currency market – easily the largest source of dollars

## International coffee market and cocaine




**Colombian coffee on the New York market[1]**

**Colombia's most important legal export cash crop – coffee – as well as its most important illegal export – cocaine – are heavily linked to the US market. Last year, US policy regarding coffee producer countries contributed heavily to the collapse of the international coffee agreement. The US backed a call for other producers of Colombian-type coffee to be given a bigger share of the export market. American trade officials hoped to increase availability and so decrease prices, but the move ended in a failure to renew the agreement. This triggered a 50 per cent fall in coffee prices, which is likely to cost Colombia some $500 million in export earnings in 1989. The estimated loss is 7.5 times greater than the $65 million in military aid that the United States offered the Colombian government last year to fight the war on drugs.[2]**

in that country – can be traced to sales of coca and coca paste.

Coca dollars loom large in precarious South American economies, but they are only the tip of the iceberg. The US Drug Enforcement Administration estimates the Colombian cocaine cartels gross about $50 billion a year, yet only $2–$4 billion accrue to the Colombian economy. Doria Medina calculated that 15 per cent of the total value of cocaine from Bolivian coca stayed in the national economy. Clearly, the greater part of profits from the western hemisphere drug nexus is invested outside source countries or held in overseas bank accounts.

The major repositories of coca dollars are banks in Europe, the United States and islands of the Bahamas and in the Caribbean. Banks wittingly or unwittingly help drug barons launder as much as $100 billion a year in proceeds from sales in the USA.

One way to trace the flow of drug money into banks is to look at currency surpluses. Under usual conditions, bank deposits and withdrawals over a given period tend to even out. A currency surplus indicates large deposits of cash from informal or illicit sources and is connected by the US Treasury Department to laundering of drug receipts.

Thus the currency surplus of banks in Florida, traditionally the main gateway for cocaine smuggled into the USA, increased from $576 million to $1.5 billion in 1976. By the end of the 1980s, the flow of cash turned into a deluge swamping the entire southern border of the United States.

The effect of the debt crisis in stimulating drug trafficking has come full circle. Loans from US banks to developing countries set the stage for the crisis, and defaults on the loans undercut the stability of the US banking system. Now the proceeds from drug trafficking are helping to buoy the liquidity of US banks and figure prominently in payments on Latin American debts. The impact of coca dollars in the western hemisphere now extends from peasant farmers in the Andean mountains to national governments across Latin America and the boardrooms of major banks.

## The cocaine economy

The cocaine industry is a major employer in the three key nations of Bolivia, Colombia and Peru. Estimates of the number directly employed range between 600,000 and 1.5 million. About three quarters are farmers and coca-leaf pickers; nearly one quarter are *pisadores* (stompers) who mix leaves and raw chemicals like kerosene with their bare feet; a few thousand work in clandestine laboratories processing coca paste into cocaine; and a thousand or so, including cartel billionaires, direct import–export and finances.

In addition, many more people owe their livelihood indirectly to the multiplier effect on local economies – although not as many as would be the case with legitimate industries of the same proportions, since most of the locally retained profits are spent unproductively on real estate, luxury goods, status-symbol cattle ranches, private armies and bribery.

What are the returns on their labour for the 99 per cent of the cocaine workforce who grow coca and turn it into paste? A study of peasant farmers in the Chapare district of Bolivia, largely Andean Indians, looked at the effects of integration into a cocaine economy. The coca leaf boom took off in 1982–3, at the same time that economic recession and a severe drought wrought havoc in the rural highlands.

Bolivia's gross national product declined by 17 per cent between 1980 and 1985, per capita consumption fell by 30 per cent, per capita income by 20 per cent, and unemployment doubled. Terms of trade for farmers suffered from inflation of 2800 per cent in 1984 and 10,000 per cent in 1985. In 1985, producers of coca leaves could earn $9000 from 2.2 acres, while those growing the next most profitable crop, citrus fruits, were averaging only $500 from plots of the same size.

