

THE MEDIA GUIDE TO DRUGS

I have despaired over the years about the hysterical and ill informed way in which the media, most especially the largest-selling popular newspapers, report on the subject of drugs. Journalists are too ready to accept myths and, by passing them on, contribute to yet further myth-making by their readers. By reacting emotionally rather than rationally to the topic, and by denying reality, newspapers do a disservice to society. This guide will surely help the next generation of journalists because it deals with facts that counter ignorance and prejudice. I believe it will prove invaluable.

**Roy Greenslade**, Professor of Journalism at City University and former editor of *The Daily Mirror*

# THE MEDIA GUIDE TO DRUGS

Key facts and figures for journalists

A user-friendly reference book featuring:

- A - Z of drugs
- Essential Q&A
- The law on drugs



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Key facts and figures  
for journalists

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DrugScope is the national membership organisation for the drug sector and a leading drug information and policy charity. DrugScope has over 600 members working in the drug sector and related fields and the organisation draws on the expertise of its members to develop policy and lobby government.

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# About DrugScope

DrugScope is the national membership organisation for professionals working in the drugs sector. Our members include people working in treatment, primary care, housing, mental health, criminal justice and education. We are also the UK's main source of independent information about the misuse of drugs.

## Why is media work important to DrugScope and our members?

There is much ignorance, misinformation and fear about drugs and one of our key tasks is to provide information, analysis and comment which is up to date, based on the best possible evidence and non-judgemental. This information is widely used by professionals, academics and researchers, politicians, members of the general public and especially by journalists.

Since the mid 1990s, DrugScope has provided a 24/7 on call service to all media. We are frequently the first port of call for comment and information, dealing with enquiries on all aspects of drugs and drug-related issues. On average, we receive over 1,000 media calls every year. We also deal with many enquiries from those studying to be journalists and consider it very valuable to work with student journalists whenever we can. DrugScope issues press releases, posts comments and information on our website and through our Twitter feed.

DrugScope also runs a free daily online news service on drugs and alcohol called DS Daily which keeps the field up to date with all the news and new reports and publications. Anyone can subscribe online at [www.dsdaily.org.uk](http://www.dsdaily.org.uk).

**You can call the DrugScope Press Office on 020 7520 7550 and select option 3. If you're calling out of normal office hours, you can call the mobile on 07736 895 563. We will also respond to enquiries by email at [press@drugscope.org.uk](mailto:press@drugscope.org.uk)**

### Who should read this Guide?

Hopefully all journalists will find this Guide useful – whether they are students, general news correspondents who just need basic information for a story or more specialist journalists who need to keep up to date with the latest trends. The Guide is on our website and will be regularly updated at [www.drugscope.org.uk/mediaguide](http://www.drugscope.org.uk/mediaguide).

### Why has DrugScope produced this Guide?

- **The public get much of their information from the media.**

The media continues to be one of the most important sources of information about issues that are outside the public's direct experience. This is especially significant when it comes to a highly charged and politicised subject like drugs where emotions run high and the opportunities for stereotyping those with serious problems are legion. An IPSOS-MORI survey from 2007 showed that among those people who said they know something about illegal drugs, most got their information from the media. See the section on 'Reporting on Drug Use' for more on how the media deal with drug issues, why this can be problematic and how we would like to help make it better.

- **Today's news is accessible for much longer than it used to be.**

There was a time when print journalism was tomorrow's chip paper and news broadcasts were heard just once and never repeated. But the advent of newspapers online and 'listen again' options means that information can be available perhaps indefinitely and easily accessible through a Google search. If you add to that, the confusing landscape of (often misinformed and polemical) websites and citizen journalism then the possibilities for all kinds of wrong information about drugs to circulate endlessly are immense. Now more than ever, journalists committed to responsible reporting on drug issues need a reliable reference point from which to derive their information.

- **The internet is contributing to an ever more complex drug scene.**

There was a time when several years might pass before a new drug appeared in the UK. Recently however, the use of GBL, Spice, BZP and mephedrone in quick succession has received widespread publicity. The internet allows for the global sale of drug 'ingredients' (known as precursor chemicals); the drugs themselves (often known as 'legal highs') as well as the platforms for debate and the exchange of experiences. All of this complicates the reporting of the UK drug scene.

- **Journalism is becoming more pressured than ever – but quality reporting is still essential.**

We are very much aware of the pressures on journalists to produce copy and the political and editorial constraints they may be working within. Even so, it is important that we do challenge the degree to which people with serious drug problems are stigmatised by the media. In this Guide, we will explore the reasons behind stigma – and what impact it has.

# Overview of the UK drug scene



### How many people use drugs?

- Of the general adult population aged 16–59, around 10 million people or 30% say they have ever tried an illegal drug. The figure drops to around 10% for use in the last year and just over 5% for use in the last month.
- For those aged 16–24, the main age group likely to be using drugs on a more regular basis, over 20% said they had used a drug in the last month.
- For those aged 11–15, around 22% said they had used a drug at least once; 15% in the last year and 8% in the last month.

### What have been the main trends in use in recent years?

- For all age groups, cannabis is far and away the most popular drug whether you are talking about once-in-a-lifetime experiment or regular use. Cannabis use has been falling in recent years.
- Overall, drug use has either fallen or remained stable in the past ten years.
- The only drug that showed a significant rise in use in the late 90s and early 00s was cocaine powder. Even that seemed to level off, then took a jump among those aged 16–24 for reasons which were unclear, before dipping again.
- After cannabis, cocaine has become the second drug of choice, leapfrogging over amphetamine and ecstasy.
- So-called ‘legal highs’ (a number of which are now banned, like mephedrone) have been hitting the headlines. However, while use appears to be widespread, these drugs have yet to figure in official statistics so it is hard to get an idea of exactly how many people are using them. However, it seems likely that the internet will play an increasing role in drug information, manufacture and distribution.

### How much does drug use cost the UK?

The drugs that cause most harm to the individual, families and the wider community are heroin and crack. These drugs account for most of the cost of drug treatment and drug enforcement and are the drugs most likely to generate crime in order to fund drug purchase. Therefore cost estimates are largely based on use and supply of these drugs. There have been two studies – one for England and Wales and the other for Scotland. The combined estimated cost came to nearly £19 bn.

### How much does the UK spend dealing with the problem?

The latest data is from 2008/09. Out of a total labelled spend of £998 million, roughly two-thirds was spent on health and third on enforcement with a very small amount (about 0.4% of the budget) spent on education. However the published figures significantly under-estimate the costs of enforcement. This is because the money spent on drug enforcement is wrapped up in the overall budget for tackling organised crime and is therefore hard to tease out. The Serious Organised Crime Agency (SOCA) has an annual budget of around £400m.

### How many people have got a drug dependency?

It is estimated that there are around 400,000 people in the UK with a dependency on heroin and/or crack. Of those, around half are in contact with treatment services.

### How many people die because of drugs?

In 2009, coroners deemed that the deaths of 2,182 people in the UK were drug-related. 72% were classed as accidental poisoning or overdose, 9% were deemed to be suicide while the exact circumstances of the remaining fatalities remained unclear. Nearly 70% of drug-related deaths (around 1400) involved heroin, methadone or similar opiate drugs.

By comparison, in 2008, just under 10,000 people died from alcohol-related diseases and over 100,000 people died from tobacco-related diseases.

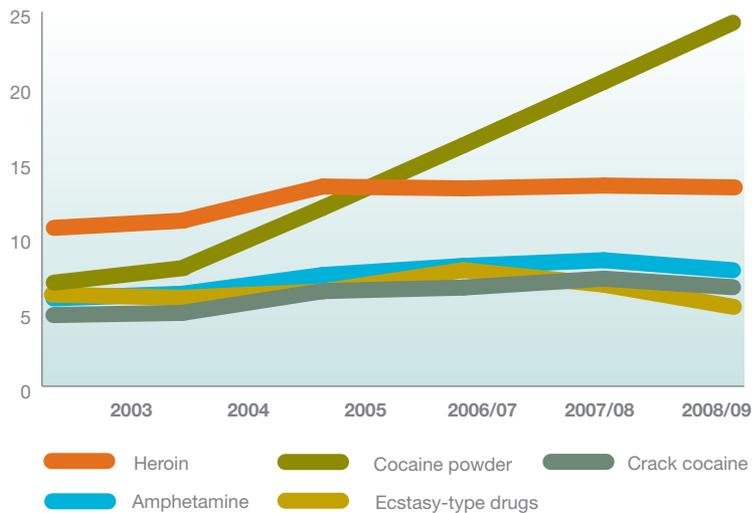
### How many people commit drug offences?

In 2008/09, there were nearly 300,000 recorded drug crimes in the UK, around 200,000 of which were warnings about possession of cannabis. The number of cocaine powder offences jumped 24% from the previous year.

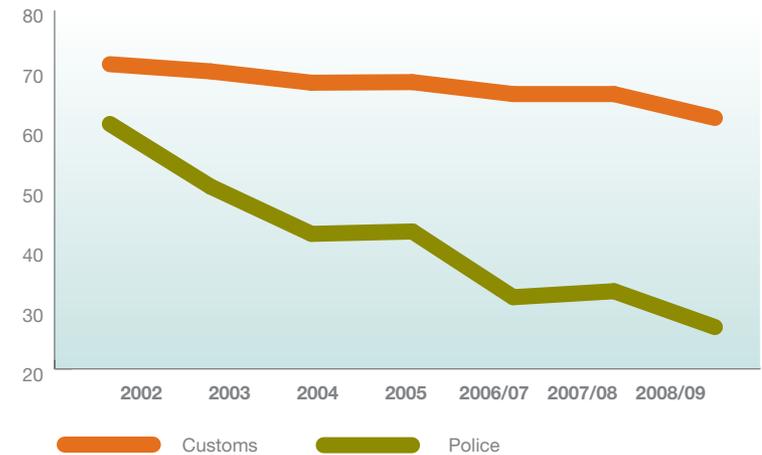
### How many drugs are seized by police and customs?

The table below shows trends in seizures. The most noticeable recent trend has been the increase in the number of cannabis plants seized, due to the number of cannabis farms discovered. Generally, it is customs who seize the largest amount of drugs in weight, while the police make the biggest number of individual seizures.

#### Number of seizures of Class A drugs (police and customs)

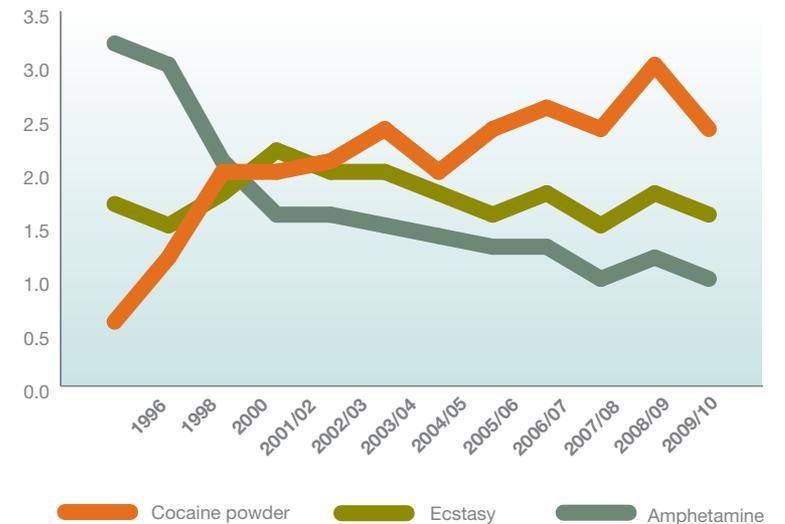


#### Average purity of cocaine powder seized by customs and police 2002 – 2008/09



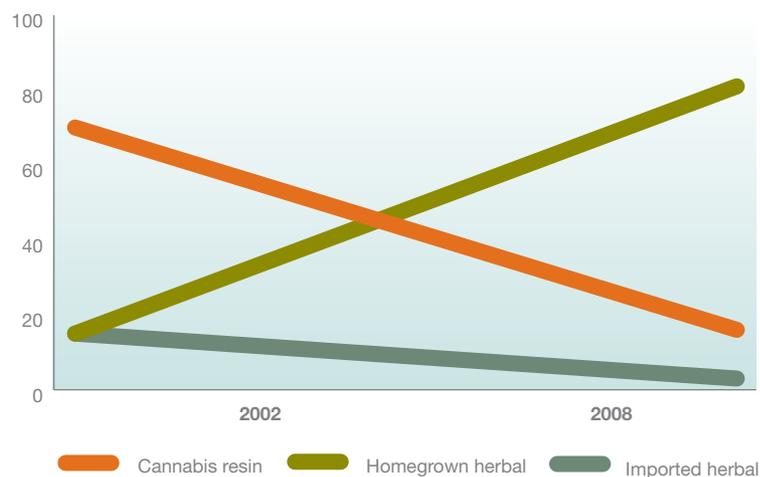
Source: Home Office Statistical bulletins: Seizures of drugs in England and Wales

#### Stimulant use among 16 to 59 year olds 1996 to 2009/10



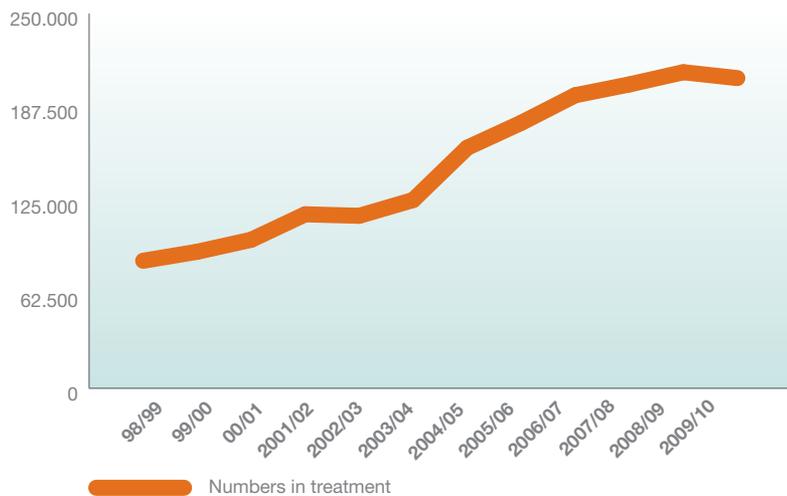
Source: Home Office Statistical bulletin: Drug Misuse Declared: findings from the BCS 2009/10

### Market share of UK cannabis market



Source: Home Office (2008) Cannabis potency study

### Number of individuals in contact with drug treatment services in England



# The A-Z of drugs

## AMPHETAMINE

Common names: speed or whizz (amphetamine)



### **Where does it come from?**

Most amphetamine comes from Europe, especially Holland.

### **What does it look like?**

Amphetamine powder varies in colour from off-white through to pink or brown depending on what other substances are mixed in with it

### **How pure is it?**

Amphetamine is probably the most impure drug on the market. Many samples tested are less than 10% pure with the rest made up with a variety of drug and non-drug powders.

### **How is it used?**

Amphetamine is usually snorted, but some users wrap it up and swallow it with a drink. A small minority inject the drug.

### **How many users?**

According to the latest figures from the British Crime Survey around 300,000 people aged 16–59 have used amphetamine in the last year.

### **How much does it cost?**

The average price of amphetamine is £9 per gram.

### **How much do people use?**

Amphetamine is sold in paper wraps of a gram, lasting the average user around four hours.

**What are the effects of using ?**

Amphetamines are stimulants. The drugs give you energy, boost confidence and keep you awake which explains their use for partying, clubbing etc.

**What are the risks?**

All drugs of this type put pressure on the heart and cardiac system. They can cause the heart to race or beat erratically and the heart rate and blood pressure to rise. Users run the ultimate risk of heart attack or stroke. Amphetamines also reduce the appetite and the need to sleep, which with continued use over weeks or months can cause significant health problems. Prolonged use can cause anxiety, paranoid states and psychological dependency.

**How many people die from using amphetamines?**

Amphetamine was 'implicated in' the deaths of 49 people in 2009. But see important note about drug deaths on page 97 which applies to all drug death information in this Guide.

**The law**

Amphetamine is a Class B drug under the Misuse of Drugs Act, but is Class A if prepared for injection.

## A SHORT HISTORY

1927 – Amphetamine discovered by a research chemist in America.

1939–45 – Amphetamine pills given to troops to combat battle fatigue in WW2 and subsequent wars in Korea and Vietnam.

1956 – Prime Minister Anthony Eden took amphetamine during the Suez Crisis.

1950s–1960s – Thousands of prescriptions written for women in the 1950s and 1960s who use the drug as a slimming aid.

1964 – Possession without a prescription banned in the UK after thefts from chemists and factories fuel the first teenage drug fashion among rival gangs of Mods and Rockers.

1970s – Many amphetamines withdrawn from the market after a voluntary ban on prescribing by some GPs.

1970s – Illicitly produced amphetamine powder becomes popular on the UK northern soul dance scene and during the punk era.

1990s–2000s Amphetamine power becomes popular again during the height of rave culture and continues to be among the top five illicitly used drug the UK, although also the most impure.

**AMYL NITRITE**

Common name: Poppers

**Where do they come from?**

Sold in pubs, clubs, bars, sex shops and online.

**What do they look like?**

Clear liquids in small bottles sold under brand names like Rush, Locker Room and Liquid Gold.

**How pure is it?**

No evidence that it is adulterated with other chemicals.

**How is it used?**

The pungent smelling vapours are sniffed straight from the bottle or can be sniffed from absorbent material including cloth or the filter of an unlit cigarette.

**How many users are there?**

Over 200,000 people aged 16–24 say they have used the drug in the last year, making it the fourth most used drug after cannabis, powder cocaine and ecstasy. Poppers are popular within the gay community.

**How much does it cost?**

Single bottles sell for £2-£3.

**How much do people use?**

Bottle sizes vary from 10ml-30ml. Effects only last a few moments, so exactly how much of a bottle will get used in a session will vary.

