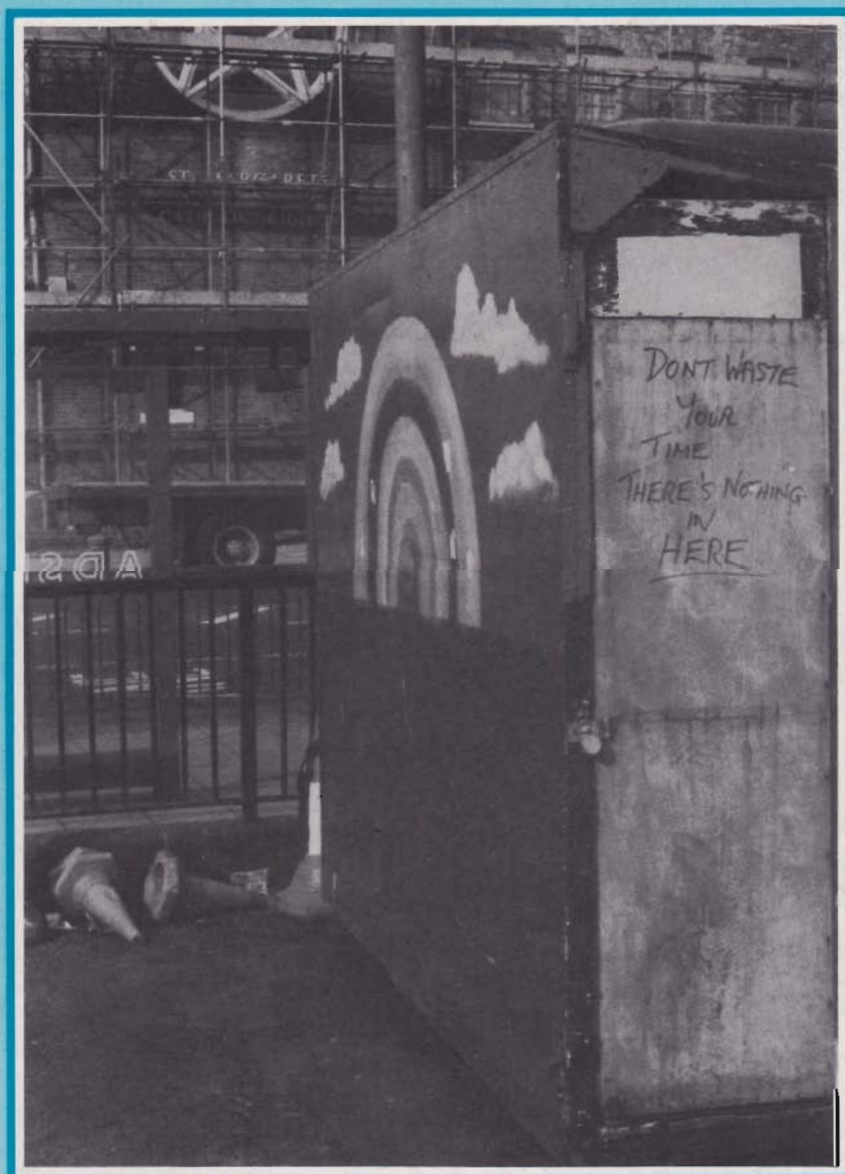


DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN

November/December 1987

And then
there were
none:
needle
exchange
schemes
close in
Dundee.
See page 8



Dole,
deprivation
and
drugs —
is there a
link?
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RESEARCH CONFERENCE

The Drug Questions Research Conference will be held at the Polytechnic of Central London from Wednesday evening, 13 April to Friday lunchtime, 15 April, 1988.

The provisional programme offers an opening panel on the 'state of the art' in drugs research; sessions on evaluation of services; research into regional differences in drug problems; research issues raised by AIDS and new epidemiological studies; studies of drug-related crime and law enforcement; and research developments in drug education relating to prevention and harm-minimisation. Please note that the conference is designed for those conducting research and does not offer training in ways of responding to drug users.

Places are likely to be in demand and there is a limit on the number of participants. If you are interested, please write for a booking form — telephone enquiries/bookings cannot be accepted.

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It offers Fellowships, annually, to enable drug specialists to study techniques and services in other member countries, or to participate in studies and research. Funding is provided to cover the expenses of the visit. In general, these are of 3-6 weeks duration. Fellowships are not intended to provide for attendance at international meetings.

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Cover photo by John Knight

Colourful psychedelic patterns redolent of the '60s drug era and a defensive message of emptiness from the '80s decorate a roadside hut in a run-down part of London's East End.

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**It only takes one prick
to give you AIDS.**

Nobody likes the idea of sticking a needle in their arm.
Even people who've already done themselves a fair bit
of damage by smoking smack.
But some people still do it and this is what they're
up against.
The AIDS virus can live on dirty needles and works.
You can't always tell by looking at people (or needles)
whether they're infected or not.
And if you share an infected needle or works, one fix
can get the virus straight into your blood.
After which, it could take you several years to die.

DON'T INJECT AIDS

For further advice, phone 0800 567 123, free of charge.

Advertising agency TBWA achieve a triple entendre in this deliberately risqué youth press ad, part of the new government-commissioned joint anti-injecting/anti-drug campaign.

TBWA managing director Sammy Harari explained that market research "showed if an ad is a bit near the edge, kids are a bit more likely to take the message more seriously because they would not expect the voice of authority to use that kind of language. The more you are talking to people who are further into the drug culture, the greater the requirement for very clear, explicit messages".

More pictures from the campaign on pages 10-12

Gloves off in anti-injecting campaign

Featuring the twin messages "Don't inject AIDS" and "Smack isn't worth it", the government's £5 million joint AIDS/drug prevention campaign was launched on 2 September. Unlike the earlier AIDS campaign, this new phase is aimed at actual or would-be drug users rather than at the general population.

John Moore, Secretary of State for Social Services, described its main target groups and objectives:

"Firstly, young people who might be tempted to use drugs. To them we say — don't, it's not worth it. Secondly, existing drug users who might be tempted to inject. To them we say if you don't inject drugs you won't inject AIDS. Thirdly, existing drug injectors. To them we say if you can't stop, never share injecting equipment."

Anti-injecting ads (catchline — "Don't inject AIDS") unveiled at the launch included five double-page spreads for the youth press, a poster, TV commercial, and four radio ads. Also in preparation is a range of material advertising the National AIDS Helpline. Further advanced than the drugs side of the campaign, these materials started appearing from day one — the TV ad was screened on the night of the launch.

The anti-drug ads were finished later and appeared after the anti-injecting ads had already come on stream, but

early on the strategy was clear — a move away from the physical deterioration and dependence themes of the earlier campaign towards emphasising the social consequences of heroin addiction (boys descending to 'stealing from mum', girls to prostitution). In these ads, AIDS prevention appears a secondary theme, but the underlying aim is to prevent spread of HIV by preventing youngsters being "tempted into drug misuse in the first place". "This is why we have developed our drug campaign," said John Moore.

In this context, it's hard to understand why the 'drug' prevention ads refer only to heroin ("Smack isn't worth it" is the catchline) when the government is saying Britain may have turned the corner on heroin and is — as Scotland's Chief Medical Officer said in the press release announcing the campaign — increasingly "concerned about young people who are injecting amphetamines and see themselves — quite wrongly — as being less at risk of catching AIDS than heroin injectors".

The plan is to run the different media strands of the AIDS/drug offensive in parallel to the end of the year, with eventually four posters displayed on 2000 sites, 80 advertising slots in 30 youth papers and magazines, 21 spots a week on independent radio and the TV ads screened three times a week as well as being shown in 1200 cinemas.

It appears no expense has been spared preparing the materials, with top TV directors and famous film and stills cameramen being engaged by TBWA, the advertising agency behind the campaign.

TBWA were also responsible for the earlier AIDS campaigns. Their managing director, Sammy Harari, came to the agency from Yellowhammer, where he ran the 1985/6 "Heroin screws you up" campaign.

Despite these links, the current campaign takes a distinctly different line from its predecessors. Last year's "AIDS: don't die of ignorance" ads with their tombstones and icebergs imagery were widely criticised for not being specific about how AIDS is spread and how it can be avoided, while the anti-heroin ads were intended to be "low key" — for some, they were 'soft'.

In contrast TBWA's new campaign has been described from within the advertising industry as taking a "powerful, no-nonsense approach", and by some drug specialists as resorting to "shock-tactics". Anticipating criticism, DHSS minister John Moore admitted: "This campaign is hard-hitting and some people may find some of the material disturbing but we cannot afford to pull our punches if we are to reach the young people who are most at risk."

Critics might say part of the reason for the shift is that the

government has finally realised its earlier TV anti-AIDS burst was too vague and generalised. The official line is that the earlier AIDS campaign succeeded in raising general public awareness and the new phase is a logical follow on targeting specific high risk groups — now drug abusers, next gays.

This time round, the press ads will be limited to the youth press — nothing will appear in the nationals — and the TV ads will be carefully slotted in around youth-oriented programmes. TBWA's brief was to reach 'at risk' 13-24 year olds and presumably to bypass those large sections of the population not likely to get involved in drug abuse or sharing needles.

The anti-injecting ads aimed at current drug users are the most graphic in their illustrations and explicit in their text, including the deliberately risqué line: "It only takes one prick to give you AIDS".

However, TBWA's paymasters appear to have placed a major restriction on the messages their ads could convey. At the launch, John Moore of the DHSS emphasised: "We are particularly concerned to ensure the anti-injecting message would not be taken as condoning other forms of drug misuse". The Scottish Office press release reassures us that all the ads had been "pre-tested" with this in mind.

In line with this requirement

the anti-injecting ads also make an unconvincing stab at attacking heroin smoking, and all the messages are negative "don't do it" warnings rather than positive advice on how to avoid infection if you intend to continue drug use/injecting.

The blood-spattered images too are intended as 'put-offs', but some health educators and drug specialists fear the effect will be to deter drug users from taking in the ad's message rather than to stop them injecting.

Speaking nearly a month after the campaign was launched, Geraldine Mulleady of St George's Hospital's drug dependency unit in London, said none of their clinic or needle-exchange clients had seen anything but the TV ads, and one who'd seen that had turned off in response to the vivid imagery.

However, compared to the hostile response to "Heroin screws you up", reaction in the drug field has been muted. Alan Parry, whose Mersey drug training unit runs the UK's largest needle exchange scheme, said the majority of his customers would reject the irresponsibility implied by shots of blood-filled syringes carelessly left around or being passed to a "friend". He also points out that the ads almost totally neglect the risks of sexual transmission of HIV from injectors to their partners. Verdict — as good as could be expected, but "irrelevant".

But Bill Nelles, drug education officer for the Terrence Higgins Trust, said THT was "very encouraged" by the campaign. His concern was that it should be backed up by action to deal with increased demands for help — when the campaign began THT's drug referrals tripled. A government grant of £300,000 will help them cope, but other agencies may not be so lucky.

Even if the campaign has little direct effect on drug users it could affect their treatment by the rest of the population. Steve Tippell of south London's Community Drug Project fears the ads will be misread as implying 'injecting equals AIDS'. Generic services just overcoming their resistance to taking on drug users might be frightened off and a 'junkie plague' label on AIDS could mean drug users generally are shunned and isolated further from society. The 'gay plague' label was successfully opposed by THT and gay groups but drug users are, it's generally thought, less able to fight back.

AIDS group to report by end of year

Drug workers in England and Scotland send evidence

The Working Group on AIDS and Drug Misuse set up by the Advisory Council on the Misuse of Drugs after their meeting in early May, is due to report by the end of the year on what the Council sees as the two most urgent issues:

— how to "provide more drug users with the opportunity of contact with appropriate helping agencies"; and

— how to help "keep people who continue to misuse drugs in contact with treatment or other appropriate services with a view to preventing or minimising unsafe injecting or other harmful behaviour".

Next year a final report will address the "wider implications of AIDS and HIV for all services for drug misusers including the provision of treatment and other services to drug misusers who have HIV infection or AIDS or may be at risk".

The reports will go to the full Advisory Council for endorsement before being submitted to Douglas Hogg at the Home Office, minister responsible for coordinating drug policy.

Only a minority of the working group are doctors. According to Dr Philip Connell, chairman of the Advisory Council, a non-doctor was chosen to chair the group because "most doctors have taken up a position in relation to the treatment of addicts". With its multi-disciplinary membership, the group may well take a more global view of the role of medical treatment than did the exclu-

sively medical body responsible for the DHSS *Guidelines of good clinical practice in the treatment of drug misuse*, now under review by the working group.

Two position statements from national organisations representing specialist drugs workers north and south of the Scottish border are almost certain to play an important role in the group's deliberations. On 17 September the Scottish Drugs Forum published its *Policy statement on AIDS*, coming down heavily against "a return to the general prescribing policy" of the '60s and '70s, but acknowledging a restricted role for prescribing of non-injectable opiate substitutes. The only candidates for maintenance prescribing mentioned in the document are those HIV-positive and prone to major infections or already suffering from AIDS itself.

Supply of needles and syringes should, the Forum says, be on a one-for-one basis to encourage return of used equipment and urgently needs to be greatly expanded — present schemes are, they say, "totally inadequate for limiting the spread of the virus". Drug agencies with counselling experience and an existing relationship with clients should, the statement says, be "recognised and adequately funded" to take on AIDS-related work.

