DDN
Drink and Drugs News
23 April 2007
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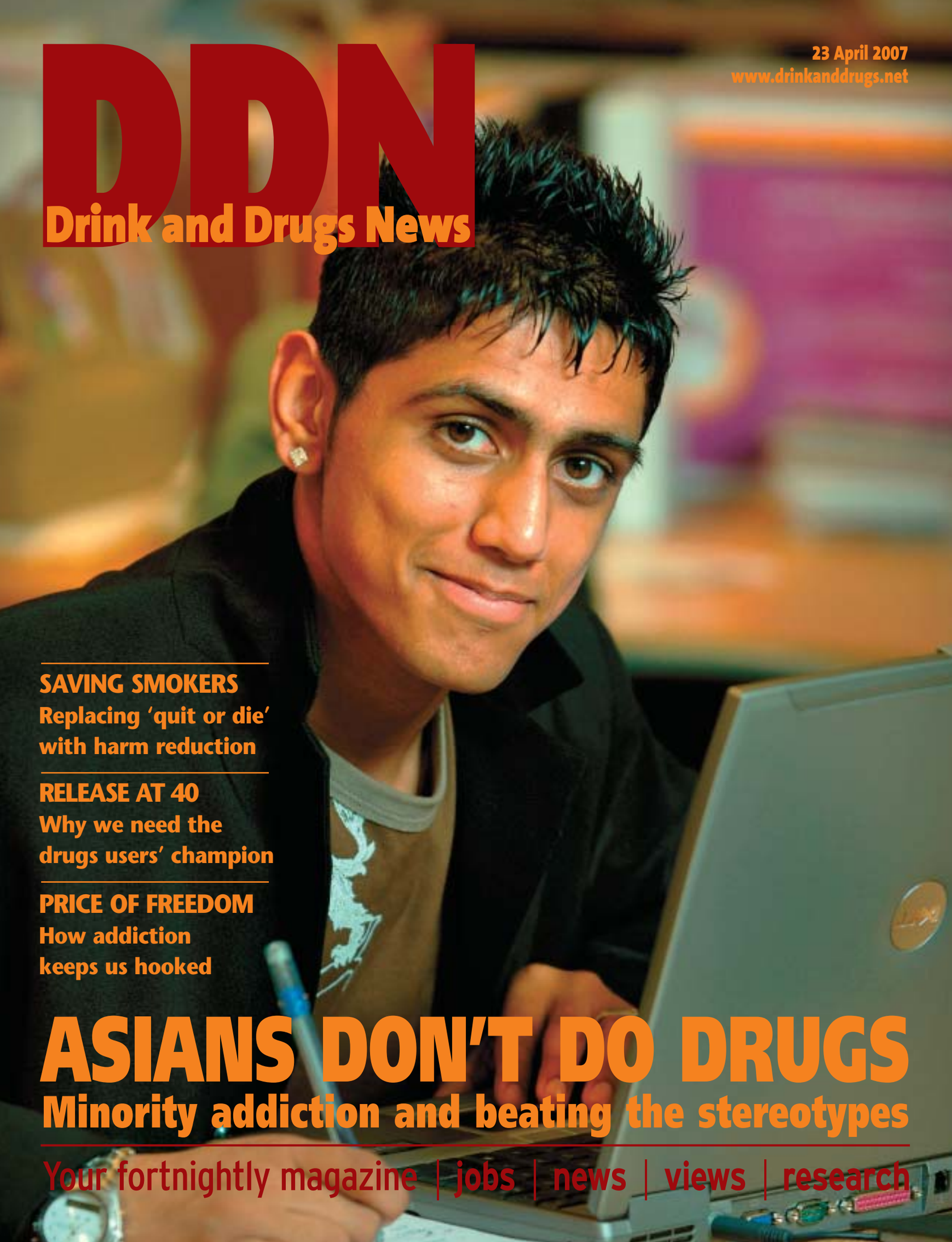

SAVING SMOKERS
Replacing 'quit or die' with harm reduction

RELEASE AT 40
Why we need the drugs users' champion

PRICE OF FREEDOM
How addiction keeps us hooked

ASIANS DON'T DO DRUGS

Minority addiction and beating the stereotypes

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drugs and alcohol today

London

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Date: Tuesday 1 May 2007 **Venue:** Business Design Centre, London

Launched in 2005, Drugs and Alcohol Today London has firmly established itself as the largest, most comprehensive and accessible event in the substance misuse calendar.

The exhibition and seminar programme provides a unique opportunity for professionals and managers involved in preventing and treating substance misuse, service users and those interested in joining the professional to come together to debate the big issues, share best practice and network.