**What are the effects?**

The drug was originally used to combat angina because it opens up blood vessels. This effects means that users will feel flushed, their heart rate increases and they may experience dizziness and light headedness. The drug also relaxes muscles so it is sometimes used to make anal intercourse less painful.

**What are the risks?**

Users report serious headaches. Poppers should not be used by those with any kind of breathing or heart problems, glaucoma. Can burn skin round mouth when sniffed.

**How many people have died from using this drug?**

There are no figures available about deaths from using poppers.

**The law**

Not controlled under the Misuse of Drugs Act, so not illegal to possess or sell.

**A SHORT HISTORY**

1857 – First developed as a treatment for angina. Also used to treat cyanide poisoning. Eventually sold in glass capsules where the patient ‘popped’ the top of the capsule to sniff – hence ‘poppers’.

1970s – Took off as a trendy drug in America – was the ‘drug of choice’ on the 1972 Rolling Stones tour of the USA where somebody described the effects as like being ‘hit in the face with a brick’; increasingly adopted by gay men in mid-late 70s on the disco/party scene.

1980s – Major scare linking popper use to HIV/AIDS through the development of Kaposi’s sarcoma, a form of cancer which can be an early indication of HIV infection. This theory was eventually disproved. Poppers were banned in the USA in the late 1980s.

1990s–2000s – Long since replaced in medical settings by other angina drugs, poppers gained in popularity in the UK on the club scene and among some young people, but remain outside the Misuse of Drugs Act.

**ANABOLIC STEROIDS**

*Note: not to be confused with corticosteroids which are used in the treatment of asthma and other conditions.*

Common name: ‘roids

**Where do they come from?**

Bought and sold online and in gyms.

**What do they look like?**

Mainly tablets and capsules in different shapes and colours, but some forms are injectable.

**How pure are they?**

Many come from illicit labs and factories in the Far East or Asia where there is no quality control. The contents of some packets and bottles will be exactly the type and dosage listed on the packaging. Others, however, may bear no relation to the packet and be a different substance or dosage entirely or contain no active drug at all.

**How are they used?**

Either swallowed or injected. Experienced users will take different sorts of steroid depending on the effects they are looking for (called 'stacking') and use different drugs in cycles over a number of weeks with rest periods (called 'cycling').

**How many users?**

The British Crime Survey cites that around 250,000 people have said they have used steroids at least once, falling to around 75,000 for those who have used in the last year. Some drug agencies have reported increasing numbers of people asking needle exchanges for sterile injecting equipment in the last 5 years.

**How much does it cost?**

A regular user could spend £500-£2500 a year.

**Who uses steroids?**

In general, there are three main categories of user, although some may overlap:

- Elite athletes – sprinter Ben Johnson being one of the more notorious examples;
- Professional or amateur competition body builders;
- Those looking to 'bulk up' either because of their job, like security guards, club bouncers or construction workers– or simply to build self-esteem or a combination of both. This group may also include professional or amateur body-builders.

**What are the effects?**

Anabolic steroids are used to pump up muscle either to simply become 'big' or to gain an advantage in competitive sport. There is still debate over whether or not steroids, for example, would make you run faster (outside of a proper training regime, supervised diet etc). There is no doubt that they build muscle strength and enable an athlete to recover more quickly from training or injury, which of itself potentially enhances performance.

**What are the risks?**

The active ingredient in these drugs is the male hormone testosterone which occurs naturally in the body. Therefore taking steroids can exaggerate physical and psychological male traits, from severe acne and male-pattern baldness through to increased aggression. Evidence is thin however that steroid use alone can provoke violent outbursts, known as 'roid rage', in otherwise placid individuals. Lifestyle factors and personality traits must always be taken into account as well.

The drugs can cause lasting damage to the liver. The presence of the drug in the body also prompts the production of female hormones; hence male testes shrink and 'man boobs' can develop.

**How many people have died using this drug?**

No figures available specifically relating to steroids. Note, however, that a death from acute liver disease caused by anabolic steroids may not necessarily be registered as a drug-related death.

**The law**

The supply of anabolic steroids is controlled under Class C of the Misuse of Drugs Act, but not possession.

**A SHORT HISTORY**

**1930s – First developed for medical use and have been used in the treatment of muscle-wasting conditions; promotion of bone growth and anaemia among other conditions.**

**1950s – First appeared in the Olympic Games to enhance performance of field athletes from the Communist Bloc and the USA.**

**1976 – Placed on the Olympic banned list of substances.**

**1980s – 'Out of competition' testing introduced.**

**1988 – Ben Johnson tested positive for steroids after winning the Olympic 100 metres final in Seoul.**

**1996– Supply of anabolic steroids made a Class C drug offence under the Misuse of Drugs Act.**

**2009 – More steroids added to the list.**

## BZP (BENZYLPIPERAZINE)

Common names: Party Pills, Fast Lane, Silver Bullet, Smileys, Happy Pills and many other brand names



### Where does it come from?

BZP (Benzylpiperazine) is a synthetic stimulant derived from piperazine, originally developed as a potential anti-depressant drug. Recreationally, BZP is often seen as an alternative to ecstasy or amphetamine, although usually considered to be less potent than these drugs. BZP pills are marketed under a huge variety of names and the tablets come in many different shapes.

### What does it look like?

It is sold as a tablet, capsule or as an off-white powder.

### How pure is it?

The chemical composition of substances sold as substituted benzylpiperazines are changing all the time.

### How is it used?

BZP can be swallowed in tablets or crushed up and sniffed.

### How many users?

BZP was mentioned in the British Crime Survey for the first time in 2010. Around 185,000 people aged 16–59 reported using the substance in the last year.

### How much does it cost?

Pills were available for £5 to £10 online.

### How much do people use?

Typically, users will take one or two tablets in one session.

### What are the effects?

The use of BZP has similar effects to other synthetic stimulants such as ecstasy or amphetamines. Users report a sense of euphoria and increased alertness, enhanced senses and a raised heart rate. Depending on the dose taken, the effects of the drug can last for up to 6 – 8 hours.

### What are the risks?

It is not clear exactly what the risks are to health as large scale studies have not been carried out, but users report a number of adverse side effects. These include vomiting and nausea, headache, palpitations, anxiety, strange thoughts, mood swings, confusion and tremors. Some of these effects occurred in the comedown period while some were experienced for up to 24 hours after use. There are reports of users not being able to sleep for up to ten hours after taking BZP pills.

More severe adverse effects may include fits and potentially life-threatening seizures.

### How many people have died from using this drug?

Between 2006–08, BZP has been implicated in 16 deaths.

### The law

BZP and related piperazines were brought under the control of the Misuse of Drugs Act 1971 as Class C drugs in December 2009.

### A SHORT HISTORY

**1950s – Early research into potential as anti-worming drugs (veterinarian medicine).**

**1970s – Some research carried out into use as anti-depressants; abandoned because of side effects.**

**Late 1990s – Recreational use took off sharply in New Zealand. Promoted as a safe alternative to methamphetamine which was rife in New Zealand and Australia following a heroin drought.**

**2000s – Began appearing in Europe, marketed (misleadingly) as a safe alternative to ecstasy.**

**2002 – Banned in the USA.**

2006 – Victoria is the last State to ban the drug in Australia.

2008 – Banned in New Zealand.

2009 – Banned in the UK and by now several European countries as well.

## CANNABIS, INCLUDING SYNTHETIC CANNABINOIDS (SPICE)

Common names: Dope, spliff, weed, skunk, puff, hash



### Where does it come from?

Currently about 80% of the cannabis used in this country is commercially home grown in cannabis farms with the rest imported resin from North Africa.

Synthetic cannabinoids are chemicals that mimic the effect of cannabis. These products are most frequently referred to by one of the most common brand names, Spice. Spice and similar products are made up of various herbs mixed with these synthetic cannabinoids. They are bought in head shops or online.

### What does it look like?

A small amount of herbal cannabis looks like a bundle of compressed green leaves. Cannabis resin is sold in small brown lumps that can be crumbled into a joint. Synthetic cannabinoid products may resemble herbal cannabis or they may be more powdery.

### How pure is it?

Forensic evidence suggests that home grown cannabis is about 2½ times stronger than imported resin. There is no forensic evidence that cannabis is frequently cut with other psychoactive drugs. In 2007 however, 'gritweed', cannabis sprayed with tiny glass particles, circulated on drug markets in the UK and Europe. The glass was intended to give the impression of cannabis that was sticky and therefore super strong. Users complained of damage to throat and lungs. Gritweed appears to have largely disappeared now.

### How is it used?

In the UK, cannabis tends to be smoked mixed in with tobacco (in the States, it is more likely to be smoked on its own). Some people smoke through a water pipe (hubble-bubble or bong).

### How many users?

Use of cannabis in the last year among those aged 16–24 stands at just over a million; double that for the whole 16–59 group. Just under ten million 16 to 59 year olds have used it in their lifetimes.

### How much does it cost?

Average prices per quarter ounce of standard quality herbal resin were £31 in 2009. For good quality herbal cannabis the price rose to £40, while for resin cannabis the average price was £21.

**How much do people use?**

Users tend to define their use in terms of money spent or weight bought rather than number of joints or spliffs smoked per day. Anybody spending £100 a week or more and smoking a joint or two every day for months on end would be regarded as a heavy user. An average single buy would be a £10 bag containing about 3.5 grams of cannabis.

**What are the effects?**

Apart from a raised heart rate and feeling hungry ('the munchies'), most effects are psychological. Users can feel 'stoned' – relaxed with a sense of time slowing down and a greater awareness of sounds, colours etc. Some people might not feel any effects at all.

**What are the risks?**

The physical effects of inhaling cannabis can impact the respiratory system, leading to oral, throat, and lung cancer. Psychologically, use of cannabis has been reported to cause anxiety and paranoia in some users, and may in rarer cases be a trigger for underlying mental health problems. Skunk has more psychoactive properties than resin as it contains higher levels of the active chemicals.

There are some suggestions that Spice has the potential to be more potent than natural cannabis.

**How many people have died using this drug?**

Figures from 2009, indicate that cannabis was 'implicated in' the deaths of 26 people, but primarily mixed in with other substances.

**The law**

Cannabis and Spice are Class B drugs. First time possession in England and Wales would probably result in a warning, then a fixed penalty notice of £80. The maximum penalty for possession is five years in prison. There is no warning process in Scotland or Northern Ireland. The maximum penalty for intent to supply is 14 years in prison.

## A SHORT HISTORY

**B.C. – Cited in ancient texts as both a medicine and religious sacrament.**

**19th century – Popular pain reliever in child birth.**

**19th century – Seven volume Indian Hemp Commission report refutes many of the wild claims made about the dangers of the drug.**

**1928 – First controlled in the UK following claims in the League of Nations from Egyptian and South African delegates of its psychoactive properties.**

**1930 – US Federal Bureau of Narcotics established. Director, Harry Anslinger, dominates thinking about cannabis both in the States and internationally for the next thirty years.**

**1960s – Beginning of the movement to reform the cannabis laws.**

**1964 – Allowing premises to be used for the smoking of cannabis banned in the UK.**

**1968 – Forerunner of ACMD concluded that the dangers of the drug did not warrant imprisonment for small amounts. Accused of being 'over-influenced' by the 'lobby for legalisation' by then Home Secretary Jim Callaghan.**

**1971 – Cannabis made a Class B drug under the Misuse of Drugs Act.**

**1979 – Government rejected ACMD recommendation regrading cannabis to Class C.**

**2000 – Runciman Report recommended regrading to Class C.**

**2004 – Cannabis regraded to Class C, but Class C supply penalties now same as Class B.**

**2009 – Cannabis moved back to Class B.**

## COCAINE AND CRACK

Common names: Coke, charlie, snow, white, C, Percy, toot



### Where does it come from?

Several thousand tons of cocaine are produced annually in Colombia, Bolivia and Peru. The substance will then be trafficked through Panama, Argentina and Brazil before being shipped to the US and Europe via the West Indies and Africa.

### What does it look like?

Cocaine is a white powder, while crack cocaine looks like small white or off coloured lumps.

### How pure is it?

The latest Forensic Science service results show average purity of 26.4% although samples can fall into single figures. Cocaine purity has dropped off considerably over the last decade.

### How is it used?

It is cut into lines and snorted through a rolled up note or a straw. Some people inject. Crack is smoked through a pipe, which might be something as rudimentary as an empty fizzy drink can.

### How many users?

Last year cocaine powder was estimated to have been used by nearly 800,000 people aged 16–59, and 360,000 16–24 year olds. It's estimated that there are around 180,000 dependent users of crack cocaine in England.

### How much does it cost?

The average UK price is £42 per gram for powder cocaine and around £10 for a 0.2g rock of crack cocaine.

### How much do people use?

The typical 'weekend' user might sniff one-quarter gram or so over the weekend while more regular users might consume up to one or two grams a day. Because the effects wear off very quickly, users can get through several grams in a relatively short period of time.

### What are the effects?

Physiological arousal accompanied by exhilaration, feelings of well-being, decreased hunger, indifference to pain and fatigue, and feelings of great physical strength and mental capacity. The effects of cocaine last for 15 to 30 minutes while the effects of crack cocaine last for 5 to 10 minutes.

Large doses or a 'spree' of quickly repeated doses over a period of hours can lead to an extreme state of agitation, anxiety, paranoia, and perhaps hallucination. As with amphetamine psychosis, these effects generally resolve themselves as the drug is eliminated from the body.

### What are the risks?

The after-effects of cocaine use include fatigue and depression. Excessive doses can cause death from respiratory or heart failure. Regular users can quickly develop a psychological dependency. Though there are no known physical withdrawal symptoms, there are suggestions that stopping use can cause sleeplessness, hunger and depression.

High doses can result in increased body temperature, extreme agitation, convulsions and respiratory arrest. The risk of overdose risk is increased if cocaine is mixed with other drugs such as heroin or depressants such as barbiturates and alcohol.

### How many people have died using this drug?

Figures for 2009 reveal that cocaine and crack were implicated in 154 deaths, more than any other drug apart from heroin, methadone and similar opiate drugs. Overall, cocaine deaths have been steadily increasing over the years.

### The law

Cocaine and crack are Class A drugs.

## A SHORT HISTORY

**Ancient history** – Coca leaves chewed by indigenous populations in South America to deal with altitude, stave off hunger and for religious/ceremonial purposes.

**19th century** – Cocaine first extracted from coca leaves and developed for use in various patent medicines to deal with breathing problems like asthma and as a tonic. Vin Mariani became a very popular coca wine in Europe. Coca-Cola originally contained about 3% cocaine.

**1916** – Exaggerated claims that soldiers on leave were being sold cocaine by London prostitutes led to control of the drug under the Defence of the Realm Act.

**1920** – Non-medical use and supply of cocaine controlled under the Dangerous Drugs Act, but cocaine could still be prescribed by doctors to those with a habit (mainly middle class professionals).

**1920s** – Cocaine use prevalent among London's 'well-to-do' at mass parties reminiscent of the rave scene some sixty years later.

**1930s–1960s** – As medical use of cocaine disappeared (apart from some uses as an anaesthetic in dentistry) and amphetamine became the recreational stimulant of choice, cocaine supplies dried up.

**1968** – UK GPs prevented from prescribing cocaine unless they had a licence from the Home Office.

**1960s–1970s** – Cocaine reappeared as an expensive drug of choice for the rich and famous in the USA.

**1980s** – Use of cocaine became symbolic of the 'loads o' money' culture of the City of London. Crack first appeared in the UK, prompting an ex-US drug enforcement officer to predict the collapse of British society inside two years.

**1990s** – The break-up of large Colombian drug cartels created many more smaller operations seeking new markets outside the USA. Europe became a target via the link with Spain

and Portugal. Use of cocaine rose dramatically in the late 1990s–early 00s as the price fell.

**2010** – From being regarded as a 'hard drug' in the 1980s, cocaine use regarded as just another drug on the scene with ecstasy, amphetamine and other recreational drugs. Price and purity remain low. Over that time crack established itself as one of the main problem drugs in the UK alongside heroin.

## EGSTASY

Common names: E, MDMA, pills, brownies, Mitsubishis, XTC, Dolphins

*Ecstasy tablets are sometimes known by the logo that appears on them such as love hearts, superman, Ferrari, though these can change quite frequently.*

**Where does it come from?**

MDMA, the active drug in ecstasy, is produced in underground labs, particularly in Holland, but also in parts of Eastern Europe. Large quantities also appear to be produced in Asia, especially in India and Thailand.

**What does it look like?**

Ecstasy is usually in the form of pills which can take various shapes and colours, often stamped with motifs such as a smiley face, heart

or Armani and Mercedes logo. An off-white crystalline powder form of MDMA has become increasingly prominent over the last decade.

### **How pure is it?**

The amount of MDMA in ecstasy tablets has been falling for some time, while the street level purity of the powder form was 58.5% according to the most recent Forensic Science Service data.

### **How is it used?**

Ecstasy tablets are usually taken orally, but may also be crushed up and sniffed, and even sprinkled into joints and smoked. MDMA can be dabbed onto the gums or tongue, or taken orally, known as 'bombing', by wrapping up the powder in cigarette paper. Some users might also sniff the powder.

### **How many users?**

The British Crime Survey report decline in the use of the drug since the early 2000s, although it is possible that respondents to the Survey are only responding to questions about ecstasy *tablets* or *pills* rather than ecstasy in general – and if assertions that use of ecstasy powder is increasing are correct, then the BCS figures might be skewed in this respect.

The BCS 2010 reports 517,000 16–59 year olds and 283,000 16–24 year olds have taken the substance in the past year.

### **How much does it cost?**

Ecstasy is sold in a wide variety of tablets of differing shape and colour for around £2-£3 each. Prices often vary in different localities.

### **How much do people use?**

Users will often take one or two tablets at a dance event, though more experienced users may take five or more.