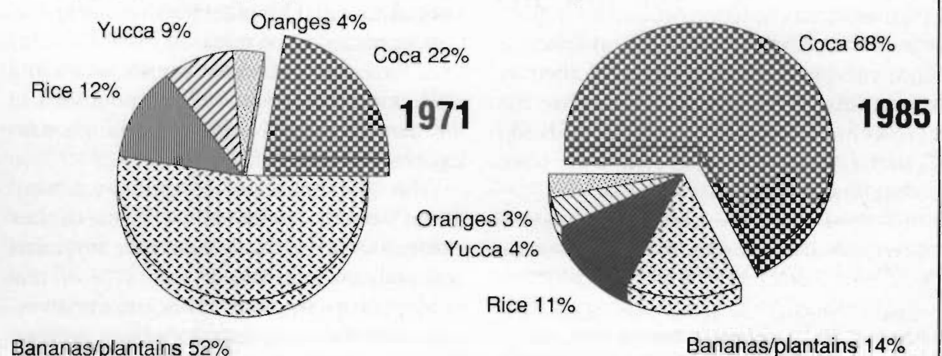
Landless farmers, and workers laid off due to the collapse of the tin market, found work as *pisadores*, earning wages six to eight times higher than those for any other skilled or unskilled labour in the legal rural economy.

Despite the immediate benefits, including sheer economic survival, there has been a high price to pay. The cost of living, once relatively low in Chapare, rose to greater heights than in any other section of Bolivia, eating away at earnings. Cash exchange

## Bolivian peasants switch land to coca[3]

**A study of the coca economy in Bolivia reports that in the department of Cochabamba, coca produces the highest net income of the local economy, that is, 3.2 times more than that obtained from oranges, and more than 6.3 times the income from banana production.**

**While the average gross domestic product per capita (GDP) for the rural areas in Bolivia as a whole was $401 in 1988, in the regions of Chapare (department of Cochabamba) and Yungas (department of La Paz) – the largest coca producing areas of the country – average GDP was $566 and $509 respectively.**




**Peasant land use trends in tropical Cochabamba, Bolivia**

replaced traditional forms of barter and mutual support that provided stability and equity in Indian communities. Food crops such as potatoes and maize were in uncharacteristically short supply, due to diversion of labour to coca.

As local development corporations did not receive revenues from the illicit coca trade, investments in drinking water supplies, plumbing and electrification were not made. The work of the *pisador*, involving the treading of kerosene–leaf mashes throughout the day, day after day, is unhealthy in the extreme. Finally, there is the subjection of local residents to intimidation and brutality – they are simultaneously vulnerable to the coercion of criminal organisations and to police and army crackdowns. For all this, the local population has become dependent on the price of coca, which has been falling sharply since 1985.

An additional impact is the breakdown of tribal, communal and cooperative rural organisations under pressure from traffickers and affiliated terrorist groups. Conversely, in Bolivia and throughout the Andean regions, areas with the strongest local organisations have best resisted submersion in the cocaine economy.

## The heroin economy

In its ability to addict consumers and generate multi-billion-dollar sales, cocaine is rivalled only by heroin. A kilogram of heroin has a wholesale value of about $400,000 in the United States; cut to 6 per cent purity, its value reaches $2.2 million. Shadowy warlords operating inside the 'Golden Triangle', a mountainous area where the borders of Myanmar (formerly Burma), Thailand and the Lao People's Democratic Republic meet, were estimated to be producing 60 tons of heroin per year in the mid-1980s. Of these, 20 tons were directed to European and North American consumers.

This indicates sales of tens of billions of US dollars in Western markets alone. The remaining 40 tons would be divided between sales in Asia, where prices are considerably lower and purity is generally higher, and caches held as hedges against confiscation or poor crop years.

As with cocaine, only a small percentage of total sales accrue to the producing region. Finance and distribution of Golden Triangle opium, morphine and heroin are handled by various outside consortia. Most utilise the freewheeling Hong Kong financial markets, although Japanese criminal syndicates have also become involved.

## Food crops no substitute for drugs

The difficulty of substituting legitimate crops for the opium poppy is indicated by a study conducted in the area of Mahaban Mountain, in Pakistan's North-West Frontier Province.

About 125,000 people live on the ridges and valleys of the mountain, most cultivating plots of land averaging only half an acre.

The opium poppy has been the main crop since the 1800s, when it was legally grown for export under British colonial rule. Thin soil, steep slopes and small plots make profitable cultivation of any other crop difficult – earnings for poppy cultivation are roughly ten times higher than for tobacco and fruit.

Crop substitution programmes have encouraged alternatives such as wheat grown from high-yield seeds, but the international price for the crop has been falling during the 1980s. A relatively undeveloped regional infrastructure provides little opportunity for non-agricultural income, and the long-standing values of the local Pushtun people place a premium on landowning status.

