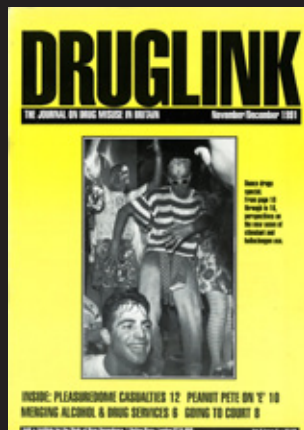
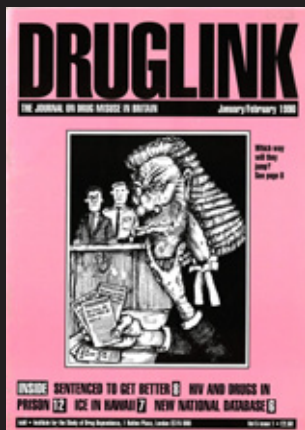
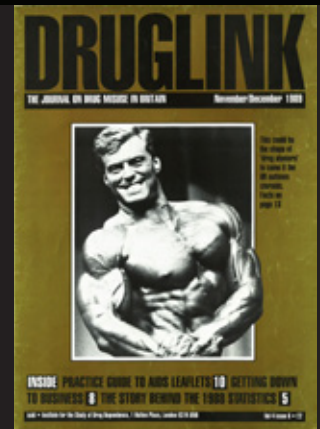
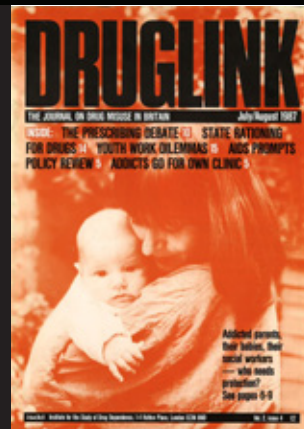
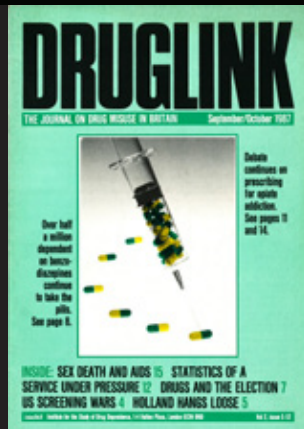
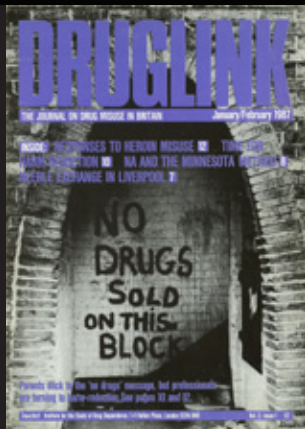


Druglink

REPORTING ON DRUGS SINCE 1975

Souvenir edition

UK drug scene – telling the story Part 1: 1986–1994



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Druglink is for all those with a professional or occupational interest in drug problems and responses to them – policymakers and researchers, health workers, teachers and other educators, social workers and counsellors, probation and police officers, and drug workers.

DrugScope is the UK's leading independent centre of expertise on drugs and the national membership organisation for those working to reduce drug harms. Our aim is to inform policy development and reduce drug-related risk. We provide quality drug information, promote effective responses to drug taking, undertake research, advise on policy-making, encourage informed debate and speak for our members working on the ground.

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Druglink



Druglink: the story so far...

The magazine started life back in 1975 as an occasional newsletter. In 1984, we stopped to reassess what was required. We launched the magazine proper in May 1986. Since then and without a break, *Druglink* has been published every two months.

It was never intended that *Druglink* would be the house magazine of the organisation, reporting only on organisational activities and policies. In effect, *Druglink* started out and remains a current affairs magazine about drugs and drug-related issues (and increasingly about alcohol too), whereby comment and opinions could appear that do not necessarily chime with DrugScope's view of the world (or those of its predecessor ISDD).

Many of us in the sector have felt the cold wind of austerity blowing through our bank balances and DrugScope is no different. While committed to uninterrupted publication, even so we had to find ways of cutting costs. It was with no little regret that we decided to end print publication of the magazine in July 2013 and move to an online 'page flick' style format. However, because of the limitations of the format, it did not allow us to take full technical advantage of having an online presence for the magazine. From next January, *Druglink* will be launched as a fully-functional web-based magazine – and moreover will be freely accessible to all. We are also planning to launch a fully searchable archive of *Druglink* articles back to 1986.

Which takes us to the plan for the next two issues. As *Druglink* is moving into a new era in its long and illustrious history, we thought it might

be illuminating to publish a selection of articles from the last 27 years of publishing that best reflect all the tumultuous changes that have occurred in the sector over that time.

This issue covers the period 1986-94, ending with the lead-up to the publication of the first proper UK drug strategy *Tackling Drugs Together*. It was during that first period that many significant debates and decisions about drug treatment were played out, including the development of harm reduction services to tackle the threat of blood-borne viruses; the fierce arguments over the future of opiate substitute prescribing resulting in the 'Orange Book' and subsequent editions; and the move towards social service funding of residential rehabilitation. In terms of drug trends, heroin use spiralled to unprecedented levels and crack made its inaugural appearance, prompting apocalyptic predictions for the future of society from US drug enforcement officials, British politicians and our own dear tabloid press. And then there was rave culture and the rise of ecstasy. This was probably the most significant step change in the UK drug scene since smokable heroin arrived from the Middle East in the late 1970s. A wave of ecstasy-related deaths, the first of which was reported in 1986, saw the development of another strand of harm reduction aimed at keeping young people safer in hot and humid club environments.

So much has happened in the drugs world over this period that we couldn't possibly reflect every development, so what you will read are only snapshots in time. Once the archive is up and running

of course, you will have access to all the features we published.

So where are we now with these issues in 2014? Sadly, young people are still dying from ecstasy and in increasing numbers. Ironically, this could partly be explained by the absence of many of the harm reduction messages which were so much part of the dance landscape in the early 1990s, but which have now been lost to a younger generations of clubgoers. In fact since 2010, in parts of government, the whole concept of harm reduction has become worryingly toxic, a view which, some believe, has become increasingly embedded in local commissioning practice. It is to be hoped that ideology trumping evidence-based practice has not been a factor in the 35% jump in heroin deaths reported in 2013 or a harbinger of things to come.

No doubt that the treatment sector is now driven by contract culture and the fears of many rehabs who predicted closure after the passing of the Community Care Act, have come to fruition. And on the drug front, while it caused enormous problems for dependent users, crack did not bring society to its knees, and, like heroin, its use has been in decline for some years now.

More seismic shifts in the next issue; say hello to a unified drug strategy, a Drug Czar, the National Treatment Agency, cannabis farms and new psychoactive substances.

Harry Shapiro

Editor and Director of Communications and Information

UK DRUG SCENE TIMELINE: 1960–1994

While *Druglink* did not start even as a newsletter until 1975, here is a simplified overview of the UK drug scene as it developed up to the point where we had, for the first time in 1995, a cross-government strategy for dealing with drugs. The timeline continues in the next issue. Compiled by **Harry Shapiro** and **Geoff Monaghan**.

PREVENTION, TREATMENT
AND REHABILITATION

LAW ENFORCEMENT

DRUG POLICY

LEGISLATION
AND CASE LAW

DRUG TRENDS



1960

Metropolitan Police (MP) Dangerous Drugs Office (set up in 1954) – comprised four officers.

1961

Report of Interdepartmental Committee on Drug Addiction published. Chaired by Sir Russell – later Lord – Brain

The Committee concluded: “the incidence of addiction to dangerous drugs is still very small... no cause to fear that any real increase is at present occurring.

1963

Metropolitan Police report revealed officers believed a number of doctors were overprescribing to addicts and that the surplus was being sold.

1964

The first year when more whites than non-whites were convicted of cannabis related offences in the UK. The total number of convictions, 544, was a little lower than in the previous two years.

1960

1961

1962

1963

1964

1960

At the time, the main drug control legislation in force was the **Dangerous Drug Act 1951**.

1960

First heroin addict under the age of 20 years appeared on the Home Office files.

1960

Number of known notified users: 437



1964

Dangerous Drugs Act 1964

Introduced a main new offence of permitting premises to be used for the purpose of smoking cannabis.

Drugs (Prevention of Misuse) Act 1964

Banned the unauthorised possession of amphetamine to counter misuse (particularly Drinamyl – ‘purple hearts’) by various youth sub-cultures, mainly ‘mods’.

The 1961 Single Convention on Narcotic Drugs ratified by the UK

RELEASE

1960s



1965
Pytch, became the first police dog in Britain to detect a controlled drug (cannabis) during a search of a house in London's East End.

1967
Release founded [George Harrison donated £5,000 to Release in 1969].

1968
First NHS drug clinics opened.

Institute for the Study of Drug Dependence (ISDD) founded.

First therapeutic communities opened in the UK – Alpha House and the Coke Hole Trust.

1968
Arrest of Dr John Petro for failing to keep a drugs register. He was one of a small group of so-called 'junkies' doctors' and was struck off later that year.

Police recommendation that Regional Drug Squads be formed or drug squad officers be attached to the Regional Crime Squads predating similar recommendation by ACPO in 1985.



1965
Publication of the influential Interdepartmental Committee on Drug Addiction (known as the 2nd Brain Committee report).

Key Recommendations

- Limitations on the rights of doctors to prescribe heroin or cocaine (only doctors holding a special licence could prescribe either of these drugs to addicts);
- The setting up of specialist out-patient NHS clinics;
- Compulsory notification of addicts to Home Office.



1967
Arrest of Keith Richards and Mick Jagger on minor drugs charges prompted the famous *Times* editorial, 'Who breaks a butterfly on a wheel' suggesting the arrests were more about who the defendants were than the severity of the crime.

Full page advertisement appeared in *The Times* paid for by Paul McCartney and signed by academics, politicians, pop stars etc calling for cannabis law reform.

First UK seizure of non-pharmaceutical 'Chinese' heroin by the Metropolitan Police.

1969
Publication of the Report by the Advisory Committee on Drug Dependence – more widely known as the Wooton Report.

The main recommendation that caused a media and political storm was that possession of a small amount of cannabis should not normally be regarded as a serious crime to be punished by imprisonment.

Also that there should be a new system for penalties based on evidence of harm. This became the ABC classification in the Misuse of Drugs Act.

1965

1966

1967

1968

1969

1966
Drugs (Prevention of Misuse Act (Modification Order)
Possession of LSD brought under control.



1967
Dangerous Drugs Act 1967
Power for the police to search and detain persons suspected of having committed an offence under drug laws.

1968
Dangerous Drugs Act: R v Finnigan
A journalist was writing an article on drug misuse which highlighted how easy it was for young people to obtain them. In order to acquire material for the article, she went to a flat and bought cannabis. She pleaded guilty to possession and was sentenced to nine month's imprisonment. She had no previous convictions. On appeal, it was held that the sentence was wrong and was changed to an absolute discharge.

1968
Medicines Act
Powers to govern the control of medicines for human and veterinary use.



1965
Number of known notified users: 927

1967
Number of known notified users: 1729

1970s

PREVENTION, TREATMENT
AND REHABILITATION



LAW ENFORCEMENT

1970
Publication of the Report by the Advisory Committee on Drug Dependence (ACDD) *Powers of Arrest and Search in Relation to Drug Offences* (also known as the Deedes report) – set up to 'review the existing powers of arrest and search in relation to drug offences'.

Main recommendations:

- The retention of the stop and search provisions of the Dangerous Drug Act 1967;
- That it was neither practicable or desirable for the law to define 'reasonable grounds';
- That police should accept and enforce the principle that particular modes of dress or hairstyle should never by themselves or together constitute reasonable grounds to stop and search.

DRUG POLICY



1973
Standing Conference on Drug Abuse founded. Set up to represent non-NHS treatment services.

1972
The *Sunday Times* published an expose of the Metropolitan Police Drugs Squad and two days later Detective Chief Inspector Vic Kelaher was charged with conspiring to pervert the course of justice along with DS 'Nobby' Pilcher and three other detectives.

1973
The Drugs Intelligence Section of the Central Research Establishment was notified of two cases involving seizures of Methylene-dioxy-amphetamine (MDA).

1974
The Central Research Establishment analysed 20 'Chinese Heroin' samples seized by British Customs and police and found that in 14 (70%) cases, they contained strychnine. In some cases the level of strychnine was 'surprisingly high'. Strychnine had long been used in the manufacture of so called 'red pills' or heroin 'anti-opium' pills in China and other Asian countries.

LEGISLATION
AND CASE LAW



1970
Number of known notified users: 2661

DRUG TRENDS

1973
Misuse of Drugs Act (MDA)

- Established the Advisory Council on the Misuse of Drugs (ACMD);
- Introduced a classification system for controlled drugs: A, B and C;
- Created the new offence of possession with intent to supply a controlled drug;
- Increased the penalties for trafficking offences (e.g. production, supply and importation and exportation).

1974
Chaotic use of barbiturates (and methaqualone – mandrax) mainly in London. During February and March, five regional laboratories reported seizures of clear, pale blue capsules containing phencyclidine (PCP – also known as 'Angel Dust') and saccharine. One seizure (Metropolitan Police Laboratory) involved 3,460 such capsules. But PCP never had a sustained presence on the UK drug scene.

1975
ACMD initiates the Campaign on the Use and Restriction of Barbiturates (CURB).



1977
Operation Julie
Following a 14 month investigation by a team of police officers from 11 police forces, raids by 800 police officers throughout the UK resulted in the arrest of 119 persons and the discovery of two clandestine LSD laboratories.



1978
City Roads in London opened as the first crisis intervention centre set up to deal with the revolving door of barbiturate users going in and out of A&E.

1979
First Narcotics Anonymous (NA) meeting in the UK.

1978
The largest ever seizure, 32 kgs of heroin (20% purity) in Britain, was made by HM Customs and Excise in September. The heroin was found concealed in car tyres.

1978
ACMD Cannabis Working Group recommended that cannabis be reclassified to a Class C drug.

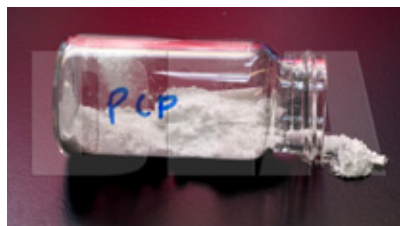
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1976

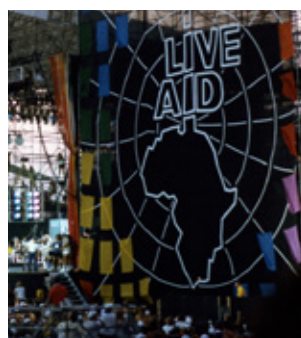
1977

1978

1979



1979
Smokable heroin from the Middle East making an impact on the UK drug scene for the first time. The start of what became the heroin epidemic that only began to abate in the past few years.



PREVENTION, TREATMENT AND REHABILITATION

LAW ENFORCEMENT

DRUG POLICY

LEGISLATION AND CASE LAW

DRUG TRENDS

1982

Publication of the *Treatment and Rehabilitation Report* by the Advisory Council on the Misuse of Drugs (ACMD).

The Report made a number of recommendations covering:

- Central and local responsibilities;
- Development of services;
- Prescribing safeguards;
- Training;
- Research;
- Funding.

Specifically, it recommended the setting up of Drug Advisory Committees (DACs) comprising representatives from health and local authorities and other statutory and non-statutory agencies. The Report also recommended further restrictions on the prescribing of dipipanone (Diconal).

1982

Customs & Excise pilot 'compounding' schemes at Heathrow and Gatwick airports. Persons caught with 10 grams or less of cannabis or cannabis resin, were given the choice of accepting an automatic penalty of £50 in lieu of prosecution.

1983

Chief of the Narcotics Squad, Amsterdam, warned delegates attending the annual ACPO Drugs Conference of the harms associated with 'free-basing' cocaine.

Largest cannabis shipment ever seized by British Customs – 11 tons.

1984

Publication of the *Prevention Report* by the ACMD.

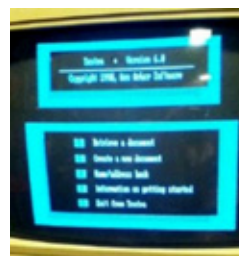
The Report re-defined the 'prevention' in the following terms:

- (a) Reducing the risk of an individual becoming involved in drug misuse
- (b) Reducing the harms associated with drug misuse

The Report made a number of recommendations including:

- Drug education should not concentrate solely on factual information about drug misuse; a balanced approach is needed which focuses more on social and cultural factors;
- National campaigns aimed specifically at reducing the incidence of drug misuse should not be attempted;
- Media coverage of drugs matters needs to be better informed.

Publication of first clinical guidelines attempting to establish what is (and isn't) good practice in the treatment of addiction.



1984

MP officers arrested a British heroin and cocaine trafficker in London. The man described how he prepared cocaine for smoking using both the 'free-basing' and 'crack' production techniques. One of the earliest documented examples of the production and use of crack in the UK.

1980

Publication of the ACMD Report on Drug Dependents within the Prison System in England and Wales.

Key recommendations included:

- Further therapeutic units for dependency on the lines of those at Holloway or Wormwood Scrubs should be established.

1982

ACMD Expert Group on the Effects of Cannabis report was inconclusive on health effects and called for more research. Government used this report as part of its reason for rejecting previous ACMD cannabis report calling for regrading.

1983

Following on from the ACMD treatment report, Department of Health established the Central Funding Initiative (£17.5m to 1989) to improve treatment provision.

1980



1980

Beginnings of what became the widespread use of solvents (generally known as 'glue sniffing') among mainly younger teenagers.

1981

Forfeiture orders were made under the MDA against those convicted in the Operation Julie trial.

On appeal, the House of Lords ruled against the forfeiture orders and 'with considerable regret' found itself compelled to allow the appeals on the grounds that section 27 only applied to things shown 'to relate to the offence'.

1982

1983
R v Aramagh (1983) 76 Cr. App. R. 190 laid down sentencing guidelines based on the value of the drug involved.

1983

1984

1984
Barbiturates controlled under the **Misuse of Drugs Act**.

1985
Intoxicating Substances (Supply) Act 1985

The Act made it an offence to supply or offer to supply, to a person under 18 years of age, a substance other than a controlled drug, if he knows or has reasonable cause to believe that the substance is or its fumes are, likely to be inhaled by the recipient for the purpose of intoxication.

