



### **The legal framework:**

The **Misuse of Drugs Act 1971** categorised substances based on their "potential to harm" into **Class A, B and C**, with legal penalties set accordingly.

**Class A drugs include: heroin, cocaine, ecstasy, LSD, hallucinogenic mushrooms** and (from January 2007) **methamphetamine ('ice')**

**Class B drugs include: cannabis, Spice** (a synthetic cannabinoid, from Dec 2009), **amphetamine sulphate (speed)** and the **barbiturates**.

**Class C drugs include: Gamma-hydroxybutyrate (GHB), Gamma-Butyrolactone (GBL), Benzylpiperazine (BZP**, both from Dec 2009), **ketamine** and **valium®**.

Within each class, penalties are highest for trafficking and dealing, less high for possession.

The 1971 Act also divided controlled drugs into **five schedules** denoting their "**therapeutic benefit**". Drugs in **schedule 1** (such as cannabis & LSD, which are deemed to have none) are the most tightly controlled, while those substances in **schedule 5** (such as mild painkillers and cough mixtures), are available from pharmacies. The majority of controlled drugs (including heroin) occupy the other schedules - those only administered in accordance with a prescription or under medical supervision.

In August 2006 the Advisory Council on the Misuse of Drugs (ACMD) said that the ABC drug classification system "***lacked transparency***", was "***unfit for purpose***" and noted that the way (successive) government(s) used "***selective scientific evidence***" to inform policy was "***a dereliction of duty***".

Research carried out in 2007 for the ACMD by medical experts, who analysed the **addictive qualities, social harm and physical damage** associated with 20 substances, produced a very different table of "potential to harm" to the one which has been in place for the last 35 years, with **alcohol** in **5th** place, ahead of prescription **tranquillisers (7th)**, **amphetamines (8th)** and **cannabis (11th)**, while **tobacco (9th)** and **solvents (12th)** were judged more damaging than **LSD (14th)** and **ecstasy (18th)**, increasing pressure for a radical review of the whole drug classification system and existing legal framework.

### **Potential to harm of 20 named substances**

20 = least risk, 1 = most risk

1. Heroin
2. Cocaine
3. Barbiturates
4. Street Methadone \*
5. Alcohol



6. Ketamine
7. Benzodiazopines
8. Amphetamines
9. Tobacco
10. Buprenorphine \*
11. Cannabis
12. Solvents
13. 4-MTA
14. LSD
15. Methylphenidate (Ritalin)
16. Anabolic Steroids
17. GHB
18. Ecstasy
19. Amyl Nitrate
20. Khat

\* Opioids (synthetic opiates)

In November 2009, Professor David Nutt was sacked from his post as chair of the Advisory Committee for the Misuse of Drugs by the Home Secretary, partly as a result of this research. This led to considerable disquiet amongst the scientific community and prompted many commentators to suggest that the present Government's avowed commitment to 'evidence-based policy making' is somewhat less than congruent.

## **HARM MINIMISATION GUIDELINES**

The way a drug affects the person who has taken it depends as much upon the psychological characteristics, personality and mood of the individual (and their *social* context) as upon the chemical properties of the drug itself. The notion that specific drugs have **fixed** and **predictable** effects (which are the *same* from *person* to *person*) remains extremely widespread, but is in fact *not* the case. The generalised confusion about which drug category some substances actually fit in to reflects this. However, current understanding identifies the following categories and effects:

**Depressants:** substances that depress the activity of the Central Nervous System and produce an altered state of consciousness. They include: alcohol; benzodiazepines (including Valium ®); GHB/L; barbiturates; solvents.

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Depending on dose, common effects include elevated mood, relaxation, loss of inhibitions, uncontrolled behaviour, slowed breathing and reactions, reduced heart rate, eventual sedation.

**Analgesics:** substances that suppress psychological distress, physical and/or emotional pain and produce an altered state of consciousness, and include: opium, morphine, heroin and codeine; paracetamol and aspirin can also be included here, as can ketamine and cannabis.

Depending on dose, common effects include euphoria, detachment, and relief from negative stimuli, slowed heart rate and breathing, drowsiness.

**Stimulants:** substances that stimulate the activity of the Central Nervous System and produce an altered state of consciousness, and include: cocaine/crack; amphetamines (speed); ecstasy; mephedrone ('meow'); tobacco; crystal methamphetamine (ice); BZP; caffeine and ephedrine.

Depending on dose, common effects include increased heart rate and energy, changes in self-awareness, suppressed appetite, euphoria, confidence, talkativeness and sociability.

**Hallucinogens (psychedelics):** substances that dramatically alter perception, sensory experience and states of consciousness, and include LSD (acid), magic mushrooms, ecstasy, ketamine (Special K), cannabis; and solvents.

Depending on dose, common effects include relaxation, changes in self-awareness, mood and cognitive functioning, dramatically altered sense of time and space, euphoria, alterations to visual and auditory sensory input.

## Depressants

### ALCOHOL



#### Methods of use:

Because alcohol is a substance in liquid form, it can often be considered primarily as a *drink* rather than as a powerful **depressant drug**.

#### How it works:

Alcohol rapidly enters the stomach and passes through the stomach wall in an almost unchanged form. It then enters the bloodstream and is transported to all parts of the body. Reaching the brain, it begins its depressant action. 'Higher' mental processes are affected first (governing relationship to self); emotions and inhibitions are 'released', giving rise to

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the common misconception that alcohol is a stimulant. Other effects felt (because **psychological and social influences** are as important as any **biochemical process**) depend on a number of factors, including how much is drunk, how quickly, the strength of the drink, the size and gender of the person, the *personality* of the drinker, their *expectations* and *mood* before starting to drink, whether food has been consumed and *where* the drinking behaviour is taking place.

Calculation for working out UNITS (**1 unit** = 10 ml of 'pure alcohol')

% ABV (% Alcohol content By Volume)

DIVIDED by 1000, then:

MULTIPLY by contents of can (or bottle) in millilitres.

**Example:** 5.5% (ABV) divided by 1000 multiply by 1000 (ml) = **5.5 units** per litre.

## Physiological & psychoactive effects:

Alcohol's initial effects include alterations in the drinker's usual relationship to their sense of self, with levels of relaxation, emotions and inhibitions all affected in different ways, **dependant on set and setting**. At higher doses, and with the accumulative impact of its depressant action increased, alcohol affects attention span, mood, co-ordination, balance, vision, reaction times, reflexes and memory, leading eventually to stupor, unconsciousness and possible coma or death. The use of alcohol in western culture clearly demonstrates the huge influence set and setting have on the drug experience, evident in the different drinking behaviours of Northern and Southern European countries, as much as in the way a **depressant** drug plays such a vital role in **stimulating** celebrations and festivals. Equally, the relentlessly promoted, celebratory and glamorous images associated with alcohol via advertising contribute massively to a widespread public misunderstanding of its 'true' nature as a substance (thinking of it as a drink rather than as a drug, for example) and the real risks associated with it. Recent research into alcohol and violence concluded that there was in fact *no* direct causal relationship, emphasising instead that: "*The probability of aggression is increased when the effects of alcohol-induced cognitive impairment are amplified or exacerbated by both the characteristics of the immediate situation and the cultural expectations that drinking causes aggression*".