In addition, pressure is exerted on them to continue poppy cultivation by opium traffickers located in the town of Gandaf, at the foot of the mountain.

The dominance of the Golden Triangle in production of opiates has been eclipsed in the last two decades by the 'Golden Crescent', encompassing lands running through Pakistan, Afghanistan and Iran. As social upheaval and civil strife in Iran and Afghanistan in the 1980s disrupted production and shipping, Pakistan became the world's largest source of heroin. By 1984, European police concluded that 70 per cent of the world's supply of high-grade heroin came from that country.

## Cost of consumption

A report commissioned by the US Alcohol, Drug Abuse and Mental Health Administration, expected to be released in 1990, states that the costs of drug abuse and drug trafficking amount to $60 billion a year in the world's largest drug-consuming country.

The bill that must be paid by United States society includes the costs of law enforcement, medical treatment for users and addicts, inflation of the price of real estate, non-payment of taxes and the diversion of money and resources from productive to non-productive enterprises. The authors admit they have not been able to track down all the side-effects of drug abuse and drug trafficking, maintaining that the complete cost is certainly much higher than $60 billion.

Drug-related costs of law enforcement and medical treatment are also rising in Europe, as cocaine pours in through a recently opened pipeline from South America to Spain and eastwards across the continent. The countries of sub-Saharan Africa until a few years ago were relatively free of drug problems apart from those associated with locally produced cannabis. Use of African nations, especially those along the west coast, as transit points for drug shipments has placed a new burden on law enforcement agencies. Moreover, trafficking in substances such as heroin and cocaine has spilled over into local populations, creating significant drug abuse problems. Australia is a major destination for heroin from the Golden Triangle.

Major drug-producing nations are also experiencing the social and economic costs of drug abuse. A 1985 US State Department *International Narcotics Control Strategy Report* estimated the number of addicts in Bolivia to be 40,000 to 50,000, about 150,000 in Peru, and 600,000 in Colombia. In these countries, where cocaine addiction was sparse a few decades ago, the drug of choice among the poor is *basuco*, a smokable mixture of tobacco or marijuana and coca paste. In the mid-1980s, there were thought to be well over a million heroin addicts in Iran, 600,000 in Thailand, and 650,000 in Pakistan.

Added to the price the world pays for drugs in terms of destruction of human and economic resources, is the destruction of natural environments. Processing of coca leaves into coca paste in the Andean and Amazonian regions of South America causes tons of toxic chemical residues to be poured into the rivers, poisoning already threatened ecologies and contaminating farmland and livestock.

On the west coast of the United States, covert laboratories producing methamphetamine for the illegal market also turn out by-products of toxic hydrogen chloride gas and lead acetate, and explosives such as ether and red phosphorus. Toxic sludge from the labs is dumped into rivers, forests and plumbing systems, contaminating dwellings and polluting the soil and water.

THE TRAFFIC IN illicit drugs, led by but not limited to cocaine and heroin, is truly an international phenomenon. The industry mimics the structure of transnational corporations, connecting production, marketing and finance in an intricate web that disregards national boundaries and penetrates every continent. The correlation between debt, poverty, unstable commodity prices and the rise in drug trafficking in the 1980s indicates that a comprehensive effort to eliminate any one of these problems must also deal with the rest. ■

1. International Coffee Organisation. *Weekly report on prices*, 3 May 1990; *Prices*, 1988. Colombian coffee was not quoted in 1988.
2. Ardila P. "Beyond law enforcement: narcotics and development." *The Panos Institute*: February 1990, p.1-8. International Coffee Organisation, personal communication, May 1990.
3. Ardila P. op cit.

# CAN LOCAL DRUG PREVENTION 'SIZZLE'?

*The lessons of an innovative local drug prevention campaign.*

**A drug prevention campaign in Brighton used local radio ads, a phonecard and other materials circulated through youth clubs to stimulate calls to an answering machine with a message on drugs. The materials evoked generally positive responses among the minority of young people who became aware of them. While local interest was generated, a lack of tie-in between elements of the campaign limited youth involvement.**

## Nicholas Dorn & Laura Gamble

*Nicholas Dorn is ISDD's Development Director and Laura Gamble is DAIS's Information Officer.* *They thank health and education staff in Sussex, especially Sue Boice; also Andrew Fraser and Lorraine Olver; and the DoH which funded the campaign and evaluation.*

FACTLINE '89 was a drug prevention campaign designed and delivered at a local level by DAIS, the Drug Advice and Information Service in Brighton. Brighton is in South East Thames Regional Health Authority, one of three approached by the Department of Health late in 1988. The department's proposal was that each RHA nominate local agencies to implement local action linking drug prevention and education services by 1 April 1989.