Controlled Drug (Penalties) Act 1985

Increased the penalties for certain offences relating to controlled drugs:

- Life imprisonment for all supply, importation, production and exportation offences relating to Class A drugs;
- 14 years' imprisonment for the same offences relating to Class B drugs.

1985

In 1985, the DHSS asked Regional Health Authorities to establish multi-agency Drug Advisory Committees (DACs) in every Health Region and District. This request followed the advice of two earlier ACMD reports which had envisaged a key role for DACs in ensuring the coordinated development of drug services suited to local needs.

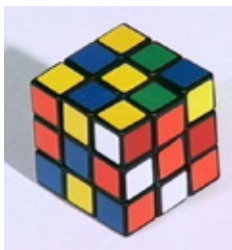
The first government anti-drugs campaign launched – 'Heroin screws you up'. Overall evaluation suggested that it only impacted on those who never intended to use in the first place.

First cases of drug-related HIV reported in Scotland

1985

The National Drugs Intelligence Unit (NDIU) was set up.

First prosecution of shopkeeper selling solvents.



1985

Publication of *Tackling Drug Misuse: A Summary of the Government's Strategy*

The Government's objective was to 'attack the problem by simultaneous action on five main fronts':

- Reducing supplies from abroad;
- Making enforcement more effective;
- Maintaining effective deterrents and tight domestic controls;
- Developing prevention;
- Improving treatment and rehabilitation.

1986

McLelland Report was the first official document to champion harm reduction as a response to drug-related HIV and recommended setting up needle exchange schemes (NEX). The first formal NEX was opened in Peterborough.

1987

DHSS formally endorses NEX.

1988

First ACMD report on AIDS and drugs states that stopping the spread of the disease was more important than getting people off drugs. This inaugurated an eventual change in clinic practice away from almost universal short term methadone detox to more longer term prescribing.



1989

Media campaign designed to discourage needle-sharing.

1989

Robert Stutman speech to ACPO warning of the dangers of crack (see pages 21–22).

Southwark in south London started a drug referral scheme.

October: the Metropolitan Police Service Force Crack Intelligence Coordinating Unit (FCICU) was set up.



1989

Crack: the threat of hard drugs in the next decade (Interim Report). The Home Affairs Committee published its report on Drug Trafficking and Related Serious Crime.



1985

1986

1987

1988

1989

1986

On 1 January the **Police and Criminal Evidence Act 1984** became law. The Act made sweeping changes to policing powers and practices including those relating to stop and search, entry, search and seizure, arrest and detention and the treatment and questioning of detainees.

UK ratified the 1971 UN Convention on Psychotropic Substances.

Section 9A of the MDA 1971 came into force prohibiting the supply of articles for use in the unlawful administration of controlled drugs. Hypodermic syringes and needles were specifically excluded from the provisions. Other injecting-related items have been excluded over the years, the most recent being foil.

1986

First recorded MDMA death: Claire Leighton from Liverpool.

1988

Number of known notified users: 12,977

1987 Drug Trafficking Offences Act (DTOA) 1986 came into force.

The Act introduced sweeping and radical changes in the law to enable the courts to recover the proceeds of drug trafficking.

1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988

1985

First mention of MDMA in a UK publication – *The Face*, a pop culture/style magazine.

1980s



PREVENTION, TREATMENT
AND REHABILITATION

LAW ENFORCEMENT

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LEGISLATION
AND CASE LAW

DRUG TRENDS

1990

First international harm reduction conference, Liverpool.

1990

NHS and Community Care Act made local authority social services responsible for the funding of drug and alcohol residential rehabilitation services.

1990

The total weight of heroin seized by Customs during the last quarter of 1990 was 320.6 kg, bringing the total weight for 1990 to 540.8 kg. This was the largest weight ever seized in a single year, and represents a 60% increase on the record figure of 331.5 kg for 1989.



1991

Publication of the ACMD's report *Drug Misusers and the Criminal Justice System Part I: Community Resources and the probation Service*.

The report made many recommendations, including the following:

- Agencies dealing with drug misusing offenders should adopt the principles of harm reduction so as to avoid setting unrealistic goals;
- Adequate resources should be made available to ensure access to drug services for convicted misusers;
- Probation Services should establish links with as many treatment agencies as possible, and take steps to dispel and reluctance on their part to work with the criminal justice system;
- Those considering the training and information needs of sentencers should give high priority to drug issues.

Second edition of the Clinical Guidelines published.

Supported harm reduction interventions while re-asserting abstinence as the ultimate goal and advising GPs not to undertake methadone maintenance without specialist advice

1992

ACMD report on CJS Part II.

1992

Publication of the Release White Paper on Reform of the Drug Laws to mark the 25th anniversary of its founding.

According to Release, the aim of the White Paper was to 'provide a concrete basis for debate and consultation' on the reformulation of Britain's drug laws in 'ways which safeguard and promote individual and community welfare'.

1991

Publication of *Drugs and the Law: a report by JUSTICE*.

Chaired by Judge Peter Crawford QC, the Committee, the objective was to consider all aspects of the law relating to drugs that might require revision and improvement. The Committee made a number of recommendations including the following:

- Extending section 8 (d) of the MDA 1971 (allowing certain drug activities on premises) to cover all controlled drugs not just cannabis, cannabis resin and prepared opium;
- Defining the word 'premises' in section 8 of the MDA 1971;
- Encouraging police services in appropriate cases, to caution drug offenders regardless of the class of drug involved;
- A new section 5A should be added to the MDA 1971 to allow a distinction to be made between commercial and social supply.

1990

1991

1992



1991

UK ratified the **United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988**

Criminal Justice Act 1991

The Act made substantial amendments to the Powers of Criminal Courts Act (PCCA) 1973 which enabled the courts to link probation orders to treatment for drug and alcohol dependency.





1993

At the ACPO Annual Drug Conference, DCS Tony White, NCIS, pointed out the weaknesses in the law which discouraged police officers from taking on controlled delivery operations involving precursor chemicals. The law was subsequently amended.,

Commander John Grieve, Director of Intelligence, MPS, made his 'Think the unthinkable' speech to delegates at the same event 'We are at the crossroads. Either we go to war on dealers across the globe, or we have to come up with new options. We need to think the unthinkable.' He suggested a liberal licensing system for all controlled drugs be introduced but would not be drawn as to how such a system might work in the UK.



1994

Publication of *Tackling Drugs Together* A consultation document on a strategy for England 1995–1998.

The 'Green Paper' set out the Government's 'new approach to strategic thinking on drugs issues'.

The proposed strategy was driven by the following Statement of Purpose: To take effective action by vigorous law enforcement, accessible treatment and a new emphasis on education and prevention to:

- Increase the safety of communities from drug-related crime;
- Reduce the acceptability and availability of drugs to young people;
- Reduce the health risks and other damage related to drug misuse.

1993

1994

1994

Criminal Justice and Public Order Act (CJPOA) 1994

Amended the Prison Act 1952 to enable prison authorities to require prisoners to produce samples of urine for drug testing.

Also tried to control rave events by defining raves in terms of 'repetitive beats' and forbidding gathering of more than 100 people or even three people if the police had reason to believe that eventually more than 100 would turn up.



1986

The battle for the right to prescribe

Through the 1970s, consultant psychiatrists in the NHS drug clinics had been moving away from prescribing any injectable drug to oral methadone – and also on a reducing dose basis. But there were still doctors in the community (both private and NHS) willing to prescribe more liberally. The 1982 ACMD landmark report on treatment and rehabilitation came out strongly against private prescribing and battle was joined in the right to prescribe.

The first guidelines of good practice were published in 1984, but like the guidelines that followed in 1991, were little more than the collective opinion and experiences of a small group of London-based consultant psychiatrists with

virtually no reference to the (admittedly slim) clinical literature.

The 1999 guidelines were a different beast – a wide range of disciplines were represented on the Working Group, not just consultant psychiatrists – and there was an acknowledgement of a wider clinical literature. Inevitably, though, prescribing was the most controversial area to be tackled; a significant departure from previous guidelines was the endorsement of methadone maintenance as an appropriate intervention for primary care, but tied to much stronger recommendations on daily supervised consumption – were still expressed. Some general reservations about the appropriateness of GP

prescribing. Like their predecessor, the 1999 Guidelines were intended *de facto* if necessary to have the force of law in cases of medical discipline against those believed to be acting outside the guidelines. So, there was a more liberal view taken on prescribing, but still a pretty restrictive view on who best to carry out the work. The 2007 Guidelines will be considered in the next issue, but at the time of writing these too are under review.

What follows is an edited version of the two articles by **Mike Ashton** which looked at the issues dividing the medical camps in 1986.



DOCTORS AT WAR

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

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

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

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

subject of our story. In this issue we trace events up to the government's response to the proposed curbs.

Curbs recommended

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

CONTROVERSY SURROUNDS THE IDEA THAT PROVIDING A CHEAP, LEGAL SUPPLY OF HEROIN OR HEROIN-SUBSTITUTES ON PRESCRIPTION CAN HELP SOME HEROIN ADDICTS LIVE STABLE, PRODUCTIVE LIVES AND UNDERCUT THE ILLICIT MARKET

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

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

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

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

Battle commences

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

The Council's proposals ended up in the hands of a Medical Working Group on Drug Dependence announced by the DHSS in 1983. It included members from

both sides of the growing divide between the psychiatrists in the drug dependency units and the doctors in general or private practice who – if the proposals were enacted – might be required to accept the psychiatrists' advice/control.

'Good practice' guidelines

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

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

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

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

Licensed to prescribe?

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

serious physical damage from its abuse by injection.

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

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

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

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

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

Temper

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

Later that year two more London clinic psychiatrists, Thomas Bewley

and Hamid Ghodse, published a research article uncompromisingly titled "Unacceptable face of private practice: prescription of controlled drugs to addicts". One of the authors served for a time on the Medical Working Group and is known to have been in correspondence with the General Medical Council concerning the behaviour of another member of the group, a private practitioner and president of the Association of Independent Doctors in Addiction, Dr Ann Dally. She had recently been prone to publicise her trenchant criticism of the competence and relevance of the NHS clinics (eg, "Have Drug Clinics Failed", *Sunday Times*, 27 February 1983).

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

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

Government decides

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

Aided by the civil servants, the

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

Battle continues

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

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

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

In the next issue, Mike examined how these mechanisms were oiled-up and put to use, creating more controversy as the leader of the ‘independent’ doctors felt the weight of the GMC’s disapproval.



DOCTORS AT WAR 2 – THEN IT GOT SERIOUS

In 1982, as the Advisory Council’s report recommending prescribing controls was being written, an Uxbridge doctor was struck off the medical register for allegedly prescribing Diconal “on demand” to private patients. His unorthodox treatment of addiction had been judged “serious professional misconduct” by the General Medical Council’s Professional Conduct Committee, the medical profession’s own disciplinary authority. In 1983, two doctors treating addicts privately in central London were similarly dealt with, the first a Harley Street doctor said to have been ‘motivated by greed’, the second, a Soho practitioner “misled by the enormous financial rewards”.

All three cases involved addict patients who had died, reflected in headlines such as ‘Doctors Who Trade in Misery’, ‘Dr Death’ and ‘Victims of the Pusher Doctor’. Alongside the professional push towards prescribing controls there developed a veritable press campaign against the prescribing doctor – ‘How Doctors Feed the Heroin Black Market’, a *London Standard* headline in November 1982, typified the theme.

Between 1972 and 1984 the GMC’s

Professional Conduct Committee acted against 38 doctors for improper prescribing, of whom 17 were in private practice. In July 1983 they made probably their most significant decision, the fallout from which led the GMC’s president to defend its actions in the medical press: the leader of the Association of Independent Doctors in Addiction was admonished for serious professional misconduct in her treatment of an addict patient.

‘Leading Independent’ disciplined

In November 1981, Dr Ann Dally organised the meeting which founded the Association of Independent Doctors in Addiction (AIDA), “a forum for doctors in both NHS and private practice who encounter addicts outside the clinics”. A ‘Harley Street’ (actually, Devonshire Place) doctor specialising in psychiatry, Dr Dally became the Association’s first president. In numerous interviews and articles in the medical and national press, she condemned the “drug dependency establishment” for its ‘inflexible’ and ‘restricted’ approach to treatment.

From the start AIDA emphasised

its commitment to “high standards of practice” in the treatment of drug dependence. It came as a shock when the treatment offered by the Association’s president to a Diconal addict living in Coventry, was condemned by the medical profession’s disciplinary panel.

Dr Dally was charged with prescribing “otherwise than in the course of bona fide treatment”, amounting to “serious professional misconduct”. The fact that the charge was found proved and because of the status of the defendant involved, have been seen as signalling a significant extension of the GMC’s role in controlling prescribing.

TOLERANCE, FLEXIBILITY, RELIANCE ON THE DOCTOR’S JUDGMENT, QUALITIES AT THE HEART OF TREBACH’S ROMANTIC VISION OF THE ‘BRITISH SYSTEM’, WERE NOW UNDER THREAT

After the last wave of concern over prescribing in the ‘60s, it had been established that the GMC had very limited powers. Proof of mistaken, negligent, excessive or even reckless prescribing was not enough. It had to be proved that the doctor did not even believe this was the right treatment (‘bad faith’), and that their conduct amounted to serious professional misconduct – issues of interpretation, rather than fact. Dr Dally’s case illustrates how far the committee is now prepared to go in interpreting imperfect or risky addiction treatment as professional misconduct. Whether the judgment was ‘right’ or ‘wrong’ is not at issue here – it is what the judgment means in the struggle over prescribing controls that concerns us.

Legal advice to the committee hearing Dr Dally’s case defined two criteria which, if either were satisfied, would mean prescribing was not bona fide treatment. The first, prescribing without honestly believing this was the right treatment for the patient, was the accepted basis for disciplinary action.

The second criterion for non-bona fide treatment, prescribing in the knowledge that the drugs might be

sold on the illicit market, but “not caring” if this happened, was more of an innovation, and appears to have formed the substance of the successful case against Dr Dally. In the words of the prosecuting counsel, the “practitioner owed a duty not merely to the patient who was being treated but also to the public at large, that is to say, those into whose hands such drugs may fall”.

Later *The Lancet* carried a barrister’s opinion that the evidence against Dr Dally “seems to fall well short of proof of lack of good faith”. In the same issue, an editorial spoke of “bewilderment” among journalists and observers at the hearing’s decision to admonish AIDA’s leader, commenting that “the evidence did not emerge as compelling”.

Britain’s other leading medical journal published the views of a well-known GMC member and medical author. His colleagues on the GMC had, he said, stuck to the rules. But observers might understandably have got the impression “that this was a political trial in which the ‘establishment’ was out to ‘get’ Dr Dally because of her heretical views...I wonder if without the background political noise a case which in the end the GMC adjudged to amount to ‘reckless’ prescribing for one patient would have reached the council chamber for the full ritual of a ‘public trial’”.

It took the Professor of an American School of Justice to draw out the wider implications. Long an admirer of the ‘gentle’ British approach to addiction, Professor Trebach feared the GMC “may well have cut out a major piece of the heart of the most civilised system of drug abuse treatment in the world”. As he saw it, the judgment had interpreted a genuine disagreement over appropriate treatment as ‘bad faith’ on the part of the dissenting doctor. Tolerance, flexibility, reliance on the doctor’s judgment, qualities at the heart of Trebach’s romantic vision of the ‘British system’, were now under threat.

GMC lays down the law

Professor Trebach’s prophecy may be premature, but the decision against Dr Dally does represent a tougher line on addiction treatment. The GMC’s submission to the recent Commons Social Services Committee investigation confirmed their willingness to act against doctors whose prescriptions find their way on to the illicit market, and added that ‘irresponsible’ as well as dishonest prescribing could be subject to disciplinary procedures.

What emerges from the controversy and confusion is that the GMC believes doctors treating addicts must have regard, not just to whether the treatment is right for their patient, but whether any drugs of dependence they prescribe may be redistributed and harm other members of the public. In any particular case the issue would be whether the doctor gave due weight to this possibility, a difficult judgment to make.

Since the majority of addicts in treatment sell some of their prescription, a severe interpretation of this criterion might land even clinic doctors in trouble. Chief Inspector Spear of the Home Office Drugs Branch has recalled a time in the ‘70s when clinic doctors became alarmed at the increasing street availability of injectable methadone, “but their proposal that general practitioners should be advised against prescribing methadone by injection for addicts had to be dropped when a survey by the Home Office...demonstrated beyond doubt that the major sources of the surplus were the clinics themselves and not general practitioners”.

Even if there is to be no extended licensing system through which to firm the Guidelines into rules, the GMC has eagerly seized on the advice from the Medical Working Group as a yardstick for deciding what is, or is not, acceptable medical practice. Speaking to the Social Services Committee, the chairman of the GMC’s disciplinary committee admitted “there was...a little difficulty in dealing with these cases, that a professional was in a position to argue regarding the validity of the treatment he used... the great advantage with this particular document is that we now have...the corporate view of what constitutes proper practice in this field”.

For the GMC, in some respects the Guidelines did not go far enough. Their 1985 annual report commended the Guidelines, but also publicised “the serious view taken by the Professional Conduct Committee of evidence that a doctor has prescribed opioid drugs to addicts in private practice where the financial circumstances of a patient were such that he would have needed to sell part of the drugs prescribed in order to cover his expenses in obtaining them, or where the fees charged have varied according to the amounts of drugs prescribed.”

The tribunals

Because the medical profession’s disciplinary committee was thought

unable to act without evidence of bad faith, the Misuse of Drugs Act allowed the Home Secretary to withdraw a doctor's authority to prescribe controlled drugs on proof of irresponsible prescribing. The interpretation given to this charge has officially been described as "narrow" and "legalistic", whilst a Home Office drugs inspector has described the procedures as "rusty" and "creaky". Charges of irresponsibility are referred to a tribunal and then (on appeal) to an advisory body, each body consisting of a legal expert plus doctors appointed by the government.

In the years from 1971 to 1984 the tribunals sat just 15 times resulting in 12 doctors losing their right to prescribe all or some controlled drugs. Half these decisions were made by tribunals sitting in 1983 and 1984, evidence for the Home Office's claim that procedures had been streamlined. There is also evidence of greater urgency – the shortcut procedure allowing a temporary prescribing prohibition at short notice was used three times in 1984, but only once in the preceding years.