It was this last point which exercised some of the delegates at a conference organised by the Standing Conference on Drug Abuse (SCODA) on 11-13

September. SCODA, the English equivalent of the Scottish Drugs Forum, plans to use the results of the conference workshops to produce guidance and advice notes for services. These will be published and forwarded to the Advisory Council's working group in November.

A theme at the conference was the extent to which drugs agencies should take on — or be taken over by — AIDS-related work. With a public and media panic pushing from behind and the lure of the new funding for AIDS work pulling from the front, the temptation is for drugs agencies to effectively become anti-AIDS agencies in the drugs field. Some embraced this prospect, for others it was not what they came into the field for, nor did they have the financial or psychological resources to cope — counselling an AIDS victim to their death clashes with the relatively optimistic work of helping young people through drug problems and on to a better life.

The need to tighten up on confidentiality and health and safety procedures, and for a wide-ranging, flexible, client-centred treatment response geared to individual needs were points emphasised at the conference and likely to emerge in the SCODA statement. One implication is that maintenance — perhaps even on injectables — may be included among the range of treatment options called for by drug workers south of the border.

Temazepam creates new 'barb-freaks'

Concern is rising over abuse of the benzodiazepine sleeping pill temazepam, a prescription-only medicine and since 1986 controlled under the Misuse of Drugs Act in a schedule which prohibits supply but not possession in the form of a medicinal product. As far afield as Plymouth (where in September local psychiatrist Tom Webb said it was the "most frequently injected drug") and Glasgow, oral and injected misuse of the drug is creating problems familiar to many from the barbiturates phase of the late '70s.

Bob Blyth of the St Enoch Society in Glasgow is so concerned that in July he produced guidelines for drug services, hospitals and police. Misusers can, he says, rapidly increase the dose and some turn to injecting to achieve a more immediate im-

pact. As with the barbiturates, while heavily under the influence they appear drunk and there has, he writes, been evidence of young misusers turning violent if provoked, sometimes later having no recollection of their actions. Concurrent alcohol drinking magnifies the problems, risking fatal overdose.

Temazepam is a relatively short-acting preparation (the effects last two to five hours) so withdrawal from high doses can be severe. Bob Blyth has seen people in convulsions during withdrawal, made worse after alcohol. According to his straw poll, there are about 470 misusers known to agencies in Glasgow, still a comparatively small problem but one that could increase if heroin becomes in short supply — most misusers take the drug as a tempor-

ary substitute for heroin.

The 1986 report from the Home Office Drugs Inspectorate confirms that, after heroin, cannabis and amphetamines, the main "substance of concern . . . comprised the benzodiazepine tranquilisers and in particular temazepam . . . It is becoming apparent that temazepam is one of the drugs of choice among street users and seems to be easily obtained by persuading doctors to prescribe it for sleep problems or by the use of forged prescriptions". In Glasgow some street supplies also come via prescriptions to alcoholics.

Temazepam comes as generic capsules and elixirs and as capsules under the trade names Euhypnos and Normison. Misusers break the capsules and dissolve the powder in water for injection.

Patients lose out in confusion after prescribing ban

Confusion following the announcement of the Privy Council judicial committee's decision (see below) aggravated the distress of Dr Dally's patients, suddenly cut off from the steady supply of drugs many had relied on for 20 years or more.

Advised by her lawyers that the ban came into immediate effect, the morning after the announcement Dally saw two patients. The first collapsed in tears at the news while the second stormed round the corner to the GMC only to be told that the ban had not yet come into force and would not until the GMC received a letter from the full Privy Council endorsing its judicial committee's decision.

The lucky few who heard the news grabbed the chance to obtain a tiding-over prescription, but there was bitterness that Dr Dally did not contact the rest to give them the same opportunity. Dally's reply is that she had no idea when the axe would fall so ringing all her 80 patients was impractical and may simply have added to their distress, as many would not have made it to the surgery in time.

To the accusation that she should

have prescribed her patients a precautionary month's supply in the days leading up to the Privy Council ruling, Dally counters that this may have been used against her as another example of supplying too much on a single prescription.

Some of her patients and some of the officials involved suspect that by failing to make arrangements in advance Dr Dally deliberately allowed a crisis to develop. One addict accused her of "using her patients to win a battle". Dally says her attempts to make contingency plans were thwarted by clinic consultants who, with one exception, refused to commit themselves until the appeal verdict was announced.

Unknown to Dr Dally, consultants in London — many annoyed at what they saw as her high-handed "will you do as I do or not?" approach — were making their own arrangements in the event of the verdict being upheld. Three months before the Privy Council's decision they met and informally agreed to take her patients on an emergency basis, bypassing waiting lists and usual assessment procedures.

Resistance to prescribing inject-

ables was and remains strong and there was a determination that an influx of Dally's patients would not be allowed to 'corrupt' the treatment regime offered existing clients. The agreement was that medication roughly equivalent to that prescribed by Dr Dally would be supplied immediately on a short-term basis until the clinic decided what to do with them in the light of its overall treatment philosophy. Rather than the stony-faced inflexibility of which they are accused, there appears to have been a recognition that people maintained on high doses of injectables for decades could not be slotted in as run-of-the-mill referrals.

Dr Dally suspects the Home Office and clinics pulled out some of their customary stops in order to prevent bad publicity from 80 previously stable addicts being thrown on the black market at once. Instead the varying time periods of the clinic contracts will, she says, 'drip-feed' the addicts back on to the streets with the same ultimate impact on their stability but without the scandal.

Whatever the truth, the wall of

hostility between Dr Dally and the consultants meant her own and their attempts at advance planning ran in parallel rather than in cooperation, with the patients the losers. Non-communication in the months before and the days after the ruling meant many patients were referred to clinics via Peter Spurgeon at the Home Office Drugs Inspectorate, who contacted the consultants to ensure the machinery for taking the patients was activated. Contrary to reports, Spurgeon emphasises that the "London clinics themselves agreed they would react quickly if there was a difficulty in placing Ann Dally's patients. We have simply facilitated this".

Within two weeks of the 14 September ruling, some 50 of the 80 patients had been placed at clinics and a handful had made their way to other private doctors usually charging over twice as much as Dr Dally. Bernie Evans, drugs advice worker at Release, has found that most clinics are in fact taking Dally's patients on an emergency basis and giving them the oral methadone equivalent of the sometimes high doses of injectable and non-

'Unproven' verdict on Dally's treatment

On 14 September the Privy Council's judicial committee upheld the General Medical Council's (GMC) ruling banning Dr Ann Dally from possessing or prescribing controlled drugs for 14 months. After endorsement by the full Privy Council the ban came into force on 15 September. It prevents Dr Dally prescribing opiates, putting an abrupt end to her treatment of 80 patients receiving prescriptions on a long-term basis as part of the 'stabilisation' or 'maintenance' regime she advocates for chronic addicts.

The judgment avoided pronouncing directly on the acceptability of long-term opiate prescribing, but its details call into question the extent to which such treatment can be provided privately and without regular attempts at detoxification.

Back in January, a General Medical Council hearing had found Dr Dally guilty of "serious professional misconduct" in her treatment of a patient codenamed Mr 'A'. The charge, now upheld by the Privy Council, was that she had abused her position as a doctor by irresponsibly issuing him numerous prescriptions in return for fees without an adequate initial physical examination, without sufficiently monitoring his progress, and without arranging for

ongoing medical care after discharging him in October 1985.

But the GMC had cleared Dally of the more serious general charge of irresponsibly prescribing for fees, involving at least 149 patients seen between March and October 1985. Here the accusation was that she'd failed to take elementary precautions before prescribing opiates long-term, including prescribing in return for fees to people who could not "in common sense" pay the fees and expenses without resource to crime. She was also accused of failing to make any "significant attempt" to reduce most patients' doses, of prescribing excessively large amounts of methadone on a single prescription, and failing to follow DHSS good practice guidelines.

The Privy Council ruling makes it clear that the case against Dally's treatment of Mr 'A' was "intended to provide a specific example" of this more general charge: Mr 'A' was spotlighted "because he was prepared to give evidence".

As the Privy Council saw it, the evidence on the general charge was inadequate but the evidence of Mr 'A' and his wife was enough to prove one particular example of the alleged general irresponsibility. Dally's defence counsel himself testified

that "she treated all her patients including Mr 'A' in a similar way".

Where this leaves opiate maintenance is hard to divine. Only some of the precautions Dally was alleged to have failed to take with the 149 patients applied in the case of Mr 'A' (such as his inability to legally pay the fees). But the implication is that if there had been sufficient evidence, a finding of serious professional misconduct might have been justified by a failure to take the precautions stipulated — potentially including failure to follow official guidelines, not making repeated attempts to reduce the dose, and prescribing too much at one go.

Barrister Diane Brahm commented in *The Lancet*: "it is clear that a stern watch will be kept over its [maintenance and slow reduction treatment] protagonists, with swift retribution dealt out to doctors who are considered to be 'irresponsible'."

Dr Dally remains convinced that the GMC case was prompted by members of the drug dependency "establishment" who were "out to get" her for calling attention to their "disastrous" treatment policies. The fact that addicts gravitated to her private practice reflects, she claims, the inadequacy of NHS

services. In the absence of complaints against her from her patients, she believes these influential doctors prompted the authorities into a 'trawl' through her records which turned up mistakes of the kind that any doctor might make. Despite the verdict she says "victory is mine — at least I have helped change public opinion and educate the press who now know what's going on, and at least now some clinics are treating these patients as they should be treated."

Not yet finished with the fight, she is taking legal advice on the possibility of an appeal to the European Court of Human Rights.

After the GMC's verdict was announced, controversy flared anew over Dr Dally's and the London clinics' response to the plight of her patients, and for the first time at least some of the patients were openly critical of her actions (see above). But despite the continuing accusations, counter-accusations and suspicions, the ultimate impression is of people on all sides genuinely doing their best to act humanely and practically within their own varying definitions of what this means in this situation. The tragedy for the addicts is that they have not been doing it together.

injectable opiates they'd previously received. But it appears that continued prescribing is usually contingent on an explicit or implicit contract tying the patients to starting to reduce within a period usually of up to three months.

For some he believes this could be the spur to change they've needed, as long as progress is not forced on them prematurely. In turn the need to come to terms with the reality of long-term, stable, articulate addicts may prompt a rethink in the clinics.

Release say the main problem has been the refusal of all but one clinic to prescribe injectables and the fact that all but the Maudsley are restricted by catchment areas laid down by their health authorities. Many of Dally's ex-patients travelled from places far afield not covered by a clinic, and fall between the gaps in the catchment area patchwork.

John Strang and his staff at the Maudsley clinic in south London had seen 31 of Dally's patients by the end of September and taken many on for treatment. After the initial handing-over period an agreement is negotiated with the addict that they will start to reduce and/or switch from injectables within a few months. Dr Strang was "surprised" that reaching agreement with most had been an easy, two-way process, with the planned schedule often coming from the patient themselves, but admits only time will tell whether the cooperation holds up when the contracts come to the crunch.

From the other side of the consulting desk, the picture hasn't always seemed so rosy. Kevin McVeigh, a married man with four children in steady employment, has been addicted for 22 years. After the Privy Council's verdict he says he approached his local clinic only to be told they couldn't cater for people like him and would not continue to prescribe injectables. The advice from the NHS clinic was to go private — he did.

For people like Kevin and his friend Peter Page, an ex-Dally patient who runs a successful business, one of the main problems with the clinics has been their insistence that clients pick up their drugs from the chemist on a daily basis. Although many at the Maudsley are said to have welcomed this as an added control over 'binge' drugtaking, Kevin and Peter insist the rule would make it impossible for them to continue in their present jobs.

With the other members of the Drug Dependency Improvement Group, they are pressing ahead with plans to open their own private clinic before Christmas. They have money and premises, and are confident of being able to find at least one doctor to treat what they expect will be as many as 70 of Ann Dally's former patients.

How many casualties of the ban against Dr Dally eventually return to the dealers may be revealed in a follow-up project being organised by Dr Cindy Fazey of Preston Polytechnic.

'8% fall' hides rise in addiction

Press reports of an eight per cent fall in the number of narcotic addicts notified in 1986 conceal a record 27 per cent rise in the figure usually quoted by the Home Office.

The figures relate to opiate or cocaine addicts (with cocaine a small minority) seen and notified by doctors. Some of these addicts are continuing in treatment from the year before, some are notified during the year, either for the first time or after a break in treatment. Statistics for 1986 released on 29 September show there was an eight per cent fall in numbers notified during the year and an even larger fall of 17 per cent in those notified for the first time. But the total number of addicts notified — including those continuing in treatment — actually increased slightly, and the number receiving drugs on the last day of the year compared to the first increased by an unprecedented 27 per cent.

The figures may well have been higher but for difficulties experienced since 1985 in computerising the notification index. According to their 1986 report, the Home Office Drugs Inspectorate "suspect that the failure of the Index to provide the medical profession with an up-to-date information service during the computer conversion may have resulted in loss of confidence in the system which in turn may have reduced doctors' willingness to notify known or suspected addicts".