DAIS constructed a strategy for a campaign with three main elements:

- two local radio commercials aimed at young people;
- a set of materials disseminated through the youth service and through colleges attended by 16-19 year olds; and
- a 'harm minimisation' phone message (the 'FACTLINE') advertised by the radio ads and the youth service materials.

Lasting one month, the campaign was initiated on 6 March 1989 by a publicity launch with press pack and by newspaper advertising, and cost just under £10,000.

DAIS adopts a broadly harm-minimisation approach to its work with clients. It also adopts a similar approach to prevention, arguing that overt anti-drug/anti-drink preaching is unlikely to be effective and may alienate young people; the important thing is to act as a credible source of information and to point out the particular dangers young people may not be aware of, such as drug/alcohol interactions. Asked to consider mounting a prevention campaign, the agency sought to marry the concerns and resources of central government to their own harm-minimisation aims.

The agency did not change its view that it was 16-25 year-olds – particularly those more independent and excitement-seeking – who are especially in need of good information, and that messages for this group have to be presented in ways they will find accessible and acceptable. Local radio commercials were seen as a suitable medium, and one relatively quick to set up.

One thing that *did* differ from the agency's previous campaigns was the tight time-frame imposed by the need for government departments to spend monies before the end of the financial year. With just nine weeks to complete the task, embellishing existing practice, rather than complete innovation, was the only practical course – one reason why the campaign included two elements from DAIS's 1988 campaign.[1]

In the youth services pack was a really creative innovation – a phonecard allowing free calls to the factline. Supplied free by British Telecom, the card came in a plastic wallet with information about the factline. Also included were a small poster, coasters, a briefing for the worker outlining the campaign, 'reminder cards', and a set of "Golden Rules" designed to promote discussion with young people.

The radio commercials were produced by a local advertising agency working to DAIS's brief. Printed materials were also locally designed and printed. The answerphone message was scripted by DAIS and the advertising agency, which arranged its professional recording.

A training/explanation/induction meeting for youth workers was planned, but proved impossible because the education department's planning schedules – worked out several months in advance – were not sufficiently flexible. This was to have implications for youth workers' and young people's understanding of and involvement in the campaign.

## The impact

The impact of the radio commercials was assessed by a survey of 552 young people five weeks after the end of the campaign.[2] Asked about the FACTLINE '89 commercials, one in ten said that they were aware of them, and three-quarters of these thought – as intended by DAIS – they had been aimed at young people in general and at *potential* drug users. Two-thirds of those who remembered them felt approval or happiness over the ads, and a quarter sadness or frustration.

The story of how the youth work materials were received by young people is

## Campaign themes

**DAIS's campaign themes were:**
- **Dangers of mixing alcohol and other drugs.**
- **Specific dangers around solvent use.**
- **Hazards of taking unknown pills.**
- **The dangers of unprotected sexual intercourse.**

told second-hand by workers either interviewed, involved in group discussions, or surveyed by post. Most of the 600 packs went to youth clubs and the rest to colleges.

In the more informal youth club setting, the poster was pinned on a wall, the coasters put to fairly immediate use and played with in various ways, the phonecard passed round and admired but not used in the club (most lack a phonecard payphone).

A postal survey of 28 youth workers confirmed that these materials were responded to positively, but most (17) reported that young people generally responded only briefly, and in nine cases there was apparently no discussion at all.

Youth workers received a briefing outlining the four themes of the campaign as well as the other materials. But, since most neither heard the radio ads nor rang the factline, they were not very well placed to facilitate follow-up activities or discuss campaign themes with young people.

What seems to have been missing is any clear follow-up structure for capitalising on the novelty value of the materials to get discussion going around the campaign themes. A similar problem seems to have occurred in the colleges. Here, the typed factsheets were potentially more relevant, but were too long and complex for many students. The coasters, described as beermats, generated some bewilderment in the context of classrooms, but some found their way into refectories and became objects of comment. The poster was quite liked, but you could not 'do' anything with it.

The phonecard was "an absolute bonus", generating much interest, but there was a need for some *intermediate* activity between 'looking' at the card and 'phoning' the number in order to keep up the momentum.