Responsibility for investigating alleged cases of irresponsible prescribing and instigating tribunal hearings lies with the Home Office Drugs Branch. In evidence given during Dr Dally's hearing, the Branch's Chief Inspector emphasised that "over-subscribing" could not be equated with "irresponsible" prescribing. Despite civil service discretion, the Drugs Branch is known to be concerned that addiction treatment in Britain may become counter-productively inflexible.

In an intriguing reversal of roles, the Home Office now opposes the medical establishment's push for blanket restrictions on prescribing, whereas in the 1920s it was the medical establishment that successfully resisted Home Office pressure to outlaw maintenance prescribing, setting ground rules for the 'British system' that lasted unchanged until 1968.

The evidence

With important policy issues and the central medical principle of clinical freedom at stake, medical politics and outraged ethical and moral responsibilities heightening emotions, but little more than uninformative official statistics to go on, research evidence on the medical response to addiction in Britain has become almost as much a subject for dispute as the issues it pertains to.

Both arguments reached a high



BUT THE FACT THAT MORE ADDICTS ARE CHOOSING TO TURN TO 'INDEPENDENT' DOCTORS RATHER THAN CLINICS SUGGESTS THE CENTRAL FINDING – THAT SOME PRIVATE DOCTORS ARE MORE 'GENEROUS' PRESCRIBERS – IS ALONG THE RIGHT LINES

point in the summer of 1983, just months before Dr Dally was called to account before the GMC. "For debate ..." said the *British Medical Journal's* lead-in to an article unambiguously titled "Unacceptable face of private practice: prescription of controlled drugs to addicts". A report of a study conducted by two prominent drug dependency unit consultants, the article did indeed provoke supportive and critical comment that ran to greater length than the original.

The two doctors had given 100 of their patients a questionnaire to complete. All 18 questions sought the patients' views or experiences of "private doctors". Two paragraphs in the two page report briefly reported findings from what appears to have been five of these questions, most answered by less than half of the patients in the study. This partial report painted a black picture of some private prescribers' willingness to 'sell' prescriptions for large amounts of injectable drugs, some of which were later resold to help pay doctors' and chemists' fees.

"It is questionable whether it is ever desirable to prescribe controlled drugs to an addict when a fee is paid," was Drs Bewley and Ghodse's comment on their findings. "If neither the General Medical Council nor a tribunal...can stop these practices, then extension of the present licensing system to include all controlled drugs...is probably the only way that this can be achieved."

'Propaganda' accusation

"... the BMJ has published propaganda disguised as a scientific paper" was the riposte from an AIDA member. Together with Dr Dally's husband, he highlighted the methodological faults in the research.

A glance at the questionnaire shows at least some of the criticism is justified. Large parts are left unreported, there are leading questions, failure in places to ask the same questions about clinic doctors and private doctors, and invitations to respond with hearsay about the actions of private doctors rather than experiences.

But the fact that more addicts are choosing to turn to 'independent' doctors rather than clinics suggests the central finding – that some private doctors are more 'generous' prescribers – is along the right lines. Answers given by Bewley and Ghodse's patients suggest there may be more acceptable reasons too – 16 out of 38 said addicts went to private doctors because they were treated better, whilst 37 out of 41 mentioned avoidance of clinic regulations.

Predictably, conclusions drawn from these facts were at variance. Bewley and Ghodse argued that the private doctors needed to change or be controlled, others argued that the clinics needed to change to become more attractive to

addicts. Far from helping to settle the issue with objective facts, the research simply added fuel to the fire.

The same befell Dr Angela Burr's observations on the illicit market for prescribed opiates in the West End of London. Her admittedly "informal observations" suggested that between 1981 and late 1982, more non-clinic doctors had become prepared to prescribe larger quantities of drugs to addict patients – the result, a "thriving market in pharmaceutical drugs from the overspill from doctors outside drug dependency units...". Her conclusion supported Bewley and Ghodse's urgings: "... the situation gives cause for concern and would appear to need urgent attention".

AIDA members were quick to reply. Without denying some private doctors were overprescribing, their letters to the BMJ ridiculed concentration on the market for prescribed opiates in Piccadilly at a time when "the main black market is in smuggled heroin which surrounds us in every town and is too big to have a centre of exchange". Such 'doctor bashing' – a phrase headlined last year in *Hospital Doctor* to describe the campaign to curb prescribing – was portrayed as an "irrelevance" which "diverts attention from the real issue".

Swings and roundabouts

Concern over prescribing for addiction currently centres on the possibility of surplus supplies being re-sold by the patient, causing physical damage and addiction among other drug users. There remains the issue of which prescribing regime is best for the patient.

Richard Hartnoll and fellow workers at a London drug clinic compared outcomes for a group of heroin addicts prescribed injectable heroin in the early 1970s, as opposed to another group prescribed oral methadone. The study tested a prescribing regime (injectable heroin maintenance) likely to be more common if some of the physicians in AIDA had their way, against one (oral methadone maintenance) favoured by many clinics. How did they compare?

A year after coming to the clinic, nearly three-quarters of the group given heroin were still in treatment. In contrast, the attractions of oral methadone retained less than a third. But although the heroin group remained in treatment, for most the effect of this treatment seemed minimal. They continued to obtain illicit drugs, remained unemployed and generally maintained a 'junkie' life style, though

perhaps less extreme than before.

The group offered only oral methadone tended to react either by becoming very deeply involved with the illicit drug scene, or by abandoning opiate addiction altogether. Most decided to continue their habit, and inevitably had to remain more deeply immersed in the drug subculture than they might have been had the clinic agreed to provide heroin on prescription.

The study indicated that the choice between methadone and heroin must be made more on a 'swings and roundabouts' basis, rather than on the basis of any definite overall advantage. In turn this means that the decision will be influenced by the priorities assigned by prescribers to various outcomes.

This kind of trade-off led the authors to comment that "a decision to prescribe intravenous heroin for maintenance involves clinical, ethical, and political judgments".

Limited gains

Now the dust has settled, what has been the impact of the original 1982 Advisory Council recommendations and subsequent events on prescribing controls? The answer must be, not nearly as much as many Council members would have wished.

Licensing restrictions have been extended, but only to dipipanone, not to all opiate-type drugs as recommended. Now only licensed doctors can prescribe heroin, cocaine or dipipanone in addiction treatment, but any doctor can prescribe other heroin-substitutes, such as injectable methadone.

Guidelines on good practice have been produced and disseminated, a notable achievement in itself. But they have not been universally accepted, nor do they stipulate that non-specialists should always work with specialist services before prescribing controlled drugs to addicts. Liaison is advised only with respect to long-term prescribing.

Without extended licensing, there is no direct means of enforcing the guidelines or of obliging GPs to work under the supervision of specialist doctors. Nevertheless (as hoped for by the Advisory Council) the General Medical Council appears willing to use the guidelines as a yardstick in disciplining doctors, though their powers to do so are limited.

The Misuse of Drugs Act tribunals and the General Medical Council's Professional Conduct Committee have become more active in disciplining 'injudicious' prescribers. The GMC in

particular is keeping a close eye on the ethics of private prescribing in addiction. But neither body is constituted in a way that would allow action against those whose prescribing appears excessive, unwise or mistaken, but not irresponsible or unethical.

The 'climate of opinion' in the country is not decisively against maintenance prescribing, even of injectable heroin – the debate is still alive. Short-term prescribing of oral drugs may have gained favour in the clinics, but it has not yet become a secure and universally accepted feature of addiction treatment policy in Britain.

Since the 1970s, a smaller proportion of addicts (estimated at one fifth or less) are seeing any doctor in the treatment of their addiction, and a smaller proportion of these are being seen by the specialists in the clinics (just 31 per cent of addicts notified during 1984). At the same time the major source of illicit opiates in Britain has overwhelmingly become the illegal importation of heroin rather than overspill from the prescribing doctor – nearly 90 per cent of addicts notified during 1984 were addicted to heroin, as opposed to less than 60 per cent ten years before.

These facts make whatever doctors decide to do with addict patients less significant in the overall sweep of drugs policy than in the days when most addicts were in treatment, and doctors' prescriptions fuelled an alarming escalation of addiction. But the symbolic significance of how Britain allows and/or encourages its doctors to treat addicts remains potent, as does the impact of that treatment on the individuals involved.

Should Britain's doctors practice 'tough love' policies on addicts who won't stop taking drugs, and should addiction treatment be taken out of the hands of doctors who refuse to toe the line? Should a lifetime opiate prescription be available to any addict who can persuade an inexperienced family doctor this is the only way they can be helped? Thanks to the government's decision not to extend licensing, these kinds of question are very much alive. After all the battles, it is still up to the individual doctor to decide to a degree unknown and unacceptable in many other countries. Even if the natives like to deny there is (or ever was) a 'British system', it must still seem almost intact to observers from more regulated lands.

1986

HIV and injecting drug use

It was in 1981 that the link was first made in the USA between injecting drug use and the risk of contracting HIV, with the first UK drug-related infections reported in Scotland in 1983. From this was born the notion of risk or harm reduction aimed at reducing the spread of infection and saving lives. It was an

issue that *Druglink* would return to many times over the years, as the advent of needle exchanges, advice against sharing and maintenance prescribing became a central plank of the UK drug strategy response, which saw the UK experiencing some of the lower HIV rates among injecting drug users in Europe.

This was first article to appear in the revamped *Druglink* 1986, written by **David Turner**, former Director of the Standing Conference on Drug Abuse, who sadly died earlier this year. As well as being an important article, we are also publishing it as a tribute to David.



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

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

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

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

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

Infection increasing

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

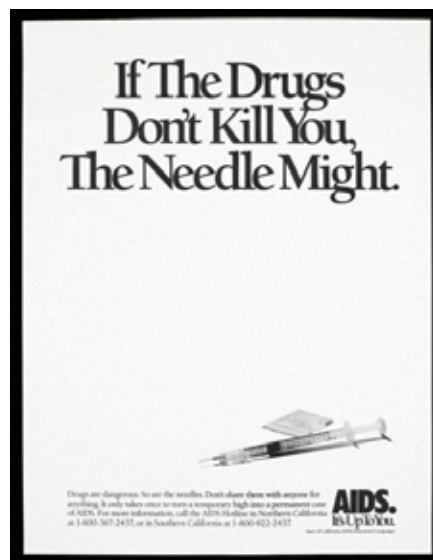
Drug-free rehabilitation communities are admitting residents from all parts of the country who are later found to be infected. The last published estimate of HIV prevalence in drug users from the Public Health Laboratory Service, based on limited sampling and excluding areas of Scotland, shows a five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

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

Many cases of infection were detected in Edinburgh and Dundee, with some in Glasgow. Even assuming no rise in the number of drug misusers infected, it must be conservatively estimated that some 40–50 young drug users in Scotland

alone will be suffering from AIDS within the next two to three years. Given that infection is almost certain to spread for some time, the numbers may well be higher.

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



Role of treatment centres

Drug treatment centres in the United Kingdom now recognise the need to act quickly to reduce risk and to prevent the spread of infection. However, they have a number of difficulties. The services they offer to injecting drug users are often perceived by those drug users as not worth pursuing. Clinics may still be some distance away and may have waiting lists which prevent the drug user getting attention until several weeks after the initial approach. Some will not prescribe substitute drugs while most will not prescribe drugs in injectable form. It is essential that no risk-reduction option is rejected out of hand because it conflicts with abstinence.

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

Some argue that offering substitute drugs to be taken by mouth is a strong

inducement to drug injectors to stop their primary AIDS-risk behaviour (unless they are also homosexual) – the using and sharing of injection equipment. Others argue they are in the business of helping people to get off drugs, not of providing drugs which help perpetuate drug dependence.

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

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

Preventing spread

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

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

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

With HIV infection now such a real threat, can we allow ourselves the luxury of refusing to deal with drug users except from a position of saying 'Abstinence is the only goal and everything we do will be designed to achieve this as speedily as



possible, whether or not you are ready to accept it'?

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

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

Our own feelings and attitudes to drug use can cloud our judgment when it

comes to devising strategies to beat the AIDS virus.

A range of options might be considered. For instance:

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

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

The tests of any intervention should be:

- Has the drug user ceased sharing injection equipment?
- Is s/he aware of the risks involved in sharing injection equipment?
- Are his/her drug using friends aware

of these risks?

- Has s/he ceased taking drugs by injection?
- Has the drug user become more controlled in his/her drug use?
- Has abstinence from drug use become a goal for the drug user?

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

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

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

1989

Crack myths and realities in the UK

Crack cocaine first made its appearance in the UK around [date]. The stories coming out of the States were of whole communities being devastated by this new form of cocaine. And like smokable heroin in the UK, the effects of crack cocaine on those areas experiencing high levels of poverty and deprivation in a time of economic recession and massive cuts back in public expenditure, were indeed extremely damaging.

But in among the realities of the damage caused, were the tabloid excesses as expressed in headlines

like 'one hit and you are hooked' – and sensational statements from politicians like then-Home Secretary Douglas Hurd who told the *Daily Mail* that crack was the worst plague to hit Britain since the Black Death – at a time when there were still relatively few users of the drug here.

The government went into overdrive and were planning to form special crack teams to parachute into local areas to deal with a problem that for the most part did not exist yet. These plans were soon modified and eventually morphed into the Home Office Drug Prevention

Initiative, which set up local drug prevention teams.

As we know, crack eventually did find a significant level on the drug scene and did cause many problems for users and the wider community. But they were not really on the scale predicted by former DEA agent, **Robert Stutman**, who came to speak to the Association of Chief Police Officers drug conference in 1989. Below is an edited version of what he had to say.



“ In the past three and a half years crack has gone from a drug which was virtually unheard of in the largest city in the United States to a major drug of abuse in 49 out of the 50 states.

Crack is an equal opportunity drug. It affects blacks, whites, Hispanics. It affects rich, poor and in-between and it has left the ghetto in United States and it has gone on to suburban America. It is truly a drug that has taken over our society and changed the face of our society.

Crack, unlike heroin, is a drug that affects females as much as males. Of all the crack addicts we have seen, about 50 per cent are female. Now what does that mean? In the United States most inner city families are run by women. These are the same women who today are becoming crack addicts.

Therefore, the last vestiges of family in the inner city, certainly in New York and most other major cities in the United States, are beginning to disappear. That's one of the major reasons why we are now seeing crack addicts in New York, 10, 11, and 12 years of age. The number of reported child abuse cases in New York City has gone from 2200 in 1986 to 8000 in 1988. Almost all of them are the children of cocaine/crack using parents.

And one figure, which I think is absolutely frightening, is that last year in New York City, of all of the children who died because of battering – where parents literally beat their kids to death – 73 per cent were the children of cocaine/crack using parents. It is a drug that produces violence.

A study that will be released by the Cocaine Hotline in the United States proves beyond reasonable doubt that the drug itself causes violence. You don't necessarily need a person with a predisposition to violence. In a survey of 17,000 crack users in the United States, the Cocaine Hotline is going to point out that 47 per cent had been involved, under the influence of crack, in a physical fight, 35 per cent in assaults with weapons, 12 per cent in child abuse, and 1 per cent had actually been involved in murders. That is a drug unlike any other drug that we have ever seen which produces those kind of numbers.

Now, what is crack? It is nothing more or less than smoking cocaine. So why does it produce this feeling that cocaine doesn't necessarily produce? One very simple reason is that smoking is the most efficient method of getting the drug to the brain. That's the only difference between cocaine hydrochloride and crack.

So why did the cocaine epidemic hit us all of a sudden? For a very simple reason: we believed our own garbage. We told ourselves it was relatively harmless, we told ourselves it certainly was not addicting and everybody believed it, so they tried it.

We now know that crack is the single most addicting drug available in the United States of America today and certainly the most addicting drug available in Europe. Heroin is not even in the same ballpark.

Crack's appeal

A study that will be released in the next two to three weeks will probably say that of all of those people who tried crack three or more times, 75 per cent will become physically addicted at the end of the third time. It is pointed out now that in most treatment centres in New York City the average crack addict is addicted within five weeks of first use.

Right now in the United States crack is considered a virtually incurable addiction. No treatment centres show any long term remission of any statistically significant number of crack addicts. Yet it is a drug that of those people who try it three times, 75 per cent become addicted. You don't have to be a mathematician to figure out you've got a hell of a problem when you've got a drug like that.

Now let me take it one step further. If I wanted to design a drug that I'm going to market to kids, I couldn't improve on crack. Let me tell you why.

It is a very expensive drug but sold in very, very small amounts so it is relatively inexpensive. Before the advent of crack if a kid in New York wanted to buy cocaine he had to lay out about \$80 for a gram. Those were the smallest amounts it was sold in.

Today you could purchase crack for as little as \$3 to \$4 a phial. Is that cheaper than the \$80? Really not, for the very simple reason that that \$3-\$4 worth lasts only 8 to 10 minutes. It is three to four times more expensive than hydrochloride, but at least the kid doesn't have to lay out a lot of money at one time. Any kid in the United States can come up with \$5 or \$10.

The second reason that crack has become so popular in our country is that the method of ingestion is so non-intrusive. No needles stuck in your arm, you don't even have to stick a white powder up your nose. Who does that, nobody, it's not a normal thing to do. We smoke it. It doesn't bother anybody to smoke something.

And then there's the third reason:

crack is the ultimate 'feel good now'. If I inject heroin it takes about two and a half minutes to feel the full effect. If I sniff cocaine, it takes about three minutes. If I smoke crack in five to ten seconds I am stoned. The problem, of course, is that it only last about 12 minutes and then you come down.

For those three reasons crack has become extremely popular in our country. The obvious problem that it has caused, certainly in New York, is violence. Crack does two things: it gives you a feeling of omnipotence – I am the strongest S.O.B. in the world, nobody can touch me; at the same time it gives you a sense of paranoia – why are you picking on me? When you mix those two things together you can imagine the problems you start to get with the user.

Now we'll take that one step further. Generally there was an unwritten rule, certainly in New York, that you don't knowingly shoot at cops. That rule has changed. In the last nine months I have had four of my agents shot. Three were shot in the head, two lived.

The third turned out to be what I think has become the most heinous crime against a law enforcement officer ever in the United States, or close to it, and that was the assassination of Evert Hatcher who was working undercover.