The report also admits that lack of up-to-date records reduced the Inspectorate's ability to chase up apparent failures to notify, easing pressure on doctors to notify. During 1986, 18 per cent fewer notifications were received than during 1985, but at least part of the fall is attributed to "system failure". This fall in notifications (each addict may be notified several times) could have carried through to produce at least part of the eight per cent fall in the number of addicts notified during the year.

What is known for certain is that overnight between the end of 1985 and the first day of 1986 apparently 419 addicts disappeared from the statistics, "as a result of the detailed examination of individual records which took place during the setting up of the computer system". Normally these two figures are identical.

Nevertheless the Home Office report says a number of indicators suggest that in 1986 the availability and use of heroin may have begun to peak. Among these was a decline in retail purity to 30 per cent and an increase in the average street price to £95 a gram. Most startling was the 39 per cent fall in the weight of heroin seized by police and Customs, down to 222kg, the first decrease since 1980.

The drop in heroin seizures is partly attributed to enforcement successes in the UK and further down the distribution chain in major processing/distribution centres such as Holland and India. Customs suggest crop failures in the Indian sub-continent over the past two years and increasing heroin consumption within the producing countries may also have reduced exports to Britain, with a drop from 80 per cent to 35 per cent in the average purity of seized heroin imports confirming shortage of supply.

But both Customs and Home Office are cautious about claiming success on the basis of one year's figures. The spring '87 opium poppy harvest in the 'Golden Crescent' region is estimated at 18 metric tonnes with more already stockpiled. "Given that only 4.8 metric tonnes were seized worldwide in 1986, it is evident there is no room for complacency" says the Home Office Inspectorate.

The long-predicted influx of 'crack' — the smokable form of free-base cocaine causing concern in the USA — had still not materialised in Britain in 1986 where there were no confirmed reports of its production or distribution. By September 1987 there had been four confirmed crack seizures but these, a

Home Office spokesman said, were small amounts prepared by users for their own use rather than for commercial distribution as happens in the USA. As of September 1987, no crack had been seized by Customs.

The more 'traditional' cocaine industry in Britain appears to be on the up, with Customs and police seizures in 1986 at a record 102kg and reports that in the first seven months of 1987, that figure had already been exceeded (*The Times*, 7 October 1987). Customs confirmed that just two seizures this year netted 70kg of the drug compared to a total 94kg throughout 1986. Their head of information, Graham Hammond, was in "no doubt that Europe is being targeted by cocaine smugglers" and that in Britain the drug is set to take over from heroin as the "number one danger".

● For the first time in at least ten years the number of people found guilty of drugs offences has fallen, down from 22,972 in 1985 to 18,951 in 1986, the lowest figure since 1981. It's thought technical changes in criminal justice procedures reducing the number of people brought to court in England and Wales partly account for the reversal.

In addition a record 21 per cent of unlawful possession offenders were cautioned, reflecting the increasing practice among police forces of cautioning first offenders found with small amounts of cannabis for personal use. The same proportion of offenders found attempting to import or export drugs were offered and agreed to a Customs-imposed 'spot-fine' in lieu of prosecution.

1. Home Office Statistical Department, *Statistics of the Misuse of Drugs, United Kingdom, 1986*. Home Office Statistical Bulletin issue 28/87, 29 September 1987. Available price £2.50 from Statistical Dept., Home Office, Lunar House, Croydon, Surrey CR0 9YD, phone 01-760 2850.

Narcotic addicts notified to Home Office

	1985	1986	% increase/ decrease
Addicts receiving drugs at 1 January:	5869	6633*	—
Addicts newly notified during the year:	6409	5325	-17
All addicts notified:	8819	8135	-8
Total number of addicts notified:	14688	14768	+1
Addicts receiving drugs at 31 December:	7052*	8445	—
— percentage increase since 1 January:	20%	27%	

*Normally these figures are identical — see report for explanation.

'Overwhelmed' needle schemes close down

Pilot needle exchange schemes north of the border have run into serious problems. The three Dundee schemes have all closed down while Glasgow's scheme has been picketed by local residents.

Dundee's first scheme opened in June at the genito-urinary clinic of Dundee Royal Infirmary and effectively ceased operation on 10 August due, it's reported, to lack of resources causing unacceptable levels of stress among the staff. There were also complaints from other clinic patients about the behaviour of the scheme's users. David Liddell of the Scottish Drugs Forum suspects closure may have been a last-ditch attempt by staff to ram home the seriousness of their plight to the authorities.

The day after the Royal Infirmary scheme closed, the scheme at Dundee's Wishart Drug Problem Centre opened, unexpectedly having to cope with patients from the earlier service. Initial uptake of the new service was good but it too closed on 18 September after a catalogue of threatening and bad behaviour by attenders, including spraying a nurse with blood from a syringe and injecting in the toilets as well as in the toilets of a community project in the same building.

A problem at the Wishart centre and elsewhere was the attempt to run needle-exchange alongside an abstinence-orientated therapeutic programme, creating tensions for staff and clients alike. Dr Johnston, consultant responsible for the centre, says the rest of their

programme was "overwhelmed" by the needle scheme whose customers often demanded immediate exchange and would not accept counselling or advice. Workers in some other schemes believe at least part of Wishart's problems may have arisen because the centre was trying to give the clients something they didn't want.

Also in Dundee a GP is reported to have pulled out of supplying injecting equipment to his patients when other drug users attended his surgery demanding needles. Dundee is now without a special scheme for supplying sterile needles and syringes, despite the fact that the 1986 report from the Home Office Drugs Inspectorate says the city has a "considerable" drugs problem and injecting is "the norm" for both heroin and amphetamines.

According to the Terrence Higgins Trust, "many of the drug misusers in Dundee are scared and angry . . . frustrated at what they see as the failure of the health board [to provide] any treatment helpful to drug users who cannot, or will not, become drug free". The Trust spotlights refusal to provide anything beyond "short, sharp detoxification" treatment as one major cause of the problems in Dundee. Others believe the general resistance to harm-minimisation in Scotland is the root of the problem.

In Glasgow, plans to open an exchange service in a disused clinic were abandoned after local opposition and the scheme was moved to Ruchill Hospital. Despite a deliberately low pro-

file, local residents started to picket the scheme deterring all but an average of less than 10 clients a week from attending. Between its opening in June and September, only 50 clients had attended the scheme and virtually none had returned.

Like other Scottish schemes, the Glasgow scheme is hampered by restricted opening hours — just two afternoons a week — coupled with guidelines originating from the Scottish Home and Health Department limiting the schemes to supplying no more than three needles a time on an exchange basis. Together these prevent heroin addicts — who may inject several times a day — using fresh equipment each time to stop damage from attempts to pierce veins with blunted needles.

The present guidelines were cleared by the Lord Advocate but any increase might render the schemes liable to prosecution under Scottish common law prohibiting "reckless" behaviour injurious to health.

Medical sociologist Dr Gerry Stimson of Goldsmith's College in London is conducting a government-funded evaluation of pilot exchange schemes north and south of the Scottish border. He believes Scottish schemes have suffered from considerable local and administrative as well as legal problems. Scottish health boards were instructed by the government to set up the schemes but in some quarters there was, Stimson says, a "marked lack of enthusiasm" for the idea.

Dave Liddell believes the

health boards were "half-hearted" in carrying out their instructions and met with resistance from practically every unit they approached to house the schemes — Wishart for one admit they only accepted needle exchange "with some reluctance". The result is too few schemes, under-resourced and under stress, with those isolated clinics that did cooperate stigmatised as 'junky centres'.

One relatively bright spot is the service at Leith Hospital in Edinburgh, where an average 10-20 injectors attend the weekly half-day session. But between April and September just 100 clients had used the scheme, a small fraction of the total number of injectors in an area where until recently heroin was almost exclusively injected.

To some experts the failure of the Scottish schemes results partly from the lack of political will within the Scottish Home and Health Department and the health boards with respect to drug services in general. Services are few and under-funded, meaning the high rate of HIV-infection among drug users creates a situation where people desperate for help have nowhere to go or are met with 'Calvinist' and rigid responses in contrast to the more 'user-friendly' schemes south of the border. At the Liverpool scheme, no incidents of threatening behaviour have been reported despite 700 customers and at one time a workload of 350-375 visits a week, but in that area the scheme forms part of a pattern of service provision generally lacking in Scotland.

Research suggests CFI-funded projects will survive

Preliminary results from a research assessment of the DHSS's Central Funding Initiative suggest that most of the projects supported by the Initiative may have secured future funding and confirms the primary role of the health authorities in the provision of new services.

Launched in 1983, the Initiative aimed to provide pump-priming grants to new and existing projects to help develop services for drug users. With a three year limit on the grants, the main question mark over the Initiative has always been whether health and local authorities in particular would pick up the tab when the DHSS

money ran out.

A pilot questionnaire sent out by the research team at Birkbeck College in London revealed that 24 out of 29 projects coming to the end of their CFI grants had secured future funding. Nearly three-quarters of the funding came from health authorities, 11 per cent from local authorities and nine per cent from social security. Twenty two of the projects had received enquiries on AIDS and "substantial proportions" of the projects' clients were continuing to inject. In the four weeks before the questionnaire was completed, an average 15 people a week sought help from the pro-

jects and 54 per cent of those helped were women.

The three year research project headed by Dr Susanne MacGregor with Dr Betsy Ettore and Ross Coomber still has two years to run, and the pilot questionnaire was sent to just 35 of the projects to receive CFI funding. A full survey is being carried out, but a detailed analysis of existing information has already pieced together a general picture of where the Initiative money ended up.

Over 80 per cent of the just over £17½ million was allocated as revenue funding. Fifty six per cent of the 188 grants were administered through health au-

thorities, 42 per cent through the voluntary sector, and just two per cent through local authorities, which could only receive grants for training. The CFI money paid for the appointment of 365 staff, 69 per cent in the statutory sector, with community psychiatric nurses the largest single category of professionals employed.

All 14 English regional health authorities received some CFI funding. Later reports may shed light on concerns that areas without existing specialist services to lobby for funds and provide evidence of local drug-taking would tend not to make successful bids.

I'VE BEEN THERE AND LOOK AT ME NOW

SELF-INFLICTED ADDICTIONS to drugs such as alcohol, heroin and glues are always talked about, but still very little is said about the addiction inflicted on millions of innocent victims of the medical profession — addiction to benzodiazepine tranquillisers and hypnotics. Prescribing these drugs is a quick way out for the busy doctor (usually male) lacking the training and the time to counsel patients (usually female) or the capacity to say 'no' when they ask for a 'chemical cure'.

TRANX (UK) is the only national agency specialising in benzodiazepine dependence. The counselling and advice workers are all recovered ex-benzodiazepine users, so when people contact TRANX they are immediately in touch with someone who's gone through it all themselves. We can put them at rest that it can be done — we've been there, and look at us now!

We often become their 'second home': here they find they do not have to pretend (as they do in the outside world) about how they are feeling and can 'let go' and be themselves. Sometimes people who are quite agoraphobic are able to be sent to the shops by us without any difficulty.

It is rare for our clients to have had serious problems before taking benzodiazepines. Their original prescriptions were often given for life events which should have been dealt with by counselling, but while on the drugs problems have accumulated that cannot be resolved until they stop. So when people come to TRANX they are often very vulnerable due to:

- physical withdrawal symptoms;
- having to adapt psychologically to living without 'crutches';
- the need to deal with emotions subdued over the years of pill-taking;
- uncovered physical ailments;
- the atrophy of their own coping mechanisms during the long period on benzodiazepines.

It is often said by the medical profession that people can come off their pills in four to six weeks and that the withdrawal syndrome is purely psychological. People find this very discouraging, as on the whole recovery is very long-term with many relapses. Often during relapses doctors

The author is director of TRANX (UK) Ltd which she founded in 1982, having used tranquillisers and other psychotropic drugs for 17 years. TRANX can be contacted on 01-863 9716 (non-client line) or write to TRANX, 25A Masons Avenue, Harrow, HA3 5AH.

At TRANX they've found ex-users can help others overcome benzodiazepine dependence where the professionals have failed. Identification and example are the keys, explains Joan Jerome.

Joan Jerome

say: "I told you, you need these pills".

There are many physical symptoms — palpitations, breathing problems, weight-loss, vomiting, abdominal cramps, tremor, etc — but I find it hard to distinguish between physical and psychological symptoms, as they are so closely related. The most common symptoms are: blurring of vision; 'jelly legs'; insomnia; tinnitus; feeling of tension in head, neck and shoulders; depression; phobias (especially agoraphobia); panic attacks; general fear, and also fear of going insane. Depression is often offset by doctors again prescribing drugs, this time, antidepressants.

However, expectations do play a part. In groups somebody may hear about another person's symptoms and ring up the next day to say they've got that too. For this reason our information pack sent out to initial contacts does not list all possible symptoms. If people want to know everything that might happen they have to write in and ask for that information.

Recovery depends very much on attitude. Those with a very positive attitude, who say they will get on with it no matter how they feel, recover far quicker than the ones who say: 'I cannot and I won't'. Again there is the client with a very dependent nature who may start using their partner as a 'crutch' instead of the drugs, with the partner very often cooperating, for whatever reason. It is sometimes hard to convince these partners or relatives that they are not helping.