### **What are the effects?**

A mild euphoric 'rush' followed by feelings of serenity and calmness and the dissipation of anger and hostility. Ecstasy appears to stimulate empathy between users, but there is no conclusive proof that ecstasy is an aphrodisiac. It tends to enhance the sensual experience of sex rather than stimulate the desire for sexual activity or increase sexual excitement.

### **What are the risks?**

Ecstasy affects the body's temperature control mechanism and can cause an increase in body temperature to dangerously high levels in rare cases. The cumulative effects of high ambient temperatures at a dance venue, coupled with dehydration due to dancing, means there is potential for a "double heat-stroke". The drug can cause the release of Anti-Diuretic Hormone (ADH) that prevents the production of dilute urine. Excessive drinking causes water build up inside the body cells which can be very dangerous.

### **How many people have died using this drug?**

Figures for 2009 indicate that ecstasy and ecstasy-type drugs were implicated in the deaths of 8 people. For 2 of those 8 people, no other drugs were involved.

The first ecstasy death was recorded in 1989 and since then, there have been over 300 deaths. One of the most widely reported drug deaths occurred in 1995 when Leah Betts died from the effects of water intoxication, believing that drinking lots of water would protect her from the possible side effects of ecstasy.

### **The law**

Ecstasy is a Class A drug.

### A SHORT HISTORY

.....  
**1912 – MDMA originally synthesised by the German pharmaceutical company Merck as a possible slimming aid, but never developed.**  
 .....

.....  
**1965 – Alexander Shulgin, a research chemist working for DOW Chemicals in the States 'rediscovered' MDMA and through trying the drug himself discovered its property of promoting 'empathy' in users.**  
 .....

.....  
**1970s-1985 – Had limited use in psychotherapy in the USA , for example, as a marital aid where a hostile couple would be given a dose under medical supervision before the therapy session began.**  
 .....

.....  
**1977 – Drug controlled as Class A under the Misuse of Drugs Act after some MDMA was discovered during a raid on an amphetamine lab in the Midlands.**  
 .....

1985 – Unsubstantiated claims of the drug's adverse effects on rats caused the drug to be banned in the USA. By then it was appearing on the streets in the USA as a drug for 'self exploration' much as LSD had been used in the 1960s. In 1985 the first article on ecstasy appeared in the UK press.

1985–95 – Starting with use among British partygoers one summer on the Balearic island of Ibiza, ecstasy comes to the UK in the mid 1980s. It helps fuel the rave scene which gains in popularity over the next decade. But alongside the smiley faces come ecstasy-related deaths which began in 1989. However, it was the death of Leah Betts in 1995 which captured media, political and popular attention.

1995 onwards – As the rave/clubbing scene became more mainstream, use of MDMA appears to peak and level out.

2000s – The price and quality of the tablets falls while some users begin to switch to MDMA powder. The drug retains a significant presence on the drug scene.

## GHB AND GBL

Common names: GBH, liquid ecstasy



### Where does it come from?

GHB is manufactured by legitimate companies, but also produced illegally from basic chemicals.

### What does it look like?

Both GHB and GBL are usually sold as an odourless liquid in small bottles or capsules (GHB does come in powder form but is rarer). It tastes slightly salty. GBL is a colourless, oily liquid with a weak odour. It is a common solvent used in products like paint strippers and stain removers.

### How pure is it?

Not known to be contaminated.

### How is it used?

The drug is mainly taken by mouth, although some, mainly dependent users, inject it.

### How many users?

None of the large UK surveys yet include GHB/GBL in their enquiries. Use appears to be restricted to dance events as well as used experimentally by young people. Preliminary findings in the British Crime Survey estimate that around 37,000 people have tried these substances at least once.

### How much does it cost?

Prices have been reported at around £5 for a capful of liquid and £10–£15 a bottle, although prices per capful can be much lower.

### How much do people use?

Some consider a dose to be a 15ml tablespoon. Elsewhere, it has been written that the customary dose is 5ml – a teaspoon. Doses are also measured out as capfuls, an indeterminate quantity in roughly the same range. Adding to the confusion is the fact that there is no telling how concentrated the liquid is, or whether it is actually GHB, and not GBL. Once in the body, GBL converts to GHB.

### What are the effects?

Users take the drug for its euphoric and sedative effects rather than as a stimulant which aids dancing – an alternative to getting drunk on alcohol rather than a dance/partying drug.

### What are the risks?

Like with other barbiturates, there is a fine line between the amount that is required to achieve the desired effect and that which will lead to coma. Even experienced users are at risk from death by intoxication. The consequences of long term use are unknown.

There is evidence that taking these drugs with alcohol or other sedative drugs adds to the risk of harm. But it is also clear that GHB and GBL can cause death when taken alone. Because GHB and GBL can really knock you out, they have been linked to drug-assisted sexual assault.

There is increasing evidence of a significant risk of physical dependence among regular and heavy users of these drugs. One hospital in South London has established the first specialist clinic to treat people with a dependency on GHB and GBL. Physical withdrawal symptoms are similar to those seen in those withdrawing from heavy alcohol use and withdrawal can be dangerous if carried out without medical supervision.

### How many people have died from using this drug?

In 2009, GHB/GBL was implicated in 21 deaths.

### The law

GHB and GBL are both controlled under the Misuse of Drugs Act as Class C drugs.

### A SHORT HISTORY

**1960s–1980s – Widely used in the States, France and Italy to aid sleep and also as an anaesthetic in childbirth, but use discontinued because of concerns over addiction and the development of safer drugs.**

**1990s – Gained in popularity as a drug on the rave scene and among bodybuilders due to its ability to promote ‘slow wave sleep’ in which growth hormone is secreted. Begins to be implicated in drug-assisted sexual assaults.**

**2003 – GHB controlled as a Class C drug**

**2007–08 – Reports of deaths from use of GBL in south London**

**2009 – In April, the death of Brighton student Hester Stewart directly linked to GBL. Drug controlled as a Class C drug in December.**

## HEROIN

**Common names: Brown, skag, H, horse, gear, smack**



### Where does it come from?

Nearly 90% of global and UK heroin comes from Afghanistan and Pakistan. The Netherlands imports and then exports a lot of the heroin into the UK, mainly to London and the South-East.

### What does it look like?

Street heroin is a poor cousin of ‘medical heroin’ or diamorphine. Street heroin is usually a brown powder instead of the pure white, indicating its crude beginning as opium paste.

### How pure is it?

Starting from upwards of 95% purity in the country of origin, street heroin is typically mixed or cut with various adulterants. The latest Forensic Science Service report indicates average purity of 35.6% in the period April-June 2010.

### How is it used?

Heroin is synonymous with intravenous use, and the common image is of a user cooking up and injecting the substance. However, intravenous users make up only 28% of those entering treatment. The majority smoke heroin, heating the powder on tin foil and inhaling the substance through a small tube, a practice known as ‘chasing the dragon’. Heroin can also be sniffed like cocaine.

### How many users?

As a household survey, the British Crime Survey doesn’t really give us a good indication of how many people use heroin, so the

Home Office commissions other research instead. The most recent research suggests that there are around 273,000 people who use heroin dependently in England.

#### **How much does it cost?**

Heroin is currently selling for around £45 per gram. One-quarter gram bags currently retail at around £20 to £25, down to £5 and £10 bags containing smaller quantities.

#### **How much do people use?**

Someone dependent on heroin might use one-quarter to a half gram each day.

#### **What are the effects?**

A large proportion of people report drowsiness, warmth, wellbeing and contentment. Opiates induce relaxed detachment from pain, anxiety and from desires for food and sex, while the individual remains fully aware. For many people, this detachment is very pleasurable. Along with or instead of these reactions, first use (especially injection) is often accompanied by nausea and vomiting.

#### **What are the risks?**

With the uncertain composition and purity of street heroin, adverse reactions are an ever-present possibility. Increasing numbers of people are overdosing on prescribed methadone, including when methadone is used on top of street heroin.

#### **How many people have died using this drug?**

In 2009 around 1,000 deaths were attributed to heroin with a further 230 deaths from methadone although some of these would have involved both drugs.

#### **The law**

Heroin is a Class A drug under the Misuse of Drugs Act 1971. Possessing it can lead to a prison sentence of up to 7 years and an unlimited fine. Supplying (which includes giving it to a friend) could lead to a life sentence and another unlimited fine.

#### A SHORT HISTORY

19th century – Opium was already in use as a painkiller in the form of laudanum (opium dissolved in alcohol). In the mid 19th century, morphine was extracted from opium and introduced onto the market. Then heroin was synthesised from morphine – and actually promoted as a ‘cure’ for morphine addiction! The name ‘heroin’ came from the German for ‘heroic’ as the drug was (and still is) the world’s most powerful painkiller.

1920 – Non-medical opium, morphine and heroin use and supply controlled under the Dangerous Drugs Act.

1920–60 – Most morphine and heroin users were middle-class, middle-aged women who had become addicted through GP prescriptions for medical conditions.

1960–70 – Beginnings of non-medical heroin use among young people of all classes, but numbers still small.

1968 – Due to concerns about over-prescribing by some GPs, doctors banned from prescribing to users unless in possession of a Home Office license.

1980s – Numbers of users rose dramatically when smokeable heroin was introduced from the Middle East. This coincided with significant economic problems and unemployment, pushing drug policy right up the political agenda. ‘Heroin Screws You Up’ was the first UK anti-drug campaign. The link between HIV/AIDS and injecting drug use resulted in the development of the first needle exchange schemes, under Margaret Thatcher’s government. The 1980s also saw the increasing use of methadone as a way of controlling the spread of blood-borne viruses.

1990s – Whereas Burma, Laos and Thailand (The Golden Triangle) had supplied much of the UK heroin market, production shifted towards Afghanistan which now supplies over 90% of UK heroin.

2000 – Price and quality have fallen over past decade with no let-up in supply, but the heroin using population appears to be both stabilising and ageing.

## KETAMINE

Common names: K, Special K, Super K, Vitamin K, ket



### Where does it come from?

Some street ketamine, which is usually a powder, comes from licit sources or is imported illegally from the Far East. Pharmaceutical ketamine is usually liquid, so street ketamine is derived by heating the liquid to evaporate the water, leaving a crystalline powder.

### What does it look like?

In street use, ketamine is most commonly encountered as a crystal powder or in tablet form.

### How pure is it?

Legally produced ketamine will be pure. Illegally produced tablets and powder are commonly found with ephedrine added.

### How is it used?

Users might inject ketamine in its liquefied pharmaceutical form. Tablets are taken orally, while powders are snorted up the nose.

### How many users?

An estimated 113,000 16–24 year olds and 159,000 16–59 year olds reported using ketamine in the last year, according to the 2009/10 British Crime Survey.

### How much does it cost?

Ketamine costs approximately £20 per gram.

### How much do people use?

Typically the normal dose for snorting would be around 60–100mg. Used intravenously, or intramuscularly, a sub-anaesthetic dose would be around 1–2mg of body weight.

### What are the effects?

Ketamine is a complex drug. It is a disassociative anaesthetic, meaning users feel detached from themselves and their immediate surroundings. The drug also has painkilling, stimulant and psychedelic effects. Ketamine effects typically take up to 20 minutes to come on if taken orally, though some are almost immediate, 30 seconds or so, if injected. Reported physical effects include an initial cocaine-like rush, vomiting and nausea, slurring of speech and vision, numbness, irregular muscle coordination and muscle rigidity. Psychological effects come on and recede faster than LSD, though the effects can be similar, including synaesthesia, or 'seeing' sounds and 'hearing' colours, euphoria, de-personalisation, confusion, plus powerful dissociative or out-of-body-sensations.

### What are the risks?

Users may feel numb, uncoordinated and nauseous for a few hours after the most intense effects wear off. Ketamine is especially dangerous when mixed with ecstasy or amphetamines and can result in high blood pressure. High doses can dangerously suppress breathing and heart function and can lead to unconsciousness. There have also been more recent reports in medical literature that suggest ketamine can cause serious damage to the urinary tract, with some regular or heavy users experiencing irreversible damage to their bladder.

### How many people have died from using this drug?

23 deaths were identified between 1993 and 2006 where ketamine was mentioned either on the death certificate or in the coroners' report. In 4 of these deaths, ketamine was the only drug present in the user's body. These deaths were most likely due to the increased risk of accident due to the disassociative effects of the drug.

### The law

Ketamine is a Class C drug under the Misuse of Drugs Act.

## A SHORT HISTORY

1962 – Developed by Parke-Davis in the USA as a safer alternative anaesthetic to PCP (later known on the streets as Angel Dust).

1967 – Became a street drug in the USA known as Green or Special K.

1960s–1970s – Used as a battlefield anaesthetic in the Vietnam War. Widely used in veterinary medicine. Also used in psychiatry and for academic research into altered states of consciousness.

1978 – Two landmark books published recounting experiments with ketamine. One author, John Lilly, injected ketamine daily for many years – but lived until he was 86. The other, Marcia Moore, disappeared in 1979 after injecting herself with ketamine and was found dead two years later in a forest near her home.

1990s – Became increasingly popular on the UK rave scene.

2006 – Controlled as a Class C drug.

## KHAT

Common names: Quat, qat, qaadka, chat

**Where does it come from?**

The plant is imported into the UK from Africa and the Arabian Peninsula. Although there are several varieties of the plant, two are generally available, including Miraa, chiefly from Kenya, and Harari from Ethiopia. The plant can be purchased at some specialist health food shops, markets and in a number of head shops.

**What does it look like?**

The plant is imported as fresh leaves or sometimes as twigs.

**How pure is it?**

Because khat comes in recognisable leaf form, it can't be cut with anything. There are two active chemicals in the plant: cathinone and cathine. Both are chemically related to amphetamines. The concentration of cathinone in the fresh leaves ranges from 0.3 to 2.1%, depending on the origin and variety of the plant. Cathine concentrations range from 0.7 to 2.7%.

**How is it used?**

Khat is a leaf that is chewed over a number of hours.

**How many users?**

Use of khat is mainly limited to certain communities living in the UK, notably groups from Ethiopia and the Arabian peninsula. Khat appeared for the first time in the 2009 British Crime Survey, with just over 70,000 16–59 year olds saying they have tried it and just over 40,000 of 16–24 year olds.

**How much does it cost?**

Prices vary, but a small bundle of leaves weighing two to three ounces will cost roughly £4.

**How much do people use?**

Users will chew a 'hit', or a small bunch of leaves.

**What are the effects?**

Khat is predominantly stimulant in effect. A typical khat chewing session is said to be the equivalent of ingesting a moderate 5mg dose of amphetamine sulphate. Following mild euphoria and talkativeness, users have often reported calming effects. Khat can also suppress the appetite.

**What are the risks?**

As it is chewed, inflammation of the mouth and other parts of the oral cavity, with secondary infections, is common in khat users. Long term effects can lead to other health problems, including heart disease and loss of sex drive in men. Certain groups are also more at risk from oral cancer, while excessive use has also been known to bring on psychological problems such as depression, anxiety and irritation, in some cases leading to psychosis.

**How many people have died from using this drug?**

Researchers have identified a total of 13 deaths since 2004 in which khat was implicated. These include related events like impaired judgement leading to road accidents, as well more direct medical effects such as liver and heart failure.

**The law**

The khat plant itself is not controlled under the Misuse of Drugs Act, but the active ingredients, cathinone and cathine, are Class C drugs. In October 2010, the government called on the Advisory Council on the Misuse of Drugs to review the status of the drug.

**A SHORT HISTORY**

**Ancient history – khat or Qat smoked from the time of Ancient Egypt. Use spread to Arabian Peninsula and other countries of Africa, especially Yemen and Somalia.**

**2000s – Now a major cash crop in Yemen. Due to increased migration, Somali communities have established themselves around the world. In response to the use of khat among these**

communities, some countries have banned the use of khat, including France, Norway, Poland and the USA. In the UK and some other countries, the active ingredients, cathinone and cathine have been controlled.

**LSD**

Common names: Acid, trips, lucy

**Where does it come from?**

LSD is derived from ergot, a fungus found growing wild on rye and other grasses. First synthesised in 1938, it is now mainly produced in underground labs in both the UK and abroad, particularly in Belgium and the Netherlands.

**What does it look like?**

A liquid soaked into blotting paper, often sold in strips.

**How pure is it?**

It is rare to come across acid that is impure.

**How is it used?**

Tabs are normally dissolved on the tongue. It can be absorbed through the skin, especially if a person is sweaty.

**How many users?**

LSD is an increasingly rare sight in the UK. According to the 2009/10 British Crime Survey, an estimated 36,000 16 to 24 year olds and 60,000 16–59 year olds were reported to have used the

drug in the last year. Levels of use have remained low and hardly changed since the mid-1990s.

### **How much does it cost?**

Prices vary in different regions, but LSD can usually be bought for between £1 and £5 a tab.

### **How much do people use?**

Typically one or two tabs, but experienced users may choose to take more.

### **What are the effects?**

A trip can take between 20 minutes and an hour to start but can last up to 12 hours, with the effect typically peaking after two to six hours. Experiences can vary, with users reporting visual effects such as intensified colours, distorted shapes and sizes and movement in stationary objects. Users may also feel as though time is speeding up and slowing down. True hallucinations are relatively rare. Trips can have an intense effect upon the psychological and emotional reactions of a user, including heightened self-awareness and even out of body experiences.

### **What are the risks?**

Trip effects are often determined by a person's imagination and state of mind. Unpleasant reactions are more likely if the user is unstable, anxious, or depressed. If panic sets in, the experience can be confusing and even frightening. Flashbacks have been known to occur where part of a trip is subsequently relived after the original experience. Adverse psychological effects can sometimes occur, especially for more regular users. There is some evidence of LSD triggering underlying mental health problems.

### **How many people have died from using this drug?**

No figures are available on deaths from LSD use.

### **The law**

LSD is a Class A drug.

### A SHORT HISTORY

1938 – A Swiss chemist Albert Hoffman, working for Sandoz, began synthesising a compound called LSD. The war stopped the work.