[http://www.sirc.org/public/alcohol\\_and\\_violence\\_8.html](http://www.sirc.org/public/alcohol_and_violence_8.html)

## Risks:

The liver can process approximately **1 unit** of alcohol **per hour**: it starts processing the alcohol around 20 minutes after the first drink. A person drinking above 24 units a day, every day, for any *extended length of time* would be likely to fulfil the **clinical (medical) definition** of alcohol dependency. The idea of dependent alcohol use ('alcoholism') as 'disease' or as uncontrollable most likely originates here, because the minute blood/alcohol levels drop below a certain point, **resisting** the need to 'top-up' will be extremely *difficult* for the drinker to do. Therefore, the message (from family, friends and concerned others) often given to a dependent alcohol user - "*Why can't you just stop?*" - can easily miss the point of how difficult and potentially dangerous this may actually be; conversely, the message that suddenly stopping use of alcohol is too dangerous to do *without* medical intervention can, if not explained properly, lead to the drinker continuing with high levels



of consumption without appreciating that a gradual reduction and slow detoxification is - in the *right* circumstances - a viable option.

The 10 most common symptoms of alcohol withdrawal are:

- Depression
- Anxiety
- Irritability
- Tiredness
- Craving
- Restlessness
- Insomnia
- Confusion
- Sweating
- Physical weakness

The contra-indications (restlessness, anxiety, depression, insomnia) of alcohol can easily reinforce a person's belief that drinking more will reduce those experiences, when it's just as likely that more will be *contributing* to those very symptoms.

Withdrawal from long-term or heavy alcohol use is one of the most severe drug withdrawal states (far more serious than that provoked by heroin, for instance, despite celluloid depictions to the contrary), and can, in certain circumstances, be **fatal**.

#### **Harm minimisation:**

Rules and rituals appear to protect individuals and groups from some of the more negative effects of alcohol use by establishing a framework that mediates, and therefore helps control, its use. These can and should be (re) introduced and can include:

- Not using on consecutive days
- Not using because angry, depressed or anxious
- Having a 'not-before-a-specific-time rule'
- Not drinking on an empty stomach
- Alternating alcoholic drinks with water or soft drinks
- Switching from a high to a lower unit alcoholic drink
- Partially diluting the drink of choice

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- Separating alcohol use from cocaine, heroin or tranquiliser use where practical or possible

## Benzodiazepines (Valium®, Yellows, Blues)



### Methods of use:

Swallowed in pill form

### How it works:

Benzodiazepine tranquilisers work by blocking the ability of receptors in the brain to receive stress-stimulating messages; their main use is to lessen both 'generalised' and 'normal' **anxiety**, although they are closely related to **sleep-inducing** prescription drugs such as Temazepam.

### Physiological & psychoactive effects:

Whether prescribed by a GP, the Substance Misuse Service (SMS), or obtained from the extensive illicit street trade in these drugs, tolerance can be marked and rapid. Users describe a range of experiences associated with their use, including a quietening of restlessness and worry, an increased sense of stillness and reduced anxiousness, improvements to mood and as a means of aiding restfulness and/or sleep. However, as with alcohol, the contra-indications (anxiety, depression, insomnia) arising from over-use of the substance can easily reinforce a person's belief that taking more will reduce those experiences, when it's just as likely that more will be contributing to those very symptoms.

### Risks:

Benzodiazepines mixed with alcohol increases the action of the respective substances as well as the relative risks associated with them.

Used in combination with any opiate-based drug (heroin, methadone) the risk of overdose increase proportionately. Working with people around reducing their combined use of these three substances will contribute massively to continuing to reduce the incidence of drug-related deaths in Brighton & Hove.

Benzodiazepines can impair manual dexterity, intellectual ability and memory during the period of their use, and for a variable time after discontinuing.

High doses of benzodiazepines - or their use in combination with alcohol - can be one of the most difficult and challenging drug presenting states to deal with - **guidelines for working with people who are (alcohol) intoxicated** can be very useful in such situations.

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### Harm reduction:

Abruptly stopping benzodiazepine use, especially at high doses, can induce a severe withdrawal state characterised by severe anxiety, paranoia and confusion.

Smoking tobacco, which affects enzymes in the liver, may lessen the effects of diazepam by increasing its rate of metabolism.

Even after tapering off the dosage (the most effective way of coming off the tranquilisers), a withdrawal syndrome may occur. In its mildest and most common form it represents a rebound syndrome, as seen with many different drugs (the legal as well as the illegal). For several days, sometimes much longer, the person feels jumpy, tense, anxious, and feverish; sleep can be poor and broken by nightmares. Panic attacks may be common. Other characteristics of withdrawal are:

- Psychological symptoms of anxiety; apprehension, mental tension, inattention, irritability and insomnia.
- Bodily symptoms of anxiety; palpitations, tremor, sweating, nausea, stomach cramps and loss of appetite and weight.
- Perceptual symptoms of heightened sensory awareness; sounds seem loud, lights bright. Pain and muscle spasms may be widespread - the person feels unsteady and there may be taste/smell abnormalities.
- Other symptoms may occur, such as 'pseudo withdrawal' - in which the person becomes anxious and apprehensive about the process of withdrawal even before any real reduction in dose has taken place. Working to re-frame this mind set prior to any reduction is an important intervention.

The duration of the withdrawal syndrome is very variable and very difficult to predict in individual cases. Most syndromes last 7 to 21 days, although residual anxiety may persist and periods of depression become more marked. However, in some users the perceptual symptoms such as pain may persist for weeks, months - even rarely for a year or two. Typically, such symptoms are **not** helped by resuming benzodiazepine use but are better addressed through counselling, cognitive behavioural therapy or some other form of treatment.

### Volatile substances (Solvents, Glue, Gas)



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### Methods of use:

Volatile substances describe a range of chemicals in gaseous or liquid form (including solvents, glue, aerosols), which are inhaled for their psychoactive effects. Gas products (butane) can be squirted directly into the back of the throat and are *extremely dangerous*. Although their use is most often associated with young people (it is estimated that 3.5%-10% have at some point experimented and that 0.5-1% are regular users), people of *any* age can and do also use these substances.

### How they work:

Inhaled vapours pass through the lungs into the bloodstream, and are delivered to the brain.

### Physiological & psychoactive effects:

Users describe a range of effects, from a rapid alcohol-like intoxication to feelings of power and strength, from anaesthetised disorientation to intense hallucinations – these are often short-term (10 minutes to half an hour) but can be sustained for longer periods by repeated administration.