One-to-one counselling is offered, but we rely more on groups. What our clients want is to be able to talk about what is happening to them and to hear from others that they've all had similar experiences, so they are OK and are not going mad.

We run two kinds of groups. The first is a detoxification group in which people stay for up to six months after their withdrawal. After this there is an advanced group which no longer focuses on withdrawal problems but provides mutual support with life problems. This is available for up to two years after withdrawal. If clients then still say they are having withdrawal problems, we say, "No, you are not — go and find yourself alternative help, such as psychotherapy or counselling".

There is no set programme of therapy. The only 'therapy' we offer is identification with an ex-user, encouragement, support, and contact with others in a similar position. Our workers are not professionally qualified but do have personal experience and so can provide someone with whom the client can easily identify.

We have a few affiliated TRANX groups. In the past we had more but received so many complaints from clients given wrong information by these groups that we now make it clear we are responsible only for information sent out by TRANX (UK) Ltd. We now only affiliate groups with a minimum of 12 members which have been running on a stable basis for at least three months, and are led by an ex-user who has been off all psychotropic drugs for at least a year. We also visit each one before their affiliation can be approved by TRANX.

MANY OF OUR clients have been to all the professionals available and got nowhere. Yet what they need is something quite simple and basic — genuine befriending and support from someone like them who has been through it and shows, just by being there, that it can be done. □



TRANX's torch symbol represents the choice between a life shackled by tranquillisers and freedom from drugs.

The government's £5 million joint AIDS/drugs prevent



NURSE: 5
Mr
Reid...
Mr Reid.
He's
ready for
you
now.



▲ **ANTI-INJECTING TV ADVERT.** Codenamed 'Why me' it shows the horrified reaction of a man told he has become infected with HIV after his first injection. Directed by *Singing detective* director John Amiel.

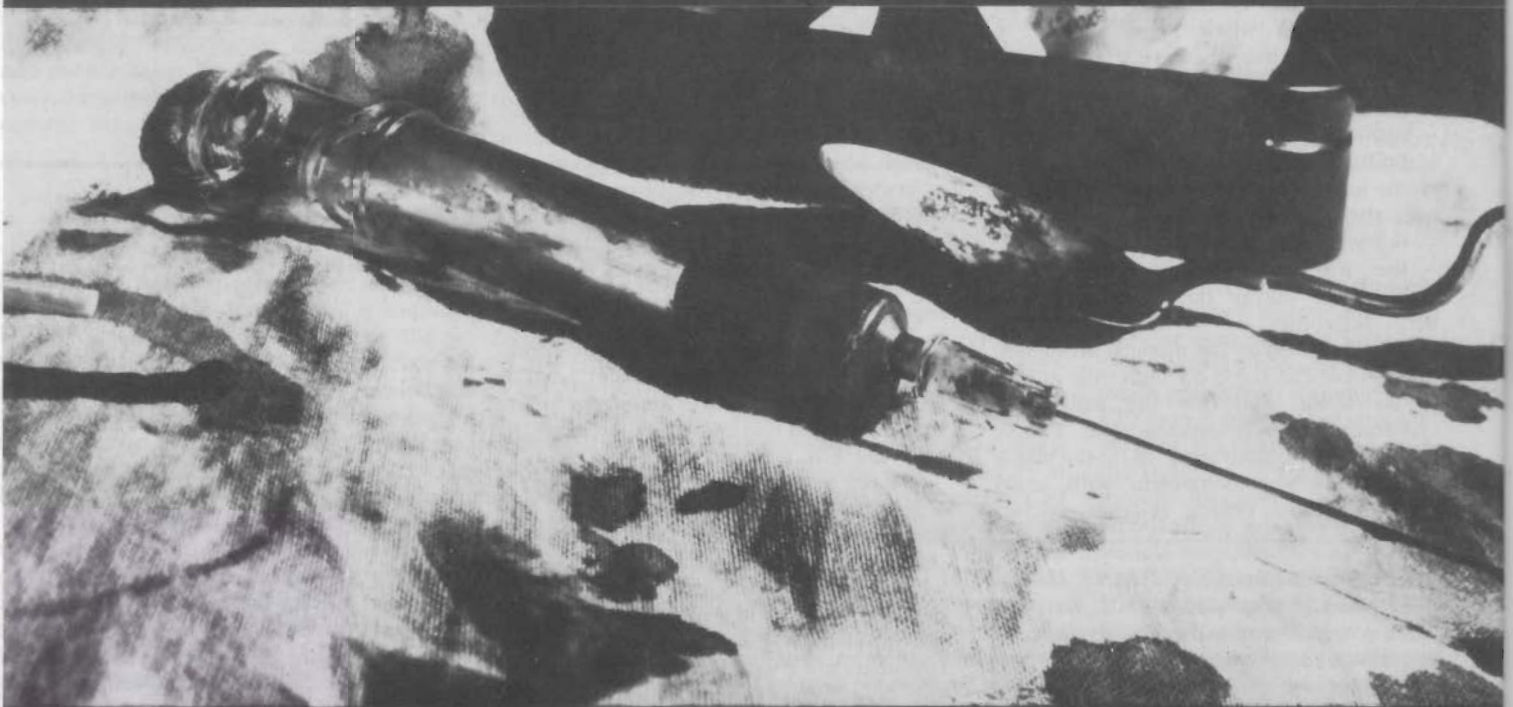
▶ **ANTI-HEROIN POSTER.** Bloody and bruised injection sites act as reminders of the thefts that paid for the fixes. COI research found warning youngsters they would steal from their mothers if they became addicted was an effective message.

▼ **ANTI-INJECTING POSTER.** The central messages of this wing of the campaign — to drug users contemplating injecting, don't; to those already injecting, never share. Again the bloody images recall how AIDS is spread.



Radio scripts and anti-heroin youth press ads on page

If you get into injecting, what's going to get int



The AIDS virus can live on a needle, syringe or equipment. Never share, not even once. DON'T INJECT A

ion campaign: 'Don't inject AIDS' is the key message

6



DOCTOR: Well, Michael, the results of your blood test have come through, and we have found antibodies that indicate that you are HIV positive . . .

7



VOICE OVER: The AIDS virus can live on dirty needles and equipment. So don't share. Because just one fix with an infected needle will really get you out of it.

8



family.

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RTH IT.

12

o you?

D S.

ANTI-INJECTING YOUTH PRESS ADVERTISEMENTS

One of the five double-page spread anti-injecting ads. All end with the phone number of the National AIDS Helpline as a free source of further advice. This one reads:

There's a very easy way to find out if someone carries the AIDS virus. Borrow his needle. The AIDS virus can live on dirty needles and works, and sharing is the quickest way to put it straight into your blood. In some parts of the country, as many as one in two drug injectors carries the virus. And you can't tell by looking at them (or their needles) whether they're infected or not. If you smoke smack, you've already started to mess up your body and your mind. If you share a needle, AIDS could finish the job off.



◀ Shock tactics like this concern health educators, but John Moore of the DHSS claims "we cannot afford to pull our punches". Text below.

To anyone who smokes smack, death can seem a long way away. (Even though smoking it still does a lot of damage.) But to anyone who injects, death is a lot closer. Nobody who smokes it thinks they'll ever inject, yet people still do it. If they don't have needles of their own, they share other people's. But the AIDS virus can live on dirty needles and works. Sharing is the easiest way to put the virus straight into your bloodstream. And just one fix is all it takes.

Campaign report on page 4

► The ads all reflect government concern "to ensure that the anti-injecting message would not be taken as condoning other forms of drug misuse". Here the words read:

This is your first fix. You've already smoked heroin quite a bit (and probably done yourself quite a bit of damage). But you've never actually planned to inject. So you're about to borrow someone else's needle. The AIDS virus can live on dirty needles and works and just one fix can put it straight into your blood. You can't tell by looking at a needle or syringe if they're infected. You can't even tell by looking at their owner. (Besides, how do you know where else they've been?) Go on. Take your pick.



ANTI-INJECTING RADIO ADS

Scripts of three of the four radio ads being broadcast 21 times a week

'Sharing'

Voice over: If you're ever tempted to inject drugs there's a good chance your first hit will be shared. So how will you know if the syringe you share is infected with the AIDS virus?

Pete: Come on, you can share my works.

Sara: Here you are, use this syringe.

Mike: Why don't you use my works?

Marvin: Use my syringe.

Jill: Just try it, take my works.

Voice over: All you've got to work out is which of these drug injectors isn't infected, because now in some parts of the country as many as one in two injectors carries the AIDS virus. And you can't tell just by looking. So if you don't want to inject AIDS, don't inject drugs.

'Choice'

Tim: Ip dip sky blue. Who's it? Not you. Ip dip sky blue. Who's it? Not you. Ip dip sky blue. Who's it? Not you.

Voice over: In some parts of the country one in two drug injectors carries the AIDS virus. So if you're injecting with a shared syringe, all you've got to do is work out if the syringe you choose is clean.

Remember you can't see the AIDS virus in the syringe. So what do you do?

Rod: Ip dip sky blue. Who's it? Not you.

Voice over: Don't inject drugs and you won't inject AIDS.

'Which Needle?'

Iain: If you're taking drugs and you're thinking of injecting, you'll need a syringe.

Today I'm holding two syringes in my hand. One of them is infected with the AIDS virus. Take a look. Which one is it, eh? Come on, closer. Take a close look.

What? Oh yes, this is on the radio. You can't see.

Well, it would be exactly the same if these syringes were in your hand. You can't see the AIDS virus and no-one ever knows they're infected until it's too late.

Voice over: It only takes one infected syringe to give you AIDS. And remember, in some parts of the country as many as one in two drug injectors carry the AIDS virus.

If you don't inject drugs you won't inject AIDS.



This is the last
of his mum's wedding ring.

Smack makes people do a lot of things they feel sick at. You might think you'll never get into the habit. But if you do, you'll need more and more money. As heroin takes control of your life, you'll start by nicking things from your family. Soon, your friends won't be able to trust you either. And while you're treating other people like dirt, you could be treating yourself even worse. You could be tempted to share a syringe, even though you swore you'd never inject. (Just like you swore you'd never steal from your mother.) And if you get AIDS, then that's the last of you.

SMACK ISN'T WORTH IT



A lot of smack heads
have the same supplier.

Their mum.

Smack makes people do a lot of things they feel sick at. You might think you'll never get into the habit. But if you do, you'll need more and more money. As heroin takes control of your life, you'll start by nicking things from your family. Soon, your friends won't be able to trust you either. And while you're treating other people like dirt, you could be treating yourself even worse. You could be tempted to share a syringe, even though you swore you'd never inject. (Just like you swore you'd never steal from your mother.) And if you get AIDS, then that's the last of you.

SMACK ISN'T WORTH IT



ANTI-HEROIN YOUTH PRESS ADS

Above, two double-page spreads aimed at young men. Below, mock-ups of two of the ads aimed at young women due to be completed with photos from Don McCullin, famous for his harrowing shots from Biafra, Lebanon and Vietnam. A third women's ad warns of the risks of being 'ripped off' by male drug users and of catching AIDS through sexual intercourse with injectors. See right hand column for text.



The best thing about smack
is that feeling of total control.

Smack makes people do a lot of things they feel sick at. You might think you'll never get into the habit. But if you do, you'll need more and more money. As heroin takes control of your life, you'll start by nicking things from your family. Soon, your friends won't be able to trust you either. And while you're treating other people like dirt, you could be treating yourself even worse. You could be tempted to share a syringe, even though you swore you'd never inject. (Just like you swore you'd never steal from your mother.) And if you get AIDS, then that's the last of you.

SMACK ISN'T WORTH IT



She used to do smack for a laugh.

Now she'll do anything for smack.

Smack makes people do a lot of things they feel sick at. You might think you'll never get into the habit. But if you do, you'll need more and more money. As heroin takes control of your life, you'll start by nicking things from your family. Soon, your friends won't be able to trust you either. And while you're treating other people like dirt, you could be treating yourself even worse. You could be tempted to share a syringe, even though you swore you'd never inject. (Just like you swore you'd never steal from your mother.) And if you get AIDS, then that's the last of you.

SMACK ISN'T WORTH IT



Smack makes people do a lot of things they feel sick at. You might think you'll never get into the habit. But if you do, you'll need more and more money. As heroin takes control of your life, you'll start by nicking things from your family. Soon, your friends won't be able to trust you either. And while you're treating other people like dirt, you could be treating yourself even worse. You could be tempted to share a syringe, even though you swore you'd never inject. (Just like you swore you'd never steal from your mother.) And if you get AIDS, then that's the last of you.

The first time you try smack, you might not be thinking about the next few dozen times. But if they happen, they'll cost you money. And what easier place to find it than home? Even if your mother finds out, she won't tell the police, will she? On the other hand, talking your way out of that won't be much fun. And if that sounds bad, try talking your way out of this one. You've used a needle. (Everyone says 'not me', but people still do.) If it was someone else's works, they could have had the AIDS virus, although you couldn't tell by looking at them. And now, your mother wants to know why you look so worried.