1943 – Hoffman resumed his work with LSD. Cycling home one day, he had strange experiences, which carried on at home. He realised this was the effect of the drug.

1940s-1950s – Psychiatrists started using the drug to treat those with various mental health problems. LSD was one of the drugs used by the US military searching for a 'truth drug' in the Cold War.

1960s – The drug was championed by leading lights of the American counter-culture, notably Timothy Leary, as a way of exploring an alternative reality to that of 'the Establishment'. Scare stories about the drug appeared in the US media – similar to the 'reefer madness' stories of the 1930s. However, there would be some notable 'acid casualties', such as Syd Barratt of Pink Floyd.

1966 – LSD banned in the USA and UK.

1970s – The UK was home to one of the world's most significant LSD labs until Operation Julie (1977) ended LSD production in the UK.

1980s – LSD made something of a comeback during the early days of the rave scene.

1990s–2000s – Use in decline as recreational drug users adopt ecstasy, magic mushrooms and later the growing range of 'legal highs'.

## MAGIC MUSHROOMS

Common names: Liberties, magics, mushies, liberty cap, shrooms, Amani, agaric



### Where do they come from?

Mushrooms can be found growing wild in most parts of the UK, in moist, often dark areas, usually in fields or near trees. They grow in autumn, with parts of Wales, and northern England and Scotland yielding large crops during this period. A number of varieties, such as *Cubensis Mexicana*, are not native to the UK or Europe but are available in some speciality shops in countries such as Holland or over the internet.

### What do they look like?

Small and tan-coloured, they bruise blue when they're touched. *Amanita Muscaria*, or fly agaric, mushrooms are red and white spotted toadstools. However, distinguishing magic mushrooms from their poisonous and sometimes deadly cousins is a complex skill and not to be undertaken lightly.

### How pure are they?

Mushrooms are not dealt with on the black market to any great extent, but the purity will depend on the freshness, variety and regional variation. The main problem with purity is ensuring that the right mushroom has been picked. Picking the wrong one can be lethal.

### How are they used?

After picking, they're often eaten raw or are dried out and stored. The fly agaric mushrooms tend not to be consumed raw as they

can cause severe nausea. Mushrooms can also be filtered and brewed in a tea.

### How many users?

According to the 2009/2010 British Crime Survey, an estimated 83,000 16–24 year olds and 132,000 16–59 year olds have taken magic mushrooms in the last year.

### How much does it cost?

Indications show that quantities of around 30 mushrooms sell for around £5 a bag. These prices are merely indicative and do not represent a recognised street price.

### How much do people use?

Most people take between 1–5 grams per use.

### What are the effects?

The effects of psilocybin-containing mushrooms are similar to a mild LSD experience. As with LSD, the experience is extremely variable and can also be strongly influenced by the user's mood, environment and intentions. Variability also arises from differences in potency among mushrooms and methods of preparation.

Users often have feelings of nausea, and can experience vomiting and stomach pains. The effects of Fly Agaric are similarly hallucinogenic, albeit more intense and introspective.

Fly Agarics are associated more with drowsiness followed by a stimulation of the senses.

### What are the risks?

Potential dangers arise from the possibility of picking poisonous species by mistake. Eating varieties such as *Amanita phalloides* or *Amanita virosa* can be fatal, even when in small amounts. In contrast, it would take large amounts of Liberty Cap or Fly Agaric mushrooms to cause a fatal overdose.

There are no significant withdrawal symptoms and no physical dependence, though individuals may become psychologically attached and feel a desire to repeat their experiences. 'Bad trips' characterised by deep fear and anxiety can occur, especially in high doses, and may develop into a psychotic episode.

### How many have died from using these?

No figures are available relating to deaths from magic mushrooms.

**The law**

Under the Drugs Act 2005, the possession and sale of raw, unprocessed fresh psilocybin mushrooms is now a Class A offence.

## A SHORT HISTORY

**Ancient history** – magic mushrooms have a long history of use for religious and ceremonial purposes in the Americas and across northern Europe and Russia.

1957 – R. Gordon Wasson, a vice-president of JP Morgan Bank and his wife, both passionate students of mushroom cultures (ethnomycologists) published a landmark study called *Mushrooms, Russia and History*. Wasson and his wife were also the first westerners to take part in the Mexican Mazatec indian mushroom ritual.

1967 – Wasson published *Soma: divine mushroom of immortality* based on studies of use of Fly Agaric mushrooms in Indian sub-continent culture.

1971 – Psilocybin, the active ingredient in magic mushrooms is controlled as a Class A drug under the Misuse of Drugs Act, but it is not illegal to possess or eat the mushrooms raw.

1978 – Wasson turned his attention to use of ceremonial hallucinogens in Ancient Greece with *The Road to Eleusis: Unveiling the Secret of the Mysteries*.

1979 – Another landmark book published on hallucinogenic plants including mushrooms: *Plants of the Gods* by Richard Schultes and Albert Hoffman, who discovered LSD.

2005 – Under the Drugs Act, it became illegal to possess psilocybin mushrooms, but not Fly Agaric or other non-psilocybin varieties.

**METHAMPHETAMINE**

Common names: crystal meth, meth, ice, tweak, glass, crank, Tina, Christine, yaba, Hillbilly crack

**Where does it come from?**

Methamphetamine is manufactured in underground 'meth labs' because the drug is relatively cheap and easy to make. However, methods may involve inflammable chemicals and the release of toxic fumes, meaning the manufacturing process can be very dangerous. The chemicals needed to manufacture the drug (e.g. ephedrine, red phosphorous and iodine) are readily available.

**What does it look like?**

The substance can come in a number of forms, as an off-colour white, yellow or pink crystalline powder, as a clear liquid, in ampoules (a small sealed vial) or small white chips known as ice.

**How pure is it?**

As with most amphetamine-based drugs that are manufactured illicitly, purity is questionable, though information on methamphetamine purity is limited in the UK.

**How is it used?**

Taken orally, snorted, injected or smoked.

**How many users?**

Thirteen thousand 16–24 year olds and a further 3,000 25–59 year olds reported using the substance last year, although most heavy and regular use is still confined to the gay club scene.

**How much does it cost?**

Methamphetamine sells for anything between £35 and £75 a gram.

**How much do people use?**

No reliable data on this for the UK, but likely that a heavy user is likely to consume several grams over the course of 'a run' lasting a few days.

**What are the effects?**

Methamphetamine is to amphetamine as crack cocaine is to cocaine. So the physiological and psychological effects of smoking crystal meth are similar to those experienced by people using amphetamine powder, only significantly magnified. Users can feel exhilarated, with effects increasing arousal and activity levels, including desires for sex. The intense rush from smoking methamphetamine can last between 4 and 12 hours.

**What are the risks?**

It's not only the effects that are amplified but the dangers with methamphetamine. They include a rapid rise in heart rate and blood pressure, putting a massive strain on the cardiac system. The higher the dose, the more potent the effects. Users may also experience intense agitation, paranoia, confusion and may act violently, particularly in response to perceived threats while experiencing paranoia. Psychosis has been widely reported in areas with large numbers of users. In cases of overdose, stroke, lung, kidney and gastrointestinal damage, coma and death are all real risks.

**How many people have died from using this drug?**

In the UK there are no figures available relating to deaths links to methamphetamine use.

**The law**

Methamphetamine was reclassified as a Class A drug on 18th January 2007.

## A SHORT HISTORY

1893 – First synthesised in Japan from ephedrine.

1940s – Approved for use in the USA for various conditions including narcolepsy and depression. It was rumoured that Hitler received daily injections and the drug was widely used among the Axis and Allied forces to fight battle fatigue and to 'psych' soldiers up for fighting. Major addiction problems in Japan resulted in a ban in 1951.

1960s – American biker gangs began illicit manufacture and trading in amphetamine and methamphetamine.

1968 – Following the UK ban on GPs prescribing heroin or cocaine to users without a license, there was a brief spate of injecting methamphetamine use in London.

1990s – New wave of illicit methamphetamine production in the States and in Far East Asia. This is ice/crystal meth in the States (smoked like crack cocaine) or yabba (a red pill smoked at the end of a cigarette) in the Far East.

2000s – Some methamphetamine production and use in the UK, largely confined to a section of the gay clubbing scene.

2007 – Methamphetamine reclassified to Class A in the UK.

## MEPHEDRONE AND OTHER CATHINONES

Common names: Meph, MC, MCAT, m-cat, 4-MMC, Miaow, Meow Meow, Bubbles, Bounce, Charge, Drone, White Magic, Ivory Wave



### Where does it come from?

Prior to their classification under the Misuse of Drugs Act, the cathinones could be bought legally on the internet or in head shops. Websites and shops advertised the products as 'plant food' and 'not for human consumption' as a way of trying to avoid prosecution under medicines, poisons and consumer laws.

### What does it look like?

Mephedrone and most cathinones are white, off-white or yellowish powders.

### How pure is it?

It is hard to tell what you are buying. Products labelled as one thing may contain something entirely different. What you may think is mephedrone might sometimes be mixed with other cathinones and caffeine.

### How is it used?

While it is usually snorted, it can also be swallowed in bombs (wraps of paper) and may also appear in pill or capsule form.

### How many users?

With its relatively recent and sudden emergence, levels of prevalence are not currently known.

### How much does it cost?

Prior to the drug's classification, mephedrone was mainly sold in bags containing a gram of the drug that retailed for between £10 and £15. There may have been changes to the average price since the drug's classification.

### How much do people use?

Users will typically use between a half a gram and a gram.

### What are the effects?

With little clinical literature of the effects, reporting relies upon anecdotal evidence from users. Many people who have used mephedrone and similar drugs report that their experiences are similar to taking amphetamines, ecstasy or cocaine, producing a sense of euphoria and wellbeing, with users becoming more alert, confident and talkative.

### What are the risks?

People who snort these substances can experience extremely sore nasal passages, throats and mouths, with burns or cuts caused by the chemicals sometimes leading to nose bleeds. The substance has an effect on the heart, with users reporting heart palpitations (an irregular or racing heart beat). As with other stimulants, the substances tend to act as appetite suppressants. Nausea and vomiting has been reported, particularly if mixed with other drugs such as alcohol or cannabis.

### How many have died from using this drug?

While mephedrone has been implicated in several deaths in the UK, currently there are very few, probably only 1 or 2, where mephedrone was the only drug to be identified. Other deaths may have involved use of this drug in combination with other stimulants.

### The law

All cathinone derivatives, including mephedrone, methyldone, methedrone and MDPV are Class B drugs under the Misuse of Drugs Act 1971 from April 2010.

## METHADONE

Common names: Mixture, meth, linctus, physeptone



### Where does it come from?

Methadone is one of a number of synthetic opiates with similar effects to heroin manufactured for medical use.

### What does it look like?

Prescription methadone is usually a liquid that is swallowed, but can also come in tablet or injectable form.

### How pure is it?

Prescribed methadone is subject to stringent controls, so is unlikely to have been tampered with.

### How is it used?

Methadone is primarily used as a medication, to help people who are dependent on opiates (usually heroin) manage their withdrawal symptoms. There is also some recreational use of methadone.

### How many users?

13,000 16–24 year olds and 32,000 16–59 year olds are estimated to have taken methadone in the last year.

### How much does it cost?

The street cost of methadone is around £1 per 10ml.

### What are the effects?

Pure opiates in moderate doses produce a range of generally mild physical effects, apart from analgesia, and a number of these have

medical applications. Like sedatives they depress nervous system activity, including reflex functions such as coughing, respiration and heart rate. They also dilate blood vessels (giving a feeling of warmth) and depress bowel activity, resulting in constipation.

### What are the risks?

Methadone users can become constipated. On high doses users are at risk of falling into a coma or stopping breathing. Withdrawal symptoms are slower to develop than with heroin, but last longer. Flu-like symptoms appear up to 2 days after last dose, peak after 5–6 days and fade after 14 days.

### How many people have died from using this drug?

In 2009, the National Programme on Substance Abuse Deaths report that 56 people died through the effects of methadone alone and the drug contributed to the deaths of a further 282 people. The number of deaths in which methadone is implicated has been rising over recent years.

### The law

Methadone is a Class A drug meaning it is illegal to possess without a prescription, give away or sell.

### A SHORT HISTORY

**1939** – Developed as a synthetic opioid in Germany for use as a painkiller.

**1947** – Introduced into the USA by Eli Lilly.

**1960s** – Research undertaken by Dole and Nyswander at Rockefeller University in New York confirmed that methadone could be used as a treatment for heroin dependency. This changed the view that dependency was ‘a character flaw’ and was in fact a metabolic disease that could be ‘treated’.

**1970s** – Methadone was the primary treatment for heroin dependency in the UK, but doctors began to reduce the time that users were being prescribed the drug.

**1971** – Methadone was controlled as a Class A drug under the Misuse of Drugs Act.

**1980s** – The advent of HIV/AIDS changed treatment practice: the imperative was to stop the spread of disease rather

than get people off drugs. Where appropriate, prescribing methadone over longer periods of time became standard practice, from a public health point of view.

1990s-2000s – Increasing numbers of people coming into treatment saw a corresponding increase in the use of methadone. Methadone treatment remained the treatment of choice in the UK, as recommended by the National Institute of Clinical Excellence (NICE). However it continues to be a controversial treatment; criticisms are voiced that too many people are left on methadone without enough being done to help them become entirely drug-free.

## SOLVENTS

Common names: Thinners, volatile substances



### Where do they come from?

Most solvents are available from a large number of retail outlets and can be found in nearly every household.

### What do they look like?

Solvents come in a variety of forms, including gas lighter refills, aerosols containing hairspray, deodorants and air fresheners, tins or tubes of glue, some paints, thinners and correcting fluids, cleaning fluids, surgical spirit, dry-cleaning fluids and petroleum products.

### How are they used?

Solvents are sniffed from a cloth, a sleeve or a plastic bag. Some users put a plastic bag over their heads and inhale that way. Gas products can be squirted directly into the back of the throat.

### How many users?

Recent studies have found that between 7–10% of secondary school pupils have tried solvents. 21% of 15–16 year olds have tried the substance. 44,000 16–24 year olds and 57,000 16–59 year olds are estimated to have used solvent in the last year.

### How much do they cost?

Butane gas can be purchased for as little as £1.50 to £2. Glues can cost even less.

### What are the effects?

The experience of solvent inhalation is like being very drunk on alcohol. Feelings of dizziness, unreality and euphoria are common, but some users might just feel sick and drowsy. Body functions like breathing and heart rate are depressed, and repeated or deep inhalation can lead to overdosing.

### What are the risks?

Users can experience vomiting and blackouts, and heart problems can kill even those trying the substance for the first time. Squinting the gas down the throat can cause it to swell and restrict breathing. Suffocation can also kill if users inhale with a plastic bag over their head. Long-term use has been shown to damage the brain, liver and kidneys.

### How many people have died from using these substances?

Solvents cause a number of deaths each year in the UK. Figures from St George's Medical School show that in the 5 years between 2003–2007, an average of 52 people died every year. The latest figures, for 2008, show that at 36, the number of deaths was at the lowest in over 25 years. Most deaths occur as a direct result of the toxic effects of the substances on the body (especially butane lighter fuel), rather than indirectly (i.e. through choking on vomit, accidents through being intoxicated, or suffocation).

### The law

Under the Intoxicating Substances (Supply) Act 1985, it is an offence to supply solvents to any person under the age of 18 if the supplier has reason to believe they intend to misuse them. The Cigarette Lighter Refill (Safety) Regulations 1999 makes it illegal to sell butane to anyone under the age of 18. Suppliers in Scotland can be prosecuted for 'recklessly' selling substances to any age group if they suspect they will inhale them.

### A SHORT HISTORY

**1970s – First accounts of solvent sniffing in the UK – mainly glues poured into small bags.**

**1980s – ‘Glue sniffing’ became a major media story usually associated with teenage anti-social behaviour; around two young people a week died from solvent misuse, with the number of deaths peaking in 1990 at 150 in one year.**

**1985 – Intoxicating Substances (Supply) Act passed. Offence for a retailer to sell solvents to anybody under-18 if they have reason to believe that the product will be misused.**

**1999 – The Cigarette Lighter Refill (Safety) Regulations made it an offence to sell lighter fuel to anybody under-18 whatever the intention. Most deaths caused by sniffing lighter fuel.**

**2000s – Young people still dying from solvent misuse, but deaths have been falling; 36 people died in 2008, the lowest number in 25 years.**

## TRANQUILLISERS

**Common name: Benzodiazepines including diazepam (Valium), lorazepam (Ativan), temazepam.**

**Non-benzodiazepines (known as Z drugs) including zolpidem, zopiclone and zopiclone.**

**Jellies, benzos, eggs, norries, rugby balls, vallies, moggies, mazzies, roofies, downers**



### Where do they come from?

There are no known illicit manufactures of benzodiazepines or z-drugs specifically for the recreational market. Those circulating on the illicit market are diverted, either by individuals selling on part or all of their prescribed drugs, or theft from pharmacies, hospitals or wholesalers. There are also increasing numbers of counterfeit products being sold online.

### What does it look like?

Tranquillisers come in the form of a small tablet.

### How pure is it?

Different tranquillisers come in different doses. Typically, tablets are between 1mg and 10mg.

### How is it used?

Usually taken orally, but some users might also crush pills for injecting.

**How many users?**

56,000 16–24 year olds are reported to have taken tranquilisers in the last year, and 145,000 16–59 year olds.

**How much does it cost?**

Prices can vary across different regions, though on average 5mg tablets are sold for around £1 for four.

**How much do people use?**

Typically users will ingest one or two tablets.

**What are the effects?**

Tranquillisers have a sedative effect and work by depressing the nervous system and slowing the body down. They relieve tension and anxiety and make the user feel calm and relaxed. Big doses can make users forgetful and send them to sleep.