The traffickers found out he was a federal agent and made a knowing decision to meet with him. They cleaned off his surveillance, met him an hour later, shot him twice in the side of the head. The most cold-blooded assassination I have ever seen of a law enforcement officer.

That is the philosophy that we now see in New York and it is due specifically, in my way of thinking, to the advent of crack and cocaine. It has changed the face of the city. Now every DEA agent, all 3000, are issued sub-machine guns. That is what has happened in our country basically because of crack and cocaine over the past three years.

How do you make crack? Any person in this room can make crack. All you take is some cocaine, some hot water, a bunsen burner and a baby bottle, and in an hour and a quarter you have crack. The geniuses in New York City didn't have to figure it out very long: if I buy a kilo of cocaine for \$18,000, and an hour and 15 minutes later I can sell it for \$70,000, that's what I am going to do. Crack started out as a cottage industry in our country with no big pedlars.

Unfortunately it didn't take very long for the traffickers to realise we're not going to leave this to individuals, and they began to organise. Right now

crack is controlled by a fairly large number of organisations, basically of two ethnic backgrounds, Dominicans and Jamaicans. As you leave New York City the Jamaicans have taken over control of much of the rest of the United States, Jamaicans who are tied back directly to New York City.

Jamaican traffickers

I don't have to tell any of you that you have a large number of Jamaicans in this country. Many have relatives and friends in New York and none of them are very stupid if they are dope pedlars to start with. These guys don't have to be geniuses to realise 'I don't have to import crack from the United States. I can make my crack right here in Great Britain and I can increase my profit by something like 300 per cent, and I don't have to worry about getting new customers all the time. Three out of four of the guys I sell crack to three times are coming back to me, they're locked in, they're a guaranteed customer.'

That's how it started in our country. Now we are basically saturated with crack, the problem is continuing to grow, the violence level has been continuing

to grow and the response of law enforcement, although we are trying to do something, we haven't made one bit of difference.

Last year the New York City Police Department and the DEA in New York made 90,000 drug arrests [and] the Drug Enforcement Administration in New York City seized 9,000 kilos of cocaine. Did all those seizures and arrests make one bit of difference? Absolutely not. There is not a single corner in New York where you can't purchase crack or cocaine.

Our mistake in New York was that we didn't see the problem early enough and we didn't get a jump on it. Three years ago Boston's mayor came to my office worried about crack. We talked about it, trained their police officers, he increased the size of his drug unit and set up task forces [so] information came from the street to the top immediately. They did away with parochialism. They started drug education in school systems and community education across the city, and today Boston has a very minor crack problem.

The only thing I would ask you is the following: learn from our mistakes. Don't be like the people in Kansas and Texas

and California who said, 'It can't happen here'. I will make a prediction and as you all know, you've got to be crazy to make them. I will personally guarantee you that two years from now you will have a serious crack problem.

We are so saturated with cocaine in the United States, there aren't enough noses left to use the cocaine that's coming in. It's got to go somewhere and where it's coming is right here.

Don't fall for that old business of 'It's only black guys'. We set up a car seizure programme in New York City in which we seized the vehicles of people coming in to high density areas. We seized 1000 cars; 80 per cent were white kids from the nice suburbs coming in to buy crack.

If you don't attack this potential problem putting aside differences and looking at a community national response that is law enforcement, education and treatment, I will guarantee you the following: three years from today you will invite me back, because you will be looking back on the good old days of 1989, and that won't be pleasant. ”

Government backs off anti-crack drive

This summer's crescendo of concern over crack with the government spotlighting it as the "spectre hanging over Europe" culminated in a decision not to single out the drug in a major anti-crack drive.

The thrust of the Home Secretary's statement issued on 3 August was that the crack threat "requires even stronger efforts on our part to prevent the misuse of drugs", rather than crack-specific initiatives. Ruled out "for the time being" was a national anti-crack campaign of the kind which appeared to be called for by the Home Affairs Committee in their interim report rushed out on 27 July after their visit to America the previous month.

Instead, Hurd reported, "we believe at this stage the further action to reduce demand for crack should be local and specific". The decision to restrict anti-crack publicity drives to particularly affected areas was taken in advance of the meeting of the Ministerial Group on the Misuse of Drugs on 26 July, which appears simply to have rubber-stamped the line hammered out in what's reported to have been an interdepartmental policy struggle.

In June the split between ministers who wanted an all-out anti-crack campaign and those who thought this would just be free advertising for the dealers surfaced in the *Times* (12 June 1989). Informed opinion has it that the line up was the Home Office and Foreign Office for the campaign versus the Departments of Education and Health, which favoured locally determined approaches integrating cocaine and crack with other drug-related initiatives

The outcome of this tussle will bring relief to most in the drugs field, whose criticism of the single-issue anti-heroin campaigns of past years appears to have been taken to heart by the government. At a local level the voices of drug workers and health education specialists are likely to carry considerable weight, helping to prevent inappropriate campaigns being foisted on them from on high.

Nevertheless this summer of crack panic has amounted to a potentially dangerous plug for crack as the quick way for dealers to make their first million and the best hit drug-weary misusers will ever experience.

Ironically, while ministers now reject

national anti-crack publicity because of the risk of stimulating interest, it is dramatic ministerial statements that have driven the media publicity.

Probably the most ticklish policy issue has arisen from the association of cocaine and crack use with black people in Britain. Opinion differs over whether this is real or imaginary, and, if real, whether it merely reflects the fact that crack has been found in less affluent areas, and these are where many black people live.

The other but not mutually exclusive explanation is that cocaine distribution is handled largely by traffickers with Jamaican connections. In March Interpol identified a new cocaine trafficking route from Jamaica to Europe, the first seizures from which were made in the UK

Areas with high black populations such as Toxteth, Handsworth and parts of South East London, have all been associated with crack. Although cautioning for possession of cannabis (another drug used by young blacks as well as white people) has become accepted police practice, the Home Secretary regards it as "important that the police should take a firm line

against possession of crack as well as trafficking". This should, he told Action on Addiction's crack conference in July, be done with "due regard" to community sensitivities, but the crack threat would "no doubt" ensure police had local support.

He was speaking after the widely reported incidents of 23 May when 120 police mounted a drugs raid on the Travellers' Rest pub in the Heath Town district of Wolverhampton. Fifteen minutes later youths converged on the building and more than two hours of street violence followed with young blacks and whites pitted against 250 police in riot gear.

Local anger and liberal misgivings over the raid were overshadowed by reaction to the "ominous" discovery of 14 wraps of crack reportedly worth £140 – this "truly diabolical" substance as the Times put it in a leader supportive of the police (25 May 1989).

Invited to congratulate the police on their actions, Margaret Thatcher said they were "entirely right" as "crack

peddlers must know they have no haven" (Hansard, 25 May 1989).

Police themselves queried whether it was all worth it, but "You have got to hit the street dealers. The best thing we can do is attack the demand... The public will now see an increase in drugs raids," said the head of the Met's drug squad referring to crack. With this drug, he had to admit, "The dealers tend to be in black areas".

West Midlands police at first suggested the Heath Town 'riot' was organised by drug dealers and for Home Secretary Hurd it was confirmation that "drug trafficking leads to violence" (Daily Mail, 2 June 1989).

For other observers it was confirmation that years of "poor policing" and deteriorating relations between police and local blacks in a socially deprived area had borne fruit. Crack, it's suggested, both here and in America, is used as an alternative to less comfortable explanations of social disorder (Searchlight, 1989, issue 169).

Among the eight points listed in

Douglas Hurd's 3 August statement, only the news that special anti-cocaine Customs teams have been set up related exclusively to cocaine. Also listed was the international conference being organised next April in London on reducing the demand for drugs, at which cocaine and crack were to be major topics.

First put by Hurd to the Council of Europe's Pompidou Group in May, backing for this conference was one of Margaret Thatcher's major achievements at July's 'G7' summit of the seven richest industrialised democracies. However, misgivings in some European nations about the focusing on crack and the fact that Britain itself is lowering its profile on the drug will probably mean that the conference takes on a broader demand-reduction remit.

With Spain as a natural European entry point for cocaine, the crack issue has become entangled with Britain's fight to keep its frontier controls after 1992, adding a further twist to the international initiatives.

The Stutman connection

"It made a deep impression on me," Home Secretary Douglas Hurd told Daily Mail readers on 2 June, and an "even deeper impression on the senior policemen who were there". An eye witness said it "scared the hell" out of the audience.

Direct from the crack-infested streets of New York, drugs investigator Robert Stutman's address to chief police officers in April put several sticks of dynamite under Britain's rumbling worries that cocaine and crack could turn downtown Toxteth, Handsworth and Deptford into US-style drug ghettos.

In turn, these refuelled concerns were broadcast on the European stage when in May Douglas Hurd addressed Pompidou Group ministers. Again we learn from the Mail that "he acknowledges that a fair part of the inspiration for that speech had come to him a few weeks earlier" from Drug Enforcement Administration special agent Stutman.

One of Stutman's most significant statements was that three-quarters of crack triers get hooked after three hits. On this much else hinges – a drug this addictive causes users to commit violent crimes and promises massive profits to the dealers, disrupting whole communities. His reference was "a study

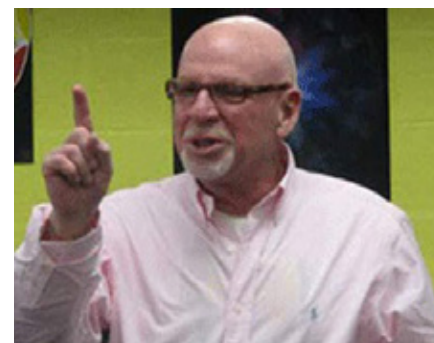
that will be released in the next two to three weeks" which would "probably" report this finding.

It was more than two to three weeks later, with no supporting study yet seen crossing the librarians' desks at ISDD, when the Home Secretary told Mail readers that "75 per cent of takers are hooked on [crack] after three goes".

A week earlier, Stutman's statement appeared as a headline in the Sun (25 May): "Three Hits Can Get You Hooked" was their version of these "terrifying statistics". Before that, the as yet unseen study cited by Stutman had become a "survey" which "showed" these disturbing facts (Times, 19 May 1989). Later the 'survey' was attributed to an impeccable source – the Home Office itself (Grimsby Evening Telegraph, 2 August 1989).

In all this there was not one shred of hard evidence, an inconvenient fact that, to their credit, seems to have become apparent to senior police officers who "attempted to trace the studies and figures quoted by Stutman and found that they don't exist" (Independent, 27 July 1989).

On the same day the House of Commons Home Affairs Committee released their emergency interim report



on crack with these same discredited 'facts' highlighted in bold.

Perhaps the police's discovery that the emperor had no clothes is the reason why later ministerial statements have not repeated Hurd's original replay of Stutman's claim as well as helping to persuade the hawkish Home Office to toe the softer DoH and DES line.

The 'three hits and you're hooked' example is just one among many – several other startling statements from Stutman's speech were given equal credence by ministers, some police, the media, and by the Home Affairs Committee.

Police at the heart of Britain's anti-drug effort have made public their concern that such uncritical regurgitation of Stutman's 'facts' was providing potentially counterproductive messages to the British public.

1987

Rehab funding

The 1990 Community Care Act changed the funding arrangements for places at residential rehabilitation placing the onus now on social services to provide the cash. Led by David Turner, SCODA fought a campaign to retain a ring fence around services for drug users. The campaign culminated in a SCODA picket in 1993 of the first European Drug Prevention Week held in London. This

was a severe embarrassment to the UK government, to the extent that all the evidence points to David's removal as Director of SCODA in 1994, as the price SCODA was forced to pay to retain government funding.

The financial pressures on residential rehabilitation have been unrelenting. The housing-related funding stream 'Supporting People'

(2003) did provide a new revenue opportunity, but only to the extent that rehabs could demonstrate they were supporting' rather than 'caring' for people. The programme still exists, but in a re-run of the Community care Act, the ring-fence has been removed allowing its gradual incorporation into local authority wider grants.

THE FUNDING CRISIS FOR DRUG REHABS

DAVID TOMLINSON

The author was Executive Director at Phoenix House.

Community care funding arrangements coming into force next April will decrease the guaranteed per-resident payment to residential drug projects and leave the bulk of the funding at the discretion of local authorities, which may need to assess each applicant. Local authorities have not prioritised care for drug users, so the result could be delayed admissions and wholesale closure of projects. To avoid this, earmarking of drugs money must continue.

Residential services for drug users – most of which are non-statutory – stand

to be hard hit by the reorganisation set in train by the Caring for People white paper and the NHS and Community Care Bill. The greatest concern is over funding. Despite attempts by SCODA and other organisations, government has rejected the proposal that local authorities should be given a specific financial allocation for the care of drug users, a 'ring fencing' scheme that would prevent money now allocated to drug services being diverted elsewhere.

Local authorities' need to exercise financial control also threatens to

impede assessment and admissions procedures, which often need to be completed quickly if the referral is to be successful.

Most drug rehabilitation houses are funded with the help of income support paid to their residents by the Department of Social Security. This is far from ideal and many agencies end up with large arrears because of the inefficiency of the system. However, it does have the advantage of being a guaranteed payment and of not being cash limited. This financial backstop

means agencies can respond quickly to people in crisis.

The introduction of care plans as proposed by the white paper and the bill will prevent agencies responding to immediate needs. Before admission, a care plan will have to be drawn up, submitted and agreed by the local authority or by the district health authority. Without this agreement, agencies risk admitting individuals with no guarantee of even the level of funding currently available.

In many cases, arguably the majority, agencies such as Phoenix operate at the whim of the court, parole board or other institution. Where the date of admission is out of our hands and out of the individual's hands, it will be extremely difficult if not impossible to draw up a care plan. Unlike many other care sectors, drug rehabilitation houses often take clients from across Britain. This, plus the mobility of drug users, will mean making care plans with authorities throughout the country – virtually impossible unless local authorities or health districts are prepared to regard approving care plans as simply a matter of exchanging paper.

Proposed changes in funding arrangements will have extremely serious implications for the treatment of people with alcohol and drug problems. From April 1991 financial support of people in private and voluntary homes over and above the general social service entitlement will be transferred to local authorities.

This will not apply to people resident in homes before April 1991, a breathing space that will be of interest to nursing homes for the elderly. However, agencies working with alcohol and drug dependence are likely to feel the impact of these changes within months or even weeks as their throughput of clients is much quicker.

Funds for community care will be transferred to local authorities as part of the government's revenue support grant. They will be expected to manage their budget and make the best use of the funds available in the light of an assessment of local needs and of each individual's needs. There will, however, be no specific allocations for any particular type of client, with the possible exception of the mentally ill.

In particular, money redirected to local authorities from the drug misuse allocation to health authorities will no longer be earmarked for drug services, but merely form part of the overall

community care kitty. As we understand it, there will be no ring fencing of the support grant.

Guaranteed funding cut

Services for drug and alcohol dependence are generally registered homes and therefore come under the auspices of the local authority. The Department of Social Security's income support grant is a guaranteed payment that amounts to £140 a week to each resident, or £190 to residents of registered nursing homes. The difference between this and the cost of each resident is made up through top-up funding sought from the resident's local authority or through grants.

In future, the income support grant will be replaced by three different sources of funding, with the guaranteed element drastically reduced. Under the new arrangements money would come from:

- income support for personal living costs, a guaranteed social security payment of about £25 a week;
- housing benefit from the local authority, again a guaranteed payment; and
- the local authority social services department as 'care costs' to cover the care element of the programme, a discretionary payment made only if the authority assesses the individual as in need of the residential care on offer.

Housing benefit is difficult to assess because each local authority will have to determine the eligible rent on which benefit can be paid. Our assumption is that they will take the average cost of a single person's rented accommodation in their district.

The bulk of each resident's funding will in future come from the care costs which must be negotiated with the local authority prior to a client's admission. No longer paid 'as of right', payment would depend on the decision of the local authority from whose area the client comes. This will slow down the admissions process, but also has other serious implications.

Many of our clients come from local authorities that have never accepted responsibility for drugs or alcohol, although they will have the final responsibility for agreeing a care plan under the new system. In view of the undoubted stigma still attached to drug clients, we suspect they will be last in the queue for care funding. Local authorities are already stretched to provide for people in residential care;



groups such as the elderly and the mentally handicapped are likely to be considered priority cases rather than drug users.

There is the possibility, although remote, that community care as specified in the NHS and Community Care Bill would be funded by the district health authority under provision for mental health services. However, the same problems would remain. Will, for example, the district health authorities be purchasing a block of service from a non-statutory agency, or will they, as we suspect, want to agree a care plan for each individual? Where Phoenix House receives funds from health authorities this is now paid through a district, but top-sliced by the region on the understanding that we offer a region-wide service. It appears that in future most spending will be devolved down to districts. Having to negotiate with each district separately would entail an enormous administrative workload.

Myself and other people in the non-statutory sector predict that, if the white paper is implemented in full, by the middle of 1991 most residential and nursing care for drug and alcohol problems will disappear. The only exception will be fee-charging services financed largely by their clients' own personal assets or by private insurance.

To avoid the demise of Britain's residential drug services we have either to seek exemption from the provisions of Caring for People and the NHS Bill, or seek to ring fence money now specifically given to district health authorities for the treatment of people with drug and alcohol problems or suffering from AIDS-related illnesses. At the time of writing, neither of these crucial changes look like being accepted.

1987

DRUG REHABS FACE CLOSURE UNDER COMMUNITY CARE FUNDING REVOLUTION

Britain could start losing most of its residential services for drug users within months of new community care provisions coming into effect in April 1991.

The provisions are part of the NHS and Community Care Bill now going through Parliament. Amendments which could have safeguarded drug services failed at the bill's Commons committee stage in March, though some will be reintroduced during the Lords debates due to start in mid-April.

Turning Point, one of Britain's largest service-providers for drug users, sees funding as the crucial issue. From April 1991 the bulk of the social security payment now guaranteed to each resident will instead be at the local authority's discretion. With no tradition of looking after drug users, the fear is that authorities will refuse funding or underfund to save limited community care budgets for 'higher priority' groups.

SCODA, Alcohol Concern and Turning Point combined to call for drug and alcohol money to be earmarked within local authorities' community care budgets, in the same way as mental health. Their amendment was turned down after Health Minister Roger Freeman argued it would restrict local autonomy, but will be reintroduced in the Lords by Viscount Falkland.