The factline call-logger recorded a rapid escalation of calls from the day after the launch, touching 60 a day in the first week and then falling back to between 10 and 60 per day over the next four weeks. Although the last commercial was broadcast on 27 March, calls continued well into April, due to a mixture of continuing news coverage, local newspaper advertising and comment, and continuing circulation of the phonecard and other materials. By the end of April, over 600 calls had been received, cumulating to over 800 over the next month.

## FACTLINE '90

The FACTLINE '90 campaign due to be launched on 3 September will draw on the experience of last year and the recommendations of the evaluation report. Because of the much longer planning time, there will be opportunity for workshop sessions for youth workers and college staff to preview all the materials. Follow-up packs will be far simpler and more activity-based and cassettes of the two radio ads will be distributed to all youth centres organising discos, so that the campaign's messages can be programmed into their music output.

DAIS is also negotiating for the secondment of a part-time detached worker to develop contacts with young people in clubs and pubs in Brighton.

Now that plans have been unveiled for the new Home Office local Drug Prevention Teams, ostensibly "fully responsive to local needs and perceptions", it will be very interesting to see how locally-developed projects (especially those built on harm-reduction strategies like FACTLINE in Brighton) will fare alongside the teams' programmes of work.

## Doing it better

The FACTLINE '89 campaign was a success in terms of the design of its parts and was quite well integrated in terms of multi-agency coordination at the tops of the hierarchies of participating agencies.

DAIS was able to tie together central government, health authority, education authority and local media around a concept of prevention of harm among young potential drug users. This is a considerable achievement – a small agency writing the agenda for wider cooperation. Government got good value for money, since DAIS's strategy of getting free publicity by encouraging local press and radio to report the campaign as *news* worked well.

But lack of time and, possibly, lack of a clear strategy for helping bridge the gap between awareness and action, limited the campaign's potential for professions 'at the coalface' and for young people.

Take-up in educational systems (youth work and colleges) was relatively poor. Lack of training/induction for youth workers and college tutors, and the compressed time scale, are the most obvious causes. Two other factors can be identified: unnecessary complexity in the materials, with too much printed matter for most young people (and for busy practitioners); and insufficient thought about how they might be used in the contexts in which they were to be delivered to young people.

These factors left too many young people intrigued but bemused, when simple participative approaches might have generated greater enthusiasm and more action. Four campaign themes and as many presentational devices are simply too much.

We suggest two areas where future campaigns may be improved. As far as informal and formal educational settings are concerned, future materials should be less diverse, more participative, and help to construct an interest-involvement-action chain. Examples might include:

– posters that *illustrate* groups of young people using the phonecard;

– games and jigsaws that convey a message and also give *specific prompts* to calling the factline;

– coasters that have printed on them very simple mini-questionnaires asking what aspects of the recorded message were fantastic/boring/stupid, providing a basis for *post-call discussion*; and

– very simple '*what to do*' sheets for youth workers and tutors.

It may also be useful to take up the point that few people over 14 frequent youth clubs. Outreach work was suggested as a means of contacting older, more drink/drugs-prone young people. However, new workers are unlikely to be able to become effective within the time-span of a short campaign.

The question remains of how to tie together radio commercials with distribution of other materials – coasters, possibly comics, phonecards, etc. One way would be to link the materials to concessions such as reduced price or free entry to entertainment venues. This could be advertised by radio, giving the number of an answerphone capable of giving a short message and then recording the caller's name and address to which tickets and campaign material could be sent.

Even in short campaigns, adequate planning time is desirable so that the local agency has the chance to build up the forward momentum needed to handle a demanding campaign without unnecessary strain, and so that campaign strategies can be translated into an integrated set of actions.

For this to happen, campaign sponsors would need to give more notice than was possible in this case. Since the political and funding dynamics of central government seem unlikely to allow this, local health and education authorities should develop outline proposals. These would suffice to support the planning, design and delivery of skeletal campaigns, which could opportunistically be expanded by short-term injection of cash from central government and/or private sources. ■

1. Fraser A. *et al. Drug Questions research register*: 1988, *4* p.133-9.
2. The survey was drawn up in a very short period of time by the advertising agency and can only give a rough idea of the response of the target group.