**What are the risks?**

Benzodiazepines are highly addictive, with some users reporting withdrawal symptoms in as little as four weeks. These can include headaches, nausea and confusion. Withdrawal from bigger doses can induce panic attacks and fits. Other side effects include short-term memory loss. Injecting crushed tablets is sometimes fatal.

**The law**

Tranquillisers are Class C drugs under the Misuse of Drugs Act.

## A SHORT HISTORY

1850–1960 – Various drugs developed to deal with sleeping disorders, anxiety and depression including chloral hydrate, barbiturates and methaqualone.

1963 – Benzodiazepine tranquilisers developed by Hoffman La Roche as a safer option in overdose and dependency compared to barbiturates. The most famous trade names are Valium, Librium, Ativan.

1970s–80s – Valium was the top selling pharmaceutical drug in the US and increasingly prescribed in the UK.

1980s–90 – Increasing concerns about benzos led to the largest ever class action law suit in the UK against a drug manufacturer involving 14,000 patients and 1,800 law firms. GPs and Health Authorities were also sued. The claim was

that the company withheld information about the addiction potential. The case never reached a verdict because the legal aid money ran out.

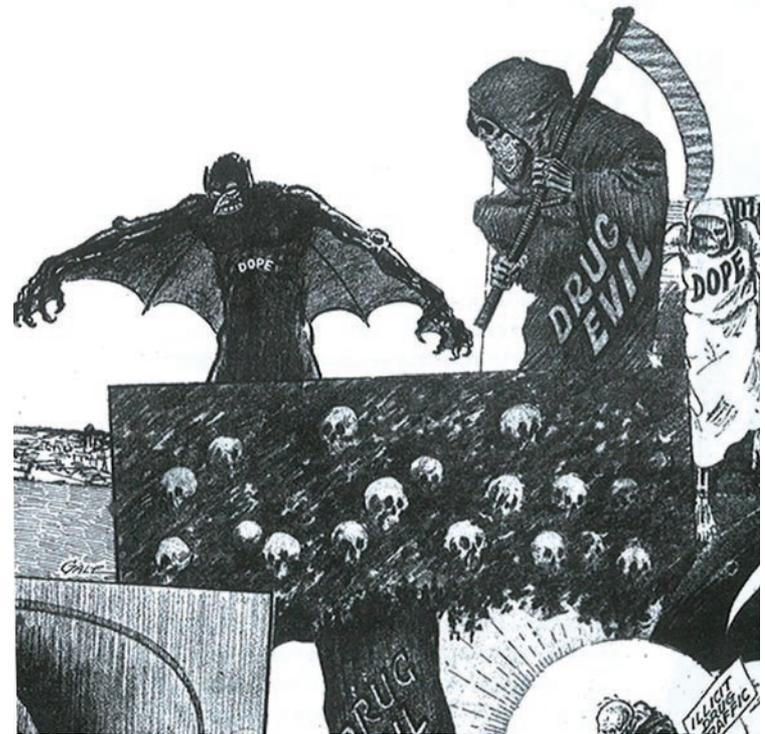
2000s – Numbers of prescriptions falling throughout this period. Non-benzodiazepine drugs like zopiclone, which act in the same way, becoming more popular – although similar concerns about dependency have been raised.

# Reporting on drug use

“At its best the media is an essential public tool, informing drug users and the general public about the harms and risks of drug use, and the nature of drug addiction. At its worst it is demonising and stigmatising of drug users, simplifying complex issues into scaremongering headlines, and stereotyping drug users as ‘evil’ junkies capable of anything to gain their fix. This discourages users from seeking help and adds stigma and shame to an already difficult process of recovery.”

Lord Adebawale, CEO Turning Point

# Reporting on drug use



## **Dope fiends and the demon drink**

Sensational reporting on drugs goes back to the early years of the last century in America and the development of the tabloid press over there. Politicians, social reformers and religious groups were concerned about all kinds of social issues fermenting in the streets of America's rapidly expanding cities – from immigration to issues of 'public morality', such as drinking, prostitution and increasingly drugs. These fears were exploited by William Hearst, the first newspaper 'baron', the Rupert Murdoch of his day and the

model for Orson Welles' Citizen Kane. Hearst instinctively knew that scandal and sensation would sell – and drugs provided the perfect vehicle, pushing every button of a public both fearful and prurient. Drugs were imported from abroad (fear of foreigners); they were mainly used by young people (fear for the future generation) and there were plenty of stories about young white girls drugged into prostitution by inscrutable Chinese criminals.

But there was more; Hearst also knew a picture was worth a thousand words, so he had skilled artists depict the evils of drugs using deeply primeval images of fear and loathing – the Grim Reaper, vampires and other supernatural beings.

During the 19th and early 20th century (and before there were drug laws in place), there were three types of dependent drug user. Middle class patients tended to be dependent on laudanum and morphine prescribed by doctors. Others became dependent on patent medicines which often contained pure morphine and cocaine. While these people were thought to have a 'moral weakness', they weren't vilified as evil. This was reserved for the third category of user: the recreational user, who apparently became dependent through choice. It is this group which have become enshrined in the popular imagination as 'junkies' and 'dope fiends.'

### **Impact on users and families**

The world is shaped by the language we use. Consider the confining impact of a word like 'junkie'. The person is dismissed, written off, blurred into a stereotype of defining a person by their action rather than who they are. It is perhaps inevitable that words like this are used as a shorthand, an easy term of reference which is readily understandable. But it also stops thought and exploration and boxes the person into a corner. And, to use that supernatural imagery again, the result is that ordinary people are demonised. It is true that if somebody has serious drug problems, then much of their daily life will focus around using and buying drugs – and obtaining sufficient funds. But that isn't the sum total of who and what they are as people.

The best outcome for everybody in society is for those with drug problems to get into treatment and ultimately recover to find their way back into society – or maybe into society for the first time.

How much harder do you think it is to come forward for treatment, maybe make that first visit to the GP to ask for help, if you think that you will be judged as a bad person?

It is especially hard for many people who experience drug problems. It is likely that many will already suffer from extremely low self-esteem. This may be due to abuse suffered as a child, the failure of personal relationships or the effect of long-term, untreated mental health problems. They may honestly believe that they are bad and worthless individuals. So to read about junkies and dope fiends reinforces the feeling they have about themselves and many believe they deserve the label and everything it implies.

Yet if you talk to those who have recovered, whatever treatment route they took, they all say that it was the dignity and respect they received from someone else –perhaps a certain special drug worker, a GP or a friend or family member – that made all the difference. Emotionally, people might think they deserve to be labelled, but what they actually need is some recognition of the human being underneath.

Labelling people as junkies or crackheads also has a devastating impact on families who have to face what they feel is the shame and humiliation of having a drug user in their midst. In February 2009, DrugScope and ICM conducted a poll that revealed that one in five people have experience of drug dependency, either personally or in their circle of friends or family. One in five people either have personal experience of drug dependency or are the relative or friend of someone who has. It suits some parts of the media to portray drug users as out in the margins, inhabiting some twilight zone, whereas they are part of the community just like everybody else.

### **Impact on public opinion**

There is an old argument that the media simply reflect what people think already – which is why people tend to only read the papers that chime with their political views. Others think that media is hugely influential in determining what we think about a whole range of issues outside our immediate experience: ironically, media academics have used the image of the hypodermic syringe to suggest that media inject news and comment directly into the body politic.

There is no doubt that drug dependency does generate much fear and concern. This is played out in local communities up and down the country. Many drug agencies face terrible trouble when they want to open a local treatment centre and face huge opposition from local people. Former users face an enormous struggle trying to find employment. They are permanently tagged as people who are inherently untrustworthy. For most people, there is little doubt that these fears and concerns are not the product of personal experience, but a summation of everything they 'know' about drug users from media representation.

However there are encouraging signs that the public might be more sympathetic to the plight of drug users than may be assumed. The 2009 DrugScope/ICM poll revealed that 76% of those surveyed agreed that public money should be spent on drug treatment. And in a 2010 poll for the drug research organisation UKDPC, over 60% thought people with drug problems were too often demonised by the press.

### **Impact on politicians**

There was an interesting blog by Mark Easton, the BBC Home Affairs correspondent posted on 16th September 2010 when he posed the question, 'should drugs policy be based on facts or opinion?' It was prompted by a reply given by the shadow Home Secretary Alan Johnson to a challenge in the House as to whether he would sign up to an evidence-based drug policy even if the evidence conflicted with public opinion. To which Alan Campbell replied, "We can take evidence, but we must also take into account what the public think about such matters." This of course poses more questions. Given that government ministers rarely if ever engage in the public debate about drugs, especially around law reform, in case this is seen to legitimise the idea – how do politicians know what the public actually thinks? And how does this nebulous construct called 'public opinion' come to any conclusions about drugs?

Some public polling does give us clues: there seem to be a majority in favour of public money being spent on drug treatment, for example, and probably little appetite for significant reform of the drug laws. Interestingly, though, some public polling by IPSOS-

MORI showed that since the early 1990s, public concern about drug use peaked during the tabloid publicity surrounding the deaths of Leah Betts (1995) and Rachel Whittear (2000). Which leads to the conclusion that as with many issues, politicians take their cues about 'public opinion' from the popular press. It will be interesting to see if over time, other outlets of news and comment such as the blogosphere and Twitter begin to exert similar influence.

## INTERVIEW



## PEARL LOWE

In 2007, Pearl Lowe published an account of her struggle with addiction, *All that glitters*. Since her recovery, she has forged a highly successful career in the worlds of fashion and interior design. But she's never allowed to forget her past.

The book was initially received incredibly well. On the outside it looked so lovely and glossy; I think people were shocked at the content of it. But a lot of the feedback I got from people was positive. I got a lot of emails, Facebook, Twitter and God knows what, just saying 'thank you', so that was great. But we're now in 2010 – 4 years away – and I'm still being tagged as a drug addict, even though I'm not, and I'm 6 years clean. I'm a mother of four, I work really hard, I have a successful design business...but the drugs overshadow everything I do, because I'll never be allowed to forget it.

I got an award last year – the O2 Celebrity Entrepreneur of the Year. At the awards ceremony, I went up to the front and collected my award and the first thing I said was "God, this is so weird. I've been called so many things in my life: mainly junkie, druggie, you know, addict. But never once has anyone called me an entrepreneur! This is absolutely amazing!" Everyone laughed. But it's so true.

Something that is really badly misinterpreted is the way I brought my daughter up. Because my daughter's very famous, she does a lot of interviews. They've all just got this one angle, which is 'poor Daisy, she grew up in this household where the mother was a junkie and she brought her brothers up...' In the book I say once that she got up and made them milk. You know, I was describing a situation where I felt really awful. I was an amazing mother, no matter what. My children were so well cared for. They would have been taken away from me otherwise.

I think that's why the book was so important, because I wanted to explain drugs and motherhood – and the fact that I had children was the reason why I got clean. I also wanted to write a book that really didn't glamorise drugs and that showed how drugs and celebrity is a horrible kind life, not in any way a life that people should aspire to live ■

## INTERVIEW



## PHIL SPALDING

Phil Spalding was a top-flight session musician who played with Robbie Williams, Kylie Minogue, Jools Holland and many others until he lost everything through addiction. Now, in recovery since 2005, he is back working.

If you think of all the addictions, all the 'defective' behaviours, why should addicts be picked out for stigmatisation? An employer won't hire somebody who's been a drug addict, but I bet he hires loads of drunks. Does he hire people who eat too much, that can't get up the stairs? Drug addiction is very easy for society to use as a scapegoat.

I know that I and some of my peers and friends, people who have come from very dysfunctional backgrounds, prison, drug dealing, all sorts of violent crime that are standing up for the fact that addicts who get a decent recovery...do lots to help people – because they can build up trust. All the addicts I know are volunteering somewhere. Most people I know in regular life haven't got the time to volunteer. I'm not saying I'm a saint, but I work in a local charity shop because I like it, it keeps my feet on the ground and helps the people who helped me when nobody wanted me. They let me in that charity shop when I was completely messed up, couldn't communicate, probably couldn't put clothes on a rail or sort books on a shelf. But they kept getting me to come back until I was able to do things. Most people who have been an alcoholic or an addict or both, when they get a committed change in their lives and their attitudes, they are incredibly useful members of society.

Most people who have suffered addiction problems have never been integrated in the first place – most have been tramps, thieves, prostitutes, people that society doesn't like to face – real street people, very intelligent, but for one reason or another suffered trauma – no self-esteem –ever. Everybody deserves a chance – how can you argue with that? ■

## INTERVIEW

## TANYA FRANKS



In the summer of 2010, the tabloids were stirred by a storyline in EastEnders which saw hard man Phil Mitchell struggle with a slew of problems in his life, finally finding his escape in a crack pipe, provided by Rainie Cross, played by Tanya Franks. Shown pre-watershed to a mass audience, the inclusion of scenes depicting people under the influence of Class A drugs was certainly controversial.

It's weird, but as an actor you want to play characters like Rainie, because there's so much going on. You also know that you have a social responsibility with taking the issues on too. I had played Rainie before and from the outset I knew she was a drug user. For me, that's a challenge – it's an exploration of an aspect of human experience, about something of which personally I don't have firsthand experience. While I did my own research, being in touch with DrugScope meant that I could ask questions and clarify things. I asked for that up front; when I took on the storyline, I said I needed someone there on set. It was really important to me to have someone there, as I wanted to do the best job possible.

I wasn't surprised that people complained about showing the scenes pre-watershed, because it pushed a boundary. But I also think that we shouldn't shy away from these issues. The whole point of soaps is to reflect a certain amount of everyday life; some of it will be light entertainment and some won't. In my opinion, the good that comes from storylines like this far outweighs whatever concerns people might have. I think it was right to show it. Even though a few people might pick up the phone to complain, other people might pick up a phone because they recognise they or someone they love needs help ■

## Talking to drug users

When covering a social issue or health problem such as drug dependency, it's very likely that your editor or producer will ask you to source an interview with someone who has first-hand experience. The 'real life case study' has become a staple part of much media coverage. But finding someone to interview – particularly at short notice – can be difficult. Drug charity press officers will probably end up being your best route to finding those true stories that 'bring a piece to life'. Many larger charities have a pool of current or former service users who are available to speak to the media about their experiences; the charity will support them to do so, with the provision of formal or informal media training and advice.

Elliot Elam, from the Communications Team at Addaction, one of the UK's largest drug and alcohol treatment charities, spoke to Ruth Goldsmith, Communications Manager at DrugScope about the pros and cons of providing case studies...

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**Ruth:** *Why do charities like Addaction supply case studies to journalists – what's in it for you?*

**Elliot:** **Partly it's about raising public awareness of the charity's work, to increase donations and income to help us run our services. It's also because we deal with a very stigmatised and maligned group of people; helping people tell their stories humanises them. Eventually we hope to change the public discourse on this group.**

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**Ruth:** *Is there any reason why charities might be reluctant to get involved with case study work?*

**Elliot:** **Not naming names, but some media outlets can be very reductive in the way they deal with someone's**

very complicated story, editing it right down to the bare minimum. When you edit something big and complicated right down, it can be viewed from a hundred different angles and none of those will be representative. And that's a big problem.

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**Ruth:** *There's also the risk that the charity's name will be omitted – probably by mistake or through over-zealous subbing, but it can be very annoying for the press officer who has spent time and energy setting something up, only to find on reading or seeing the piece that there is no mention of the organisation. What about anonymity for service users?*

**Elliot:** **The option of anonymity should always be there and it should be accepted without question when someone asks for it. At Addaction, we don't give out the real names of our service users nor would we ever supply a photo. These people are in treatment and our number one duty is for their personal safety and care. Even if the individual says they are completely fine with it, their family might not be and if they are named or photographed in the media it could be very restrictive when they are looking for employment.**

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**Ruth:** *Given the potential risks involved, why do you think your service users want to talk to the media?*

**Elliot:** **A lot of the time, when someone's been through drug treatment, they want to do everything they can to help other people who are still experiencing problems. They also want to say thank you to the organisation that's helped them in their recovery. Being a case study can be a really positive experience too – seeing a good article or news piece can really boost confidence and help someone in their recovery.**

### TOP TIPS FOR INTERVIEWING PEOPLE WITH DIRECT EXPERIENCE OF USING DRUGS

- Make sure that you – the journalist – and the drugs organisation that is helping you are absolutely clear what you are trying to achieve with the case study. You must make sure you spell out to the charity what you are after – otherwise you could waste the time of the charity, the journalist and the drug user because the case will not be published. If your magazine has asked for a lesbian who takes crystal meth, then say so.
- Do your research so that when you talk to the charity or organisation, and the drug user that you can ask informed questions. It also helps cut out misunderstandings, mistakes and wasted questions.
- Always adopt a friendly tone with people when you are conducting a phone or face to face interview. Remember that they probably haven't spoken to a journalist before and are expecting to be grilled like Jeremy Paxman's victims on Newsnight!
- Put yourself in their shoes; imagine you are being asked to talk about something in your personal life that you found traumatic. Sometimes people may get emotional when recalling their experiences – just be patient and be sensitive to topics that might be distressing for them.
- If anything is confusing or controversial, check with the interviewee. Make sure you have understood their response properly and if necessary read back and the quotes and change material so that both sides are happy. This is not the same as giving copy approval, but remember the interviewee is doing you a favour, so respect them and make sure everyone is happy with the final interview.

- Ask the interviewee what they would like to get across, too. It's very easy to only talk about the bad experiences but you should always give people a chance to tell you about their successes and achievements as well. Don't paint anyone as a 'hopeless case' – because no one ever is.
- Check with the source organisation how they would like to be acknowledged. To keep your press office contacts sweet, you must make sure their organisation is referenced. Ask them whether they would like a helpline number, web address or logo printed alongside the case study. This is not sucking up to press officers – it's good journalism. They've helped you out, so you should return the favour if possible. Plus you will almost certainly want another case study or quote in the future – and press officers have long memories!