SCODA's Residential Services Officer Kazim Khan explained that the intention was to safeguard the £14 million allocated to health authorities for drug misuse services, plus other money spent

on drugs by health or local authorities – perhaps a yearly total of £25 million. Without a protective 'ring fence' round it, the concern is that much of this money will be diverted to other groups.

The intensity of the lobbying from organisations such as SCODA, Turning Point and Phoenix suggests they seriously believe houses could close after April 1991. Turning Point's PR department has mail shot peers and is seeking high profile publicity to get the funding amendment through at what may be their last realistic opportunity.

Also to be reintroduced in the Lords is an amendment to allow emergency admissions without having to wait for the relevant authority to assess the potential resident – crucial to agencies such as London's City Roads crisis intervention service.

The amendment failed, but Tory support in committee persuaded junior Health Minister Virginia Bottomley to reconsider the issue. What may emerge is a commitment for health authorities to fund the first few days of an emergency admission.

Just eight clauses of the NHS and Community Care Bill deal with community care, providing no more than a legislative skeleton. Department of Health project groups are developing guidance notes on how local authorities and other bodies should implement the new system.

Even if the bill is passed unamended, input into these groups could still help avoid the dire consequences predicted

for drug services. The last backstop is organising locally to influence your own local and health authority.

A foretaste of what's to come in the UK may be seen in the current furore in the USA over treatment programme cutbacks forced by the drive to cut costs. There 'managed care' is already doing what many fear 'care managers' will do for the UK under the new community care system. The major casualty has been inpatient or residential care – the sector most at risk in Britain.

In the last few years, health insurance companies and employers have taken fright at the cost of treating alcohol and drug abuse – for General Motors in 1987, a bill totalling \$78 million. Their response was to hire 'gate keeping' companies to determine what treatment was needed and for how long.

With an assessment role disturbingly similar to the proposed local authority care managers in the UK, these gatekeepers served their employers by minimising access to expensive inpatient care and cutting outpatient treatment to the bone. One major US company, GTE, cut its mental health care costs by a quarter after introducing managed care.

Managed care has spread rapidly to the point where treatment providers now claim centres are being forced to close or cut treatment capacity. That capacity is still needed, says the president of the US national treatment providers' association, but funders are refusing to pay for it to be used.

1987

Time to build bridges

There was much that was unhelpful and counter-productive in the sector 'abstinence v harm reduction' furore that kicked off in 2008 after the government struggled to respond effectively to media claims of treatment ineffectiveness.

However from the ashes of that firestorm came a more productive debate

about what recovery actually meant and an acknowledgement that those who were often seen at the margins of the mainstream treatment highway including residential rehabilitation and peer support groups of all stripes, all had something to offer to clients depending on individual need. However as far back

as 1987, came a call from **Dr Brian Wells**, then a senior registrar at the Maudsley drug dependence unit in south London, that the treatment sector should not be so dismissive of the philosophy of the 12 steps approach, and accept that for some people, it is an approach they can successfully embrace.



NA AND THE 'MINNESOTA METHOD' IN BRITAIN

No one seems to know who coined the term 'Minnesota method'. Many object to it, including most who practice it, preferring terms such as 'abstinence model', 'multidisciplinary treatment' or a 'twelve step approach'. To some not involved, the term conjures up a picture of private companies fleecing the wealthy and those with medical insurance for a form of 'treatment' that involves concepts such as 'the disease of addiction', the need for abstinence from everything including cannabis and alcohol, and the introduction of God or religion as essential to recovery. Not an easy mixture for the politically aware street agency drugs worker to feel comfortable with.

Narcotics Anonymous (NA) – the self-help group that Minnesota method projects refer clients to – is sometimes seen as a clique, centred on Chelsea, of use only to the articulate, vocal and preferably rich. The package of Minnesota method 'private' treatment with subsequent referral to NA is unsavoury to some with influence in the field of drug abuse, resulting in attitudes that at times even discourage the NA attendance of drug abusers who may have little else going for them.

Much of the conflict is due to misunderstanding and ignorance. Many assumptions are made about NA and its apparent links with the 'private sector', often via second-hand reports from clients unable or unwilling to engage in either NA or associated treatment, or both. Some assumptions are understandable, others are due to political bias and rigid attitudes, while genuine adverse experiences have at times occurred. This article will attempt to clarify some of the issues.

Narcotics Anonymous

NA started in July 1953 as an organisation directly modelled on Alcoholics Anonymous (AA). The first of the "Twelve Steps" was modified from "We admitted that we were powerless over alcohol ..." to "We admitted that we were powerless over our addiction ...". Otherwise the AA programme was adopted as it stood to embrace the "illness of addiction".

Sporadic growth in the USA was followed by the post-Vietnam War NA explosion; by 1980 there were an estimated 20,000 'addicts' recovering in NA. Growth since has proceeded by 30 to 40 per cent per year; should this

continue, by 1990 NA membership in the USA will exceed that of AA. In July 1986 over 6,500 NA groups meeting regularly were registered with the World Service Office, 36 countries were featured in the World Directory, and a 'guesstimate' placed the worldwide membership at around 250,000.

In Britain NA started in August 1980 and has grown from a single weekly meeting to over 60 a week in the London area, with daily meetings in Bristol and Weston-super-Mare. Growth in the remainder of the country has occurred on an ad hoc basis, showing signs and patterns of development seen previously in the US – 'strongholds' in some major cities, the strength and quality of meetings elsewhere remaining variable.

NA caters for people suffering as a result of using any of the entire range of psychotropic chemicals, including alcohol (just another sedative drug). The majority of 'addicts' attending have experienced polydrug misuse, many having been dependent upon opiates, but others have simply had problems resulting from drugs such as tranquillisers, alcohol, other sedatives, cannabis, hallucinogens and stimulants.

In NA's definition of addiction, no mention is made of withdrawal symptoms, routes of administration or specific drugs: "Very simply an addict is a man or woman whose life is controlled by drugs...The only requirement for membership is the desire to stop using". In practice, the attending population varies according to geographical and socio-economic variables, with patterns of drug misuse following suit.

NA philosophy and programme

12/NA says "addiction" is a progressive illness for which there is no cure, though its progress can be arrested by complete abstinence from all mind-altering chemicals. Addicts are seen as sick people who need to become well, not bad people who need to become good. "Recovery" is seen as an active process that can only occur once abstinence is achieved. The addict is therefore 100 per cent responsible for the initiation and maintenance of their own recovery: "Just for today...for one day at a time...we do not use any mind-altering chemicals".

Once abstinence has been achieved, the 'addict' needs to take active steps to become comfortable in a world without chemicals and to start rectifying the core deficit, a poor sense of self-esteem,

or low self-worth. In the new member's early days, NA recommends:

- frequent and regular attendance at meetings (90 meetings in 90 days where possible);
- active involvement with a home group which they are committed to attending and servicing in some way, such as making coffee or cleaning up ashtrays; and
- the selection of a sponsor with whom to form a special one-to-one relationship and discuss matters difficult to discuss in the group (someone of preferably the same sex on whose experience the new member can call at any time).

NA encourages newcomers to accumulate telephone numbers to facilitate 'sharing' with other members. Such sharing is generally supportive, non-judgmental and based upon a collective wisdom – "experience, strength and hope". After a while it usually becomes necessary for the person in recovery to take a look at the "Twelve Steps".

The Twelve Steps of recovery

Much has been written about the "Twelve Steps" of recovery. Most newcomers (and many professionals) focus with horror upon the word "God", who is referred to in six of the steps. Provided they are not frightened off, people tend either to ignore this or to become comfortable with the idea of a "power greater than ourselves", usually the power of the group.

As recovery progresses, many do find a spiritual component to their programme; for some this is organised religion, for others a form of meditation, often with a vague notion of "God as we understand Him". NA is not a religious organisation but a spiritual component is available and strongly recommended to those wishing to achieve a "quality recovery".

Otherwise, actively working the steps involves:

- accepting the need for abstinence;
- gaining personal insight;
- making restitution for damage previously done;
- accepting the need for honesty and adaptability leading to growth; and
- a continuing commitment to carry the message to other still suffering addicts: "We keep what we have by giving it away".

Attending NA provides companionship, places to go (including endless post-meeting cafe visits, fund-raising events, etc) and the opportunity for peer group support while remaining drug free in the community. Some professionals insist it involves 'brain-washing', a hysterical attitude to substances and even 'psychological damage and retardation' in those who become 'addicted' to NA. "This is not the real world" is a typical sentiment.

There is no doubt that cliques exist, that some members have little time for treatment approaches not involving NA attendance, and that at times things go wrong. People relapse, sometimes taking others with them; meetings deteriorate, fold and then start up again. Surely this is the real world?

There is something important going on here that professionals need to be open-minded, even enthusiastic, about, preferably via attendance at some NA open meetings. At the recent NA World Convention in Wembley, there were members from America with over 20 years 'clean time', and over a thousand from the UK abstinent for up to eight years. Of these, relatively few had paid 'private sector' fees for treatment.

The Minnesota method

This unpopular and misleading term refers to treatment practised by several facilities in the US state of Minnesota (such as Hazelden and the Johnson Institute) and many others dispersed across the USA (including the Betty Ford Centre, Alina-Lodge, etc).

Treatment involves the education and persuasion of the client that:

- they have an illness;
- abstinence from all mind-altering chemicals including alcohol is a prerequisite to recovery; and
- recovery can and will take place if the principles of Alcoholics and Narcotics Anonymous are adhered to.

The programme (residential or outpatient) is based on the first three, or first five, of the Twelve Steps. Step one might involve the addict reading out their life story to the group, and writing down 60–100 examples of how their inability to control their drugtaking has hurt or damaged themselves or others. The aim is to reach the point where the addict absolutely accepts and surrenders to the fact that they must remain abstinent.

Most addicts find the idea of a "God"

hard to accept, so usually the group of addicts becomes the "power greater than ourselves" referred to in step two, to whose care (in step three) the addict turns over their will and life. In practice this is achieved by explicit evaluative feedback from the group, which may decide when each of its members is ready to progress to the next phase of the programme.

Following this relatively short spell of 'primary care' (28 days in most US facilities, six to eight weeks in the UK), the client is discharged to 'aftercare' and attendance at NA or AA meetings, living at home or in a halfway house.

Aftercare provided by the projects is variable and can include weekly attendance at groups or residential sessions monitoring the well-being of the client during their recovery in the twelve steps fellowships such as NA. Often advice is given on sponsorship, working the steps, frequency of meetings and personal 'relationships', sometimes including specific issues such as bereavement. Occasionally the client is referred for more in-depth psychotherapy. Issues such as relapse are dealt with constructively with emphasis on keeping the client in the community and 'on the programme'.

In the United States the structure of health care has allowed treatment of "chemical dependence" to become big business. People with medical insurance (most of the population) have been covered for admission into a 28-day treatment programme, so a large number of such programmes (with prices ranging from \$5000 to an amazing \$28,000 for 28 days) have sprung up. Recently the insurance companies have been less forthcoming, causing many treatment facilities to become highly competitive, others to close, and others to look elsewhere (eg, Europe).

In Britain there are now a number of facilities using a 'twelve step' approach to treatment. Some are strictly for profit – private companies charging £700–£1500 plus additional charges per week. But most are charitable trusts registered as nursing homes, and require funding from whatever resources are available.

Very few beds are funded by health authorities or via other government sources, so money needs to be raised from fee-paying clients, those (few) with insurance, those able to make donations, and those entitled to supplementary benefit (the DHSS will fund £180 per

week for a place in a registered nursing home). At around 75 per cent full, a 50-bed unit needs £300 to £500 per client per week to break even. 'Assisted' places are available to clients unable to pay these fees, subsidised through charges levied on fee-payers or those with insurance.

During the last 12 years Broadway Lodge, the oldest such facility in the UK, has always provided more assisted places than those provided for payers. In 1985 the figure was 66 per cent assisted places. Clouds House runs at around 70 per cent assisted places; Western Counselling (outpatient facility), the Promis Recovery Centre and Broadreach House vary the number of assisted beds according to their means. Generally (and sadly) the waiting period for an assisted place is longer than for one privately-funded, so until such facilities receive most of their funding from sources other than their clients (eg, public authorities), the taint of the 'private sector' is likely to remain.

Four years ago, London NA was active primarily in wealthy areas such as Chelsea and Hampstead, many of its members having paid fees for treatment. Now the picture is approaching that in the USA where NA is 'without class', most members having entered directly 'from the street', from NHS facilities, or from an assisted bed.

NA has indeed been slow to penetrate areas with apparently high rates of drug abuse, such as south London and parts of northern England. In the USA it was introduced into similarly 'difficult' areas, such as Harlem and Watts, by enthusiastic workers who could see the potential in groups of drug abusers directing their energies towards 'getting well', albeit via a philosophy that felt alien and sometimes like a 'con'.

Encouragingly, some of the more established rehabilitation houses that do not operate a Twelve Steps programme are now exploring ways in which NA can be used in the 're-entry' phase of their programmes, in spite of differences over fundamental issues such as total abstinence. The exaggerated (and irritating) treatment claims of those still interested in 'big business' need to be ignored while impartial and well-conducted research takes place. Meanwhile, there is much that workers can learn from Narcotics Anonymous, its open meetings, its members and its literature.

1988–1992

Everything starts with an E

1985 saw the first mention of ecstasy in the UK press. It came in the November edition of a style magazine called *The Face*. The magazine dubbed ecstasy as 'the yuppie way of knowledge', showing that back then, the drug was regarded as a vehicle for introspection among the Hampstead dinner party set.

Flash forward to 1988 and ecstasy had become the fuel for a new all-night dance culture called Acid House and the whole rave scene took off. But ecstasy was more than the latest drug on the block. The rise in drug use since 1945 has not been a smooth curve; there have been tipping points which have caused step changes in history. The drug scene of the 1980s was dominated by heroin and solvents, substances associated with deprivation and poverty. At £25 a pill, associated with the aspirational club/rave scene and the belief that the drug was relatively safe, ecstasy sparked a more accepting period of drug use among young use and encouraged experimentation with other drugs including ketamine and cannabis. The mid-90s was the era of 'Cool Britannia'.

But it came at a price; the first official ecstasy death was recorded in Manchester in 1986 and the numbers kept rising over the years. While attempts at harm reduction in this area were initially publicly vilified (see page xx), soon drug agencies, the medical profession and the government all responded with a new stream of harm reduction initiatives aimed at reducing the death toll. Sadly, it is a problem which is not only still with us, but which appears to be on the rise again – most likely as a result of the particular ecstasy currently in circulation, some of which is very strong, while other types have been mixed with the more toxic PMA.

The following articles and news items capture the early history of MDMA in the UK.



'Huge' numbers using MDMA, say Release

MDMA – methylenedioxymethamphetamine to the chemist but 'Adam', 'XTC' or 'Ecstasy' to its users – is being used by "huge numbers of young people" say Release, the national drugs and legal emergency service. However, police in London and nationally query the validity of their claims.

MDMA, controlled under the Misuse of Drugs Act in class A, is related both to mescaline and to amphetamine, hence its curious psychedelic/stimulant pharmacological profile. Taken by mouth in doses of 100–150mg, after some 20–60 minutes the user commonly experiences a mild but euphoric 'rush' followed by up to three hours of heightened sensory awareness, euphoria and a tendency to feel empathic intimacy with the nearest members of the human race.

Unlike LSD, only with atypically high doses is there loss of contact with reality. Though MDMA produces the physiological stimulation characteristic of amphetamine, the accompanying feeling is usually relaxation. Like amphetamine, the energy of the high is followed by fatigue.

What brought MDMA to Release's attention was the other side of this seemingly rosy picture. Some of the recent spate of callers had been distressed by the psychedelic side of MDMA, days later feeling anxious and worried both by the original experience and by continuing visual distortions, or by events that reminded them of their 'trip'.

The description of their reports given by Release's Director, Jane Goodsir resembles the "delayed anxiety disorder" described among a few novice MDMA users in the USA in 1986, and attributed then to MDMA's release of previously suppressed anxieties, hostility or guilt. The explanation is credible because the drug is universally credited with the ability to dissolve defence mechanisms and inhibitions.

MDMA's amphetamine side seems responsible for the other type of problem seen at Release. As with the so-called 'speed run', MDMA devotees sometimes take frequently repeated doses over several days. Too much of this without a break leaves the user in a "chaotic and burnt-out state" and people "are experiencing extreme anxiety, confusion

and depression following heavy use."

Release say MDMA has become an "indispensable part of the evening" for large numbers of fashionable young people who get stoned together at music clubs and warehouse parties. Most see it as a good-time 'up' drug that causes few problems. This picture accords with the *New Musical Express* exposé (16 July) which linked MDMA with the new 'Acid House' music scene flourishing in London clubs.

Jane Goodsir believes the first half of 1988 saw MDMA percolate out of elite fashionable circles to a mass youth market, outside as well as inside the capital. Freelance journalist Peter Nasmyth, author of two prescient MDMA features in *The Facet*, says the drug is also being used as a tool of self-exploration in "therapy circles".

Police are aware of MDMA's place in the youth/music scene, but dispute Release's account of the extent of recent use. The National Drugs Intelligence Unit were not aware of any recent upsurge, while Superintendent Maclaurin of the Metropolitan Police Drug Squad said he would "be surprised if it was as

widespread as [Release] have indicated." His reasoning was that the price (Release say £20–25 a tablet, his estimate was £25–30) would make it a poor economic proposition compared to amphetamine, and that, if huge numbers were using, police would be making many more seizures. A quick check with his lab revealed eight or nine MDMA samples in the last couple of months – unusually high, but still, he believed, not consistent with mass use of the drug.

Peter Nasmyth believes there are "definitely more people using MDMA than police would imagine," but says they are not usually the kind of people that fall foul of the police. Middle class with jobs and money, they have neither the need nor the inclination to run the risk of arrest in order to finance their drug experiences.

A recent record MDMA seizure in London and Release's concern that the relatively high price could be driven down as large quantities come on to the market, could mean that police and the rest of us see much more MDMA in the future.

New ways with old skill

To agencies, these young people do not present new and unique problems: skills learnt in the 'love and peace' era of the 1960s and forgotten in the '80s are directly applicable. However, we do need to urgently address ways to provide appropriate risk reduction messages.