### Risks:

The risks involved in the use of volatile substances are **considerable**. They include nausea, vomiting, blackouts, burns to face and hands, potential damage to the liver and kidneys, circulatory and heart problems. The propellant gas in aerosols is refrigerated and if it is sprayed directly into the mouth it can cause the larynx to go into spasm, blocking off air supply and causing asphyxiation and death.

### Harm reduction:

There is no such thing as the safe use of most volatile substances and it is important to note that most of the desired effects are available via a range of other, far less dangerous drugs (see Hallucinogens section). However, they are more dangerous to use alone than in a group, to use in a confined space with no adequate ventilation and in a hazardous environment where accidents are more likely while intoxicated. The use of glue - because its vapours do not contain the most damaging compounds - because its vapours do not contain the most damaging compounds - probably carries the *least* risk, but as use is often with a plastic bag, potential suffocation remains a real concern.

### GHB (Liquid X, Liquid E,)



### Methods of Use:

GHB (gamma-hydroxybutyrate) usually comes in the form of a powder. When used

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recreationally it is diluted with a small amount of liquid, usually water. Accurate dosing is *essential*. Individual doses should be measured out as required.

### How it works:

GHB affects the release of dopamine in the brain. The onset of the effects might be expected to take 10-30 minutes but could take an hour (for this reason, re-dosing should be **avoided** for at *least* an hour). It is a short-acting drug, with most people reporting effects of an initial dose lasting for a couple of hours.

### Effects:

GHB is used medically as a mild anaesthetic or to aid childbirth (because of its muscle relaxant effects) in some countries. The effects of GHB are variable with dosage and with the influence of set and setting, with each individual having their own 'optimum dose' and the euphoric feeling that comes with that optimum dose fuels its recreational use. Many people also use GHB as an enhancement to sex, as touch becomes more sensual and inhibitions dissipate. It also has certain qualities in common with alcohol (indeed, many people use GHB as an alcohol substitute) - at lower doses it induces alcohol-like dizziness and slightly drunken slurring, while at higher (or too high) doses, GHB induces sleep (often a difficult-to-arouse or coma-like sleep), can stimulate muscle growth and is used by some people as an anti-depressant.

### Risks

There are two major risks. The first is mixing GHB with alcohol (or other depressants or analgesics) as this causes cumulative depressive effects, increasing the risk of nausea, vomiting and potential overdose. For this reason, **alcohol should not be used** prior to or during GHB use. The second risk is overdose: this is almost entirely related to the extremely sharp "dosage response curve" of the drug. What this means practically is that the difference between the optimum, euphoric dose and sleep or coma-inducing overdose is **very** slight. Non-fatal overdose is extremely common with GHB. The user becomes totally non-responsive and breathing is depressed. Easily mistaken for a non-specific depressant OD, GHB induced sleep is actually **relatively** safe if used on an empty stomach (eating food prior to use will increase the likelihood of vomiting) and if the user has **not** mixed the drug with **alcohol** or **another substance**.

GHB can also be sold in liquid form but as there is no way of knowing the concentration of GHB in that liquid, it's important that service users appreciate that the gradual 'swigging' of an already made-up solution may produce a more prolonged experience as well as increase the risk of overdose.

Psychological and physical dependence can both arise from the habitual (one or more doses a day) use of GHB, with some people reporting withdrawal symptoms such as insomnia, intense craving and physical discomfort (aches and pains) but these appear to pass completely once the period of withdrawal is over (following a gradual **tapering off** to zero use over a 2-3 week period).

Despite persistent media coverage to the contrary, evidence of the widespread use of GHB as a 'date-rape drug' remains statistically unconfirmed (with 4 out of 120 investigated

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cases in the UK, according to the 2006 Operation Matisse research), and can minimise the role of the main drug implicated in the majority of sexual assaults, which is alcohol (119 out of that 120). However, given its range of effects and the fact that it can potentially be added to the drinks of unsuspecting victims, it is important to highlight such concerns to both male and female users.

People who are epileptic, have heart problems, high blood pressure or are asthmatic should avoid using the substance.

GHB-related **fatalities** are usually linked to some sort of **poly-drug** use, with alcohol particularly implicated.

### **Harm Reduction:**

GHB should **not** be mixed with alcohol.

GHB should **not** be mixed with alcohol (this cannot be said enough).

Anyone taking GHB in a public place should write the letter G on their hand in case of accidental overdose.

It is important to follow these rules when it comes to re-dosing:

1. Find an optimum dose by starting low (as low as 0.75g) and work upwards in small increments
2. Never re-dose within an hour
3. When re-dosing after an optimum dose, never use more than 1g. A quarter to a third of the initial dose would be a rough guide.

Using GHB alone should be **avoided**.

In 2003 GHB was made a class C drug under the 1971 Misuse of Drugs Act. The repercussions of this have been an upsurge in the use of another chemical, **gamma-Butyrolactone**, or GBL, a common industrial cleaner. GBL converts to GHB in the body. Users describe the experience as being similar to but 'harsher' than that offered by GHB. The dose for GBL is much smaller leading to an even easier propensity for accidental overdose. Its use is now commonplace and increasing.

In late 2009, it was also categorised as a class C drug.

Additional research courtesy of Geoff Chapman/Planetgeli.

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## Analgesics

### HEROIN:



### Methods of use:

- Intravenous use (IV) = reaches brain in **7 to 8 seconds**
- Intramuscular or skin-popping = **5 to 8 minutes**
- Smoking/chasing the dragon/snorting = up to **15 minutes** (for a 'peak experience')

### How it works:

- Heroin mimics the action of the body's natural painkillers, endorphins.
- Unlike with alcohol, there is little or no effect on motor coordination, sensory or cognitive awareness and capability.

### Physiological & psychoactive effects:

- Dilation of pupils
- A reduction in the depth and frequency of breathing (because of opiate receptors in the lungs)
- Intestinal functions are inhibited (causing constipation)
- Reduced sexual capacity and interest
- At high doses it can cause drowsiness - 'gouching' in the street vernacular
- Women may experience irregularities in their menstrual cycle and use during pregnancy can affect the foetus.
- Users report an experience of intense euphoria which reduces fear, distress, pain and other negative stimuli; this warm surge can then be followed by a period of tranquillity, of feeling drowsy and wakeful, warm and content, cocooned and emotionally self-contained, stimulated and sociable; or else dreamy, relaxed, and 'wonderfully detached' (**all dependent upon dose, set and setting**).

### Risks

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- Pure, unadulterated heroin is comparatively benign; it does no damage to the body's organs or tissues and leads simply to developing a strong tolerance for the drug (where the user needs an increased dose of the drug to obtain the effects previously obtained with a lower dose).
- Because opiates suppress feelings and emotions, relations with others can be adversely affected through reduced 'social functioning'
- The adulterants often added to street heroin (including bicarbonate of soda, sugar powder, brick dust and talcum powder) are a real concern
- B.B.V. (blood born virus) infection (HIV, Hep C) being spread via sharing of 'works' (syringes, spoon, water, tourniquet, etc)
- Methods of administration
- Frequency of IV use
- Abscesses
- Unpredictability of purity and dose
- Unsafe injecting environment (setting)
- Acquisitive crime committed to pay for the drug.