## CASE STUDY: THE MUDDLE OVER MEPHEDRONE



Apart from issues around the way people with drug problems are portrayed in the media, there is also the matter of how information can become mangled and how information on drugs becomes 'misinformation'. Of course, this problem is not confined to reporting on drugs and is not solely the fault of the media – but it does illustrate the old adage about not letting the facts get in the way of a good story.

It must be said that the British media do enjoy a good drug scare. During 2009, it became increasingly apparent that a new drug called mephedrone was in general circulation in the UK – both in the drug market and on the newsstands. The added frisson in this case was that it was legal and could be bought online.

There was no doubt that the drug had the potential to cause harm. DrugScope's own magazine *Druglink* reported that several young people had been hospitalised and the internet drug chat forums had many accounts of bad experiences. However a number of myths about the drug – with the conveniently snappy street name of 'meow, meow' – were constantly recycled.

### **Mephedrone was plant food.**

No it wasn't – as anybody trying to grow tomatoes with it would have found out. In fact, mephedrone could have been marketed as shoe polish or anything. This was simply a ruse used by sellers to try and dodge medicines and poisoning legislation by saying that the substance was not being sold for human consumption. It didn't help that senior police officers were quoted confirming this bit of misinformation. Subsequently another new drug with the nickname 'Ivory Wave' started being sold as bath salts – but it definitely wouldn't have made your bath smell nice.



### **Mephedrone was responsible for over twenty deaths in the UK.**

Media reporting 'linked' mephedrone to several fatalities, but that isn't the same thing as the drug being directly attributed as 'the cause of death'. One of the most widely reported cases involved the deaths of two young men in Scunthorpe. Several months later, it was revealed by the coroner that in fact they had taken the opiate-based drug methadone and had not taken any mephedrone at all. The point here is that until there is an inquest informed by pathology and toxicology reports, it is impossible to confirm the cause of such deaths. Even then, where more than drug is involved, it can be very difficult to attribute cause of death to one drug or another.

### **Teachers were powerless to act because the drug is legal.**

This was just plain wrong. Teachers are perfectly entitled to confiscate any item they wish from school students, if the item breaks school rules or in any way puts the students or others at risk.

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***The government dragged its feet over banning the drug.***

This wasn't true. The government is obliged by law to consult its drug experts as part of the process of deciding whether or not a drug should be controlled. If they decide it should be controlled, then the legislation has to be drafted and put through the parliamentary process. Because the Misuse of Drugs Act is a legal instrument, this has to be done carefully and so naturally does take some time. It was simply mischievous to suggest 'lives could have been saved' if the government had acted more quickly. Partly in response to the speed of the emergence of 'legal highs' like mephedrone, the government is now planning to introduce temporary bans on new drugs while consideration is given to their potential harm.

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***Banning the drug would remove the problem.***

It does seem that some young people who are not normally part of the drug scene were encouraged both to use and sell the drug because it is legal. It was reasonable to assume that if mephedrone was banned, this group would probably stop for fear of prosecution or because of its illegal status. Banning the drug would address its open sale. However, it was clear from internet postings that more seasoned drug users were using mephedrone both because it was legal and because the purity level was more guaranteed than drugs like amphetamine or cocaine. There was an additional problem which still prevails – stopping internet sales from the sites located in countries where the drug is not banned, although imports into the UK are now illegal since the drug was controlled under Class B of the Misuse of Drugs Act in early 2010.

Overall, there was a huge amount of coverage devoted to mephedrone and if accounts of sellers are to be believed, this contributed to significant sales of the drug during 2009. On the other hand, it could be argued that so much negative coverage of its effects could have discouraged some young people from trying the drug in the first place. In the run up to control, DrugScope gave around 100 media interviews where we both dispelled the myths and emphasised the dangers; during the same period, there were over 16,000 downloads of our factsheet about the drug and its risks. As they used to say in the X Files 'the truth is out there'.

# Drug Q&A

In this section, we've set out some of our most 'frequently asked questions'. Some of these appear simple but are actually quite complicated to answer. In the space available here, we've had to be brief – but we've included links to sources of further information and if you need any further detail, you can always contact us directly.

**You can call the DrugScope Press Office on 020 7520 7550 and select option 3. If you're calling out of normal office hours, you can call the mobile on 07736 895 563. We will also respond to enquiries by email at [press@drugscope.org.uk](mailto:press@drugscope.org.uk)**

## **General information about the effects and risks of using drugs**

Despite the fact that illegal drug use has been a hot media and political topic since the 1960s, there is still much we don't know about the effects on drugs on humans. Most of the scientific work focuses on chemistry and the effect of drugs on animals. We also know a fair bit about what happens to people who use large amounts, seek help or get into some kind of trouble with drugs because they are the ones most likely to come to the attention of, for example, doctors, drug agencies and the police, and therefore most accessible to researchers. But this kind of information and research doesn't necessarily help much in understanding the 'everyday' use and misuse of drugs and only offers a very rough guide to what is likely to happen to individuals.

### **Why don't we know more about the effects of different drugs?**

Most of the money to do this kind of research is going to come either from government or the pharmaceutical industry. The US Government does fund research through the National Institute on Drug Abuse, but there is no similar government-funded research

programme in the UK. Nor is the pharmaceutical industry likely to be interested in spending money researching illegal drugs when there is no commercial payback.

But it's not just about the drug. Here's a simple example. Alcohol is used to celebrate a happy event, but we also use alcohol to 'drown our sorrows'. If you drink when you are happy, you feel even merrier; if you drink when you are sad, you feel worse. So it can't just be about the drug – in this case, alcohol.

Those who try and 'control' the LSD trip because they are anxious about what will happen are more likely to have a bad experience than somebody who 'goes with the flow'. And people who use drugs like LSD or magic mushrooms in strange surroundings or with people they don't know, might have a worse experience than those using in the company of people they know and trust.

### **How easy is it to overdo it?**

There are two ways of overdoing it. Someone could take too much in one go leading to distressing or even fatal consequences. Or someone can take too much over a long period of time. In this scenario, normal, everyday functioning can become damaged. Relationships may narrow down to a small group of people with similar habits and finding or keeping work and housing may be difficult. As dependence develops, the need to buy more drugs can add to the problems and may drive the user towards crimes like shoplifting. Normal desires for food or sex and reactions to discomfort and pain may be dulled by the drug. The resultant self-neglect can damage health.

Even in moderate doses, most drugs mess up reaction times, bodily control and the ability to maintain attention. These effects can last several hours. No matter how the person feels, they are not as capable as they were before. Driving, operating machinery and even the crossing the road become more dangerous, both for the individual and those around them.

### **Why do some people respond so differently to the same drug?**

Drug information often focuses on what 'usually' happens with a drug. But is there such a thing as 'usual' or 'normal'? How a drug affects the body will vary enormously from person to person and the factors influencing how someone will respond are manifold.

Psychologically, someone's mood, expectations and mental state can directly impact whether they enjoy a drug experience or not. Physically, underlying health conditions can be a risk factor. For example, people with heart problems such as angina may find the normally insignificant increase in heart rate caused by cannabis painful. Bodyweight can also play a significant role, with lighter people experiencing greater effects and consequently greater dangers from the same drug dose than heavier people will. We don't know too much about how drugs affect men and women differently, but, for instance, it is known that women who are dependent on alcohol are more susceptible to liver disease than men, due to physiological differences.

### **Why is injecting drugs so much more dangerous than other types of drug use?**

Of all the ways of taking drugs, injecting is the least common, but definitely the most dangerous. Why?

- 1 A drug can only have an effect when it reaches the brain – injecting into a vein is the quickest way to get a drug to the brain. The effects can be felt in seconds. This is why some people who overdose from heroin are found with the needle still in their arm. They may not have died immediately, but the rapid effect of injecting can render somebody unconscious very quickly.
- 2 If somebody injects a drug, the whole dose goes in at once, so there is no control over what happens.
- 3 Because the drug gets to the brain in seconds, the effects are very intense and pleasurable. Those who inject heroin, cocaine or crystal meth often say that the experience is better than orgasm. The trap is that because tolerance to the effects of these drugs develops rapidly, regular users try and recapture that feeling with ever

increasing amounts of drug. Eventually, as dependence takes hold, they are taking the drug to stop feeling unwell.

- 4 There is a high risk of contracting blood-borne viruses such as hepatitis C and HIV from injecting drugs. This is because users may be sharing injecting equipment that is not sterilised between uses.
- 5 Other health risks include blood poisoning, abscesses and gangrene and vein damage caused by injecting drugs that are not meant to be injected (like crushed up pills).
- 6 It sounds weird, but people can get hooked simply on using needles – and will inject warm water if no drugs are available. Why? It is complicated, but briefly, although the life of a street drug user is often dangerous and chaotic, the rituals of drug use can bring a strange kind of stability and certainty that might have been missing from their life before drugs.

### **What happens when someone takes more than one drug at a time?**

Depressant drugs like heroin, methadone, alcohol, tranquillisers and GHB/GBL are particularly dangerous when taken together. This is because the drugs ‘depress’ various bodily functions including breathing. All the body’s systems slow down and eventually everything can stop. The individual might die if they don’t get help.

Those with an opiate dependency might use these sorts of drugs in combination especially if their drug of choice is in short supply. A heroin user is at more risk of overdose by using heroin and then drinking alcohol on top than by using the heroin alone. And a lower dose of heroin than usual could prove fatal if mixed with other drugs. Alcohol is actually the worst mixer in this respect and is implicated in many drug overdoses.

Mixing cocaine and alcohol produces a new drug in the body called cocaethylene. Cocaethylene is more toxic than either drug in isolation. It is associated with an increased risk of heart attack and is very damaging to the liver where it is formed.

### **Which are the most dangerous drugs?**

All drugs, whether they are used legally or illegally, for recreation or for medical purposes have effects and side effects. If they had no impact on the body, they wouldn’t be drugs.

In fact it is very difficult to draw up a ‘league table of harm’ although Professor David Nutt and colleagues at the Independent Scientific Committee on Drugs (ISCD) did attempt this recently in a paper published by *The Lancet*. But this kind of exercise cannot answer questions like – what is more dangerous, a line of coke, an ecstasy pill or a can of very strong lager? The person with an underlying heart condition might come to grief through a line of high purity coke and a different person with a different physical constitution might react very badly to an ecstasy pill. Solvent use can be highly dangerous and many young people have died at their first attempt.

Certainly the drugs that do the most harm in terms of absolute numbers are alcohol and tobacco. That is both a function of the drugs themselves and the fact that both are legal and widely available. But from the point of view of government policy, the most harmful drugs are heroin and crack. In the current UK drug scene, they are the drugs with a high potential for addiction that cause the most harm to individuals, families and local communities.

### **What’s the difference between hard and soft drugs?**

There is no legal or scientific basis in the terms ‘hard’ and ‘soft’ drugs. These are more ‘shorthand’ terms for drugs that are generally regarded as causing more or less problems. So even though ecstasy (A), cannabis (B) and ketamine (C) are all in different classes within the Misuse of Drugs Act, they would all be regarded by drug users as ‘soft’ or recreational drugs, unlike heroin or crack which would be regarded as ‘hard’ drugs mainly because of the addiction risks they pose.

In 2009, the government’s drug experts, the Advisory Council on the Misuse of Drugs, advised government that ecstasy should more appropriately be a Class B drug, as did the Home Affairs Select Committee back in 2002. Interestingly the public perception of drugs can change with increasing use and availability. Twenty years ago, cocaine would have been regarded as a ‘hard’ drug, but

within the last 10 years, as a 2006 YouGov survey showed, that perception has shifted.

### Is it true that all drugs are cut with poison?

No. Not least because drug dealers want their customers coming back for more, rather than dropping dead. That said, the purity of drugs on UK streets has been falling over the years. Some samples of amphetamine and cocaine have tested in single figures for the actual drug.

So if a sample of say cocaine is 20% – what is the rest? Users will be snorting one of two sorts of substance:

- a A substance which looks like cocaine and is there just to make up the weight. This might be glucose, lactose or a similar powder which has no drug effect.
- b A milder stimulant drug which might give the user the impression they have bought the real deal. This might be caffeine or a drug more closely related to cocaine in its effects – like benzocaine or lidocaine.

However some drugs can be much more seriously contaminated. Several heroin users have died through using heroin contaminated with anthrax and other bacterial infections. This is not through deliberate contamination, but because the heroin could have been produced in an area where anthrax was endemic among livestock. Alternatively, heroin buried in soil to avoid detection, could become infected with soil-based bacteria.

It is possible that maybe to settle scores, somebody might be given or sold a ‘hot shot’ containing a poison or, paradoxically, a super strength dose. However, there is no consistent forensic evidence that this happens. Of course, most of the drugs on the street are never tested because they aren’t seized.

### Can you become instantly dependent on a drug?

Much has been made of some drugs’ power to turn the experimenter immediately into a dependent user. In 1972, an American book about heroin called *It’s so good, don’t even try it once* became famous; the title was a quote from a heroin user who was speaking to researchers. When news of crack cocaine first broke in the British press in 1989, *The Sun* had the headline, ONE HIT AND YOU’RE HOOKED.

There is no doubt that for some people, the initial drug experience can be so overwhelming – and largely this applies to the most powerful drugs like heroin, crack and crystal meth, especially when injected – that there is an equally powerful drive to repeat the experience. But people do not become physically or psychologically dependent ‘instantly’. It’s a process that takes time, usually weeks or months. Tolerance builds up, until people start using a drug not for its euphoric effects, but simply not to feel ill.

Those most at risk of becoming dependent are people who are experiencing a range of personal problems. Their drug use will invariably be underpinned by a desire to escape reality. Again, it’s a matter of looking at the individual using the drug and their situation, rather than looking only at the drug itself.

## Drug statistics: how to find the figures

Since the early 1980s, concerns about drug use in the UK have been rising steadily. From that time, significant improvements have been made in the collection of data helping to assess the nature and extent of the problem. But because we are dealing with an illegal activity, much of the data available is based on estimates and it is likely that there is a degree of under-reporting. Care must be taken to treat most statistics, particularly those concerning prevalence, with caution – and not to assume what can be read into an apparent pattern in the data.

### How do I find out how many people use a particular drug?

The best sources of data on people's drug use are the National Crime Surveys. The British Crime Survey (BCS), published by the Home Office, covers England and Wales, with the Scottish and Northern Ireland Crime and Justice Surveys (SCJS and NICJS) covering the rest of the UK. These surveys are household surveys that look broadly at the population's experiences of crime, including the use of drugs.

The BCS Drug Misuse Declared bulletin, published by the Home Office once a year, can provide useful information on trends. It has

been collecting drug use data since 1982 and has been annual since 2001. The survey only covers those aged 16 to 59 years, so misses drug use among those in their early teens (this data is captured in other surveys).

Also because the BCS is a 'household survey' for which interviewers visit people in their own homes, it misses out certain groups in society who are more likely than others to use drugs, such as students in halls of residence, the homeless and those in prison. The BCS underestimates the use of drugs such as heroin and crack cocaine, as groups of people who are most likely to be using these drugs dependently are not covered by the survey. But it does report in detail on the main age group of drug users in the UK, those aged 16 to 29 years.

The latest BCS surveys can be found on the Home Office Research, Development and Statistics site under the subject heading 'Drug use prevalence': <http://rds.homeoffice.gov.uk/rds/drug-use-prevalence.html>

The Scottish Crime and Justice Survey (SCJS) can be found on the Scottish Executive site at: <http://www.scotland.gov.uk/Topics/Statistics/Browse/Crime-Justice/crime-and-justice-survey>

The Northern Ireland Crime and Justice Survey (NICJS) can be found on the Northern Ireland Statistics and Research Agency website here: <http://www.csu.nisra.gov.uk/survey.asp17.htm>

### What about drug use among young people?

Scotland and England carry out Annual School Surveys. Both set their national baselines for levels of smoking, drinking and, since 1998, drug-taking among 11- to 15-year-olds in England and 12- to 15- year-olds in Scotland. The survey for England, *Smoking, drinking and drug use among young people in England*, is now published annually by the NHS Information Centre, a public authority tasked with gathering and publishing data on health and social care. *The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)* is carried out every four years and is published by Drug Misuse Information Scotland, an information body run by the Scottish Executive.

Smoking, drinking and drug use among young people in England can be accessed on the NHS Information Centre website here: <http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/smoking-drinking-and-drug-use-among-young-people-in-england>

*The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)* can be accessed on the Drug Misuse Information Scotland website here: <http://www.drugmisuse.isdscotland.org/publications/abstracts/salsus.htm>

### **How can I find out how many drugs are being seized from our streets?**

The Home Office produces an annual bulletin that details the amount and numbers of drugs seized by police and customs, including regional breakdowns by police areas.

Seizure figures should not be regarded as an indication of whether drug use is going up or down. Rather, they indicate activity levels among police and customs. This is why the figures can go up and down year-on-year. One huge seizure can distort the figures for any given year. Figures may also indicate a change in police tactics or a sudden crackdown on local drug markets. The best way of regarding seizures figures is to look at general trends over a number of years.

The Home Office statistics on drug seizures can be downloaded here: <http://rds.homeoffice.gov.uk/rds/drug-seizures.html>

### **How can I find out how many people die from drug use?**

Official data on drug-related deaths are held by the Office for National Statistics (ONS) and the General Register Offices (GRO) for Scotland and Northern Ireland. The first two established special databases on drug-related deaths several years ago. All the data come from death certificates, supplemented by information from coroners following inquests or, in the case of Scotland, from pathologists. The National Programme on Substance Abuse Deaths (np-SAD), based in the Department of Addictive Behaviour

& Psychological Medicine at St George's Hospital Medical School, receives data on a voluntary basis on drug-related deaths from most coroners in England and Wales. Recently, they have started to receive data from coroners in Northern Ireland and their Scottish equivalents (procurators fiscal). There is also the annual survey of volatile substances (solvent) deaths collated by the Department of Public Health Sciences at St George's Hospital Medical School.