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One of the most popular features at our exhibitions is our 'zones', which offer visitors a vast array of free activities, helpful advice, and fun events

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Event sponsored by: The Huntercombe Group

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Monday 18 June 2007 at the Hampstead Theatre, London

Nearly 40 years after the Misuse of Drug Act, experts agree on one thing – UK drug policy isn't working. At our anniversary conference, you will hear commentary from high calibre speakers from the worlds of politics, social reform and medicine on how drug policy affects us all.

Simon Hughes MP
The importance of civil liberties - for all

Helena Kennedy QC – criminal barrister and social reformer
Women, drugs and criminal justice

Simon Jenkins - Guardian and Sunday Times columnist
Drug policy – politicians bowing to the tabloids?

Joe Boyd – Record producer/author
Drugs and rock'n roll – an inside story

Caroline Coon – Release founder
Needed then - needed now

Prof. Graham Foster – professor of hepatology, KCL
Hepatitis C – casting a long shadow

Sebastian Saville – executive director, Release
To hell and back in 48 weeks

Ethan Nadelmann – executive director, Drug Policy Alliance, USA
Methamphetamine epidemic……and other myths

Lord David Ramsbotham – former chief inspector of prisons
Prison – no place for rehabilitation

Allen St Pierre - executive director, NORML, USA
The cannabis plant is medicine in the USA - so why not in the UK?

Conference debate
Topic and speakers to be announced

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Editor's letter

This week the new UK Drug Policy Commission launched – an event covered widely in the media. As newspapers used the opportunity to explore different aspects of the UK's failing drugs policy, the UKDPC emphasised that it would bring evidence and analysis in front of policymakers.

Current drug strategy is underpinned by Public Service Agreement targets that have spawned hits and misses within the drug treatment workforce. For the ticks that are placed against channelling more drug users into treatment, there are as many crosses against letting criminal justice focused policy override public health.

There have also been notable successes, such as lower rates of HIV among drug users than in other comparable European countries. The Commission's job will be to highlight what works – obviously harm reduction measures in this case – as well as what doesn't.

The new charity has already involved a diverse body of expertise – including some that normally comment on policy, rather than help to form it. It will be interesting to see whether informing drug policy will mean influencing it in the near future, to the point of salvaging us from the bottom of the European league table of drug problems.

Being informed is equally important at community level, as highlighted in our cover story. Yaser Mir is a natural communicator, but his story illustrates how easy it is to get it wrong when offering drug and alcohol services to diverse cultures and communities.

Yaser warns against 'parachuting in academics and professionals to stir things up' and his experiences illustrate just how easily this approach could push the problems of young Asians and their families underground. Hearteningly, a diversity policy does not have to be a prohibitively expensive overhaul, which hopefully should inspire managers to make sure the team's up to speed.

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In this issue

Commission to tackle policy with evidence

A new commission has been set up to provide independent and objective analysis of UK drug policy.

With a panel of experts from drug treatment, medical research, policing, public policy and media, chaired by Dame Ruth Runciman, the UK Drug Policy Commission (UKDPC) will run for an initial three years as a registered charity, funded by the Esmee Fairbairn Foundation. Chief executive is Roger Howard, formerly head of Crime Concern and DrugScope.

Its role will be to analyse drug policy and help policymakers better understand its implications. Dame Runciman said: 'We are not starting from the position that all current drug policy has failed, but rather that we don't know enough about which elements of policy work, why they work and where they work well.'

As the current ten-year drug strategy comes to an end next year, the UKDPC seeks to fill a perceived gap in evidence-based research. The UK has severe drug problems compared to most other European countries, coupled with some of the most stringent penalties for drug possession and supply. Escalating heroin and cocaine problems have contributed to a ranking of the second-highest rate of drug-related deaths in Europe.

The charity has declared that it is committed to seeking a constructive dialogue with cross-sector bodies and the public. With a remit that includes publishing briefing papers on drug policy, analysing the evidence base and involving leading researchers, an early priority will be to look at the effectiveness of outcomes relating to the criminal justice system, compared to non criminal justice settings.

The UKDPC's work is informed by 'An analysis of UK drug policy', a report by Prof Peter Reuter and Alex Stevens. Available at the commission's website, www.ukdpc.org.uk

New look and a recruitment service for **DrinkandDrugs.net**

The DrinkandDrugs.net web portal has been expanded and redesigned to make it an even more useful tool for both substance misuse specialists and those working in wider health, social care and criminal justice settings.

It provides: information on training, events and qualifications; guidance on workforce development and professional standards; access to drug and alcohol facts; links to research and guidance and other publications; careers guidance and jobs listing; and advice on getting help with a drug or alcohol problem.

It also includes a *DDN* microsite through which visitors can view both current and archived copies of the magazine.

More ways to find your new job...

We have expanded our recruitment service to help both job hunters and recruiters by adding a CV search. Jobseekers can now lodge their CV with us free of charge and we will email them details of the latest vacancies that match their criteria, while for a small fee, recruiters can search the CV database.