### **Key risk factors in the intravenous use of a drug:**

**Substance related factors:** Drugs being injected; strength of drug; contaminants in drug; interaction *between* drugs.

**Injecting-specific factors:** Equipment used; sites used; sharing of equipment; ASCEPTIC (free from harmful bacteria) technique.

**Personal factors:** Physical health; mental health; cultural and personal factors.

**Environmental factors:** having a safe space to inject; access to resources; access to equipment.

**Quantitative risks:** - Dosage; strength/toxicity; frequency

**Qualitative risks:** - Access (to substance); preparation; route/style of use; poly-drug use (particularly tranquiliser-alcohol-methadone-heroin combinations; aftercare (the 'come-down' space)

### **Harm reduction:**

Rules and rituals appear to protect individuals and groups from some of the more negative effects of drug use by establishing a framework that mediates, and therefore helps control, that use. These can be (re) introduced as a way of 'managing' heroin use and can include:

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- Respecting the 'pleasure principle' by not constantly using on consecutive days because the heroin user recognises that it's impossible to be anywhere *all* the time – the paradox of pleasure is that what is *enjoyed* has to be *respected* if it isn't to become a source of *pain*.
- Having a 'not-before-a-specific-time rule'.
- Separating heroin use from alcohol or tranquiliser use where practical or possible.
- Recognising that the idea that smoking heroin leads *inevitably* to IV heroin use is an unhelpful myth and the belief that once having started injecting heroin it is impossible to return to smoking (or other methods of administration) is equally problematic, as viable options to address and reduce areas of harm arising from the *method of use* can be blocked.
- Tolerance can go *down* as well as up, and working with this fact in a creative way might be very useful in the **decision** or **action** stages in the **cycle of change**.
- Encouraging people to care about their physical, emotional and mental health by improving their injecting technique, reducing the incidence of IV use and exploring alternative ways of using the drug can *all* be areas for useful investigation.

### METHADONE:



A commonly held view within drug treatment services (and from a 'medical model') is that "there's no excuse for someone on a methadone script using heroin on top."

- Methadone is an opioid (synthetic opiate) commonly used in substitute prescribing and is a longer-lasting drug than heroin (withdrawal symptoms are unlikely for 24 hours after use).
- It can reduce or stop the *physical* withdrawal symptoms of coming off opiates, but does *not* reproduce the psychoactive effects (the "rush") offered by and associated with heroin use, which is one reason why people may continue to use heroin even when on a script.
- It *can* be a useful intervention for people in the **decision** and **maintenance** stages of the cycle of change (or to help people stabilise during the **contemplation** stage) but many people would nonetheless prefer the option of a diamorphine script.

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- It is usually taken orally (liquid or tablet) but can also be injected.
- Because methadone takes time to build up and have a complete effect (often up to about 4 days after treatment commences), missing a dose can cause considerable discomfort – having a regular pattern/time of use will reduce any physiological discomfort.
- Despite urban myths to the contrary, it appears that methadone can be prescribed safely for many years without causing damage to bones, liver, brain, heart, reproductive or immune systems, although high-sugar content methadone does appear to damage teeth and gums, while profuse sweating and weight gain are also common.
- The withdrawal state associated with methadone is recognised as being more arduous, intense and longer lasting than that associated with heroin, although this may have as much to do with the context in which any reduction might be happening as it does to the non-psychoactive nature of the substance.
- A dangerous drug in its own right, methadone has a higher mortality rate than that associated with illicit heroin, with the risks of an overdose increasing dramatically when mixed with other opiates, alcohol, sleeping pills or tranquilisers, and when the person using the substance has no tolerance (naive users).

## Subutex

- An opioid in pill form; it is most likely to be prescribed for those who *smoke* heroin. It is a 'partial antagonist', which means it sits on the brain's opiate receptors to block the high produced by heroin.
- Subutex is most commonly used for short-term detox in Brighton & Hove, although it can be used for longer-term maintenance.
- The tablets can be crushed and snorted in order too induce an altered state of consciousness, although this is more likely when *other* sources of opiates or opioids are not readily available.

## Stimulants

### COCAINE/CRACK: (Coke, Charlie, Rock)



### Methods of use:

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- Snorting
- Orally (via gums)
- Smoking
- Injecting

### How it works:

- Cocaine and Crack work by releasing surges of neurotransmitters (chemical messengers) into the central nervous system that are already present in the body but not *usually* available in such large quantities.
- It is important to note that these are part of the instinctive behaviour patterns that govern responses to danger and which reward and reinforce behaviour.
- The increased and altered levels of awareness are produced by adrenalin and the neurotransmitters dopamine (initial high, energy, reinforcement of behaviour) and serotonin (pleasure, prolonged high, elevated mood).

### Physiological & psychoactive effects:

The release of these neurotransmitters is usually calibrated on a kind of scale, with food = low release, social contact = medium release and sex = high release. Cocaine and crack release these in much larger quantities than normally available, potentially putting them way above sex on the reward and reinforcement scale. Users describe a "*powerfully attractive experience*", including euphoria, laughter, talkativeness, increased libido and energy. Despite the quite divergent perceptions of cocaine (glamorous, high-achieving, recreational) and crack (dark, depraved, addictive) the differences between the two come down to production method, cost (and therefore *class* of user), and delivery system (smoking being a more immediate and intense way of taking the drug than snorting), and not any *real* pharmacological or biochemical distinction between them.

### Risks:

#### Injecting:

- Breaking down rocks of crack with citric acid makes them become more caustic, leading to possible abscesses.
- The **anaesthetic** effects of the drug are increased at high doses. This can mean that needle-stick injuries or misses are not felt or noticed, finding alternatives to "snowballing" (using heroin/cocaine simultaneously) is an important **harm minimisation** intervention.
- IV use also puts extra pressure on the heart by restricting blood vessels, increasing the risk of seizures or strokes.