For a pathologist, trying to ascertain exactly why a person died can often be very difficult. It might be clear that a person died of lung failure or a heart attack, but exactly what caused this to happen can hard to ascertain. With drug-related deaths, there are a number of extra problems to contend with. For example, if the person had a number of different drugs in their body, it would be difficult to isolate any one substance that precipitated the death (usually by overdose). Also if alcohol is involved alongside heroin and tranquillisers, it might well be that it was the presence of alcohol that actually tipped the balance, yet it would probably be logged as a drug-related death.

Drug-related deaths may well be under-reported. For example, when someone dies after contracting HIV or hepatitis through injecting drug use, their death is not registered as a 'drug-related death' despite the fact that it is intimately related to their drug-taking behaviour. There is also some anecdotal evidence that coroners might be reluctant to record a drug-related death to save the feelings of the bereaved, especially where a young person is involved. Coroners may opt instead for a verdict of 'death by misadventure' or similar.

The annual bulletin of ONS statistics, entitled *Deaths related to drug poisoning*, can be accessed here: <http://www.statistics.gov.uk>

The annual reports of the National Programme on Substance Abuse Deaths (np-SAD), based at the International Centre for Drug Policy at St George's Hospital Medical School, can be found here: <http://www.sgul.ac.uk/about-st-georges/divisions/faculty-of-medicine-and-biomedical-sciences/mental-health/icdp/our-work-programmes/national-programme-on-substance-abuse-deaths>

## CANNABIS

### Some key questions

Cannabis is the most widely used of all the illicit drugs in the UK, with just under 10 million adults (16 – 59 year olds) admitting that they have ever used the drug. The drug has probably also taken up more column inches than most other drugs as well; it consistently stimulates fierce public, political and media debate about its harms and its legal status. Here, we attempt to answer some of the big questions on cannabis.

#### **Is it true that taking cannabis leads to use of other drugs?**

The idea that using cannabis inevitably leads the user to take other drugs is otherwise known as ‘the gateway theory’. It suggests that there is something inherent in cannabis that propels users to move from this drug to one with a more intense ‘high’. Using the logic of the gateway theory, everybody who uses cannabis runs the risk of becoming dependent on heroin.

The logic doesn’t stack up, however. While many heroin users probably started their drug use with cannabis along with cigarettes and alcohol, there are around 300,000 heroin users in the UK. Whereas the estimated number of people aged 16 – 59 in the UK who have ever used cannabis is just under 10 million.

While there has never been any scientific evidence to suggest that the gateway theory is valid, it is true that cannabis users might come into contact with heroin dealers simply because both are traded on the illegal market. This was part of the reasoning of the Dutch government in allowing the smoking of cannabis in designated sites as a means of ‘closing the gate’ between young people and the heroin market.

In 2002, the Home Office published a survey that looked specifically at the sequence of initiation into drug use experienced by 4,000 young people. Called *The Road to Ruin?*, the report concluded that there was “no significant impact of [so-called] soft drug use on the risk of later involvement with crack and heroin [and]...very little impact of soft drug use on the risk of later involvement in crime.” It also concluded that “a significant but small gateway effect probably exists linking soft drug use to the social drugs ecstasy and cocaine.”

#### **Isn’t cannabis much stronger than it used to be?**

Over the past ten years, stronger strains of cannabis have appeared in the UK. Initially, these would have been samples brought in from Europe, particularly the Netherlands, where an industry of high-tech indoor cannabis growing had developed.

The idea of growing cannabis indoors first emerged in the USA as a means of avoiding detection – naturally grown cannabis plants can reach several feet in height. Growing cannabis indoors without soil under powerful lights produces strains that have a higher concentration of THC, the active chemical in cannabis.

Although skunk was only one type of indoor cannabis, it quickly became the catch-all name for stronger cannabis and the media was full of unsubstantiated claims about cannabis being anything up to 50 or 100 times stronger than the type smoked back in the 1960s and 1970s. It was claims such as these that were in part responsible for the continued reviews of cannabis after it was reclassified to Class C in 2004 and which eventually led to the drug’s return to Class B in 2008.

## CANNABIS

The debate about strength heated up in 2007 when it was discovered that organised gangs had opened up numerous cannabis farms in the UK – often suburban houses converted to grow indoor cannabis.

Once samples were properly tested, some evidence on THC strength began to emerge. It was found that whereas in the early part of the decade, the average strength of cannabis was around 7-8%, this had risen to 12-14% as a result of the market switch from imported cannabis resin to home grown indoor cannabis.

But what this means remains unclear. Is 12% cannabis twice as dangerous as 6%? If so, how? And might it be that some people cut back on their use of cannabis on account of it being too strong? According to Home Office statistics, cannabis use has been falling for some years, including during the period in which cannabis had been reclassified from B to C. Many feared that reclassification would 'send a message' that cannabis was harmless and use would rise. In fact, use continued to fall. It may be that the rise in cannabis strength has caused users to cut down as they manage their own dose levels.



## What's the government doing about drugs?



Drugs first became a political issue in the late 1960s; from then to the mid 1980s British drug policy can best be summed up as 'masterful inactivity', as one British criminologist puts it. There was no coordinated strategy and no national drug treatment policy. Drugs moved up the political agenda during the 1980s as a result of the dramatic increase in heroin use, but still nothing emerged that you could call a national strategy.

Eventually in 1995, the Conservative government under John Major produced *Tackling Drugs Together*. This strategy introduced the idea that drugs are an issue that not only cuts across central government departments, but also needs to be similarly ‘joined up’ at a local level.

When Labour came to power in 1998, they continued what the Conservatives had started with *Tackling Drugs to Build a Better Britain* (1998) and followed that up with an updated strategy in 2002 and 2008. At the time of writing (Nov 2010), a revised strategy is being drawn up.

### **What is the main purpose of the drug strategy?**

Throughout the life of the last Labour government, the key purpose was to break the link between drugs and crime through a substantial investment in the treatment system. This is still important for the Coalition government, but there is now an added emphasis on getting ex-users into work and off benefits.

Whatever the rhetoric, no government believes it can ‘stamp out drug use’, but it does make sense politically to focus on that aspect which cause most problems across the board. This would be heavy or dependent use of heroin and crack cocaine, where much drug use is financed by crimes such as shoplifting, burglary and low-level dealing.

### **So who does what?**

#### **Home Office (HO)**

Because drugs has always been regarded as a law and order issue since the first UK drug laws in 1920, the HO remains the lead government department for drugs, takes the lead in developing the Drug Strategy and is the only department which has a Minister who is solely responsible for drugs. Under the Home Office is:

- the Advisory Council on the Misuse of Drugs (ACMD), whose Chair is appointed by the HO;
- the drafting of all legislation including the Misuse of Drugs Act;
- the police service including the Serious Organised Crime Agency (due to be folded into a new National Crime Agency);

- the Drug Intervention Programme (DIP) – the main criminal justice programme for engaging offenders in drug treatment.

#### **Department of Health (DH)**

The main contribution of the DH is to oversee the work of the National Treatment Agency for Substance Misuse (NTA) which is an NHS special authority, set up in 2001 to bring down waiting lists, get more people into treatment and improve treatment standards of care. It has been announced that the work of the NTA will be absorbed into the new Public Health Service in 2012.

Under DH of course is the NHS, which makes a significant contribution to the provision of specialised drug treatment and primary care to those with drug problems through the work of GPs.

DH also has the public health brief, so is responsible for the information which appears on the FRANK website and which is given out by the FRANK call centre staff.

#### **Ministry of Justice (MOJ)**

This was created in 2007 by splitting up the Home Office. The MOJ is responsible for probation, the court system and prisons.

#### **Department for Work and Pensions (DWP)**

Responsible for the benefits system and employment, but under the Coalition has played an increasing role in the development of the ‘recovery agenda’ – reintegrating former drug users into society.

#### **Department for Education**

Responsible for drug education in the school curriculum and is one of the departments responsible for FRANK, the government’s drugs help and advice initiative.

# Drugs and the law

# Drugs and the law



## How do the drug laws work?

The main law governing the possession and supply of controlled drugs is the Misuse of Drugs Act 1971. It was rightly determined that not all drugs are equally dangerous, so they were categorised into three classes of risk – A, B and C with Class A drugs such as heroin and cocaine attracting the most severe penalties.

Note that it is not illegal to use drugs, only to possess and supply them. This is an important point; it means, for example, that somebody could not be arrested simply because they have needle

marks on their arms if no drugs are found. This is not the case in many other countries.

The drugs controlled back in 1973 (when the Act became law) were those drugs already controlled through international treaties. However it was enshrined in the legislation that a group of experts called the Advisory Council on the Misuse of Drugs (ACMD) would advise government on future controls.

The wording of the original Act was such that it did try and capture future variants of controlled drugs that might come along, although it soon became clear that further legislation would be required to manage new drug problems as they presented themselves. In 1977, legislation was passed to bring ecstasy under control, even though it was not being used in the UK at the time. New laws have been enacted since the late 70s to enable to Act to cover anabolic steroids and previously 'legal highs'.

### **What happens if you are caught with illegal drugs?**

There are three basic drug offences:

- 1 Possession (small amounts of a drug for personal use);
- 2 Possession with intent to supply (larger amounts which could be sufficient for a charge of supply);
- 3 Supply (obviously too much for just for personal use like a kilo of heroin) – and production (like growing cannabis in a cannabis farm or making drugs in a lab).

Maximum sentences differ according to the nature of the offence – less for possession; more for trafficking, production, or for allowing premises to be used for producing or supplying drugs. They also vary according to how harmful the drug is thought to be. Class A has the highest penalties (up to seven years and/or unlimited fine for possession; life and/or fine for production or trafficking). This class includes heroin, the more potent of the opioid painkillers, hallucinogens, cocaine/crack and methamphetamine. Class B has lower maximum penalties for possession (up to five years and/or fine) and includes cannabis, less potent opioids, other synthetic stimulants and sedatives. For trafficking, the penalties are up to 14 years in prison or an unlimited fine or both. Any Class B drug

prepared for injection counts as Class A. Class C has the lowest penalties (up to two years and/or fine) for possession, but for trafficking and supply the penalties are now the same as for Class B drugs. Class C includes tranquillisers, some less potent stimulants, ketamine and dextropropoxyphene, a mild opioid analgesic.

Most offences are possession and most of these will be for cannabis. In 2008, a new system of 'cannabis warnings' was introduced. The warnings only apply to cannabis and essentially the system operates on a 'three strikes and you're out' basis.

If an adult is caught in possession of cannabis:

1) for the first time – they will be issued with a cannabis warning. A cannabis warning is a spoken warning given by a police officer, either on the street or at the police station. The police have the option of using a cannabis warning when someone is caught with a small amount of cannabis for personal use.

2) for the second time – They will be issued with a Penalty Notice for Disorder (PND) for cannabis possession. PNDs are tickets that police officers can issue at the scene of an incident or in custody – they carry an on-the-spot fine of £80.

3) for the third time – police officers will consider further action. This could include caution, conditional caution, prosecution or release without charge.

All subsequent offences are likely to result in arrest. In the case of someone being brought to prosecution for cannabis possession, as a Class B drug the maximum penalty is five years imprisonment.

Neither a warning nor a PND count as a criminal record.

### **What about somebody under 18 found in possession of cannabis?**

A young person found to be in possession of cannabis will be arrested and taken to a police station where they can receive a reprimand, final warning or charge depending on the seriousness of the offence. This must be administered in the presence of an appropriate adult.

Following one reprimand, any further offence will lead to a final warning or charge. Any further offence following a warning will normally result in criminal charges. After a final warning, the young offender must be referred to a Youth Offending Team to arrange a rehabilitation programme.

### **What about possession of drugs other than cannabis?**

Few people actually go to prison just for possession of drugs with no other aggravating circumstances. Most likely people will be cautioned and/or fined. Depending on the circumstances, this might even apply to possession with intent to supply. Most of those in prison for drug offences are convicted drug traffickers.

### **Other drug-related offences**

In an attempt to break the link between drugs and crime, the previous government set up a new system whereby people were essentially 'sentenced to treatment'. This would begin if somebody was arrested for one of a number of 'trigger offences' like burglary. They would then be drug-tested and if heroin and/or cocaine showed up they would be required to engage with treatment or be sentenced for the original crime. This was called the Drug Intervention Programme and still exists.

## **What are the issues around legalisation?**

A perennial favourite and for many, it seems, the \$64 million dollar question: should drugs be legalised? There are many people who stand very firm on either side of this debate. DrugScope believes that it is not a black and white issue, however, and tries to take a more nuanced approach. Here, we unpick some of the ideas and concepts around law reform.

### **What do we mean by legalisation?**

Legalising drugs would mean putting currently illegal drugs on the same legal footing as alcohol and tobacco. They would be taxed and subject to various regulations and controls around sales to minors, advertising, sales outlets, consumption in public, manufacturing controls and so on.

### **Is legalisation the only way of reforming the drug laws?**

No – if you 'decriminalised' possession of drugs, it would mean taking possession out of the criminal law. So, for example, you might get the equivalent of a parking ticket for possession of drugs. You can also 'depenalise' drugs – make the penalties less – as the UK did in 2004 when cannabis was regraded from Class B to C meaning the penalties (for possession at least) were less severe. However it was decided to increase penalties for cannabis supply up to same level as for Class B drugs.

### Has any country legalised drugs?

No – most of the countries of the world are signed up to various UN Conventions which mean that laws have to be in place to control possession and supply of certain drugs. However some countries have relaxed the laws on possession and currently several States in the USA allow cannabis possession for medical purposes.

### What about Holland? Isn't cannabis legal there?

No – possession of cannabis is still illegal under Dutch law, but it was decided to allow cannabis smoking in special designated premises called 'coffee shops'. However, the amount of cannabis that any person is allowed to possess in a coffee shop has been substantially reduced and many of these premises have been closed. And it has always been the case that those supplying the coffee shop could be arrested, especially if they were caught supplying drugs other than cannabis.

### So the experiment failed?

No – when the laws were relaxed, cannabis use did not escalate out of control, as was predicted by opponents. However, there was international pressure and also a change in the political climate in the Netherlands has brought about change.

### So who wants to legalise drugs?

In the UK, there are campaigning groups such as Transform, Release and pro-cannabis groups along with The Green Party who want significant reform of the laws. *The Economist* favours reform and in the past so too did *The Independent on Sunday* around cannabis until it had a change of heart. A small number of MPs are committed to reform while some outgoing diplomats, judges, doctors and police officers have publicly declared in favour of law change.

### What are their main arguments?

- a Prohibition has failed. Drugs are freely available to anybody who wants them and the whole trade – worth billions worldwide – is in the hands of criminals;
- b Because criminals control the trade, it ferments violence, corruption and political instability, especially in producer countries and there is no quality control over the product;
- c Most drug use is a victimless crime and it is wrong to criminalise thousands of (mainly) young people who might otherwise be law-abiding.

### What would be the main arguments against?

- a Governments have a duty to protect people, even from themselves. That's why we have laws which force drivers to wear seatbelts and motorcyclists to wear helmets. Given the damage caused by alcohol and tobacco, why would you want to have more drugs even more available than at present?
- b It is naïve to think that legalising drugs would seriously undermine organised crime. Many gangs already diversify their activities and would probably set their own businesses to produce legal drugs which would just be front for their other illegal activities.
- c Anybody who tries drugs knows the risks they are running both legal and health-wise.

### Does that mean then that nothing will ever change?

No – history is full of examples of different drugs being freely available or banned at different times. If there was any political will to make adjustments to the laws – and that could be to make them more punitive, rather than more liberal – then this is most likely to happen bit by bit than through dramatic legislative change.

# Drug treatment

“Most papers make things worse. It seems people who have a problem with drugs are perpetually hated. Newspapers’ derogatory headlines and language are alienating people who just need help. People see a group who are not vulnerable, but just scum, the scourge of society. There is never anything about how drug treatment can help turn lives around”.

John Howard, Reading Users Forum



### What kind of treatment is most effective?

Which treatment works best and for whom are hotly debated topics. However, despite many research studies, there are no definitive answers because there are too many variables.

Stabilising heroin users on methadone is the standard treatment of choice in the UK. There is plenty of evidence that this intervention provides a much-needed respite from often chaotic lives. Using methadone as a way of encouraging people into treatment and away from street drugs is a life-saver. You can't recover if you are dead. Many of those who receive a methadone prescription begin to rebuild relationships and hold down jobs.

But how long should a person be on a prescription? Are services just doling out drugs, or are people being helped to engage in other therapies as well, in order to move them through the treatment system and out the other side? Is there a risk that methadone is being used as a form of social control, just to keep the crime figures down?

There are those who say that the only acceptable form of treatment is one that is totally abstinence-based, of the sort usually available from residential rehabs or using self-help groups like AA or NA. They say that there is much more evidence for methadone because that's where most of the research money has been spent. This is countered by those who say that there is little independent evaluation of residential rehab – and that some services make exaggerated claims of success in order to attract desperate patients into what may be very expensive facilities.

### So what can we say about drug treatment?

Some key points:

- 1 There are many pathways into drug addiction; although there are common themes of poverty, family dysfunction, alienation and abuse, no two stories are exactly the same. It is the same with recovery.
- 2 There is no 'one size fits all' treatment for dependency.
- 3 Whatever the treatment is, the longer people stay in treatment, the better they do.

- 4 Many people relapse and have several goes at treatment, but each time they come back, the chances are they will do better than last time. This is why dependency is called a 'chronic relapsing condition', but it does not mean that nobody gets better and becomes drug-free.
- 5 There are different types of intervention and most people will try most of them. So for example, many of those who took part in a heroin prescribing trial had also been in rehab and also had methadone prescriptions.
- 6 People talk about 'the treatment journey', but it often isn't very linear – starting with a chat with a drug worker, perhaps moving to a phase being prescribed methadone to stabilise and maybe progressing towards a stay in rehab with the aim of leaving completely drug-free. But people will move in and out of clinics and rehabs in no set order. A lot will depend on personal circumstances, treatment availability and funding and where someone is 'at' in dealing with the problem.
- 7 Irrespective of the treatment type, evidence has demonstrated that a key factor in treatment success is how well the person is treated by those delivering treatment and how much personal attention they receive.