Campaign
report on
page 4

This is your first smoke of heroin. Thrilling, isn't it? And things can get a lot worse. No-one ever thinks heroin will end up controlling them. But when it does, it's not a pretty sight. You lie, you scrounge, you steal from your family and friends to get money. Your face, your body and your mind get messed up. And if you ever get tempted to share a syringe (which a surprising number of people do) you're in danger of catching AIDS. If that happens, that could be your whole life down the toilet.

Suppose you try smoking smack just the once, just for a laugh? It won't turn you into a prostitute just like that. But if you get further into it, it'll cost you more and more money all the time. Which will turn you into a liar, a scrounger and a thief. If you get really desperate for money, you might even sell your body. Or, you may be tempted to share a needle or equipment. You probably swore you'd never do either. (Like you probably swore you'd only try smack once.) Both these things can put you in danger from AIDS. And as anyone who's got it will tell you, there's not many laughs in that.

PRESCRIBE WITH CAUTION

PRESCRIBING OPIATES to people dependent on them has always been associated with some controversy. However, research¹ has shown that methadone can be an effective treatment when administered to chronic narcotic addicts who are actively addicted and living in an environment where narcotics are readily available. Out-patient methadone treatment can also be a stepping stone to permanent discontinuation of narcotic addiction and appears to provide control over some of the personal and social consequences of addiction, including criminal activity.²

Other studies have concluded that patients do well on any dose but those on high doses generally used fewer drugs and tended to do better.³ It has also been shown that, while abstinence after narcotic dependence was possible, it was not always a realistic goal and premature detoxification could be associated with a high relapse rate.⁴ Methadone can be used to treat those pregnant addicts who are unlikely to detoxify. Detoxification is not advised early or late in pregnancy.

A British study⁵ conducted in the mid-70s concluded that prescribing oral methadone constituted a more confrontational response than prescribing injectable heroin, resulting in a higher abstinence rate but also a greater dependence on illegal sources for those continuing to inject.

Prescribing drugs of addiction to patients who are dependent on them can be an effective treatment, and is also acceptable medical practice in Britain, but such prescribing must always be done responsibly and in a carefully controlled way. In 1980 I recommended⁶ the medical profession should consider whether there was any place for private treatment of addicts

Thirty five years treating alcohol and drug addiction have taught Dr Bewley caution and respect for research.

Thomas Bewley

where a fee was contingent on a prescription. Since then several doctors have appeared before tribunals or been found guilty of serious professional misconduct.

In 1980 I also published guidelines for prescribing psychoactive drugs to addicts and suggested safeguards which I believe are valid today. In particular, the least required from a doctor prescribing opioids to an addict is that:

▶ A diagnosis of physical dependence has been made, confirmed by an appropriate history and physical examination. It is also desirable to arrange urine analysis to confirm which drugs have been used.

▶ Extra care should be taken with patients not already known to the doctor, particularly those treated privately or as a temporary resident.

▶ No treatment, apart from emergency treatment, should be given without first finding out what treatment the patient has had, or is having, from other doctors.

▶ If a patient attends a doctor privately the doctor must ensure they are coming for treatment and not solely to obtain drugs in return for the fee. Questions to be asked in such a case are:

— has the doctor special expertise in the treatment of drug dependence?

— has he proper facilities such as access to hospital services like urine analysis?

— is he providing treatment other than a prescription for a controlled drug?

— is he prescribing in such a way (eg, more 'liberally', larger amounts, prescribing drugs attractive to addicts and not otherwise available) that there is an inducement to addicts to attend privately?

— does he prescribe drugs such as amphetamines, for which there is little medical indication, for patients who might want them for non-medical reasons?

The current belief that doctors in NHS treatment clinics now have a treatment philosophy that all patients have to be detoxified from methadone within a short period, and that there is no place for long-term methadone treatment, may be due to a misunderstanding of the report of the Medical Working Group on Drug Dependence.⁷ This stated that "the aim of treatment should be to help drug misusers to deal with problems related to their drug misuse and eventually to achieve a drug-free life". The important word here is *eventually*, as there is good evidence that many patients benefit from long-term treatment and do better than those prematurely detoxified.

However, long-term treatment is only appropriate when short-term treatment has been unsuccessful. Those who do well following detoxification immediately or after a short programme of methadone

prescribing, cease to be among those who might need a continuing prescription. At the St. Thomas' Hospital's clinic in 1987, 40 per cent of patients with a prescription for methadone had received this for less than a year, but 25 per cent had been receiving it for seven years or more.

A new complication associated with opiate addiction is the spread of HIV between addicts. Needle exchange schemes have been proposed as a way of minimising the spread, based on the proposition that some addicts will inject themselves anyway, so it would be better if they were to do so with uncontaminated needles. There is no evidence at present that exchange schemes have this effect, nor is there any to suggest they make it easier and more acceptable for people to inject.

In this situation the DHSS decision to have a limited number of pilot projects appears the only sensible way forward. It now appears likely that a number of similar projects will be set up by other agencies keen to do something helpful. The relevant question is the extent to which the sharing of injection equipment can be reduced by providing free syringes and needles, beyond the reductions that have already occurred in response to the AIDS threat.⁸

Previous surveys⁹ have shown that drug misusers do inject themselves in very unsterile ways and are more likely to do this while intoxicated or in withdrawal, when they may have a strong craving for an instant 'fix'. In these circumstances they are unlikely to postpone injection because of a lack of sterile needles, nor are they likely to boil them for long enough to ensure sterility. Immediate sterilisation (with bleach or some other way) is probably the method drug misusers would be most likely to practise.

The advantages and disadvantages of issuing syringes and needles are finely balanced. If one is endeavouring to encourage all patients to take drugs orally but they are simultaneously given needles and syringes, they might be more likely to inject themselves, contrary to the treatment philosophy. On the other hand, if they are injecting themselves, they might do this in a more hygienic way if they obtained sterile syringes and needles. There is no proven advantage either way.

THERE REMAINS a strong desire to be doing something positive to prevent the spread of the virus between addicts. The spirit is similar to that of physicians who 200 years ago treated tuberculosis with inhalations of garlic and blood-letting. This did nothing for the patients — in many instances was positively harmful — but the physicians needed to be 'doing something': it possibly made them feel better, if not their patients. In the same way needle exchange schemes currently appear to be very popular, because of the need to be doing something positive. More validated research is needed. □

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The author is consultant psychiatrist at the drug dependence treatment units of St Thomas', St George's and Tooting Bec hospitals in London.

DRUGS AND DEPRIVATION

AS DRUG MISUSE has claimed its increasing share of public attention and fantasy, there have been good reasons for demanding sound, independent information about the nature and dimensions of the problem. Locally-based prevalence studies have been the primary source of new information, and several of these have begun to consider whether there is a link between deprivation, unemployment and drug misuse.^{1, 3, 4, 8}

The most usual approach has been to assess the social characteristics of an area using indices of deprivation. The extent of the correlation between high prevalence of reported drug misuse and severe deprivation has then been examined. Results from different areas have proved remarkably similar. The Nottinghamshire survey¹ correlated the geographical reporting of individual problem drugtakers (as defined by Hartnoll *et al* in 1981²) to a recent district index of deprivation. The report concluded: "With a good degree of certainty there is a strong correlation between an index of deprivation and the prevalence of drug misuse in Nottinghamshire".

The Wirral prevalence study³ used nine socioeconomic indicators derived from 1981 census data to analyse the distribution of drug misuse within the survey area, concluding: "These areas with large numbers of problem users clearly have the highest rates of unemployment and other indicators of relative social deprivation". Both studies also suggest that in any area those individuals who suffer relatively high levels of social deprivation will be more likely to become problem drugtakers.

Perhaps the most striking finding in the Wirral was that over 80 per cent of identified problem drugtakers were unemployed, of which more than two-thirds had been unemployed for over a year.

The Nottinghamshire and Wirral studies identified individual drug users (mainly

Politicians score points and academics wrangle, while to the 'man in the street' the relationship between drugs and deprivation probably seems beyond question. But just what is this relationship? Ira Unell investigates one of the most politically sensitive issues in the drugs field today.

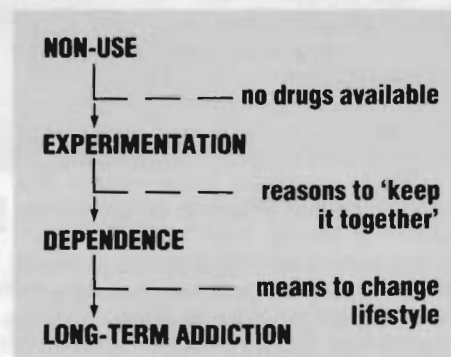
Ira Unell

using markers instead of names) and could show statistical correlations. Other studies, such as that carried out in Glasgow,⁴ did not mark individuals but concluded: "Qualitatively, heroin use has become normalised among some groups of young people and has spread particularly rapidly in communities which are currently experiencing high levels of unemployment and, as a consequence, multiple social deprivation".

ment is that problem drug users drift into the poorer areas of cities as they progressively lose status, job, family and home. This is countered by the view that the deprived circumstances experienced by some individuals make oblivion through problem drug use a viable alternative to the harsh realities of their lives. In both these versions, drug misusers are seen as passive victims, either of their drug use or of their economic circumstances.

But how far do drug users actually feel oppressed by their circumstances? Does the image of the 'trapped' user simply provide conventional society with an explanation for the 'inexplicable' behaviour of people who have rejected its goals and values? Nigel South and Nick Dorn⁵ have suggested that drug misusers are not passive, lazy loners, but active and committed entrepreneurs within a fast-growing fringe economy. This alternative economy generates a wide diversity of enterprise, including: small-scale production; cash-in-hand building work, repair and renovation; transport; personal and sexual services; and the buying and selling of drugs. It is precisely in areas of economic decline that this fringe economy will grow the fastest. It is regulated not only by economic forces but by the need to organise personal, social and economic life around the opportunities available in areas in which the formal economy has retracted.

So there is a dichotomy between the perception of drug misusers as active, entrepreneurial actors on the broad stage

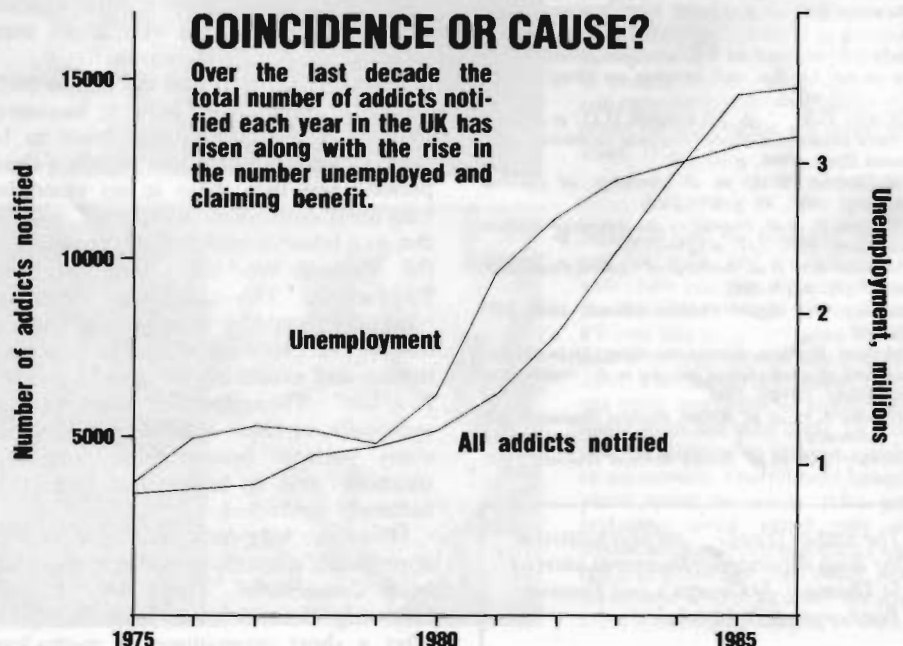


Factors which could block the transition from non-use through to addiction may be lacking in deprived areas.

Recent research therefore confirms the common intuitive assumption that problem drug use and deprivation go hand in hand. Explanations for this relationship are of two main kinds, roughly corresponding to two political philosophies. The first argu-

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4. Haw S. *Drug problems in Greater Glasgow.* Glasgow: Standing Conference on Drug Abuse, 1985.
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7. Pearson G. "Social deprivation, unemployment and patterns of heroin use." In: Dorn N. *et al.* eds, *A land fit for heroin?*, London: Macmillan, 1987.
8. Polley S. *et al.* *Drug survey 1985-86.* Leeds Addiction Unit, 1986.
9. Personal communication.

The author is the senior social worker at the alcohol and drug unit of Mapperley Hospital in Nottingham. He has also worked in two London street agencies.



of the fringe economy, and those who see them as the passive, dejected victims of an economic system which limits choice. Rather than wholly embracing one or other of these contrasting views, it may be more realistic to see drug misusers, like other people, as taking both active and passive roles within personal, social and economic relationships. However, it is likely that some forms of drug misuse exaggerate the swings between active and passive orientations. Hyperactivity brought on by amphetamine use may, while it lasts, make the user more inclined to act on pressing but mundane problems such as a disconnected electricity supply. When withdrawing from amphetamines, lethargy may descend.