This is quite a challenge because our target groups see themselves as quite sophisticated in their tastes – for instance in clothes, music and entertainment – perhaps including their knowledge about their chosen drugs. However, in some respects they are vulnerable:

- they are strongly influenced by peer pressure;
- most do not see their drug use as causing any life problems;
- most do not consider themselves at risk of physical or mental harm.

The 'casualty' users who present to DAIS are the easiest to address; they offer us direct access by recognising a problem and choosing our service. If we give useful (and credible) help then we may be able to convince the rest of the peer group that our advice is worth having. So for this group our goals are quite simple:

- continue to raise awareness of our service and build credibility;
- emphasise that we are totally confidential and 'user-friendly';
- offer information and counselling and referral for treatment if necessary;
- provide detailed help on specific risk areas such as bingeing, injecting, unsafe sex.

Ecstasy use by young people in Britain

■ **Geoffrey Pearson, Jason Ditton, Russell Newcombe and Mark Gilman.**

Geoffrey Pearson was Professor of Social Work at Goldsmiths' College. Jason Ditton was Director of the Criminology Research Unit at the University of Glasgow. Russell Newcombe is a freelance researcher. Mark Gilman formerly at Lifeline in Manchester – now Public health England.



Over the last ten years, the flexible location acid-house pay-party scene of the early 1980s has matured – at least in the north west of England – into one where an estimated twenty to thirty thousand young people go to ‘raves’ every weekend. How many use drugs is a matter of contention. There are two extreme views: ‘the rave scene is riddled with drugs’, as against ‘drugs are no more common at raves than at other youth leisure venues’. Despite local and regional variations, the conspicuous use of drugs at raves is generally uncommon.

Ecstasy (MDMA, 3, 4-methylenedioxymethamphetamine – or to the ravers, just ‘E’) is the ravers’ cultural drug of choice. Although reliable indicators of prevalence are absent, some sense of the sheer range of products can be distilled from a list of named brands currently available in the thriving Manchester club culture: Love Doves, Disco Biscuits, Burgers, Big Brown Ones, New Yorkers, Californian Sunrise, to name, as they say, but a few.

It is hard to assess now what problems the use of ecstasy will create. Medically speaking, the American experience is that ecstasy is a very odd drug – “radically different from other recreational drugs”. Ecstasy enjoys a benign image – ‘no bad trips’, ‘no side effects’ – but experience shows that it can produce paradoxical effects. Increased doses and longer periods of use are commonly associated with fewer positive effects and more negative effects, such as disorientation.

Although there is no evidence that recreational use permanently damages the brain, neurotoxicity has been established in animal studies. Compulsive use is unknown, so ‘addiction’ – however defined – very unlikely.

Culturally, American research does not seem very relevant. One famous study monitored ecstasy use among a group for whom “time was sometimes spent in silence, prayer or meditation before taking the MDMA. After ingestion, the patient sat quietly waiting to feel the effects, or lay down, donning eyeshades to decrease outside distractions. Music was played, usually via headphones, and was always instrumental, except for vocal pieces sung in foreign languages. The genre was classical, ethnic or modern. Typical composers included Mahler, Beethoven, Wagner, Faure, and Deuter.”

Similarly, early reports from a more recent American study of 100 ecstasy users are based on the quoted experiences of a “30-year-old civil engineer” or a “46-year-old PhD”, a “51-year-old airline pilot” or a “38-year-old psychotherapist”.

The social chasm between such respondents and ecstasy users in a typically British setting invalidates any plausible cultural comparison. Ecstasy use here is by dense packs of young people meeting in the small hours and dancing until after dawn.

The vigorous activity simultaneously engaged in Britain may well even interact chemically with the MDMA to produce experiences qualitatively different to those felt when the body is relaxed (and listening to Beethoven).

Indeed, several deaths have been attributed to ecstasy use in Britain. There are also reliable reports of paranoid psychosis following use. Such feelings may well be associated with simple ignorance of the drug and how to minimise adverse effects, so the spread of ‘raver-friendly’ leaflets such as Lifeline’s “E By Gum” should help calm unnecessary fears as well as transmit the

“Golden ‘E’ Rule” of never taking more than one in a session.

Nevertheless, the standard British response of making it illegal (Graham Bright’s private Entertainment (Increased Penalties) Bill) and then sending in the police has failed to do much but create conditions of open warfare, culminating, on one occasion in early August this year, in a rave-in-a-cave near Lake Windermere being policed out with a later recommendation that the cave itself be blown up to prevent future raves!

At the moment, a case can be made for claiming that most of the major problems ravers face are legal ones. Lifeline has produced another leaflet, ‘The Drug Laws’, to counter the popular sentiment that the law probably treats ecstasy as a ‘soft’ drug. The reality is that ecstasy is classified as a class A, schedule 1 substance in the Misuse of Drugs Act, attracting the same severe maximum penalties as heroin or cocaine.

So what could (or should) hard pressed agency personnel do? Experience in some parts of the country is that rave organisers are highly responsive to advice and consultancy on drug-related problems. Key issues to raise when approaching rave organisers are:

- Safety: rave organisers need to provide more than the legal minimum, and this probably extends to crush barriers, better ventilation, chill zones and rest areas.
- Security: trained bouncers (not heavy friends), chosen in consultation with the police.
- Silence: minimise public nuisance by staging raves away from residential areas, supplying good maps, transport and parking.
- Supply: permitting supply of illegal

Ecstasy deaths

drugs on the premises is illegal and neither this nor promotion of drugs should be tolerated.

- Sense: pass health information to ravers to help minimise harm
- Site: nothing beats working on site, where bouncers and other rave staff can be persuaded to become part of an informal paramedic team capable of dealing with all incidents from feeling bad, through fainting, to full collapse.

Finally, drug agencies have reported that some users telephone seeking advice or reassurance about feelings of irritability, moodiness and 'weirdness' which they experience some hours or even days after taking ecstasy. Typically these calls are received on Monday mornings, and callers only rarely visit the agency for face-to-face consultation.

For workers receiving such calls a detailed assessment is clearly impossible, but callers do need clear and confident advice. 'Es' have a benign image leading users to attribute bad effects to themselves rather than to the drug, so the first message to give is that unpleasant and frightening experiences can occur – especially when users have done 'too much, too often'. Then callers should be encouraged to stop using for at least a month and get back to the agency if after this break the effects persist.

The challenge for drug workers is to devise means to monitor their scattered experiences and pool their knowledge of ecstasy related problems so that practice can begin to be informed by the distinctly British context.

MDMA first came to public notice in this country around 1985–86, but not until 1989 was the first Ecstasy-related death recorded. This involved a 16 year-old girl who collapsed at a Manchester club. However since April this year, five young men under 21 have died in Manchester, Liverpool, London, Slough and Portsmouth. Generally the same symptoms have been noted in each case resembling a condition known as neuroleptic malignant syndrome, a rare reaction to major tranquillisers such as haloperidol and chlorpromazine used in the treatment of acute psychosis and schizophrenia. These symptoms include convulsions, dilated pupils, very low blood pressure, accelerated heart rate, high temperature (in excess of 39°C) and coma while the actual cause of death in most cases appears to have been respiratory failure caused by disseminated intravascular coagulation (DIC).

There are chemicals in the body which determine how and where blood will coagulate so that when you cut yourself, you don't bleed to death. What seems to be happening is that MDMA somehow reacts with these chemicals and blood starts clotting where it shouldn't (DIC) – in this case in the lungs. This prevents air from getting through and the person dies from respiratory failure. In one case, there was also profuse bleeding which suggests that conversely, the blood wasn't clotting where it should.

There is no any indication that Britain's recent victims had any underlying health problems such as asthma or heart disease which could have been fatally triggered by taking MDMA. Nor were other drugs implicated. Many questions remain about Ecstasy fatalities. For example, blood levels appear to correlate poorly with toxicity. The American literature cites cases where users with high levels of MDMA in their blood have survived 'overdoses' whereas users taking a 'normal' dose (approximately 100–150 mg) have died. Then again, American psychiatrists have reported using 100mg doses of (presumably pure) MDMA with patients in therapy with no ill effects at all. In this country, deaths appear to have occurred across a range of dosage levels from one tablet to perhaps five, although it has proved impossible to determine precisely how much of the drug has been consumed.

In terms of health advice, it remains that anybody with a known history of cardiac problems should not take the drug, because of its strong stimulant properties, nor should anybody take any more than one tablet per session. But the exact nature of MDMA toxicity is unknown. Ultimately, it is possible that a completely idiosyncratic reaction is taking place without any way of knowing who might succumb and thus making it very difficult to advise on safety, other than to point out the risk.

Press release rewritten

Earlier on the 29 January (1992) front-page banner headlines in the *Sun* and the *Daily Star* had blasted the Mersey centre's Chill Out leaflet for claiming the "deadly drug ecstasy is good for your sex life" and "telling youngsters it's OK to use ecstasy". The official government line is that ministers had been "actively considering" the Mersey centre's ecstasy campaign but had frozen the grant pending further information about the campaign.

Alerted by the press coverage, Home Office and Department of Health ministers had obtained copies of the

leaflet and were concerned that it might form part of the project they were being asked to fund. Ministers were planning the next day to extract PR benefits from the allocation of the Seized Assets Fund; the PR risks from the revelation that part of the money might support a publication branded as encouraging drug use were enough to force a last-minute decision not to fund the Mersey centre's project.

In fact, Chill Out was not to be part of the Mersey ecstasy campaign, which is planned to involve prevalence research and harm reduction information for

parents.

The storm over Chill Out illustrates that, despite increasing professional and government acceptance, a high profile harm reduction approach can still generate sufficient media reaction to threaten official funding. But hints from Whitehall that the grant will be reinstated once the fuss has died down and the regional health authority's defence of the leaflet suggest that officials and politicians may now feel confident enough to stop short of a withdrawal of support.



Into the Pleasuredome

The 'Pleasuredome' is Brighton's central entertainment area with young people's clubs, pubs and music venues. An open drug market developed involving cannabis, LSD, ecstasy and amphetamines. Use of these drugs became part of the area's youth leisure culture and 'casualties' approached the Drug Advice and Information Service (DAIS) with problems related to stimulant and hallucinogen use. Health education strategies were devised to incorporate risk reduction messages into this group's leisure lifestyle.

■ **Andrew Fraser, Laura Gamble and Peter Kennett.** Andrew Fraser was Director and Laura Gamble was Information Officer at Brighton's Drug Advice and Information Service (DAIS). Peter Kennett was a detective chief inspector with Sussex police.

Nine o'clock on a warm summer evening and Brighton's 'Pleasuredome' marketplace is crowded with traders and customers. Business is brisk as style-conscious young people mill around the traders' pitches – but the goods on sale aren't look-alike designer labels or bootleg cassettes – they're drugs.

The 'Pleasuredome' is our nickname for the entertainment centre of Brighton – an area of less than a tenth of a square mile which forms the focus of local young people's leisure activities. A magnet for young people, the area is a complex network of narrow lanes

and pedestrian precincts lined with boutiques, pubs, wine bars, live music venues, fast food outlets, bordered by Brighton pier with all its attractions and amusement arcades.

Use of drugs is considered by many young Pleasuredomers as a valid component of their leisure, along with their dress style, choice of friends, music and clubs.

Development of a visible, organised street drugs market catering specifically for Pleasuredome customers posed unique problems for the police. Because of the narrow, low age-band of both customers and traders, undercover work by plain clothed officers was impractical and intelligence from the market was of poor quality. The street market employed look outs, runners and minders; dealers used radio pagers and public call boxes to conduct business: overt uniformed police action would have been fruitless.

As the only practical option, an

expensive, labour-intensive video surveillance operation led to the conviction of a number of the street dealers for possession and supply of cannabis, amphetamine sulphate, ecstasy and LSD.

The dealers' response was to retreat from the streets into the clubs and pubs of the Pleasuredome. In April a TV programme demonstrated that it was still possible to score drugs in less than a minute by just asking any young person walking in the Pleasuredome.

Last year DAIS began to see an increasing stream of young drug casualties from the Pleasuredome. They came with the classic symptoms of problematic use of hallucinogenic drugs or stimulants – paranoia, disorientation, panic attacks, depression, anxiety, flashbacks, or simply trips that didn't stop – reminding older staff of festival medical tents in the '60s.

A younger DAIS worker commented

that the Pleasuredome drug scene had “brought in a different and nicer type of drug user into DAIS”. To test whether they really were “different” we examined the data sheets for 92 Pleasuredome ‘casualties’ who presented to DAIS from June to December 1990.

Most lived within a 15-mile radius and were aged 18–22. Equal numbers of men and women use the Pleasuredome, but more young men than women came to DAIS. This may be explained by more frequent drug use among young men, or by male peer groups encouraging excessive drug use while young women’s groups discourage it as unacceptable.

The casualties were almost all in employment or further education. Living at home with their parents meant that, even on low wages, they had a significant disposable income for leisure. A very small percentage either had a history of offending or a criminal record.

Over 90 per cent of the young Pleasuredomers said they came to DAIS because of problems caused by the use of either cannabis, amphetamine sulphate, or ecstasy, but their drug use profiles over the past month revealed a different picture. All were dedicated polyabusers, using not one drug but a whole range of different drugs concurrently: cannabis, ecstasy, amphetamine sulphate, LSD, and excessive alcohol consumption being the order of frequency of use.

The typical Pleasuredome casualty was not a daily drug user: they used once or twice a week, always in association with peer group leisure activities. Their leisure ‘binge’ would consist of two or three illegal drugs, usually with alcohol. Before gravitating to the Pleasuredome, they had used cannabis from the age of 13–14, amphetamine from 15–16, LSD from 16, and had started to use ecstasy and binge polyabuse within the last year: nice, middle class young people, living at home with their parents, with conventional, orderly lives, but at weekends drug bingeing – the 1990s version of the 1980s lager lout.

As a group they were strongly anti-heroin: “It isn’t a fun drug and it’s not lively enough to be appealing”; “It’s a socially unacceptable drug so there’s a lot of peer pressure not to get involved”; “It’s an estate drug that’s popular among young people in high unemployment areas”.

But a quarter had injected amphetamine and of these nearly half admitted sharing syringes. This high rate of sharing could be predicted with a group of ‘impulse’ rather than regular injectors, who would therefore not have their own syringes.

Risk reduction campaign



What is much more difficult is to reach the ‘happy consumers’ having a good time out in the Pleasuredome and unaware of any risks. There could be at least a thousand of these and perhaps as many as two thousand at any one time.

They are difficult to target with risk reduction messages; although they gather in the Pleasuredome, they live over a large area and have little else in common. They see their drug use as pure enjoyment and can easily afford it. Almost certainly they see traditional anti-drug campaigns as irrelevant; any media messages directed at them need to be new and sophisticated.

For our FACTLINE ‘91 campaign, based as in previous years on a recorded telephone message, we are attempting to incorporate relevant risk reduction information directly into the leisure lifestyle of young Pleasuredome devotees. Promoting FACTLINE in local entertainment magazines, on the backs of gig flyers, and on club coasters, is intended to make this information part of the club/pub/live music leisure package.

Tailored to the leisure context, the risk reduction messages spotlighted are:

- take ‘one drug at a time’ – don’t mix;
- beware fake ecstasy tablets of dubious composition;

- take a break from speed if you feel paranoia creeping.
- avoid sexual intercourse when stoned;

Those already part of the Pleasuredome scene may well have strong peer-group pressure to conform with what we would see as excessive behaviour, and the group may encourage a kind of stylised recklessness. A small-scale local study of how young people obtain information on a range of issues confirmed that friends are the major source. Asked who they would talk to if they needed help, 91 per cent replied “a friend” and 77 per cent said they would use “friends” if they wanted information. Whether drug use or alcohol-use patterns can be linked to social activities is more controversial, but the survey showed that 62 per cent of those who go regularly to night clubs said they had used drugs recently – against only 22 per cent who do not go to clubs. And the figures for pub-goers are 53 per cent as against 18 per cent. ‘Infiltrating’ this peer group is therefore a key tactic. We also hope to influence some of the 15 and 16-year-olds, the ‘apprentice’ group, waiting in the wings to enter the Pleasuredome.

'Heatstroke' cause of ecstasy deaths

Surprise evidence of liver damage in long-term users

An analysis from the National Poisons Unit at Guy's Hospital of seven ecstasy deaths confirms that heatstroke caused by a combination of the drug and the rave environment caused all the deaths. But the report in the *Lancet* (July 1992) adds the surprising finding of potentially serious liver damage after long-term repeated use.

From January 1990 to December 1991, the Poisons Unit monitored in detail seven sudden deaths directly related to ecstasy (MDMA), though Dr John Henry, consultant physician at the unit, admits there may be up to 20 deaths in total. Also studied were five cases of severe reactions short of death, five ecstasy-related road traffic accidents, and seven cases of liver damage.

Invariably the main drug found on analysis was MDMA, with a few examples of MDA and amphetamine and one of MDEA as additional drugs. All the cases had taken MDMA, rather than some of the more exotic mixtures which have been turning up at raves and parties. The report is clear that the deaths and severe reactions were not due to excessive doses – "the pattern of toxicity seen was not a result of overdose".

All the deaths and most of the severe reactions were associated with rave environments, confirming that combining ecstasy use with vigorous dancing in very hot atmospheres for hours on end, risking severe dehydration, can result in potentially fatal heatstroke in sensitive individuals.

MDMA's role in these reactions seems twofold. Its stimulant effects help prolong and increase the vigour of the dancing, which itself increases body temperature, but this is a property shared by other amphetamines (such as amphetamine sulphate), not generally associated with heatstroke. Although the Poisons Unit cites one paper which refers to amphetamine-related overheating,

it might be significant that no spate of heatstroke deaths was reported during the '60s when amphetamine pills fuelled mod dancing in hot, steamy clubs, nor in the '70s when speed was taken both by punks in similar circumstances and by the all night dancers on the Northern Soul circuit.

The key to why heatstroke deaths have been seen with MDMA but not amphetamine sulphate may be the fact that ecstasy itself appears to directly raise body temperature, aggravating the impact of stimulant-supported dancing in atmospheres sometimes deliberately kept hot and steamy and where fluids may be sold at exorbitant prices.