There is plenty of evidence from clinical studies and official reports that as an intervention, drug treatment 'works'. Ultimately, however, somebody who is forced into treatment by family, friends or the threat of prison, is likely to experience a less successful outcome than someone who feels they are ready to engage in treatment.

## The value of treatment

These are just a sample of the many real life quotes we could have chosen from drug users who have benefited from drug treatment.

### **Realising that enough is enough**

“I’ve had enough... Just the lifestyle. Being ill all the time and having to go out and make money all the time. Just depending on that all the time, do you know what I mean? Every day, even when you’re like sat there smoking it, you’re still thinking of where you’re going to get the next lot of money from... Are you going to wake up ill in the morning? ... Just had enough.”

**John**

“And the best thing I ever did was go ‘Do you know what? I can’t do this. I need help’. And from that moment, funnily enough, things started to get better.”

**Dave**

### **Getting help**

“I see [my worker] once a week. She’s so wonderful, really, she’s great. I love her... I think, she really like understands how I feel, you know. She’s the kind of person to go way out of her way for me.... I think she’ll probably come, you know, she will come and see me at rehab and stuff... She’s lovely....she’s great, really feel really supported by her, you know.”

**Suzie**

“With the methadone programme, it’s been brilliant. Things have got a bit easier in my life. It’s not so hectic. I’m starting to enjoy doing things that I used to do that I stopped doing when I was using drugs.”

**Alison**

“What made me decide [on] coming to rehab is the things I need to come to terms with, and things I need to change in my life. I know I can’t do that on the out [in the community], because I’d end up going back on to drugs... And also it gives me a chance to challenge myself as well, on everything like, and actually look back over what my life has been like.”

**Peter**

“And then I went to a meeting. Thank God I went to that first fucking meeting...I already knew a couple of people there which was really helpful... one of them being my sponsor now. Just with their help it's been so much easier to get off, to come off the drugs. My home detox for methadone was ten times quicker this time than last time.”

*Nicola*

“Knowing that I can get my kids back, knowing that I've got the full support of my friends and my family, knowing that I can cope with life now really without, without drugs or drink.”

*Ben*

***But treatment is just the start of the recovery journey***

“Having somewhere safe to live, that's important. Because when you haven't got anywhere to live it's impossible. It's just you don't have any self worth. Not working, just having nothing, just having nothing, nothing else going on really, if you see what I mean. So it's a passing the time thing. It's like this...‘What am I doing tomorrow?’, just...not having anything to do.”

*Mary*

# Drug education and prevention

# Drug education and prevention



## **Does drug education work?**

It all depends what you mean by 'work'. Despite the many evaluations of drug education programmes that have taken place both in the UK, USA and elsewhere, there is very little evidence that drug education in schools actually prevents young people from experimenting with drugs. This was always the hope of drug education initiatives, especially the very early ones which relied solely on 'shock-horror' posters and films to try and literally scare children into not using drugs. Other types of programmes have included those based on simply providing information and assuming young people will make 'informed' choices or trying to instill 'resistance skills' into young people so they can resist so-called 'peer pressure' – essentially 'Just Say No'. Overall, the best that can be said about the use of drug education in actually bringing about 'behaviour change' (rather than simply increasing knowledge

and raising awareness) is evidence that some programmes have been able to delay the smoking of cigarettes.

Of course, it is impossible to say how many children might have been prevented from trying drugs by the use of shock tactics or any of the other programmes. Those most likely to have been put off are those who were probably not really at risk in the first place. And there is always what is known as the 'decay' factor in terms of scary public health messages. For example, smokers who are exposed to TV documentaries about the dangers of smoking depicting diseased lungs in glass jars will often resolve to stop. But the effect 'decays' rapidly over the following two or three weeks until they have forgotten about the programme.

In any classroom, there will be young people with a whole range of experience and knowledge from those who are totally naïve about drugs to those who may actually be trying to cope with serious drug problems at home. It is very difficult to devise programmes that work from where the students are 'at' in their life experiences of drugs.

### **So it is all a waste of time and money?**

While some elements of drug education are a statutory part of the science curriculum in schools, government guidance recommends that the non-compulsory Personal, Social and Health Education (PSHE) curriculum is used to cover drug education. In July 2010, Ofsted published a report on PSHE education in schools, which found that at three out of four schools visited, PSHE teaching was either good or outstanding. However, it was acknowledged that drug education remained one of the weaker parts of the PSHE curriculum and at one in five secondary schools visited, student's factual knowledge of drugs (including alcohol and tobacco) was "inadequate". Teachers may not always feel comfortable discussing drugs with their students and should be supported to develop the specialist knowledge, training and skills necessary to do so. But over and above this, it is probably unrealistic to imagine that schools can do this job by themselves without input and support from parents and local youth and community groups. And there is much to be said in trying to tackle the issue of drugs in the context of all

the other issues that impinge on children's and teenager's lives, like sex and relationships, drinking, bullying and healthy eating.

### **What about government campaigns like FRANK?**

Government drug policy primarily concerns itself with the drugs that cause most harm to individuals, families and communities: heroin and crack cocaine. Of course, there are a whole range of other illegal drugs in circulation and the government needs to address 'recreational' drug use in some way as well. One of the major pieces of ongoing government activity around recreational drug use is embodied in the FRANK campaign. Run by the Department of Health, it provides a 24/7 drugs helpline, a website containing drug information and a programme of advertising campaigns which have focused on cannabis, powder cocaine and legal highs. FRANK is primarily targeted at younger people, although the website does contain resources for parents concerned about their children's drug use.

There is no evidence that public campaigns actually reduce drug use – they mainly raise knowledge and awareness. Research conducted in the mid 80s evaluating the government's *Heroin Screws You Up* campaign revealed that at best it reinforced the antipathy towards heroin among those who would never have used it in the first place.

FRANK started out delivering a high proportion of harm reduction messages to young people concerned about drug use, with the website providing information about safer drug taking and how to limit the risks from drug use. Recently, however, it has begun to move towards a more overtly 'Just Say No' stance. Its popularity among young people appears to be on the wane although recognition and support for the campaign among parents has increased. It's undeniable that from a brand recognition point of view, the campaign has been very successful. At the time of writing, (November 2010), however, its future is uncertain.

# Resources

# Drug terms

**Abstinence** means not using substances. The term's use varies but abstinence-based or abstinence-focused can be used to refer to drug or alcohol treatment programmes that aim to help the person stop using drugs or alcohol for the rest of their lives. The definition of abstinence varies; for example, some people do not consider an individual to be abstinent when they are in receipt of substitute prescribing such as methadone.

**Addiction:** see *dependence*. The term addiction is inextricably linked to society's reaction to the user, and so medical experts try to avoid using it, preferring the term dependence instead.

**Addict** is a term often used to describe someone who is dependent on drugs. Many people in the field prefer to talk of dependent drug users instead, as addict can be seen as a morally loaded term that reduces the individual to the sum of their behaviour.

**Blood-borne virus (BBV)** is a virus that people carry in their blood. BBVs can spread to another person, whether the carrier of the virus is ill or not and may be transmitted sexually or by direct exposure to infected blood or other body fluids contaminated with infected blood. The main BBVs of concern are: hepatitis B, hepatitis C and hepatitis D, which all cause hepatitis, a disease of the liver, and human immunodeficiency virus (HIV) which causes acquired immune deficiency syndrome (AIDS), affecting the immune system of the body.

**Controlled drugs** in the UK are those controlled under the Misuse of Drugs Act. This divides drugs into three classes: A, B and

C according to an assessment of their danger to individuals and society at large. Class A attracts the highest penalties for possession and supply. These drugs are also controlled under the Misuse of Drugs Regulations which divides drugs into five schedules according to their medicinal value.

Schedule 1 would be for drugs for which a prescription is not available such as LSD or ecstasy. Drugs like morphine, which is used in the treatment of severe pain, are in Schedule 2. The Schedules cover such issues as manufacture and supply, prescribing and appropriate record-keeping.

**Come down** is the hangover or after-effect of taking a drug. Reflecting the low feeling experienced after the high of taking a drug, come down is mostly associated with the after-effects of stimulant taking, in particular ecstasy, which can last anything up to four days.

**Dependence** describes a compulsion to continue taking a drug in order to feel good or to avoid feeling bad. When this is done to avoid physical discomfort or withdrawal, it is known as physical dependence; when it has a psychological aspect (the need for stimulation or pleasure, or to escape reality) then it is known as psychological dependence.

**Dependent drug user** is someone whose drug use causes serious physical, social or psychological problems for them and/or for those around them. Another frequently used term to describe this group is problem drug user.

**Designer drugs** is a term coined in the 1980s to describe drugs specifically synthesised to circumvent regulations on controlled substances. Ecstasy is often cited as a designer drug, but this is incorrect. As a drug which is chemically similar to amphetamine, there was no need for new legislation to control its use when it became popular. Drugs such as Spice or mephedrone could, however, be considered designer drugs. Spice was synthesised to mimic the effects of cannabis, a controlled drug, and mephedrone was developed as a stimulant that would (initially at least) circumvent the law.

**Detoxification** is the process by which a user withdraws from the effects of a drug. It usually refers to withdrawal in a safe environment (a detoxification/detox unit), with help on hand to minimise the unpleasant symptoms.

**Drug use/misuse/abuse:** drug use is an easy term to understand. Misuse and abuse are more difficult to pin down, as they are highly subjective. In most circles, misuse means using in a socially unacceptable way. However, the definition currently being adopted defines misuse as using drugs in a way that results in experience of social, psychological, physical or legal problems related to intoxication and/or regular consumption. The term abuse may be regarded as too judgemental, as it suggests impropriety regardless of how the drug is being used. As abuse and misuse can be morally 'loaded' terms, some prefer to talk of drug-taking, or of harmful or problematic use instead, when appropriate.

**Harm reduction** refers to policies and projects which aim to reduce the health, social and economic harms associated with the use of drugs. Needle exchange programmes, for example, are a key harm reduction intervention. Harm reduction recognises that society is unlikely to ever be drug-, drink- or nicotine-free. Harm reduction does not exclude abstinence as a goal for individuals who are dependent but, rather, provides people with pragmatic choices such as limiting their intake or using drugs more safely.

**Headshops** are retail outlets which sell a wide variety of paraphernalia that may be associated with the use of illegal drugs (such as pipes or herb grinders for use in cannabis smoking). Headshops also frequently sell legal highs.

**Legal highs** are drugs that do not fall under the Misuse of Drugs Act, although they may be controlled under the Medicines Act. Some are herbal (also called herbal highs) such as ephedrine, yohimbine and salvia, but some, such as poppers, are synthetic or processed. They may be sold as legal and 'safe' alternatives to illegal drugs, but are usually retailed without a licence, and are not without their own risks to health.

**Needle exchange** is a harm reduction intervention enabling drug users to exchange used injecting equipment for new sterile equipment, reducing the risk of the spread of BBVs.

**Polydrug use** is the use of more than one drug, often with the intention of enhancing or countering the effects of another drug. Polydrug use, however, may simply occur because the user's preferred drug is unavailable (or too expensive) at the time.

**Problem drug use** can refer to drug use of any kind, regular or irregular, which is causing or exacerbating problems in the user's life (i.e. they may experience social, financial, psychological, physical or legal problems as a result of their drug use). However, it is worth noting that when the phrase problem drug use is used by UK government departments, they are usually referring to the dependent and/or chaotic use of heroin and crack cocaine, as these are the two drugs most likely to cause an individual, their family and their community the most problems.

**Recreational drug use** is the use of drugs for pleasure or leisure. The term is often used to denote the use of ecstasy and other 'dance drugs', and implies that drug use has become part of someone's lifestyle (even though they may only take drugs occasionally).

**Smart drugs** refers to drugs which are used to enhance cognitive abilities (such as concentration, alertness or memory). Some are stimulants – amphetamines such as Ritalin or Adderall – and some are designed to promote wakefulness, such as Modafinil, which has been used to help soldiers stay awake in battle.

**Substitute prescribing** is a harm reduction intervention which aims to help people manage their withdrawal from illicit drugs. In the UK, it most commonly refers to the prescription of medicines such as methadone, Subutex or buprenorphine as a way of managing withdrawal from heroin.

**Tolerance** refers to the way the body gets used to the repeated presence of a drug, meaning that higher or more frequent doses are needed to maintain the same effect.

**Withdrawal** is the body's reaction to the sudden absence of a drug to which it has adapted. The effects can be stopped either by taking more of the drug, by managed detoxification or by 'cold turkey' – which, depending on which drug was being used and in what quantities, may last for up to a week.

## Common acronyms

### **ACMD (Advisory Council on the Misuse of Drugs)**

An independent panel of experts who report to the Home Office, with a statutory responsibility to advise government on the continuing operation of the Misuse of Drugs Act 1971 and changes in the law deemed necessary in the light of emerging evidence.

<http://www.homeoffice.gov.uk/drugs/acmd/>

### **ADP (Alcohol and Drug Partnerships)**

Announced in April 2009 by the Scottish Government, the partnerships replace the previous model of drug and alcohol action teams still operating in England (see below). Partnerships are set up in every local council area.

### **CDT (Community Drug Team)**

Specialist drug treatment services operating at a local level.

### **DAT (Drug Action Team)**

Multidisciplinary teams drawn from health, social services, education, police and voluntary services backgrounds to lead and co-ordinate local and regional collaboration and ensure coherence in relation to the government strategy. Teams may also deal with alcohol.

### **DIP (Drug Interventions Programme)**

DIP involves identifying offenders who are using heroin and/or cocaine as they go through the criminal justice system and ensuring that they receive treatment. DIP encompasses a range of interventions such as Arrest Referral, drug testing on arrest and DRRs (see below).

### **DRR (Drug Rehabilitation Requirement)**

If an offender's sentence includes a DRR, it means they will be obliged to undertake drug treatment (either in the community or in a residential setting) and submit to regular drug testing. DRRs can be used instead of custody and offer courts a vehicle for tackling the drug misuse and offending of serious and persistent drug-misusing offenders. The DRR is one of the 12 requirements which can be included in a community sentence. It replaced the Drug Treatment and Testing Order (DTTO) in 2005. The idea of the DTTO was to enable courts to order offenders to enter treatment or face punishment (usually prison). The DRR also replaced the Drug Abstinence Order/Requirement as these were both found to be ineffective in reducing reported heroin and/or cocaine use among offenders.

## Useful organisations

**DrugScope is the national membership organisation for professionals working in the drugs sector. Our members include people working in treatment, primary care, housing, mental health, criminal justice and education. We are also the UK's main source of independent information about the misuse of drugs. You can find out more about our work on our website: [www.drugscope.org.uk](http://www.drugscope.org.uk)**

**A major part of DrugScope's work involves communicating good quality information about drugs to anyone who needs it. Working with the media helps us achieve this. Our spokespeople undertake hundreds of interviews every year and staff in the Press Office are always available for the provision of information and background briefing for journalists.**

**You can call the DrugScope Press Office on 020 7520 7550 and select option 3. If you're calling out of normal office hours, you can call the mobile on 07736 895 563. We will also respond to enquiries by email at [press@drugscope.org.uk](mailto:press@drugscope.org.uk)**

### **Addaction**

One of the UK's largest specialist drug and alcohol treatment charities which works with around 26,000 people every year. As well as adult services, Addaction also provides services specially tailored to the needs of young people and parents.

**[www.addaction.org.uk](http://www.addaction.org.uk)**

### **Adfam**

Adfam is the national umbrella organisation working to improve the quality of life for families affected by drug and alcohol use.

**[www.adfam.org.uk](http://www.adfam.org.uk)**

### **FRANK**

FRANK is the government's national anti-drugs campaign which provides drug information aimed primarily at young people. FRANK operates in England and Wales only (see Know the Score for Scotland).

**[www.talktofrank.com](http://www.talktofrank.com)**

### **Know the Score**

Know the Score is the Scottish Executive's national anti-drugs campaign which, like FRANK in England and Wales, provides drug information aimed primarily at young people.

**<http://knowthescore.info>**

### **NTA (National Treatment Agency)**

The NTA is a Special Health Authority, established by the government in 2001 to increase the availability, capacity and effectiveness of drug and alcohol treatment in England. In July 2010, it was announced that the NTA is to be abolished in April 2012, when its functions will be absorbed into the proposed Public Health Service.

**[www.nta.nhs.uk](http://www.nta.nhs.uk)**

### **Phoenix Futures**

Leading provider of services for people with drug and alcohol problems. Phoenix Futures offers services within community, prison and residential settings in England and Scotland.

**<http://www.phoenix-futures.org.uk>**

### **Release**

A centre of expertise on drugs and drug law which provides free and confidential specialist advice to the public and professionals, as well as campaigning for drug law reform.

***<http://www.release.org.uk>***

### **Scottish Drugs Forum (SDF)**

A non-governmental drugs policy and information agency working in partnership with others to coordinate effective responses to drug use in Scotland.

***<http://www.sdf.org.uk>***

### **SOCA (Serious Organised Crime Agency)**

The agency was formed from the amalgamation of the National Crime Squad (NCS), National Criminal Intelligence Service (NCIS), the part of HM Revenue and Customs (HMRC) dealing with drug trafficking and associated criminal finance and a part of UK Immigration dealing with organised immigration crime (UKIS). In July 2010, it was announced that SOCA could be folded into a new National Crime Agency.

***[www.soca.gov.uk](http://www.soca.gov.uk)***

### **Transform**

A charitable think-tank established to promote drug policy reform and examine alternatives to prohibition.

***<http://www.tdpf.org.uk>***

### **Turning Point**

A UK social care organisation which provide services for people with complex needs, including those affected by drug and alcohol misuse, mental health problems and those with a learning disability.

***<http://www.turning-point.co.uk>***