#### 'Piping':

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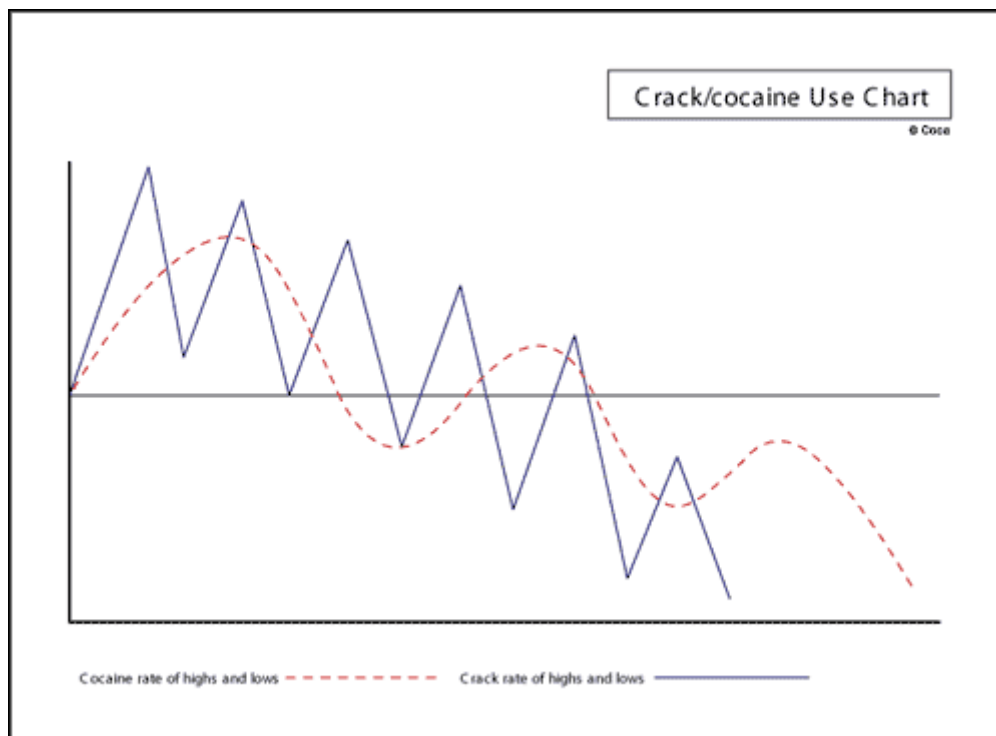
- The most common means of delivering a crack hit is to use a tin can, water bottle, or asthma inhaler, as these provide high doses relatively efficiently to the central nervous system (and actually produces a 'better' high than via IV use).
- The presence of toxic paints on tin cans can be problematic as they are likely to contribute to respiratory and/or lung damage.

### Snorting:

- Snorting powdered cocaine via a rolled note or other **shared** delivery device (biro, customised glass tube) carries the risk of Hep C transmission through the membranes in the nose (which bleed easily)

### Harm reduction:

- **The Flush System:** the dopamine and serotonin released through repeated crack use demonstrates the "law of diminishing returns", in that their "re-uptake" is inhibited (reduced) and therefore the necessary ingredients for the high are no longer available within the central nervous system. This is the reason why the compulsive crack binge in pursuit of the initial high will inevitably fail to deliver, no matter the quality or amount of the drug used. This can be underlined 'visually' with Coca's Using Chart and be demonstrated via the 'toilet flush system' to enable people to actively appreciate this important point.



- **Spliffs/chipping:** Rolling 'chipped' pieces of a crack rock in a joint provides an inefficient, low dose but allows much greater controlled use (the dealer's choice).

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This is **not** possible with cocaine as it ceases to be psychoactive at such high temperatures.

- **Parachuting (lessening the impact of the come-down):** the invitation is to consider alternatives to heroin, tranquillisers or alcohol use when managing or 'taking the edge off' the comedown experience. *In this context*, using cannabis would be a preferable **harm minimisation** intervention.
- **Mixing with alcohol:** cocaine and alcohol create a third substance in the body, coco-ethanol, which can badly damage the lining of the stomach and *increase* the risks of cardiac problems. Separating out the use of both substances has **important** harm reducing potential – using alcohol prior to any stimulant use is likely to involve much higher amounts of the drug being taken (than would be otherwise necessary) because of alcohol's depressant action on the central nervous system.

With grateful acknowledgement to Coca's "Working with Cocaine & Crack" training.

## **METHAMPHETAMINE (Crystal meth, meth, Ice)**



### **Methods of use:**

Non-medical methamphetamine is produced in tablet, powder and crystalline form ('ice' is chased – smoked - via a pipe or bong).

### **How it works:**

As with other stimulant drugs, use of methamphetamine releases high doses of the neurotransmitters dopamine (initial high, energy, reinforcement of behaviour) and serotonin (pleasure, prolonged high, elevated mood) in the brain.

### **Physiological & psychoactive effects:**

- These are more pronounced and intense than those provided by amphetamine but have a less prominent impact on the peripheral nervous system (hence its street name, '**ice**', according to some).
- It increases arousal and motor activity: users describe a very different, powerfully altered sense of self (with increased confidence and sense of potency common themes); it diminishes fatigue and the need for sleep and hugely suppresses appetite. The **rapid, euphoric rush** can be highly **reinforcing** and compulsive, with 'chasing' adding a potential for dependency through ritualism & the

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- Talk of a "95% addiction rate" is more a reflection of tabloid sensationalism than research data, which precedence shows is unlikely to stop people experimenting with the drug but which undoubtedly contributes to the creation of an unhelpful (mind) set - not dissimilar to the one associated with crack cocaine in the 80s and 90s – and long before the substance has any kind of real presence in the UK.

## Risks

- Increased heartbeat can put prolonged strain on the cardio-vascular system, with hypertension, agitation, feelings of being 'frazzled', short-tempered, irrational, with 'scratchy skin' (note that these all match similar symptoms when a person experiences extended periods of sleep-deprivation), weight loss and calcium deficiency also common.
- Long-term or heavy users display "poor performance on verbal reasoning, working memory and there were deficits in attention, decision-making and memory" (**AMCD report, 2005**), although all these areas show improvement after a (prolonged) period of abstinence.

## Harm reduction:

- Eating food prior to any use of the drug
- Keeping hydrated during the duration of methamphetamine use
- Employing the **3 Rs (rules, rituals and respect)** as a means of 'managing' use of the drug
- The extremes of methamphetamine-induced exhaustion (or 'psychosis' as sometimes unhelpfully described) following prolonged smoking/chasing has, according to experienced users, only one antidote - **sleep**, and lots of it. This then needs to be followed by an extensive period of "repair time", involving replenishing those areas 'drained' by methamphetamine use.

## ECSTASY: (XTC, X, E, MDMA)



## History:

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- MDMA (methylene-dioxy-methamphetamine) was first synthesised in 1898, and was patented in 1912, prior to (allegedly) being experimentally used as an appetite suppressant during the 1st World War. A substance that sits on the continuum between a stimulant and a hallucinogen (dependent upon set and setting) MDMA was 'rediscovered' in the mid 70s by bio-chemist Alexander Shulgin, before going on to be used in both therapeutic and recreational settings in the US and Europe. Its arrival on the UK club scene in the mid-to-late 1980s started a process that led to what became known as the second Summer of Love, transforming whole aspects of mainstream and youth culture, from football hooliganism to music ("sounds wholly or predominantly characterised by the emission of a succession of repetitive beats," according to the 1994 Criminal Justice & Public Order Act's description), fashion and design - indeed, to a whole generation's attitude *to* and ideas *about* drugs and drug use.
- Statistics from the Henley Centre show that visits to pubs by young people fell by 11% between 1987 and 1991 (because the 'set' for ecstasy at this time did not include alcohol use). Concern within the alcohol industry about these figures prompted the introduction and aggressive marketing of a whole new range of drinks ('alcopops' among them) aimed particularly at the dance generation and young people. The contemporary club and dance scene is now characterised by the widespread use of both these substances (along with cocaine, crack, GHB and ketamine), despite the attendant problems (including increased risk of dehydration and heatstroke, as well as the push/pull on the central nervous system of simultaneous use of depressant and stimulant drugs).