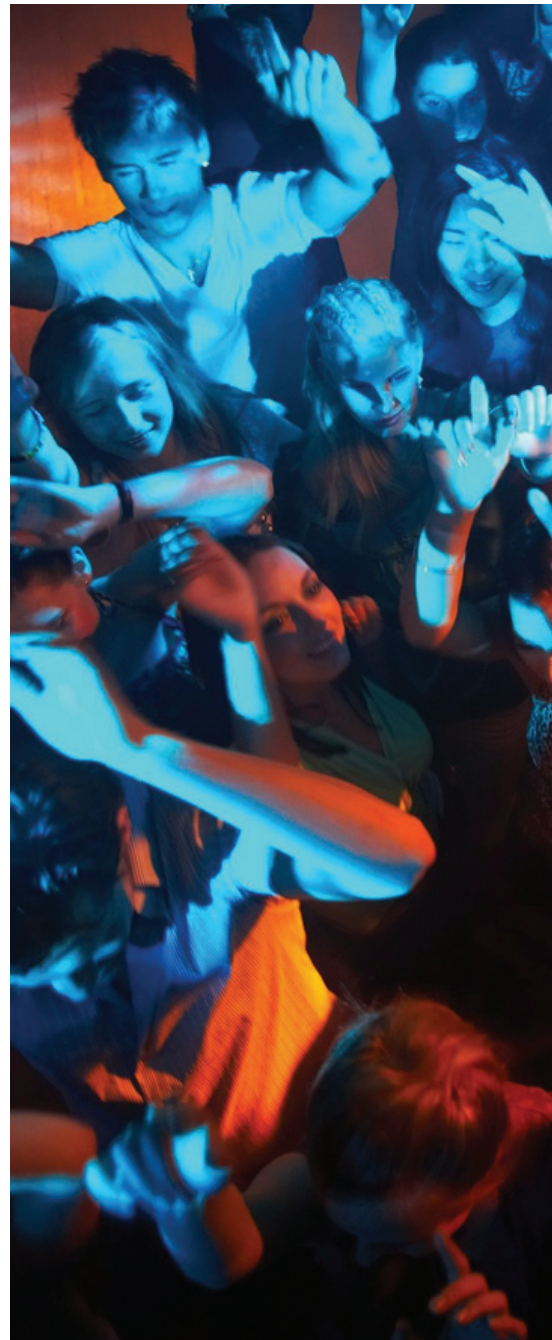
The Poisons Unit's findings point to a clear harm reduction route for ravers who despite the risks take ecstasy, validating advice to take advantage of the 'chill out' areas made available at some raves and to drink lots of water or soft drinks to prevent dehydration.

Rave organisers too must now seriously question whether it is responsible to allow – or even engineer – tropical atmospheres in their venues, despite the demand from their customers, and look at their provision of drinking water. DJs too might consider breaking up the non-stop up-tempo dance songs with slower numbers or chill out breaks.

The question of brain damage as a consequence of long-term use of the drug remains open to question, but liver damage now appears to be a distinct possibility in susceptible individuals. Of the seven cases cited, one required a liver transplant, while another died. Dr John Henry, says, "If you'd asked me six months ago whether or not ecstasy could cause liver damage, I would have said no – now the picture is very different".

There is as yet no indication as to why ecstasy should cause liver damage. The authors recommend that ecstasy misuse be explored with any young person presenting with unexplained jaundice or enlargement of the liver.

Brian Moss's death last October in Liverpool, on which the coroner has only recently adjudicated, was not among the Poisons Unit's cases. His may be the only death recorded in the UK so



far directly caused by using ecstasy but not associated with a rave-type event. In this case, the drug (only 70mg) was consumed at home, resulting in fits and a fatal heart attack. At least one similar fatality has been reported from the USA.

In an editorial published in the *British Medical Journal* (July 1992), Dr Henry concludes, "claims by abusers and agencies that ecstasy is 'safer than alcohol' appear to be premature. It seems that the drug is not addictive. However, it would be unwise to restrict legal controls over a drug whose 'benefits' are debatable and whose risks are evident".



Tabloid storm

The incident started on the 28 January with a front-page story in the *Liverpool Echo* about the “glossy drugs leaflet that every Merseyside parent will view with outrage”. Overseas Development Minister and local MP Lynda Chalker complained that Chill Out told readers “how to take [drugs] safely” instead of “hammering home the message that drugs are wrong and drugs kill”.

Ignoring the leaflet’s large-type warning that “Using any drug involves risks”, the *Echo* interpreted its cautions about regular use as “suggesting that occasional use... could be harmless”. Filtered via the *Star* and the *Sun*, in the *Daily Mail* (31 January) this claim transformed itself into the assertion that Chill Out claimed “Ecstasy was ‘virtually harmless’” – no such words appear in the leaflet.

The press campaign reached its nadir in a *Star* editorial (29 January) suggesting local parents find out where the leaflet’s authors “hang out” and then “storm the place and dump all 20,000 copies of this pernicious pamphlet deep in the Mersey. Followed by Mr O’Hare”.

Pat O’Hare, director of the Mersey Drug Training and Information Centre, was shaken by the attacks on a leaflet which the regional health authority had had OK’d by local police, doctors and drug experts. To its credit the originator of the scare, the *Liverpool Echo*, balanced its coverage by giving Pat O’Hare and the leaflet’s author Alan Matthews a page to reply and running a letters page on the issue in which 13 out of the 16 correspondents supported the leaflet.

A columnist in the *Echo*’s sister paper the *Daily Post* defended the leaflet’s harm reduction approach (3 February) while a leader in the *Manchester Evening News* (4 February) criticised the media coverage and said “Pat O’Hare is quite right.

Screaming from a high moral standpoint merely provokes the rebellious tendencies of the kids”.

How Mersey Regional Health Authority will react to the controversy is unclear. The region’s chair Sir Donald Wilson, a long-time supporter of Mersey’s harm reduction initiatives, is on record as backing the leaflet as one closely targeted at people likely to be using ecstasy. However, a letter from a district health authority chair to Lynda Chalker admits that some of Chill Out’s phraseology is unacceptable and promises that it will not be reprinted in its current form.

Underneath the press overreaction Pat O’Hare admits there is a legitimate issue to be addressed. He accepts that the leaflet will be read by non-users of ecstasy who may be tempted to try the drug, but points out that even shock-horror educational approaches lead to increased use among some individuals.

Harm reduction dilemma

The dilemma is sharper for Chill Out because in attempting to gain credibility with ecstasy users the leaflet acknowledges the drug’s positive effects from the user’s point of view. The assumption is that any harm arising from a few non-users being led to use the drug will be outweighed by the reduction of the harm they and existing users suffer as a result of that use.

An evaluation of the impact of the pilot print run may provide evidence to back this assumption.

Officially Mersey RHA are saying their decision on reprinting the leaflet will be influenced solely by the evaluation results but it’s likely that the media reaction will at least lead to the toning down of the few sentences which provided the hook for the criticism.

Grant frozen after ministers see ecstasy leaflet

Tabloid press urge parents to dump author in Mersey

A government grant to the Mersey Drug Training and Information Centre has been withheld following a tabloid press storm over the ecstasy information in the centre’s Chill Out leaflet. Mersey Regional Health Authority, which funded the initial 20,000 pilot print run, says it backs the centre and the leaflet, but may nevertheless require criticised passages to be revised in a new edition.

Advance copies of a Home Office

press release announcing the allocation of the Seized Assets Fund listed a grant of nearly £15,000 to the Mersey centre for an ecstasy campaign, but the item was missing from the final press release dated 30 January.

The previous evening recipients of the advance notice were told the item had been deleted at the request of the government’s Public Relations Branch, and were instructed to keep its earlier inclusion secret.

1993: Hepatitis C

While all the attention was justifiably focussed on the preventing the spread of HIV, another BBV among injecting drug users was gaining ground that either went unnoticed – or as Dr Waller believed, was known about, but ignored because the public health implications of actually finding out the scale of the problem were too great.

The latest report (2013) from the Health Protection Agency on infections

among people who inject drugs clearly shows how serious the situation remains. While there are fewer heroin injectors, injecting of other drugs such as performance-enhancing drugs and stimulant drugs such as mephedrone are on the increase – as are all the indicators for Hep C-related deaths, first hospital admissions and first registration for liver transplants.

The public health message is clear; as the report says, “Services to prevent infections among people who inject either psychoactive drugs or image and performance-enhancing drugs need to be maintained and be responsive to any changes in drug use”.



■ **Tom Waller** was a doctor with the West Suffolk Drug Advisory Service of which **Roger Holmes** was the Clinical Coordinator. Tom was also a GP and a member of the ACMD.

As many as half the drug injectors in Britain may be infected with hepatitis C, a virus which can lead, sometimes after many years, to cirrhosis and fatal liver cancer. Treatment is successful in only a minority of cases. As with HIV, the body's antibodies do not neutralise the virus and those infected with it can continue to transfer it to others via shared injecting equipment, unsafe sex or from mother to baby. Extra funds are urgently needed to help services cope with the prevention and treatment workload. Like HIV, hepatitis C can be deadly; unlike HIV, it is already widespread among British injectors

Just as predictions for HIV are being scaled down and inertia and complacency are setting in, another virus infection has raised its head. Hepatitis C is a virus that is transmitted in basically the same way as HIV. Like HIV disease, there is a long latent period before chronic disease surfaces and very serious consequences. Unlike HIV, hepatitis C already has a high prevalence among injecting drug users.

Hepatitis C has been described as a "sleeping giant". It has only been possible to test for this virus since 1989 when an antibody test was developed. Before this, diagnosis had been simply a process of exclusion. Hepatitis viruses that were not hepatitis A or B, cytomegalovirus or Epstein Barr virus, were lumped together as 'non A, non B hepatitis'. Now we know there are a several different viruses in this group, including hepatitis C.

Widespread testing for hepatitis C can have an impact on drug services as dramatic as that seen in Edinburgh in the mid 1980s when HIV first appeared in numbers. Our drug service in West Suffolk has experienced at least a 30 per cent increase in counselling workload involving people who have tested positive, and a fourfold increase in needle exchange take up.

The amount of distress felt by those who are seropositive for hepatitis C, and the implications for childbearing, life insurance, and sexual partners, are very similar to those associated with HIV. If, as appears likely, most injecting drug users in the UK are infected with hepatitis C, the long term consequences – for the individuals involved, for their families, the health service, and for the

nation as a whole – will be staggering. There is a strong case for pre and post test counselling for hepatitis C and an urgent need for all drug workers to be fully conversant with the effects of the virus. This in turn has implications for the staffing and training needs of drug services.

Infection control

Preventing the spread of HIV and of hepatitis C each call for the same sort of measures (although advice on syringe cleaning needs review), underlining the importance of continuing to expand this kind of work.

Among the estimated 500 million people worldwide infected with hepatitis C, drug use is probably not the commonest route of infection. But in the UK, injecting drug users are probably the largest high-risk group. Injecting drug use has only taken off in the UK since the 1960s, undoubtedly contributing very significantly to a rapid increase in the prevalence of this virus. The consequences of this development are only now beginning to emerge.

Sexual spread of hepatitis C to the wider population – once disputed clearly does occur, although substantially less often than with hepatitis B or HIV. However, hepatitis C is more easily spread sexually if the individual is also infected with hepatitis B or HIV

Transmission also occurs from mother to foetus. This was thought to occur only occasionally but a recent study using sophisticated testing procedures showed that 8 out of 10 babies born to seropositive mothers were harbouring the virus.

Hepatitis C is similar to HIV in that the body's antibodies do not seem to neutralise the virus or prevent it multiplying. Recent research using more sensitive techniques has shown that infection may persist in virtually all those infected with the virus, even if there is no liver disease.

A positive antibody test for hepatitis B implies immunity against that virus. In contrast, for hepatitis C, like HIV, a positive antibody test implies persisting infection, possible progressive deterioration and a continuing risk of infecting others.

Positive antibody tests are common in injecting drug users. Studies have shown the following prevalence rates: 57 per cent in suburban New York, 74 per cent in Amsterdam, 48 per cent in Munich, 70 per cent in Spain, 86 per cent in New South Wales, 70 per cent in Italy, 85 per cent in Baltimore and 80 per cent in Sweden. Preliminary figures from the UK

are similar 85 per cent in Glasgow and 61 per cent in West Suffolk.

Sleeping giant

With the availability of a test for the virus, post transfusion hepatitis has now been shown to be caused almost exclusively by hepatitis C. Because hepatitis following blood transfusion has been studied for more than 20 years, the disease processes for hepatitis C are well known, despite the recent discovery of the virus. However, during transfusions much more of the virus enters the body than when injecting equipment is shared; how far the consequences of receiving a pint of infected blood can predict the consequences of receiving less than 1ml is yet to be fully clarified.

Surprisingly there is some evidence that sporadic cases of hepatitis C for which no cause has been identified, and where the volume of infected blood must have been small, have a worse outlook than those infected by transfusion.

For a long time it was thought that chronic persistent hepatitis (liver enzymes normal or only sporadically elevated) was a benign condition – as opposed to chronic active hepatitis (enzymes persistently elevated), which was known to be a serious progressive disease. We now know that chronic persistent hepatitis commonly progresses on to liver failure and cirrhosis and is far from benign.

Often there is a long latent phase during which those with chronic hepatitis C feel well and before serious complications arise. Studies of post transfusion hepatitis suggest this period is commonly 20–25 years for cirrhosis and 30 years for cancer of the liver, though there have been several cases of cirrhosis occurring within a year of infection.

The higher the level of liver enzymes, the more likely it is that the infected person will be showing symptoms of the disease. Most drug users with chronic hepatitis C start with normal or near normal levels. One study of injectors with chronic hepatitis C showed that after 43 months, 39 per cent showed signs of chronic active hepatitis, 15 per cent signs of early cirrhosis, and 3 per cent full-blown cirrhosis.

Time will clarify what proportion of drug users with hepatitis C do go on to develop cirrhosis and cancer of the liver after 20 or 30 years. All we can say now is that some will develop these very serious and sometimes life-threatening conditions. A few can improve, most slowly deteriorate. Unhealthy lifestyle, heavy drinking, continued injection

of high levels of street drugs, use of unsterile injecting equipment, infection with hepatitis B or HIV, or repeated infection with hepatitis C, may all worsen the outlook.

Another similarity between hepatitis C and HIV is the high cost of treatment. Treatment may be needed to prevent progressive deterioration during chronic hepatitis and to limit advancement to cirrhosis or liver cancer. (Treatment of acute hepatitis C is currently under evaluation.)

The drug interferon alfa gives remission in 50 per cent of cases, though 50 per cent of these will go on to relapse. A 25 per cent prolonged remission rate for a life-threatening condition is very acceptable, even though the treatment is expensive (£60 per week) and consists of three injections weekly for at least six months and perhaps for a year.

In a recent study nearly two-thirds of a sample of 97 patients infected with hepatitis C in the community went on to develop chronic hepatitis. With hepatitis B, 5 per cent of those who show symptoms after the infection progress to chronic hepatitis; in contrast, over 80 per cent of those showing symptoms after an infected blood transfusion go on to develop chronic hepatitis.

There is no evidence that hepatitis C causes acute fulminant liver failure – a rare but often fatal condition. But research suggests that the incidence of liver cancer with chronic hepatitis C is four times higher than for hepatitis B. An important point for drug users is that alcohol, particularly in excess, promotes cancer of the liver, so all those who have tested positive for hepatitis C should be warned about drinking.

Diagnosis

Chronic hepatitis C from injecting drug use is not so easy to define as in 90 per cent of cases there is no jaundice. Most people feel a bit run down – but among drug users this is not unusual. Until testing became widely available, transfusions were thought to be the commonest cause of hepatitis C infection. We now know this to be untrue; injecting drug users have now joined haemophiliacs as the highest risk groups.

Antibody testing has been refined with two improved second generation tests commercially available, ELISA and RIBA. The lengthy window period of up to nine months before the body produces antibodies (see chart) means that many infections may be missed in the early stages. With the amount of



blood transferred in injecting drug use being so small, often 0.1ml, reaction to infection is often mild and may be readily dismissed as a few days feeling rough after a 'dirty hit'.

As most people with hepatitis C do not have symptoms, the disease can easily be overlooked. Recognition of risk behaviour is the important factor. Among injecting drug users, hepatitis C, like HIV, is a behaviourally related infection. Antibody testing should be available to all clients believed to be at risk, though tests done in the acute phase (first two to three months after infection) are likely to prove negative.

If a patient is within a risk group but the initial test is negative, the best option

is a repeat test a year after the patient was last exposed to the risk of infection. This applies whether or not the client shows symptoms of infection.

Injecting drug users or ex users are unlikely to mount the same political lobby for funding hepatitis C prevention and treatment that the gay and heterosexual community have mounted for HIV. Without additional direct monies from central government, district health authorities or fundholding GPs will probably be unable to meet the costs involved. Yet not to do so will lead to a longer term cost that is considerably greater, both in terms of finance and human suffering. It may be wise to let sleeping dogs lie, but not sleeping giants.

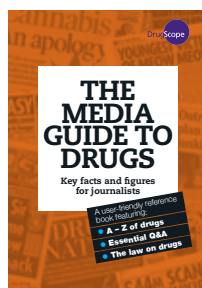
50 BEST DRUGS BOOKS

PART 1

BLAINE STOTHARD
DRUGLINK REVIEWS EDITOR

The first thing to say is many thanks to those in the field I approached to send in their own titles and comments. Responses are still coming in which bodes well for part two – and there will be fifty titles covered. But the big revelation for me was how much literature there is which practitioners, commentators and policy makers value. I was beginning to add titles to my own list – ‘Ceremonial Chemistry’ is one example, in my ‘to read’ pile for several months and mentioned by four contributors – but, inevitably for someone like myself with an education and prevention background, there have been many surprises, additions and revelations. Never too late to learn.

PRIMERS AND INTRODUCTIONS

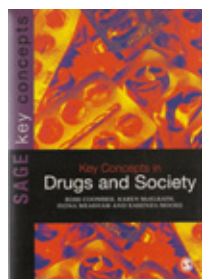


The media guide to drugs: key facts and figures on drugs for journalists and others

DrugScope, 2010.

This is an excellent and must read guide for everyone that is either interested in drugs or is dealing in some way with people who use substances. The guide provides lots of useful and relevant information and statistics on drugs from A-Z – what they look like, how they are used, what effects they have.

Lisa Luger, Visiting Lecturer Middlesex University; LLC Consultancy.