The jobs microsite traffic is continuing to build and last month saw more than 4,000 jobseekers search the jobs page. More than 2,200 active job hunters have registered for email updates of the latest vacancies.

The developments are part of our commitment to providing a comprehensive cost-effective recruitment vehicle for the field – while keeping your *DDN* subscription free of charge.

UK drink-driving has worsened over decade

The problem of drink-driving in the UK has worsened over the last decade, with a lack of effective strategies, according to a new report from the European Transport Safety Council.

The report, *Reducing deaths from drink driving*, shows that during the period 1996 to 2005, drink driving deaths in the UK have increased by an average of 0.5 per cent each year. In 2005, drink driving deaths accounted for 17.5 per cent of all road traffic deaths. The UK was one of a handful of countries – including Hungary, Lithuania, Spain and Finland – where inaction was 'hampering' overall European progress on the issue.

The ETSC drew comparisons between countries and ranked the Czech Republic as the nation most successful in tackling drink-driving deaths. Here, during 1996-2005 deaths from alcohol-related accidents fell more than 11 per cent faster, per year, than other road deaths. The result was a 50 per cent reduction in drink driving deaths in this period.

The ETSC attributes this to the country's strict enforcement of the 0.0 legal blood alcohol limit. Screening tests have increased significantly and education campaigns meant drink-driving has been made socially unacceptable.

Overall, the report calls for stricter enforcement of legal blood alcohol limits coupled with awareness-raising campaigns. 'There is a trend to lowering the BAC [blood alcohol concentration] limits in European countries,' said Jorg Beckmann, ETSC executive director. 'However, the enforcement of these limits is another issue. Today, alcohol checks are more of an exception than a rule and too few countries apply the strategies that have been proven to work.'

Reducing deaths from drink driving can be downloaded at www.etsc.be/PIN

Growing gap between students' understanding and behaviour

Drug education in England's schools is improving and is providing students with a good understanding of drugs and their effects, reports Ofsted.

However, while drug education given under the personal, social and health education (PSHE) curriculum provides students with knowledge, it does not necessarily deter them from taking drugs, or equip them with the skills needed to deal with peer pressure and refuse drugs.

Given so many students were well aware of the risks associated with alcohol and drugs, it was 'worrying' so many students failed to modify their behaviour, and failed to make links between alcohol and drug use and other unsafe behaviours, such as unprotected sexual activity.

Through its report, Ofsted reiterates its previous calls for a comprehensive evaluation of the effectiveness of drug education programmes in schools.

'One of the problems is that it is still not known what approaches to education about drugs have the most significant impact on pupils' behaviour. Some studies have shown the impact of drug education programmes on pupils' attitudes, knowledge and resistance skills but few have examined their impact on pupils' long-term behaviour,' the report states.

The Drugs Education Forum welcomed the report. Co-ordinator Andrew Brown said it was clear that drugs education was improving, and agreed that PSHE needed to do more than provide information. 'Teaching children and young people about drugs must go beyond explaining what drugs are and their legal status and start to encourage pupils to develop their skills and attitudes to take the right decisions about their health,' said Mr Brown.

'Time for change? Personal, social and health education'. Available at www.ofsted.gov.uk

Grant cut jeopardises young people's services

Funding for young people's drug and alcohol prevention and treatment services is being cut by more than 10 per cent over the next year, DrugScope estimates.

The cuts come despite new government figures which suggest existing measures are having a positive impact on young people's drug and alcohol consumption.

Prompted by calls from local projects, DrugScope conducted a survey of England's drug and alcohol teams and discovered funding for 2007/08 will total around £55.2m – a significant drop from last year's £61.8m. The cut is being made to the Young People's Substance Misuse Grant, which is used to fund education and prevention projects and treatment services for children and young adults. London, the North West and the South East will be the hardest hit, with each of these regions losing around £1m in funding.

DrugsScope chief executive Martin Barnes said these cuts were disastrous for services. 'Many of these services are working with vulnerable children and young people with drug and alcohol problems, or at risk of becoming problem users,' Mr Barnes said. 'Officials say that budgets for adult drug treatment can be used to make up shortfalls in young persons' treatment – [but] adult services have demanding targets to meet and in some areas funding for adult services has been reduced.'

The cuts have come to light as the Department of Health released figures from a 2006 survey that suggested prevention strategies and projects now in place were having an effect on young people's alcohol and drug consumption. The new figures showed only 21 per cent of participating students, aged 11 to 15 years, had consumed alcohol in the week before the survey – down from 26 per cent in 2001. Almost half said they had never drunk an alcoholic drink. There was also a reported drop in drug consumption – 17 per cent said they had taken drugs in the last year, compared to 19 per cent in 2005.

Home office minister Vernon Coaker attributed this success to the FRANK education campaign and the hard work of local professionals – staff that DrugScope fears will be made redundant amid the cuts. Even more financial uncertainty is likely to arise next year as the grant loses its 'ring-fenced' status.