### Methods of use:

- Widely available in pill, tablet or crystal form, either swallowed or mixed with soft drinks, fruit juice or water.

### How it works:

- A substance that sits on the continuum between a stimulant and a hallucinogen (dependent upon set and setting).
- Ecstasy, like other stimulant drugs, affects both the amount of, and the way in which, the neurotransmitters serotonin and dopamine are produced in the brain and experienced by the individual person, offering a range of effects which users describe as intensely powerful and pleasurable.

### Physiological & psychoactive effects:

- The brain cells in question that MDMA seems to affect are rooted near the brain's base but have long nerve fibres that fan out into its higher regions. Here the fibres meet and communicate with other nerve cells, "messaging" them by squirting serotonin into the synapses that connect all the nerve cells in the brain. MDMA turns these squirts into surges. It causes the cells to shoot virtually their entire load of serotonin and reabsorb it unusually slowly, by latching onto certain proteins

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dotting the surfaces of the nerve cells, called serotonin transporters. The usual job of these proteins is to absorb serotonin back into cells. MDMA makes the protein work in reverse and pump the neurotransmitter out instead.

- After the **euphoric peak** (of the experience), in which the person's usual relationship to self and others is markedly transformed, there is an extensive **plateau stage**, of enhanced emotional, sensory and psychological awareness, followed by a (gradual) **descent** back into an ordinary state of consciousness. These experiences are heightened or *otherwise affected* by the 'set' of the user and the 'setting' in which the drug is taken.

## Risks:

- To dispel some of the more lurid media claims and urban myths about MDMA/Ecstasy is *not* the same as saying there aren't real problems that can arise from its use. As with any stimulant drug, the raw resources present in the central nervous system provide the essential ingredients for the drug experience, and the exhaustion of those resources, through over-use of the drug, means that people can get into a compulsive pattern of pursuing an ever elusive euphoric or 'loved up' high by using more of the drug in ever larger quantities. This particular vicious circle is only likely to be broken by taking time *off* from the drug and allowing mind and body time to restore and repair.
- The widely distributed (US) **National Institute on Drug Abuse** 'brain scan' postcards, which show a "normal brain" (looking healthy and well) alongside a "brain after ecstasy" (a lump with dark blotches and holes) are often mentioned in drug education material and media reporting. As a result, many past and current users of the drug can have real anxieties about its short and long-term effect on their mental and/or physical health. However, an extensive investigation by **New Scientist** (2002) found that few experts believe that the research has yet proven ecstasy causes lasting damage to human brain cells or memory, and that "*some of the highest-profile evidence to date simply cannot be trusted, having more to do with politics than with science*". According to this respected magazine, it's an open secret that some research teams have failed to find deficits in ecstasy users and had trouble publishing their findings as a result. And yet as the magazine points out, "*if people think the health warnings are exaggerated or at odds with their own experience (of the drug), the authorities risk losing credibility, and with it their chance to educate anyone about drugs*".
- In fact, many users continue to claim "*long lasting improvements in self-awareness, self-esteem, openness and insight into personal problems*", according to a report from the University of Louisiana and anecdotal accounts on a recent (2007) Radio 4 documentary. Despite the "*mid-week mood dip*" reported by many users, the researchers could also find no significant relationship between depression and recreational ecstasy use.

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- Despite its use in a variety of therapeutic settings, including for relationship counselling, people suffering terminal illness and in the treatment of post-traumatic stress disorder, Ecstasy is so regularly linked in headlines to cognitive impairment or brain damage, and even to sudden death, that many users themselves believe these risks to be **more** rather than **less** likely as a result of their use of the drug. A recent study in the **British Journal of Psychopharmacology** estimated that 750,000 regular users consume about 26m tablets a year (the true figure is undoubtedly **much** higher). To date, there have been around 90 E-related fatalities in the UK, with **heatstroke, water toxicity, high levels of alcohol use and heart failure** implicated in the majority of these, rather than as a result of MDMA use per se. Statistically speaking, eating peanuts, playing rugby or going fishing all carry far higher levels of actual risk, hence its position (18 out of 20) in the recent ACMD "potential to harm" report (2007).
- While the anecdotal and media reports claiming long-term depression in users do not seem to be born out by any reliable research data, the **come down** (or **contrast**) **experience** to the drug **high** (usually 2-3 days after use) can undoubtedly leave the user feeling low in mood, comparatively speaking. It is important to note that this too will pass, given sufficient rest.
- There *is* some evidence to suggest that frequent and high levels of MDMA use may lead people to experience highly developed levels of internal, mental imagery – as though the barriers usually separating conscious from sub-conscious or unconscious processes have been reduced – which can be disturbing and anxiety-inducing for the user.

## Harm reduction:

- A sustained period of non-use appears to reduce these 'echoes' and enable the person to integrate their experiences over time and/or with appropriate support.
- Once levels of serotonin have been depleted, regular or compulsive use will *not* deliver the high the user will be looking for – the influence of set, setting and additives in the pill or powder (caffeine, ephedrine) and the impact of sleep deprivation impacting on consciousness can, however, leave the user feeling as though they are in an altered state, albeit one characterised by being frazzled and exhausted. Rest and sleep are likely to be the best options in such instances.
- The current dearth of MDMA/Ecstasy in the UK has contributed to a potential increase in risk by creating a situation where Ecstasy-like substitutes are actively sought out by users. Rising levels of methylmethcathinone (mephedrone/meow) and BZP use are arguably testament to this phenomenon.

Based in part on D.Concar's **New Scientist** article, "Ecstasy on the Brain" (2002).

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## Hallucinogens (psychedelics):

### KETAMINE: (Special K, Vitamin K, Kit Kat, Ket)



#### History:

A synthetic drug invented in 1962, ketamine has a very similar action in the brain to the African plant **IBOGAINE**. K was re-classified as a **class C** drug by the Advisory Council on the Misuse of Drugs at the beginning of 2006. According to a Radio 4 documentary in 2008, its potential use as a treatment for depression has generated a great deal of excitement in the medical research community.

#### Methods of use:

Snorting (a "**bump of K**"), IM (intra-muscular), IV, via the rectum as a suppository and in pill form.