ALL THE MODELS outlined so far imply a causal relationship between drug use and deprivation, but even if valid, they cannot provide a full explanation. What is certain is that the decision to use a drug is a complex one. It is influenced by many factors including price, availability, peer-group pressure, boredom, the wish to enjoy the consciousness-altering effect, personality and, for some, physical and or psychological dependence. How does social deprivation interact with these factors?

Over the last five years the cost of some illicit drugs, particularly heroin and amphetamines, has fallen.⁶ As a result, at least in some areas of the country, they now compete with legal drugs such as alcohol or with less harmful prohibited drugs, notably cannabis. Younger poly-drug users can show great flexibility in switching between drugs. The lower price of dangerous drugs, combined with their wider availability in areas of social deprivation and high levels of use, make experimentation more likely — a pattern further encouraged by the high price of cannabis.

Many unemployed people complain of boredom, and this is especially true of young people without personal or family commitments who have many 'vulnerable' hours in the day. High unemployment in an area is usually associated with a poor standard of public housing and leisure provision. There may be very few activities which are both socially approved and acceptable to young people themselves. Illicit drug use, however, is exciting and absorbing — an effective antidote to boredom. One of the more bizarre effects of the recent advertising campaign against drug misuse has been the elevation of the youth with the spotty skin and the heroin habit into a minor cult hero in many areas. The chance to identify as a 'junkie' may compensate for some of the emptiness of unemployment.

An individual's use of drugs can range from 'one-off' experimentation to physical and psychological dependence. So far, little research has been done on the relationship between experimentation and the availability of illicit drugs. However, it is not unreasonable to assume that the wider availability of drugs in deprived areas is a stimulus to experimentation. But do deprived social circumstances encourage experimental users to go on to develop a more permanent habit? Once again, there is no conclusive evidence. But it is likely

that such circumstances give experimenters few persuasive reasons for 'keeping it together'.⁷

Also, users may become trapped into a deviant identity if they turn to crime to finance their habit. The combination of criminal activity and use of illicit drugs is more likely to make users targets for social control than drug misuse alone. Recent publicity about drug problems among pop stars and the sons and daughters of the rich and famous is a timely reminder that drug misuse happens at all social levels. However, because privileged drug users have independent financial resources and high social status, they are both less likely to need to resort to illicit means of sustaining their habit, and less likely to be suspected of drug misuse. They may therefore indulge in drug misuse with less risk of becoming confirmed in a deviant identity.

The power of social circumstances to limit personal choice is revealed most starkly among drug users from deprived areas who decide it is time to change and abandon their habit. Change requires the construction of a new, non-drugtaking identity. Access to money, the ability to move house, supportive family contacts, non-drug using friends, and educational qualifications, are among the resources needed for this transformation. For people in socially deprived areas, they may simply be unavailable.

While there appears to be an association between social deprivation and drug misuse, simple 'cause-and-effect' explanations cannot do justice to the complex factors involved. It must be remembered too that not all areas of high unemployment have a high prevalence of drug misuse. Leeds, for example, has an unemployment rate well above the national average but a relatively small drug problem.⁸ Perhaps a combination of factors is needed to provide a fertile environment for a drug problem to grow. A deprived area with poor transport networks may be less likely to import illicit drugs or to generate the small active core of opiate users who provide the first stimulus for the growth of a local market. Drug treatment units in areas where drug misuse is at a low level, may help prevent such a market from growing. As one patient with a long-term prescription said: "Methadone makes you lazy, you don't always want to go out and hustle".⁹

A PROPER UNDERSTANDING of drug misuse demands more than 'off-the-peg' explanations of deviant behaviour. There is convincing new evidence of an association between social deprivation and drug misuse, but this cannot be explained by a simple cause-and-effect relationship. The operation of any local drug scene shows that it is constantly shifting and adapting to a complex variety of circumstances, including illicit and prescribed drug supply. Individual drug users therefore act within a changing social and economic context which may affect the likelihood of their coming across and deciding to experiment with or continue to use drugs, but never absolutely determines their behaviour to the exclusion of other, often more important factors. □

UNEMPLOYMENT AND DRUGS: THE POLITICAL DEBATE

"... although high unemployment might be a factor in causing frustration and difficulty among youngsters, the evidence shows that drug abuse does not necessarily reflect the economic circumstances of an area."

— Sir Bernard Braine, Conservative MP, April 1984.

"... the Government must take a major share of the blame for the substantial increase in drug addiction... Most importantly, they have created the social conditions, in terms of unemployment, which have allowed drug abuse to flourish."

— Robert Kilroy-Silk, Labour MP, March 1985

"Of course Labour is worried by the drugs menace... [but] people do not become depraved just because they are deprived."

— *Yorkshire Post* editorial on the 1985 Labour Party conference.

"Perhaps some sought sanctuary in drugs because of the hopelessness and misery of bad housing, unemployment and run-down inner cities. Maybe others were lured because so-called 'fashionable' people talk of getting a kick..."

— Neil Kinnock, Labour leader, May 1985.

"Historically, heroin has always been depicted as the drug of despair and there is certainly much despair and hopelessness about in parts of Britain today. It has, however, been vigorously denied by this Government that there is any link between drug addiction and employment... [This] Government... bears a considerable responsibility for increasing the unemployment figures, but it is ridiculous to pretend that they are responsible for the growth in drug offences or narcotic addicts."

— Dr David Owen, SDP leader, October 1985.

"... the Government has so far been totally silent over the [Home Office] Report's recommendations for alleviating drug abuse in terms of policies 'directed towards the well-being of society, including measures for redistributing wealth and reducing unemployment'. They have a vested interest in doing so. Because changing the day-to-day reality of most people's lives... would mean changing the basis of our society which rewards the few at the expense of the many."

— from *Cold comfort* by Labour MPs Michael Meacher, Margaret Beckett, Frank Dobson and Harriet Harman. (Michael Meacher, 1984)

SUBSTITUTION IS NOT A SOLUTION

When clinics all around began long-term opiate prescribing, Doctor Rathod's prescribed none at all. He still believes giving in to blackmail helps neither the addict nor society.

Raj Rathod

THE ARGUMENT THAT drug misusers are entitled to drugs because they suffer from an illness, and doctors have always prescribed drugs for illness, is based on uncertain foundations. 'Illness' is difficult to define, especially when the principal symptom is socially unacceptable behaviour. In the end, illness is anything doctors and society decide to label as such.

For example, not so long ago homosexuals were considered psychologically 'sick'. They became 'patients' to be treated by psychiatrists and even received some protection from the law. A few years later homosexual behaviour was legitimised and almost overnight referrals ceased.

Accepting misuse as an illness has implications for its management. The misuser is cast into the role of a 'patient', and expects to be prescribed 'treatment' (drugs) for their 'illness'. Many deviancies are accepted as part of the 'illness' and the misuser is offered some immunity from taking responsibility for his or her own behaviour. Comments such as: "What he did was wrong, but he could not help it," or: "I stole because I had no money and needed the stuff," are common. Repeatedly shielding people from their responsibilities may be counter-productive as it promotes learnt helplessness.

Prescribing means ordering or advising a remedy. Although this may be counselling, or advice, in practice 'prescribing' has come to mean 'prescribing drugs'.

Two categories of drugs are available for treating heroin misuse. 'Agonists' share many of the properties of drugs of addiction and as such can be substituted for them — hence the term 'substitute prescribing'. Methadone is the most widely used of these heroin-substitutes. In contrast, the other category, known as 'antagonists', control or reverse the effects of drugs such as heroin. If patients on antagonists take heroin they experience little if any positive effects and may even suffer withdrawal symptoms.

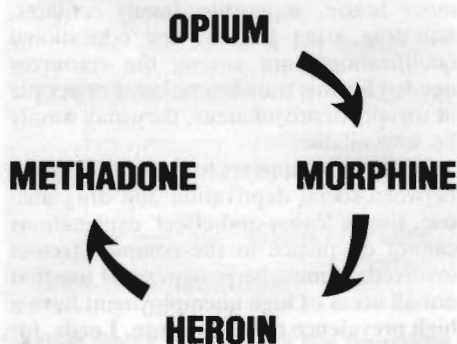
It is difficult to understand why prescribing of antagonists is minimal in the treatment of heroin addiction while substitute prescribing, backed by tradition and an unproven theory, is commonplace.

The tradition of substitute prescribing includes a number of notable failures. It is claimed that Sigmund Freud treated an

The author is a consultant psychiatrist who has worked in the substance abuse field for 24 years. He is now project leader of the Substance Abuse Project in Crawley. This clinic has never prescribed opiates in the treatment of opiate addiction.

opiate addict with cocaine: the patient was weaned off opiates but became a cocaine addict. It was thought heroin would put an end to morphine addiction, but heroin soon became a drug of addiction in its own right. Methadone was introduced to wean misusers off heroin, but a great number end up being maintained on methadone and we are gradually accumulating a pool of methadone addicts.

The theory behind substituting methadone is that the addict's craving is caused by the need to take heroin or similar drugs to counteract a metabolic defect. The nature of this defect has remained illusive:



A road to nowhere: substitution of one addictive narcotic for another.

if it is biochemical, then presumably users will have to be maintained on some kind of narcotic *ad infinitum*, in the same way as diabetics have to take insulin. How, then, do we explain the fact that a sizeable proportion of heroin addicts achieve sustained abstinence without substitute medication?

HOW DID SUBSTITUTE prescribing come to be accepted in Britain? In part it was due to the unforeseen consequences of the practice of 'registration'. The intention was merely to keep a list of notified addicts on a Home Office register. Being on that list at no time implied an automatic right to heroin or methadone. However, most addicts, once 'registered' with one of the new NHS clinics, expected and got prescriptions for narcotics. When, as the addicts saw it, these 'rights' were threatened, they took to all kinds of manoeuvres (exaggerating usage, pleading, threatening, etc) to get 'their' narcotics. We may still be suffering from this unfortunate historical development.

Another factor influencing substitute prescribing in the late '60s and early '70s was the fear that addicts not prescribed sufficient amounts would take their 'custom' elsewhere, ie, to illegal dealers. Re-

sponding to this threat became an integral part of treatment strategy. It was almost tantamount to blackmail; the surprise was that doctors submitted to it. Rarely has such a situation prevailed in medical practice.

A new threat of a similar kind may be on the horizon. The user 'threatens' to go on injecting irrespective of the risk of fatal overdose, AIDS and other infections. He is not going to change, we must adjust to suit him, which in this case means supplying sterile syringes and needles. What is overlooked is that injecting is often an impulsive act. Also some injectors *prefer* to share and when a novice is introduced to injecting, it is usual to share the initiator's equipment.

Although well meant, this policy may inadvertently be promoting injecting, especially sad when users are at last getting the message that injecting is far more dangerous than use by other routes.

Whatever the explanation, substitute prescribing is widespread and is likely to continue. What has been achieved so far? Substitute prescribing was aimed at eventually achieving sustained abstinence, reducing the spread of misuse from one person to another, and consequently reducing demand for illicit heroin. After years of this treatment involving many thousands of 'patients', the results are not encouraging.

Long-term follow-up studies show that sustained abstinence among misusers so treated is no greater than among those in drug-free therapeutic communities, in clinics which do not prescribe notifiable drugs, or among those who achieve abstinence without medical help. Spread of heroin misuse is in no way contained, nor is demand for the drug: the illicit market must feel assured of willing customers. Heroin is used by many who are treated with methadone and it is also the commonest drug of addiction among newly notified and re-notified addicts. In addition there is an enlarging pool of people who have become addicted to methadone through its use in the treatment of their heroin addiction.

IN VIEW OF THESE facts it is difficult to comprehend the medical profession's attitude to substitute prescribing, especially as — despite all the arguments put forward in defence of substitute prescribing for heroin — the profession would not contemplate adopting this policy for alcohol misuse! In the words of the late Sir Aubrey Lewis, "As has been common in the history of drug dependence, Satan has been used to drive out the sins". There are possibly more rewarding alternatives! □

THE NEW HEROIN USERS. Geoffrey Pearson. Oxford: Basil Blackwell, 1987. 194 pages. £6.95 paperback, £17.50 hardback.

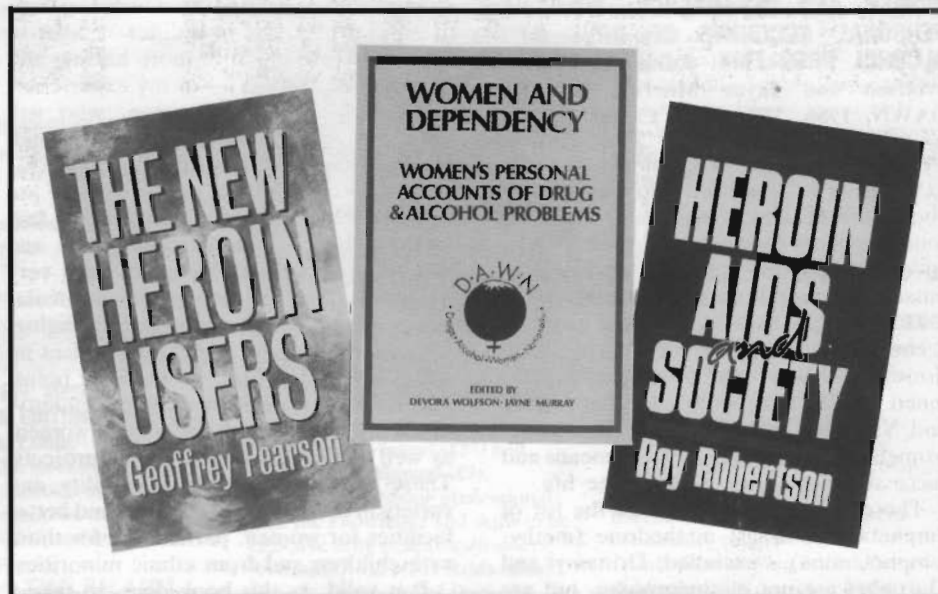
This book's central theme is the assertion that heroin use has taken on a novel aspect. Indeed, the author attempts to answer the question set on the cover: "What is the new heroin problem really about?" The answer to this crucial question appears in the concluding paragraph and points to structural remedies in an unfair class society. Implicitly, the author calls for radical action to a collective problem.