**REVIEW**

# Relapse and Addictive Behaviour

EDITED BY MICHAEL GOSSOP

**'It's not the getting off, but the staying off.' A leading clinical psychologist has assembled the latest wisdom on the difficult end of addiction treatment.**

**RELAPSE AND ADDICTIVE BEHAVIOUR. Michael Gossop *ed.* Tavistock/Routledge, 1989. 305 pages. £29.95.**

*Relapse and Addictive Behaviour* comprises a series of articles by several authors reviewing the concept of relapse, under the editorship of Michael Gossop. Reading it is rather like eating a whole box of expensive chocolates. Some parts are succulent and appetising, others, if not hard to swallow, certainly hard to digest.

The contributors are mainly clinical psychologists, as is the editor, and this bias is reflected in the largely behavioural analysis of the process of relapse. Like Jim Orford's *Excessive Appetites: a Psychological View of Addictions* (1985), the analysis widens the boundaries of addiction to include eating disorders, sex offending, gambling and high-risk AIDS-related activity.

The theme which runs through the book is that relapse should no longer be regarded as an event but as a process of cumulative stresses, effects of internal and external stimuli, negative and positive emotional states, expectancy effects and conditioning. This is set in stark contrast to the medical/traditional model of 'craving' leading to 'loss of control'. The book complements neatly the psychological perspective espoused in *Treating Drug Abusers* edited by Gerald Bennett (1989), from the same publishing stable.

As always, I will deal with the tasty chocolates first. The book provides, to my knowledge, the best and most complete analysis of relapse available. It underlines the importance of relapse prevention (since most of our clients relapse most of the time), and the clinical implications provide rich pickings for those who persevere. Strategies for avoiding or coping with high risk situations are identified, including modifying the abstinence violation effect which makes so many lapses progress to relapses.

The powerful roles of expectancy effects and 'subjective expected utility' (an internal weighing up of the pros and cons of various actions) are examined, with important implications for clients' subjective prediction of treatment outcome.

I especially like the chapter by Saunders and Allsop and their suggestion (seldom tackled in the literature and widely condemned as heresy) that relapse might be a necessary stage in the process of recovery. This is a challenging thought with far-reaching implications. Should we actually be stage managing lapses as learning experiences to weaken the powerful priming effect whereby one lapse can lead to another?

In the same chapter the authors identify the negative social conditions which outweigh the positive impact of psychological intervention in relapse prevention. They argue, therefore, that relapse prevention might better be achieved by social rather than clinical intervention.

On the negative side (chocolates to be offered around to unsuspecting friends) is a level of technical jargon which limits the scope of the book's readership. Clinicians will have to struggle with the dryness, the text continually broken up by references, and a level of analysis and discussion which sometimes renders the obvious obscure.

The authors' professional backgrounds are reflected in the frequent use of psychological terms and concepts. To get the most out of the text you will have to have a working knowledge of attribution theory, learning theory, AIDs (apparently irrelevant decisions) and other terms such as cognitive vigilance, proximal and distal causative factors, etc. A glossary of terms might have been useful for the uninitiated, but has not been included in this edition.

This is an important work which bestows justified importance on the concept of relapse and the role of relapse prevention in treatment. Its academic/psychological bias may decrease its accessibility to some of the clinicians and practitioners who need to expand their understanding of relapse, but, like my box of chocolates, there's something in there for everyone. Just don't eat it all at one sitting.

**Michael George**

*Principal Clinical Psychologist, Options Project, Worthing.*

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**LETTERS**

## Group living is the key to recovery

Dear Editor,

The article "Nursing by Rote" by David Richards (***Druglink***, March/April 1990) advocating "individually tailored" inpatient treatments, fails to appreciate the importance of group experiences and rule-setting in drug rehabilitation. Through these experiences, therapeutic regimes are evolved by the addicts rather than, as Richards suggests, imposed by staff.

Recovery or rehabilitation houses developed in the '60s and '70s from ideas of the 'community in therapy'.[1]

Social structure, hierarchies and rules inevitably became an important part of treatment programmes, enabling the treatment community to act as a microcosm of society. Today in residential treatment centres, daily group living with all its rules and boundaries, has become the therapeutic workbench.[2]

That "drugs are not the problem, but merely a symptom of the problem",[3] is an insight that many behaviour modification programmes fail to recognise. Short-cut symptom treatment lacks the quality to really effect long-term change.

Within the structured treatment community today, drug workers feel the need to be less directive and to allow residents and clients to 'grow' and make their own decisions. Suspension of old chaotic behaviour is as a result of peer group pressure rather than therapist intervention. Firm and safe boundaries are set by the community and perpetuated by senior residents who, having been drug free for about a month, are ready to take more responsibility for themselves and others.