#### How it works:

Ketamine is a **dissociative anaesthetic**: snorting a sub-anaesthetic dose (100-200 mg) allows an almost immediate range of psychedelic experiences (including entering a **K hole**) and can often "*raise spiritual questions in the minds of those who take it, having a profound effect on the psyche that are not usually seen with heroin, amphetamine, cocaine or alcohol*", (Jensen, 2005). When swallowed in pill form, speech and co-ordination are impacted within 15 minutes, before the effects on the mind become profound (because more numbing and sedating), and are longer lasting (up to 4 hours). If injected, the effects come on more quickly and intensely but are of a shorter duration.

#### Physiological & psychoactive effects:

A wide variety of users describe a range of consistent phenomena associated with their initial experiences of the drug. At peak experience these can include:

- A sense of dying or entering other realities and alternative universes
- Telepathic communion with god/the controllers of the universe
- Visions
- Music experienced as an organic, living entity
- Out of body experiences
- Old memories re-emerging to the point of being re-experienced

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- Eternity (in either its positive or negative aspect)
- Re-living birth experiences and experiencing womb memories
- Inner and outer space travel
- Trance

### Risks:

Long-term or heavy use **reduces** and/or **negates** the psychedelic effects and leads to **rapid** and **marked tolerance**, while the ability to **recall** the experience also fades. The attempt to recapture these lost aspects of ketamine can certainly fuel **psychological** dependence but there is little evidence of any **physical** dependency arising from its use. The **Cocaine-like** stimulation, **opiate-like** calming and the potential relief of anxiety, depression & mental craving (the 'altered' relationship to the self) are all reasons users give for their continued use of the drug.

IV use of ketamine should be discouraged due to the range of risks arising from injecting *any* drug: intra-muscular use, although still carrying risk, would be a preferred option.

When users stop a K binge, there remain high levels of **norketamine** in the body, which takes days to subside and can provide a "parachute or deflating cushion" (actually reducing the need to take another substance to manage the comedown, contrary to popular myth). How a person feels after a binge is influenced by the main thoughts & moods during the final phase of the experience. The user's need for sleep is reduced. The real physical dangers arise mainly from **setting** (an unfavourable setting = an unfavourable outcome), mixing with alcohol, Valium® or heroin, and frequent, compulsive levels of use (leading to potentially serious bladder/urinary tract damage).

While talk of the incidence of '**flashbacks**' following use of hallucinogenic drugs remains widespread, there is a strong body of evidence to show this is in fact **non-drug** related experience. Acute anxiety or any other strong emotion-based memory can *itself* induce 'flashbacks' in people who have never taken drugs and this can provide invaluable and anxiety-reducing reassurance to users.

Also, despite concerns about **impairment** of **memory function**, there is no clear evidence that the impact on memory is long-term or that these problems persist if use ceases (**note that all altered states of consciousness associated with different drugs are characterised by experiencing time as non-linear, which has obvious implications for short-term memory retention and function**).

According to research by Dr. Karl Jensen, frequent and heavy levels of hallucinogenic drug use may lead people to experience highly developed levels of internal, mental imagery – as though perforations have been made in the barriers usually separating conscious from sub-conscious or unconscious processes. A sustained period of non-use appears to reduce this "Pandora's Box Syndrome" and these 'echo' experiences.

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The most **unhelpful** and **counter-productive** way of describing the ketamine experience or dealing with the subsequent impact of that experience on a person using the drug is for it to be framed as **K-induced psychosis** - because if the individuals' **experiential reality** is *automatically* seen as being the equivalent of mental illness, then the ketamine user is left without the language or means to articulate their *felt* experience. This in turn will reduce the capacity of any 'concerned other' to communicate effectively or usefully with the person using ketamine. However, it is important to note that ketamine can reverse the effects of the mood-stabilizing drug lithium and can also trigger latent bipolar affective disorder or manic depression in some users, although this does not appear to be **causal**.

## Harm reduction:

- A "**watcher**" is the **1st rule** of **K** (that is, having someone present during the experience who is *not* on the drug to oversee those who are) as **automatic** body movement without conscious will or awareness – stumbling, falling over, walking into walls - during the K experience are very common problems, particularly for novice users. It is important to emphasise the importance of a safe environment on the both the quality and the safety of the experience.
- If a **DEPRESSANT** drug is also used, the risk of suppressing breathing and airway reflexes rise **sharply**.
- An empty stomach reduces risk of nausea and vomiting.

Adapted in part from **Ketamine: Dreams & Realities** by Dr. Karl Jensen

## LSD (Acid, Trips, Tabs, Blotters)



### Methods of use:

Most LSD comes in the form of small squares (7 mm by 7mm) of card or paper with a specific (often cartoon or symbol) design, although can it can also be sold as a colourless and odourless liquid.

### How it works:

LSD (d-lysergic acid diethylamide) is a synthetically produced hallucinogen manufactured from ergot, a fungus that grows on rye and other grasses. The main effects of the drug last for 6-8 hours, with a further 2-6 hour period of 're-entry'.

### Physiological & psychoactive effects:

Users describe a wide range of perceptual changes, including profound shifts in

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consciousness, self-perception and awareness, visual, auditory and tactile enhancement, non-linear thinking and quickly changing emotions, confusion, a transformed relationship with all aspects of the internal and external world, which can be euphoric or horrific, dependant on set and setting. Despite this variety of powerful psychoactive effects, LSD produces very few physiological changes other than dilated pupils, increased muscle tension and pulse rate, and a slight rise in temperature.

## Risks:

Tolerance to LSD builds rapidly and it is not recognised to be either physically or psychologically dependence inducing. 'Bad trips' are often the result of a poorly considered setting and/or a negative set (pre-existing emotional problems, anxiety, bad mood, distrust of companions), and active consideration of these factors should be encouraged for anyone considering use of the drug. Talk of 'flashbacks' as a specific LSD-related phenomena does not appear to be accurate (any powerful emotional experience can be experienced as a flashback, in fact), although people with pre-existing mental health concerns should be particularly cautious with *any* use of hallucinogenic substances.

## Harm reduction:

Users should feel calm and confident about using LSD, know and trust the people they are using it with and have given active consideration to establishing a favourable setting for the experience. Anxiety, panic or other negative aspects of the experience are best dealt with by reassurance (the effects of the drug *will* pass). Resisting the effects of the drug are more likely to enhance those very effects and make 'navigating' the experience more difficult. Alcohol use, any activity requiring concentration and/or potentially hazardous environments should all be avoided while using the drug.

## CANNABIS: (Grass, Bud, Green, Weed, Herb, Hash, Dope, Solid, Soap Bar, Resin)



## Methods of use:

Smoked in a spliff or joint (either mixed with tobacco or neat), in a pipe or via a 'bong' (water delivery system) or with a vapouriser. It can also be eaten in food (cooking increases the psychoactive effects of the drug) or in a drink (tea).