Whilst not disagreeing with this analysis, it would seem from the evidence provided that the emphasis on the *novel* aspect of heroin use is significantly misplaced. What emerges from the book is a picture of heroin use, with its accompanying myths, not altogether different from countless experiences 15 to 20 years ago. Heroin users, now as then, come from various class backgrounds and vary in the degree of control they exercise over their drug use.

During the last seven to eight years, the number of heroin users has significantly increased and the locations of so-called 'heroin black spots' have changed due to a myriad of reasons. However, the *nature* and *experience* of heroin use has not radically changed. What *has* begun to change, primarily for pragmatic (ie, AIDS) rather than ideological reasons, is our perception of what we are observing and how we should respond.

Nevertheless, Pearson offers valuable insights into heroin use in its sub-cultural setting, based largely on interviews with users and an interpretation of events by the author.

The book begins by demolishing the myth of the 'evil pusher' who corrupts the minds of schoolchildren — a crucial point for those planning prevention strategies. The question of whether potential or actual drug users exercise judgment and make choices is usefully explored, and is a theme running throughout the book.



The reader is taken through a useful step-by-step account of heroin use as experienced by users and reported verbatim, beginning with experimental use and running through to what the author has unfortunately termed "compulsive" drug use. Use of this term implies total loss of control, enslavement, passivity and irresponsibility. This view is, however, contradicted throughout the book, both by drug users (although sometimes ambiguously) and by the author.

Of particular interest in this section is Pearson's suggestion that the critical factor differentiating controlled from less controlled heroin use, is the presence of other commitments in a user's life competing with the experience of heroin use, eg, employment, personal identity, and related social networks.

In the second part, the book explores the process of decision-making as experienced by drug users, from first deciding to inject through to the decision to 'come off'. A short passage on AIDS corroborates the contention that drug users, given accurate

information, do change from high risk to low risk behaviour. An informative section titled "Dealing, hustling and robbing" has implications for current arguments around prescribing and maintenance.

The author observes that rehabilitation options are scarce and points out that the values and assumptions of many rehabilitation programmes unhelpfully reflect a middle class bias, consequently becoming unattractive or even irrelevant to potential customers.

Pearson's remedy to a problem he describes as "one of the most threatening social issues of the 1980s" is to devise forms of help accessible within the user's community, rather than expecting drug users to uproot into an alien environment.

This is an interesting and forward-looking book, useful to both specialist and non-specialist workers who want to look beyond the popular image of heroin use.

Andy Malinowski

The reviewer is project leader of Druglink, Swindon.

LETTERS

AIDS risk missed from Health matters drugs booklet

Dear Editor,

I was disappointed that the review of *Health matters* (*Druglink*, July/August, 1987, p.17) did not highlight the fact that the *Deciding about drugs* booklet in the pack missed the opportunity of informing and educating young people on issues concerning HIV/AIDS. This information was omitted throughout the booklet.

In the opiates fact-sheet in the booklet there seem to be no risks or hazards of taking these drugs, with no mention of injecting even though a picture of a syringe is displayed on the sheet. There were missed opportunities to have a fact-sheet on the hazards of injecting and a sheet of factual information on HIV/AIDS with addresses of where to get help.

The pack as a whole is a good concept, providing a framework to build on which can help many professionals to raise teenagers' awareness and promote discussion. It can be recommended to any person working in the youth field and will, I hope, be purchased by all health education/promotion units so people in the field can borrow it.

Jane Kennedy

AIDS Information Officer, Standing Conference on Drug Abuse.

Prescribing opiates: who benefits?

Dear Editor,

Alan Rosenbach (*Druglink*, September/October 1987, p.16) asserts that maintenance prescribing is not of proven efficacy. But the contrast between England since the

1920s (where controlled availability of opiates was accompanied by a reduction of the addict population to 500) and the USA (where non-prescribing went along with ever-increasing heroin consumption) puts the onus on him to prove that prescribing is not helpful.

His analogy with anorexia misses the point — anorexics do not want food, whereas drug addicts want drugs. As for 'leakage' onto the black market, Marjot estimates illicit heroin consumption at 5000 kg p.a., licitly prescribed opiates at 50 kg p.a. The Home Office and the police confirm that only "a tiny fraction" of these prescribed drugs can be leaking. So what 'leaks' must be a drop in the ocean of illicit supplies.

I would agree that treating a social phenomenon with substances (eg, marital problems with benzodiazepines) is harmful, but here we are treating the consequences of a private vice by minimising harm

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

until the habitue desists. Moral or punitive assertions do not help the problem, they only salve the consciences of moralists.

Prescription helps the addict's health, helps protect society from crime and helps protect other people from being peddled illicit drugs. It does not help the prescriber who is faced with a difficult balancing act and is subject to moral criticism. The easiest thing in the world would be not to prescribe at all — but for whose benefit would that be? Only, I think, the prescriber.

John Marks

Consultant psychiatrist, Liverpool drug dependency clinic.

WOMEN AND DEPENDENCY: WOMEN'S PERSONAL ACCOUNTS OF DRUG AND ALCOHOL PROBLEMS. Edited by Devora Wolfson and Jayne Murray. London: DAWN, 1986. 100 pages. £2.50

I welcome a book on this subject, the first to my knowledge written solely by women about women and dependence. The personal accounts by women of their experiences give a very valuable perspective, missing in most books on the topic.

However, it is a pity there are no accounts by women who have been through some of the treatments condemned by the book — the concept houses and Narcotics Anonymous — since many women do receive help by these means and successfully maintain a drug free life.

There are technical errors in the list of amphetamine drugs: methedrine (methylamphetamine) is excluded; Drinamyl and Durophet are not diethylpropion, but are both amphetamines and far stronger than the diethylpropion group.

I agree with the editor's contention that

women who use drugs (by which I include alcohol) are viewed in a different light to men and are thought of more harshly and treated with disdain — in my experience, particularly by other women, who will accept 'boys will be boys' but think women should be more responsible and sensible.

It is also true that many women are frightened of seeking treatment for fear their children will be taken into care, and certainly many clinics have not been very understanding of women's particular needs. However, the situation is changing. There are far more local drug centres all over the country. Still, as this book points out, there is a need for more community-based projects, easily accessible to women, as well as for separate women's projects. There needs to be more flexibility and variety in the treatments offered and better facilities for women, particularly for those with children and from ethnic minorities.

It is valid, as this book does, to take a strongly political viewpoint on drug abuse, which has certainly become a political issue. However, drug abuse is one way in

which both men and women cope with the pressures of modern living, and there are far more political issues behind the current increase in drug use than are mentioned in the book.

This book emphasises a political viewpoint of women's situations, rather than concentrating on how women overcome their dependency on a personal and spiritual level. Reading it left me feeling rather depressed, as (apart from one personal account) the book does not address the issue of how to enjoy a life free from drugs.

However, *Women and dependency* makes a valuable addition to books in this field and should be read by anyone working with drug users as well as by the public at large.

Catherine MacGregor

The reviewer is a team leader at Phoenix House.

The book is available from DAWN, Omnibus Workspace, 39-41 North Rd, London N7 9DP (£1 to women with dependency problems).

HEROIN, AIDS AND SOCIETY. Roy Robertson. London: Hodder & Stoughton, 1987. 133 pages. £9.95

It's about time somebody sat down and wrote a book about AIDS and drug misuse. Not only are drug users one of the most vulnerable of all the current high risk groups, but tackling AIDS in this group is one of the most complex and controversial areas of the AIDS pandemic. Failure to check the spread of infection in this group has implications, not only for the face of drug treatment over the next twenty years (how many sick and dying drug users will want to hear much about treatment?), but also for society as a whole. Eight out of ten of all cases of heterosexual infection in the USA, and a similar percentage of paediatric infection with HIV, can be traced back to an injecting drug misuser.

Not surprisingly, Dr Robertson has seen what few of the rest of us have — a glimpse of a future suffused with grief and tears. It was he, and his colleague Aidan Bucknall, who more than two years ago first identified substantial HIV infection in the Edinburgh addicts they were seeing. Over the months since AIDS has come to dominate discussion in drug treatment circles, he has continued — with nothing in the way of resources — to care for one of the largest populations of infected youngsters in the UK. The author is a GP, not a consultant. He does not now have a specialist drug unit in his area — it was done away with in the early '80s. In one of the most deprived areas of the country, he fights apathy and denial in civil servants and drug users alike.

It's clear Dr Robertson knows that whereof he speaks. So why then do I feel uneasy with this book? On first examination, it is a good, competent investigation of the issues. The author starts by examining the debate over the nature of drug dependency itself, its social consequences (neatly underlining the shift from treatment and care to outright control through law enforcement that he has witnessed

over the last few years) and the different patterns of drug misuse to be seen. He then teams these observations up with a thorough section on AIDS, illness and death. It is towards the end that things start to go wrong, as the author rather selectively fuels the policy debate on the response to AIDS with his own, frankly one-sided views on harm-reduction through drug prescribing.

It could be that Dr Robertson sees mainly young people, who are often not yet physically addicted and for whom it may be inappropriate to think of substitute prescribing — but he rejects methadone or legal prescribing as even remotely useful in the control of HIV infection, or in attracting unmotivated clients at high risk to present for treatment before the worst can happen. He makes no mention of the value of prescribing in helping HIV-infected addicts stop unsterile black market drug use that might stress their immune systems past the point of no return. He supports syringe exchange, but does not examine the issue of just where that leaves the client — still a criminal, using sterile needles to inject unsterile, contaminated poison from the local dealer.

What is one to make of quotes Dr Robertson uses such as:

"Scientifically, until many of the short- and long-term effects are answered, methadone maintenance remains an unproven enigma. Medically, to subject approximately 100,000 human beings to a potent chemical without proper controls is malpractice of the most insidious sort."

No mention of the thousands who have found their way back into mainstream society through such programmes, or the fact that methadone, as used for opioid addiction, is probably one of the most researched drugs in use — with literally thousands of papers on its effects. I can't believe Roy Robertson expects all the infected addicts to meekly give up their syringes and stop using.

Perhaps my greatest area of concern was the lack of discussion about caring for

those addicts who cannot and will not stop using. If we completely ignore their feelings and perceived need for drugs — regardless of how we may feel about it — we commit the cardinal error of forcing our values on our clients, and being perceived by them as moralising. That won't help us to engage addicts in a debate and help them to change — they'll just write us off as the persecutors they know so well in other guises and uniforms. I suspect Dr Robertson has been influenced by too much exposure to the Scottish Psychiatrist's Syndrome . . . 'cure 'em or hang 'em'. No mercy here for those who do not repent.

Of course, it's not so simplistic an issue as whether or not we should fling drugs or chuck syringes at people. But genuinely flexible options attractive to as yet unmotivated addicts are the key — and prescribing too useful a tool to ignore. Maybe Dr Robertson fears, as do so many, that this is the course of action those 'radical renegades' in the field wish to see implemented. But anyone with any sense knows the issue is far more complex, with pros and cons galore.

Inflexible decisions, such as the one taken in the early '80s to make Scotland one big 'no prescribing' zone, may well be one of the factors that led to Scotland being so hard hit with HIV infection in addicts.

On balance, however, the book is informative and well written. It may be of greatest help to AIDS workers looking for information about drug use. More power to your pen, Dr Robertson. You're one of that still too rare breed of GP — one who cares about drug users.

Bill Nelles

The reviewer is the Drug Information Officer at the Terrence Higgins Trust.

I. Bratter T.E. "The crime of methadone maintenance treatment programs". In Miller L. ed, *Abstracts of the Third International Symposium on Drug Abuse*, Graphess, 1974.

For a free listing, send a copy of your new publication/audio-visual material to ISDD's library. Courses, conferences and other events also listed — send details to the editor at least six weeks in advance. Inclusion cannot be guaranteed.

PUBLICATIONS

Sociology/politics

► **DRUGS IN ADOLESCENT WORLDS: BURNOUTS TO STRAIGHTS.** Barry Glassner and Julia Loughlin. Basingstoke: Macmillan, 1987. x, 301 pages. £25.50. Book.

Sociological perspective viewing drug use by adolescents in terms of their social worlds made up of peers and families.

Available through bookshops.