The similarities between rehabilitation houses – run by non-nursing staff – and inpatient units like Bethlem – statutory and run by nurses – are most striking. This suggests that the 'new models' of residential treatment have evolved from the addicts' needs, rather than from the interventions of directive practitioners.

David Richards queries whether the same regime can be suitable for new, younger users and for older users. But ages in all treatment units vary, and for good reasons. Variety in the group is the necessary spice of the community, as it is our differences which bring us together rather than our similarities.

Group living is the central focus of therapy in successful treatment centres. The theme of separation and isolation of individuals from groups is an unfortunate trend of the '80s, and of many behaviour modification programmes.

I agree that the way forward is to continue to develop programmes where users can determine their needs and negotiate their own objectives. At both non-statutory recovery houses and hospital units like the Bethlem, the staff must continue to work as both "friend and therapist"[4] within the all-important social structures.

HIV, AIDS and substance abuse are 'group affairs'. Recognition of this has meant that dependency treatment centres like Phoenix, Alpha and the Bethlem, have survived when other less group-orientated programmes have failed.

1. Main T. "The hospital as a therapeutic institution." *Bull Menn Clin*: 1946.
Jones M. *Social psychiatry: a study of therapeutic communities*. Tavistock, 1952.
2. Winship G. *Witley Two – The social structure, systems and philosophy*. 1989. (Unpublished – available Witley Two, Bethlem Royal Hospital.)
3. Statement by Alpha House. In: SCODA. *Directory of residential treatment centres*. SCODA, 1989.
4. Strang J. "Psychotherapy by nurses." *J. of Advanced Nursing*: 1977, 7, p.167-171.

**Gary Winship**

*Nurse and Team Leader, Bethlem Royal Hospital drug dependency unit.*

## Clarify GPs' role

Dear Editor,

In "Ways to Open the Surgery Door" (***Druglink***: 5(3)), Dr Waller discusses financial inducements which might encourage more GPs to take more interest in drug misusers.

But any such move must be preceded by the acceptance of a clearer view of what GPs can aim to achieve. Doctors are expected to be good at preventing, diagnosing and treating diseases. Focusing on that should sharply improve their clarity of vision.

There are two main reasons why some GPs lack enthusiasm in dealing with drug misusers. The first is confusion over their role. Trying to be a social worker, a prescription writer or an authoritarian figure seem unlikely to maintain GPs' interest, yet may be thought appropriate by others.

The second is a belief that any effort made by the GP is doomed to fail. This may be a self-fulfilling prophecy if advice and care lack conviction.

Dealing with drug misuse can be professionally challenging and fulfilling if the prevention, diagnosis and treatment of disease are emphasised. Financial implications must take second place for any real improvement in the care of drug misusers to be achieved.

**Robert Scott**

*GP and Medical Officer to Wilton Street Drug Rehab. Unit, Glasgow*

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

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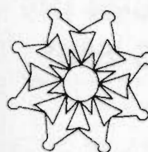
RET has long been recognised in the chemical dependency field as an effective tool against negative thinking and "frozen feelings". Basic course content focuses on effective counselling skills, assertiveness, identification of thinking causing anxiety, fear, jealousy, anger, shame and other self defeating behaviours.

**MELVIN BOWLER, MACS, CMC**

Psychotherapist. Specialist in human relationships education. Founder first Australian Adult Children of Alcoholics clinic, and a number of self help programmes.



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## HAMLIN & HAMMERSLEY WITHDRAW WORKSHOPS
### Autumn 1990 Programme

**Managing Benzodiazepine Withdrawal I**

27-28 September LONDON
13-14 November BRISTOL

**Improving Relationships Using Transactional Analysis**

11-12 October BIRMINGHAM

**Motivational Interviewing**

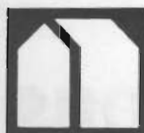
29-30 November LEICESTER

These 2-day workshops are skills-based and participants are encouraged to draw on their own experience from work settings.

*Brochure and further details from:*

**Hamlin & Hammersley/Withdraw Workshops**
515a Bristol Road,
Birmingham,
B29 6AU

**Tel: 021-471 3626**



## Stonham Housing Association

### BRIGHTON SUBSTANCE ABUSE PROJECT
### RESIDENTIAL PROJECT WORKER

Stonham provides housing for people with special needs in projects throughout England and Wales.