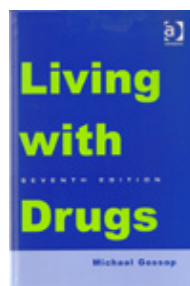
Key Concepts in drugs and society

Coomber, McElrath, Measham & Moore, Sage, 2013.

This volume seeks to bridge the gap between the many existing texts on drugs and current issues linked to drugs and drugs policy. It covers types of drugs, effects of drugs patterns of use, treatment, perceptions of drugs and drugs policy. It has an extensive and valuable collection of references in each

section. The content is comprehensive, the style calm and authoritative – I wish I had a copy years ago. I would like it to be on politicians', civil servants' and media commentators' reading lists.

David MacKintosh, Policy Adviser, London Drug and Alcohol Policy Forum.



Living with drugs

Michael Gossop, 1982, Seventh edition, Ashgate, 2013.

In his chapter on cannabis Gossop perceptively writes “I am well aware that some readers will take exception to the things that I have written in this book.” This comment serves as a reflection on the continued UK failure and reluctance to accept some of the realities and evidence available to us about drugs and their use, and a political persistence – pushed by much of the media – on clinging to out-dated and disproven attitudes and practices in the drugs field. Gossop's work – each edition has been updated to take account of new developments and evidence – patiently and thoroughly presents a carefully argued and presented account of drugs, drug use, drug policies and their impacts, and alternatives. It's to his and the publisher's credit that this

volume remains in print, to wider official discredit that so much of the evidence remains ignored or dismissed. For example, the longest section – still – is on tobacco. And Gossop's closing words continue to be highly relevant: "Drug taking is here to stay and one way or another we must all learn to live with drugs."

Blaine Stothard, Prevention specialist and DrugLink book reviews editor.



Drugs 2.0: How the world gets high

Mike Power, Portobello Books, 2013.

Many traditional industries have been disrupted by the advent of the Internet and drug dealing is no exception. Mike Power explores how you can order drugs as easily as any other online impulse buy and how the Internet is behind the growth of novel psychoactive substances. Power brings journalistic writing skills combined with a researcher's rigour to produce an entertaining and enlightening book. Highly recommended.

Russell Webster, Researcher, evaluator, writer, trainer in drugs, alcohol and crime. Blogs at www.russellwebster.com

Drugs policy and the public good

Babor, Caulkins, Edwards et.al., 2010, Oxford University Press.

An ambitious and highly readable exploration of the contribution that science can and should make to drug policy.

John McCracken, Programme Manager, Drugs, Department of Health.

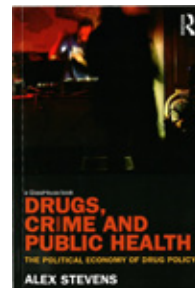
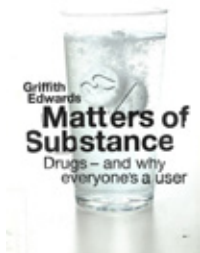


Matters of substance: Drugs – and why everyone's a user

Griffith Edwards, Allen Lane, 2005.

The late Professor Griffith 'Griff' Edwards was a leading force in the treatment of drug and alcohol dependency. In *Matters of Substance* he attempts to review the relationship between a wide range of substances and those who use them. Rather than a taxonomy of the characteristics of drugs he includes the inter-relationship with the users' social and psychological aspects and how this affects outcomes. Overall he produces an interesting introduction to the understanding of the use of drugs and alcohol in society. His conclusions, regarding how to control the impact of this use, give the reader a basis from which to develop their own position. At a time of an increasingly politicised policy context, an awareness of the complexity of responding to drug and alcohol problems, this book offers interest to both the general reader and treatment worker.

Paul Wells, General Manager for Substance Misuse Services in Coventry and Warwickshire until 2011. He has contributed to UK Harm Reduction Alliance and Action on Hepatitis C.



Drugs crime and public health: the political economy of drug policy

Alex Stevens, Routledge, 2010.

Includes a critique of the evidence that crime reduction measures featuring coerced treatment for offenders have reduced overall crime levels in Britain and more generally of the use of evidence in policymaking, based partly on observations made while the author was a government adviser.

Mike Ashton, Drug and Alcohol Findings. Also submitted by Transform.

ALCOHOL

Alcohol: the ambiguous molecule

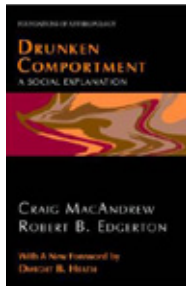
Griffith Edwards, Penguin, 2000.

Edwards was a prodigious researcher whose long career introduced 'alcohol dependence syndrome' in 1976. He later led on the writing of *Alcohol Policy and the Public Good* in 1994 – a book that transformed our understanding of the scientific basis for public health policy in relation to alcohol. *The ambiguous molecule* demonstrates another of his talents – the ability to communicate complex science to the general reader. The sweep of the book takes in: alcohol's chemistry; a social history of its use and drunkenness across the millennia; our progressive formulation and understanding of alcohol problems; accounts of major developments such as the evolution of the disease concept, the USA's experiment with alcohol prohibition, and Alcoholics Anonymous; the impact of alcohol on health; and,



future options for alcohol policy. Although some of the science has moved on, this remains an excellent primer. Its breadth and style mean that it is also a rewarding read for the more experienced 'alcoholologist'.

Neil Hunt, freelance researcher and trainer; Honorary Senior Research Associate, University of Kent; Honorary Research Fellow, Centre for Research on Drugs and Health Behaviour, London School of Hygiene and Tropical Medicine.



Drunken comportment

MacAndrew and Edgerton, Percheron Press, 1969.

A marvellous cross-cultural and historical analysis with many memorable descriptions of how people drink and get drunk. The book attacks the disinhibition hypothesis that alcohol consumption determines behaviour and affects it for the worse. MacAndrew and Edgerton argue that how we drink and how we behave when drunk is influenced by cultural context. Alcohol is not always a 'disinhibitor.' My favourite is the description of the Mixe Indians who always go armed and who like to drink and get drunk. When drunk they challenge and fight. However when they begin to fight the first thing they do is to lay down their weapons and fight with their fists. Harm reduction! The "domestication" of drunkenness leads us to re-think the links between alcohol, boisterousness, violence, and sexual promiscuity.

Gerry Stimson, Director Knowledge-Action-Change; Emeritus Chair, Imperial College; Visiting Professor, London School of Hygiene and Tropical Medicine.



The drinker

Hans Fallada, Originally published in Germany 1950, Melville House 2009.

Hans Fallada is best known for his work *Alone in Berlin*, but it is in *The Drinker* where he excels in his depiction of a man who loses everything, unable to end his relationship with "La Reine," his name for alcohol. Fallada himself drank excessively, and *The Drinker*, discovered only after his death, was written in code whilst he was being treated in a Nazi psychiatric asylum. The central character has a level of awareness about what it happening to him which makes the novel all the more poignant – not even

his intelligent insight can prevent his descent.

Sally Marlow, Addictions Department, Institute of Psychiatry, King's College London.



Twenty thousand streets under the sky

Patrick Hamilton, 1929, Vintage Classic, 2004.

A semi-autobiographical trilogy set in the 1930s, this work explores the lives of three people whose lives cross in the *Midnight Bell*, a pub on the Euston Road. It is Hamilton's portrayal of Jenny, a prostitute who is dependent on alcohol, which makes this book worthy of inclusion in any book list on addiction: from the first taste she is gripped, and the life she might have had starts slipping away from her.

Sally Marlow, Addictions Department, Institute of Psychiatry, King's College London.



Alcohol-related violence: prevention and treatment

McMullan, M (Ed) Wiley-Blackwell, 2012.

This book highlights the relationship between alcohol consumption and violence and the harm which can emerge as a result. It is an essential must read book for all those who are interested in understanding and reducing alcohol-related interpersonal violence. The book draws on contributions from authors internationally and covers areas for the reader to get an understanding of the problem of alcohol related violence and its extent, but also provides examples of good practice for prevention and treatment.

Lisa Luger, Visiting Lecturer Middlesex University; LLC Consultancy.

MEMOIRS – ANTHROPOLOGY – TELLING IT LIKE IT IS



Too high too far too soon: tales from a dubious past

Simon Mason, *Mainstream*, 2013.

A fascinating account of a man who was at the rock 'n' roll heart of Britpop in the 90s, who fell into heroin addiction and petty crime to fund his addiction, but eventually managed to become clean after being 'rescued' by Banksy from a camper van in Spain. Why it's my choice: This is a cracking read that tells it like it is. The bleakness of addiction to drugs is laid bare and the enormous difficulties he faced overcoming his addiction. Ultimately it's a story of hope for all those who want to beat their addiction and to those struggling to help them.

Norman Baker M. P., Crime Prevention Minister at the Home Office.



Mother's ruin

Nicola Barry, *Headline*, 2008.

A memoir from a woman who grew up in a well-to-do Scottish family with a mother who drank. Nicola captures the secrecy, shame and neglect she felt as a young girl who was in effect her mother's carer, while her father wilfully ignored what was happening. Nicola's mother eventually drank herself to death, and afterwards Nicola had to deal with the hereditary aspects of addiction, and battle her own alcoholism.

Sally Marlow, Addictions Department, Institute of Psychiatry, King's College London.



Junkie

William Burroughs, *Ace Books*, 1953.

William Burroughs's insider account of life with heroin. From a middle class, Mid-West family, he started using heroin during the Second World War. This noirish autobiography echoes 1950s crime novels: capers with minor criminals, Times Square characters, cheap lodging houses, brushes with corrupt police, encounters with doctors, and of course, scoring heroin and other drugs. A good eye for the urban landscape – 103rd and Broadway is junk territory – 'junk haunts the cafeteria, roams up and down the block...a ghost in daylight on a crowded street'.

Challenges ideas about intention and addiction. Full of memorable insights. No one sets out to be a junkie, he says – 'You don't wake up one morning and decide to be a drug addict': you drift into it, it takes time to become a junkie. 'One day you wake up sick and you're an addict.'

Gerry Stimson, Director Knowledge-Action-Change; Emeritus Chair, Imperial College; Visiting Professor, London School of Hygiene and Tropical Medicine.

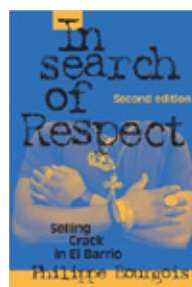


Righteous dopefiend

Philippe Bourgois, *University of California Press*, 2009.

This powerful study immerses the reader in the world of homelessness and drug addiction in the contemporary United States. For over a decade Philippe Bourgois and Jeff Schonberg followed a social network of two dozen heroin injectors and crack smokers on the streets of San Francisco, accompanying them as they scrambled to generate income through burglary, panhandling, recycling, and day labour. *Righteous dopefiend* interweaves stunning black-and-white photographs with vivid dialogue, detailed field notes, and critical theoretical analysis. Its gripping narrative develops a cast of characters around the themes of violence, race relations, sexuality, family trauma, embodied suffering, social inequality, and power relations. The result is a dispassionate chronicle of survival, loss, caring, and hope rooted in the addicts' determination to hang on for one more day and one more "fix" through a "moral economy of sharing" that precariously balances mutual solidarity and interpersonal betrayal.

Magdalena Harris, Faculty of Public Health and Policy, London School of Hygiene and Tropical Medicine.



In search of respect

Philippe Bourgois, *Cambridge University Press*, 2002.

This book has the sub-title 'selling crack in El Barrio', which is part of what makes it a "drugs book" I suppose. But it would be a disservice to this fine book to see it on only one dimension. It is a multi-layered and multi-dimensional study of a group of people, perhaps a community of "Nuyoricans" in East Harlem, New York. Based on immersion in the environment and close connection to the people he writes about, Bourgois provides both

an appreciative and critical perspective on their lives and situation. This book won the Margaret Mead Award when it was published and, nearly two decades on, it remains an important read on the dynamics of ethnicity, class and gender and their links to the drugs trade.

Karim Murji, Open University.

Also submitted by Alex Stevens, Professor in Criminal Justice, University of Kent, and Jim Orford, Emeritus Professor of Clinical and Community Psychology, Birmingham University.

TREATMENT AND WORKING WITH USERS

Helping drug users

Nicholas Dorn & Nigel South, Gower, 1985.

2014 is the 50th anniversary of the founding of the Blenheim Project, a notable achievement in itself. This book, long out of print but available second hand, is the product of research that looked at the way three London 'street agencies' – Blenheim, Community Drug Project and Hungerford – operated in the early 1980s. It is hard to imagine in today's current context of large national service providers that, at that time, London was served by about 10 to 12 drug workers. These projects were responsible for much innovative work, some of which underpins the services for drug users today, while others, such as the CDP injecting room, have not been replicated in 40 years. This book captures the different styles of working and offers an insight into understanding how the work with drug users has developed since the mid 1980s, following the rapid development of services.

Paul Wells, General Manager for Substance Misuse Services in Coventry and Warwickshire until 2011. He has contributed to the UK Harm Reduction Alliance and Action on Hepatitis C.

Motivational interviewing: preparing people for change

William R. Miller & Stephen Rollnick, Guilford Press, 2002.

Working with patients with drug and alcohol problems in general practice I soon realised 2 things 1) that they were the same as any other patient and 2)

I needed the same patient-centred skills. Early on I was fortunately to have a counsellor working with me and he introduced me to Motivational Interviewing. After a day's introduction course I realized that I was using some of the methods but I had so much to learn. I was recommended to read this book and I was smitten! It improved my communication with all patients and seemed to be particularly helpful with people who had any kind of addiction problems and allowed me to support their desire to change. Perhaps most importantly it took me away from usual doctor skills of wanting to fix things and control everybody and showed me how best to support, encourage and inspire someone you care about – to develop their own decisions.

Chris Ford, former London GP and co-founder of Substance Misuse Management in General Practice; founder of International Doctors for Healthier Drug Policies.

Drugs and addictive behaviour: a guide to treatment

A. H. Ghodse, Cambridge University Press, 4th edition, 2010.

Provides an excellent and accessible textbook on practical and evidence based approaches for all aspects of managing addiction and substance misuse. An invaluable text book for students of addiction, and for those working in clinical settings. It is written in a clear and objective manner. The promotion of their interests, and to distort and discredit researchers' findings which run counter to those interests.

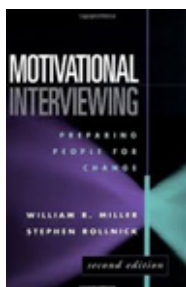
Christine Goodair, Programmes Coordinator (Substance Misuse) Population Health Research Institute, St. George's University of London.

The reduction of drug related harm

Pat O'Hare et. al. (eds.), Routledge, 1992.

There are now many books on harm reduction that bring together a range of authors to discuss theoretical issues and practical applications in relation to different drugs, used in different ways, within different settings. For a good contemporary example, the EMCDDA's 2010 monograph *Harm reduction: evidence, impacts and challenges* is a better resource to consult. Nevertheless, I retain a deep personal attachment to this early

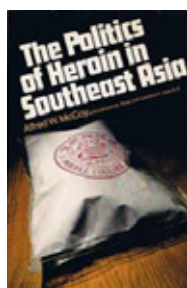
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book because it helped introduce me to many of the ideas that have been central to my work ever since. And quite a few of the people too. More than any other chapter, I value Russell Newcombe's 'conceptual framework for theory, practice and research' in which he sets out the arguments that radically transformed my understanding of drug policy. Beyond this, there are chapters on many topics that continue to resonate today: harm reduction and dance drugs/stimulant use; 'Smack in the Eye' and the controversy that can arise when developing user friendly information grounded in people's lived experience; the role and relationships with the police; reducing risks within sex work; drug consumption rooms; the effectiveness of different policies on regulation and control; and the impact of representations of the 'drug user'. Plus ça change...

Neil Hunt is a freelance researcher and trainer; Honorary Senior Research Associate at the University of Kent; Honorary Research Fellow with the Centre for Research on Drugs and Health Behaviour, London School of Hygiene and Tropical Medicine.

INTERNATIONAL



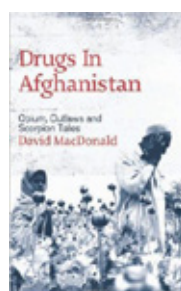
The politics of heroin: CIA complicity in the global drug trade

Alfred W McCoy, Lawrence Hill Books, 2003 (revised edition).

First published in 1972 and revised twice to update a continuing story, this book tracks through Sicily, Marseille, Vietnam, Hong Kong, the Golden Triangle, Afghanistan and Latin America. In the 20–30 years between the first and later editions, what had once been an obscure subject had spawned a huge literature. What began as a Cold War issue mutated into the US 'War on Drugs'. As other reviewers have said 'the appalling fact' is that McCoy's updates of his classic work remain as relevant as ever. As much reportage as analysis, and packed with direct observations and quotations, it is supported by extensive reference to documents. Today as voices critical of the War on Drugs grow in number, this book demonstrates the deep roots and formidable strength of the interests which sustain it.

Susanne MacGregor: Professor of Social Policy at the London School of Hygiene

and Tropical Medicine; Associate Editor of the International Journal of Drug Policy



Drugs in Afghanistan: opium, outlaws and scorpion tales

David Macdonald, Pluto Press, 2007.

Macdonald graphically shows us, if we needed to know, that 'supply countries' are not just grey shapes or targets on a map but seething, complex living worlds, made up of powerful, active, organised societies and people with cultures, interests and histories which need to be respected if we are to understand the phenomenon of the drug trade. His book should be required reading for politicians or commentators before they voice their opinions on Afghanistan or on the 'War on Drugs'. Based on many years intensive work as a drug demand reduction specialist in Afghanistan, Macdonald describes in detail the overlapping markets, supply routes, patterns of use and demand for a range of substances, from traditional medicines to modern pharmaceuticals, vodka and other alcohol, as well as conventionally defined illicit drugs like heroin. He shows how the war economy led to social destruction, warlord power, poppy cultivation, rule of the gun and breakdown of central government power. He is critical of the concentration of attention in current global drug policy on cultivation, production and trafficking and its neglect of the deep causes of demand for intoxicants. Drug consumption in Afghanistan is a way of coping with the pain of existence in an impoverished and war-wrecked land, and drug production is a necessary economic survival strategy.

Susanne MacGregor: Professor of Social Policy at the London School of Hygiene and Tropical Medicine; Associate Editor of the International Journal of Drug Policy

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