► **THE GREAT DRUG WAR AND RADICAL PROPOSALS THAT COULD MAKE AMERICA SAFE AGAIN.** Arnold S. Trebach. London: Collier Macmillan, 1987. 401 pages. £19.45. Book.

Why the punitive approach to drug use has failed. Calls for a shift of resources with treatment appropriate to the individual.

Available through bookshops.

► **DEALING WITH DRUGS: CONSEQUENCES OF GOVERNMENT CONTROL.** Ronald Hamowy ed. Lexington, Mass.: Lexington Books, 1987. xi, 385 pages. £30. Book.

Collection of papers analysing various aspects of US drug policy. Subjects include: the effects of prohibition; drugs and foreign policy; medical research; and options for reform.

Available through bookshops.

► **WHEN SOCIETY BECOMES AN ADDICT.** Ann Wilson Schaeff. San Francisco [etc]: Harper and Row, 1987. viii, 152 pages. £11.95. Book.

Argues that addiction is woven into the fabric of western culture and that people act in addictive ways because of the way society functions.

Available through bookshops.

Treatment

► **CLINICAL MANAGEMENT OF SUBSTANCE ABUSE PROGRAMS.** Robert J. Craig. Springfield, Ill.: Charles C. Thomas, 1987. viii, 240 pages. Book.

Comprehensive guide to the clinical management of programmes concentrating on the programme level rather than clinical care of the individual patient.

Available from Charles C. Thomas, 2600 South First Street, Springfield, Illinois 62717, USA.

► **CRAVING FOR ECSTASY: THE CONSCIOUSNESS AND CHEMISTRY OF ESCAPE.** Harvey B. Milkman, Stanley G. Sunderwirth. Lexington, Mass.: Lexington Books, 1987. xvii, 222 pages. £10. Book.

Brings together what is known about compulsive pleasure-seeking. Shows how drug abuse and

alcoholism are linked to other forms of problem dependence, social deviance and mental illness.

Available through bookshops.

► **THE POWER FACTOR.** George and Meg Patterson. Milton Keynes: Word Books, 1986. 154 pages. £3.50. Book.

Outlines the authors' spiritual psychotherapy based on Biblical models.

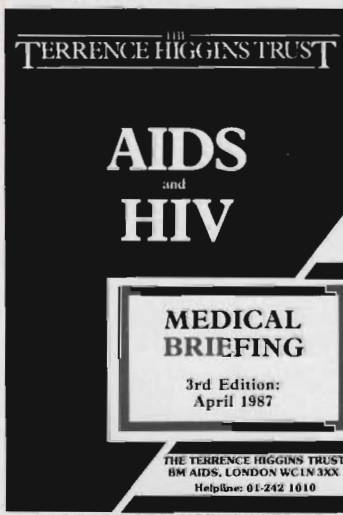
Available through bookshops.

AIDS

► **AIDS AND HIV: MEDICAL BRIEFING. 3RD EDITION.** Terrence Higgins Trust. London: THT, 1987. 23 pages. £0.30. Booklet.

Essential information on the AIDS epidemic covering the transmission of HIV and AIDS and testing for HIV infection.

Available from THT, BM AIDS, London WC1N 3XX.



► **AIDS: THE POSITIVE APPROACH.** British Medical Association in co-operation with the BBC AIDS campaign. London: BMA, 1987. 15 pages. £1. Booklet.

Basic facts and how to prevent spread of HIV infection.

Available from the British Medical Association, PO Box 295, London WC1H 9TE.

Cocaine

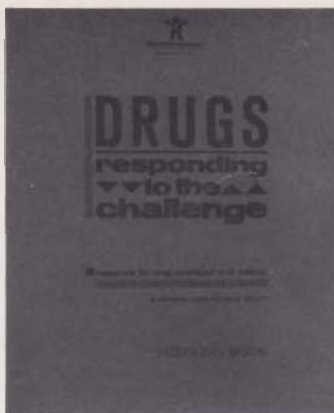
► **CRACK: WHAT YOU SHOULD KNOW ABOUT THE COCAINE EPIDEMIC.** Calvin Chatlos and Lawrence D. Chilnick. New York: Perigree Books, 1987. 111 pages. Book.

Information about crack based on interviews with adolescent users and experiences at an adolescent treatment unit.

Available from Putnam Publishing Group, 200 Madison Avenue, New York NY 10016, USA.

Training/reference

► **DRUGS: RESPONDING TO THE CHALLENGE.** Barbara Howe and Linda Wright. Health Education Authority, 1987. Drug education/training course consisting of



Facilitator's Manual (£27) and Participant's Manual (£7).

Designed to provide professionals with the knowledge and skills to be effective drug educators/trainers.

Available from HEA Addictions Project, University of Durham, School of Education, Leazes Road, Durham DH1 1TA, phone 091 374 3484.

► **DRUGS AND DRUG ABUSE: A REFERENCE TEXT. 2ND REVISED EDITION.** Terrence C. Cox et al. Revised by Michael R. Jacobs et al. Toronto: ARF, 1987. xxv, 640 pages. \$29.50. Book.

A new edition of the most comprehensive and up-to-date compendium of drug facts revised to take into account changing patterns of drug use in North America.

Available from the Addiction Research Foundation, 33 Russell Street, Toronto, Ontario M5S 2S1, Canada.

COURSES

► **AIDS AND DRUG USERS.** Surrey Drugs Resource Scheme. 10 November 1987. Epsom. £20, voluntary agencies £15.

For professional and voluntary groups who come into contact with drug problems.

Details from Training, Surrey Drugs Resource Scheme, 80 East Street, Epsom, KT17 1HF, phone 03727 29425.

► **LIMITING YOUNG PEOPLE'S DRUG USE.** National Children's Bureau. 11 November 1987. London. £20.98 for members, £27.88 non-members.

One of a five-part series of seminars on young people and drugs, aiming to provide practical help to those working with young people.

Details from NCB, 8 Wakley Street, London EC1V 7QE, phone 01-278 9441.

► **ORGANISING HEALTH AND DRUG EDUCATION COURSES.** TACADE. 7-9 December 1987, Berkshire. 21-23

March 1988, Warwick. 22-24 June 1988, Wakefield. £95.

To help trainers organise courses for teachers and other professionals.

Based on the *Free to choose* and *Alcohol education syllabus* courses. Details from TACADE, 3rd Floor, Furness House, Trafford Road, Salford M5 2XJ, phone 061 848 0351.

► **PREGNANCY, CHILDCARE AND ADDICTION.** 18 February 1988.

► **PREVENTING ALCOHOL AND DRUG PROBLEMS.** 17 March 1988. Leeds Addiction Unit. Leeds. £12 each.

The first course is for workers involved in the care of pregnant women or young children. The second is for a variety of community and advice workers and concentrates on the provision of community resources.

Details from Gillian Tober, Tutor in Addiction, 40 Clarendon Road, Leeds LS2 9PJ, phone 0532 456617.

MEETINGS

► **AIDS AND DRUG MISUSE: CONFRONTING THE CRUCIAL ISSUES.** 13 November 1987.

► **ALCOHOL AND DRUG PROBLEMS IN THE WORKPLACE: THINKING ABOUT POLICIES AND PRACTICE.** 27 November 1987.

Addiction Research Unit, Institute of Psychiatry. London. £40 each.

Two in a series of one-day seminars on current issues in problems of substance use.

Details from Ms Betsy Thom, Addiction Research Unit, Institute of Psychiatry, 101 Denmark Hill, London SE5 8AF, phone 01-703 5411, ext. 110 or 128.

► **PSYCHOLOGY AND ADDICTION.**

Joint annual symposium of the Society for the Study of Addiction and the British Psychological Society. 26-27 November 1987.

Cardiff. Non-members registration fee £50, accommodation available. Papers presented on the psychology of addictive behaviour and psychological techniques for its prevention or cure.

Further details from Professor A.H. Ghodse, St George's Hospital Medical School, London SW17 0QT, phone 01-672 1255, ext. 4098.

► **SEMINAR FOR DRUG RESEARCHERS.** Drug Abuse Research Team, Nucleus. 3 December, am, at the Boardroom, 40 Eastbourne Terrace, London W2. Free.

A discussion forum for researchers in and around London.

Details from Yasmin Balliwala (01-370 7054) or Ian Golton (01-570 7715, ext. 2251).

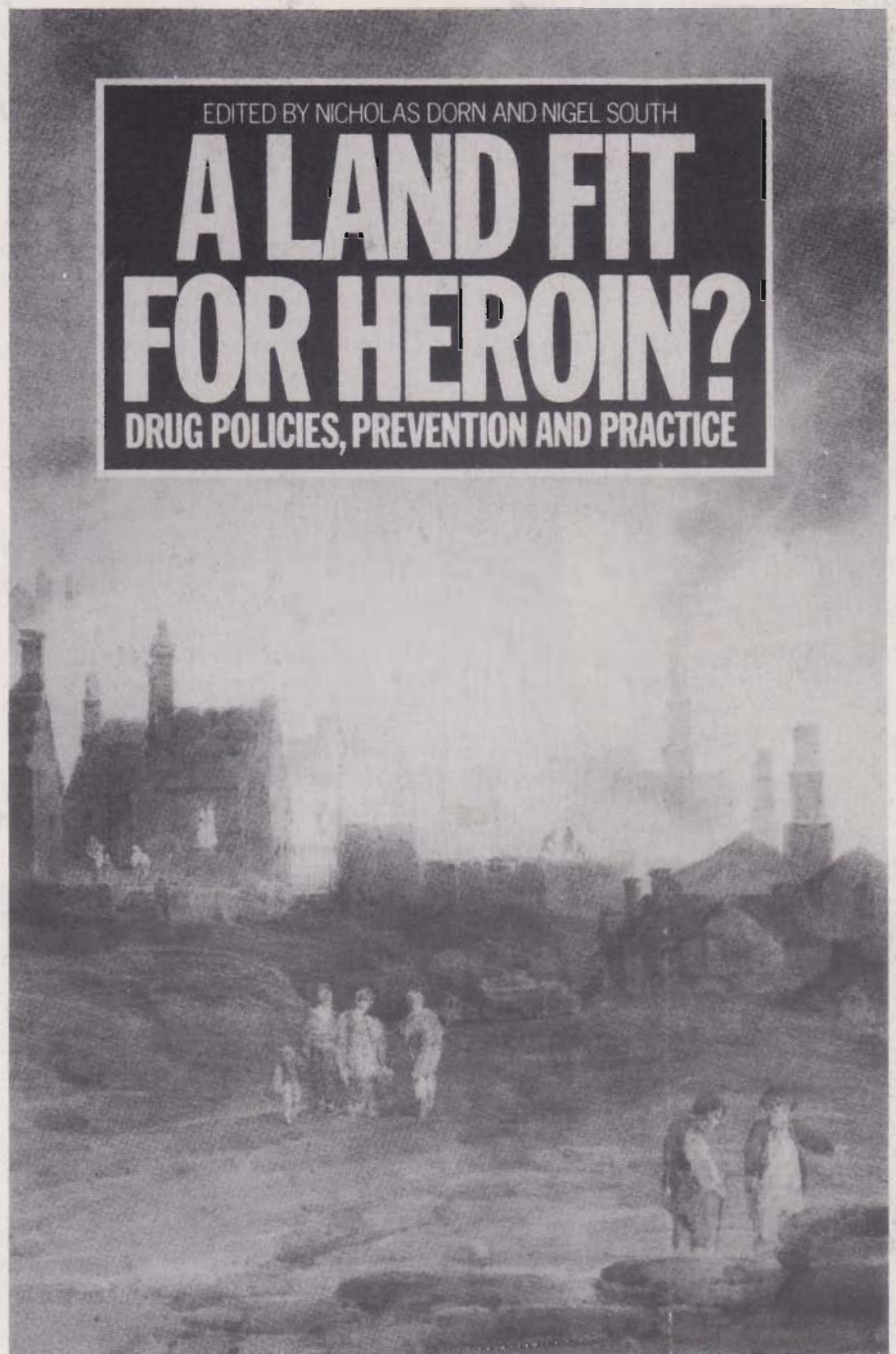
Call the Information Officer on 01-430 1991 for more information and advice on any of the publications listed, all of which are normally available for reference in ISDD's library. ISDD's *Drug abstracts monthly* gives a much fuller summary of the content of the most significant publications received by the Institute's library — phone 01-430 1991 for subscription details and a specimen copy.

ISDD PUBLICATIONS

Heroin has become a major issue for politicians, the helping professions and the public. Increasing availability of the drug in the 1980s has promoted greater efforts to control the heroin trade and to care for users. Drawing on the most up-to-date research, the contributors to *A Land fit for heroin?* question commonly held tenets and consider:

- ▶ why crop substitution and anti-trafficking measures are not more effective
- ▶ the extent to which the problems popularly associated with heroin can be blamed solely on the drug
- ▶ how we can understand the struggles and strengths that characterise family and neighbourhood responses to heroin
- ▶ the problems that arise in areas of poor housing and high unemployment
- ▶ how social work responses can be better developed alongside medical care

The contributors present a policy agenda that offers a practical and coherent approach to the heroin problem. *A Land fit for heroin?* is essential reading for all concerned with drug issues.



Edited by ISDD researchers Nicholas Dorn and Nigel South and published by Macmillan Education in 1987.

£7.50, inc p&p.

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