## How it works:

The way that cannabis actually works is still little understood. Research has identified that cannabinoid receptors are present in the human brain, and there are suggestions that taking cannabis mimics the effects of these naturally produced cannabinoids *to some extent*.

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### Physiological & psychoactive effects:

The effects of taking cannabis are variable and highly subjective. These can be influenced by a number of factors, including:

- amount taken
- strength and composition of the cannabis (whether grass or resin)
- method of use
- the expectations and experience (mind set) of the user
- other substances used
- the setting in which the use takes place

People who use cannabis can expect to get a range of different psychoactive effects at different times. The following key symptoms can be described as **positive**, **neutral** or **negative** and can include:

- **Lifting of mood, euphoria, laughter, relaxation, reduced stress, creative, philosophical or more connected thinking, increased appreciation of and connection with music, increased awareness of sensory perception, increase in mind/body connection, pain relief, increased appetite, sleepiness and boring or repetitive tasks can be made to feel 'easier';**
- **An alteration in relationship to the self, slowness, shift in visual perception, tiredness and lethargy, restlessness and racing thoughts, dry mouth, disruption of linear memory, alteration in sense of time (compressed or stretched);**
- **Nausea (especially in combination with alcohol, some pharmaceuticals or other substances), coughing, asthma, upper respiratory problems, disruption of short-term memory, racing heart, agitation, feeling tense, mild to severe anxiety, panic attacks in sensitive users or at high doses, dizziness and confusion, lightheadedness, clumsiness and loss of co-ordination (at high doses), paranoia, *psychological* dependence and can *possibly* exacerbate or precipitate latent or existing mental health difficulties for some people.**

### Risks:

- While cannabis is demonstrably *less* dangerous than other **licit** and **illicit** drugs, this does not equate to it being a harmless substance. There are inherent risks in all kinds of socially accepted activities (from sports to sex to driving), and the use of cannabis is no different. When undertaking education or harm reduction work, it is important not to assume that its use is *necessarily* problematic or indeed *non-problematic*. Cannabis is widely acknowledged to be **non-physically dependence inducing** (unlike the tobacco in joints), but it is equally clear that its use can be **psychologically dependence-inducing** and therefore involve a range of

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perceived withdrawal symptoms, the severity of which will be determined by the frequency of use, individual sensitivity, (mind) set and setting.

- Smoking cannabis can have a damaging effect on lung health but research by the British Lung Foundation and others suggesting that smoking it was as much as four times more damaging than smoking tobacco-only cigarettes without cannabis (a much-quoted piece of research in the media) needs to be treated **cautiously**. The form in which the drug is consumed and the mechanism/delivery device used to take it can and does make a difference to levels of risk. Smoking cannabis *without* tobacco, via a bong, vaporizer or in neat joints (while increasing the potency of the high) would substantially reduce lung damage and other physical health problems.
- **Cannabis** used together with **alcohol** increases the risk of experiencing a high level of dizziness, disorientation and nausea (related to the combined impact of using a depressant with a hallucinogen). While unpleasant, these effects do not *appear to be* particularly dangerous.
- The greatest risk arising from cannabis use is undoubtedly due to its status as a prohibited substance, with the attendant risks for users of a criminal record and/or custodial sentence.

## Duration of cannabis being detectable after use:

**One-off use:** 2 days - 4 days

**Infrequent light use:** 2-8 days

**Moderately frequent use:** 5--20 days

**Heavy or frequent use:** anything from 20-30 days to 40 – 50 days (possibly longer)

## Harm reduction:

- A panic-based response to **non-problematic** cannabis use is neither desirable nor helpful, but necessarily involves the cannabis user **and** concerned others having a more developed and nuanced appreciation of the issues involved than is likely to be provided by much of the media's recent coverage of skunk cannabis. In fact, the statistical and evidential base for the spate of "*skunk increases risk of mental illness by 40%*" media headlines is far from reliable: the initial "*skunk 25 times stronger than normal cannabis*" claim was first made in 1997 by a DEA (Drug Enforcement Administration) agent - never a particularly *reliable* source of **factual information** when it comes to drugs - but as the data collated by a range of more **credible** sources (including [www.badscience.net](http://www.badscience.net), the Forensic Science Service and the Advisory Committee on the Misuse of Drugs) have shown, **2-3** times stronger is actually a more *accurate* figure and the differences between the weakest and strongest strains available are actually similar to what's been available since the 1960s (according to UN seizure figures). Given the influence of **set** and **setting** on the drug experience, it is also a very *unhelpful* way of framing any debate. It is also worth noting that "**reefer madness**" in the USA between the end of alcohol prohibition and the late-1950s was in part only made possible by the

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transformation of what everyone had previously thought of as 'hemp' suddenly becoming 'marijuana' (which being the plant's *Mexican* name, sounded more suitably foreign and threatening) and being repeatedly linked to psychosis, uninhibited sexual expression and extreme violence. The transition from 'grass' to 'skunk' in both tabloid and common-sense vocabulary reflects a very similar process.

- In fact, claims of a link between cannabis use and madness are nothing new. Allegations of its insanity inducing potential go back to at least the mid-19th Century, but from the Indian Hemp Commission in 1895, through New York Mayor LaGuardia's Marijuana Commission in 1944 and Baroness Wooton's 1968 Home Office Select Committee report, from the 1970 LeDain report in Canada to the decision, having reviewed all the available evidence on the link between cannabis and schizophrenia, (by **29** votes to **1** in 2005 and by **19** votes to **4** in 2008) by the Advisory Committee on the Misuse of Drugs that *no* causal link exists, have **all** challenged such a connection. Nonetheless, the Home Secretary announced in May 2008 that she was minded to reclassify cannabis as a Class B drug, and did so in 2009, in order to send a "clear message to young people" (quite *what* that 'clear message' might be was *less* apparent). However, the role of 'negative drug effects reporting' on people's beliefs and therefore behaviours is well established, and this, along with what we know about **labelling theory** and self-fulfilling prophecies can be a very damaging combination for **all** concerned.
- Jacques-Joseph Moreau (1804-1884), one of the earliest Western researchers into cannabis use, established that those choosing to use the drug should be: **feeling calm** and **confident** about using it: **free of repressed emotions** and **among congenial, non-manipulative people**. This advice remains as relevant today as it was then; it takes the emphasis *off* the drug and focuses awareness onto the *person* themselves, a far more useful perspective from which to work.
- In **Living with Drugs**, Michael Gossop points out that **fear**, which invariably gets called **paranoia**, is the most common negative consequence of using cannabis. And if you have people who are very frightened that they are going mad (because that's the language they've been given to interpret their experience - on both the *user* and *professional's* part), combined with the specific effects of cannabis (the 'altered state of consciousness' it offers being quite different from that available from 'being drunk' on alcohol but which **remains many people's 'bench-mark' for understanding how a substance affects them**), you can have something that might easily be mistaken for acute psychosis, the *least useful* way in which understanding the experience of the drug might be framed.