The Substance Abuse Project in Brighton is a new scheme. It will provide temporary accommodation and support for five residents recovering from substance abuse problems.

The person appointed will have responsibility for the day-to-day management of the project, with support being provided by a part-time worker, the local committee and volunteers.

Applicants will need to demonstrate a commitment to special needs housing. Relevant experience in the field of substance abuse is essential. No specific qualifications are required.

The post is residential and a self-contained flat is provided on the premises free of charge.

**Salary: £10,290 pa (NJC Scale 22-25)**

*For an application form and further details please contact:*

**Stonham Housing Association**
**94 High Street, Dorking**
**Surrey RH4 1AY**
**Phone: 0306 76409**

*Closing date: 24 August 1990*

# LOCAL DRUGS PREVENTION TEAMS

## BIRMINGHAM and LEWISHAM

We are looking for committed individuals to form drugs prevention teams in Birmingham and Lewisham to carry forward a new Home Office initiative aimed at limiting drug misuse.

In partnership with local communities, the teams will develop projects aimed at preventing the misuse of drugs and strengthening the communities' resistance to the spread of drugs. The team will be guided by a local advisory group.

### Team Leader £20,000+

You will need to be innovative and able to influence and gain the respect of local people and organisations. You will also need high-calibre management skills to run the team and its resources.

### Team Member £15,000+

You will deputise for the team leader and work on specific tasks and projects with the minimum of supervision.

The appointments, on secondment or limited period basis, will be for 3 years in the first instance. Applicants should have experience of working in a drugs related or similar field; knowledge of the local area and experience of working in a multi-racial environment are desirable.

For further information about the initiative, telephone Sandra Brown on (071) 217 8166. Application forms, with further information about the jobs, are available from Sarah Noor, on telephone (071) 217 5268/5787. The closing date for applications is 3 August.

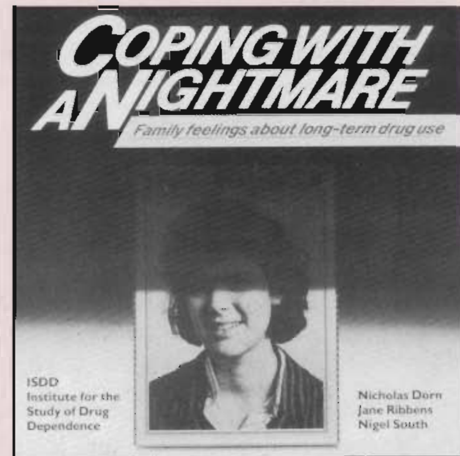
Teams will be set up in other areas in due course.

The Home Office is an Equal Opportunities employer and welcomes applications from suitably qualified individuals regardless of race, religion, sex, or disability.

**Home Office**

**isdd services**

# HELPING FAMILIES TO HELP THEMSELVES




## Coping with a nightmare – family feelings about long-term drug use

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The inside story of how it feels to have an addict in the family.
Will help you understand parents' needs.
Families tell in their own words:

☆ what they felt
☆ how they acted
☆ what happened when they went for professional help.

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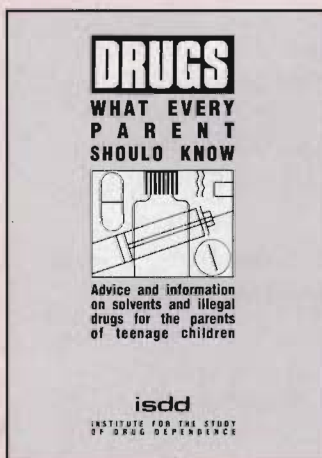



## Drugs: what every parent should know

*ISDD*

An information guide for parents who want to know more about drugs.

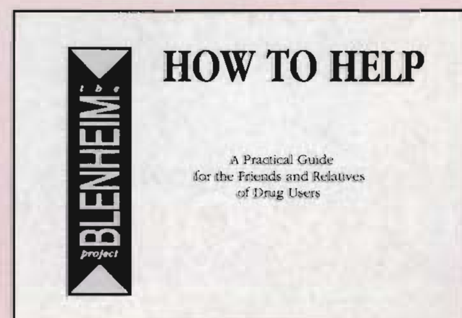
**32 pages £1.25**

## How to help: a practical guide for the friends and relatives of drug users

*Blenheim Project*

Ways a problem drug user's contacts can help them cope with or overcome their dependence.

**12 pages £0.95**

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