Universities need stronger role in drug prevention

Colleges and universities need to increase alcohol and drug education campaigns to challenge the acceptability of substance misuse among students, and in turn reduce the harm they cause, according to Mentor UK.

Binge drinking and experimentation with illegal drugs are considered normal behaviour by most students, the national drug prevention charity claims, and the associated risks are rarely spelled out to them at these institutions.

In the new report, *Alcohol and drug prevention in colleges and universities*, Mentor UK notes a variety of harm minimisation strategies and information campaigns are used to educate students, and many of these have been developed in conjunction with student unions. However there was no strong evidence that these had the desired effect.

The report notes that as evidence suggests that many students significantly overestimate the alcohol and drug consumption of their peers, social marketing campaigns that target their misconceptions around these social norms may be effective. But overall, what was needed most was evidence of what strategies worked, and why.

'Colleges and universities can play an important role in preventing alcohol and drug use and harm,' said Eric Carlin, chief executive of Mentor UK. 'We need to build the evidence of drug prevention and support further education colleges and universities to deliver effective interventions.'

Existing alcohol and drug education and prevention programmes needed to be monitored and evaluated, and research into 'social norms' intervention conducted. Furthermore, given the absence of any statutory framework or guidance on the issues, Mentor UK has called for the establishment of a body to support colleges and universities to deliver prevention strategies.

'Alcohol and drug prevention in colleges and universities', by Apostolos Polymerou, can be downloaded from Mentor UK's website at http://www.mentorfoundation.org/uploads/UK_Prevention_Colleges_and_Universities.pdf

Belfast study gives insight to adolescent cannabis use

An ongoing study at Queen's University Belfast has found 14- and 15-year-olds are using cannabis on a daily basis.

Research from the university's Youth Development Study, a longitudinal study of adolescent drug use, has found that of those who had previously reported smoking cannabis, one in ten had become daily users.

Around 4,000 teenagers from 43 schools in Belfast, Ballymena and Downpatrick have taken part in the study each year since they began secondary education.

'While the numbers in our study who told us they were using cannabis each day may seem small, these young people are telling us that by the age of 15 they have moved beyond experimental or recreational of an illegal drug to a more sustained use,' said senior research fellow, Dr Patrick McCrystal.

Those reporting frequent cannabis use were also more likely to smoke, drink alcohol and use other illegal drugs. Of those using cannabis daily, one in six reported abusing solvents each week, and one in three reported taking ecstasy each week. Delinquency and antisocial behaviour were also high among this group.

'The findings tell us that the school children who use cannabis every day are placing themselves at increased risk due to drug related social and health problems now and in the future,' said Dr McCrystal.

The Youth Development Study questionnaire is at Queen's University's website, www.qub.ac.uk

Ring-fenced funding on prison alcohol called for

Alcohol-related crime is a well-recognised social problem, yet there is a distinct lack of services for prisoners with drinking problems, according to Alcohol Concern.

The situation exists despite evidence from international studies suggesting that up to 30 per cent of male prisoners and 24 per cent of female prisoners are alcohol dependent. In the UK, a recent survey of prisoners at HMP Winchester revealed that 35 per cent felt they had an alcohol problem, and 46 per cent felt alcohol was a causative factor in their crime. Some prisoners reported drinking up to 157 units of alcohol a week before their arrest.

The level of services for alcohol-dependent prisoners falls far short of the level offered to those who are drug dependent, says AC. The charity claims existing prison care pathways suggest that prisoners who are poly drug users are able to access more structured interventions. The most widely available form of support for prisoners with a drinking problem is Alcoholics Anonymous – yet AA groups only operate in around half of all UK prisons.

AC has called for ring-fenced funding to 'kick-start' the development of alcohol interventions in prisons, and for structured throughcare for prisoners with alcohol dependency. The charity is also calling for more research into what interventions work, and how these can help to reduce re-offending.

Asians don't do drugs

Reaching people from different cultures and communities does not have to hinge on complicated diversity policies. **DDN** finds out from Yaser Mir how actions can speak louder than words in connecting to those labelled 'hard to reach'.

There's so much rhetoric around race and diversity that it's easy for nothing to get done, says Yaser Mir. As mentor to many community organisations, he opposes this mindset with passionate energy. His mission is to show treatment services and institutions that their labelling of 'hard to reach' can all too easily be translated as 'easy to avoid' – and that, he says, is not acceptable.

Mir is based at the University of Central Lancashire, in Prof Kamlesh Patel's Centre for Ethnicity and Health. His current project as part of the Community Engagement Programme is on citizen-focused policing, and is funded by Scotland Yard. Before that, he played a lead role in advising the Home Office on race and diversity in relation to the Drug Intervention Programme, and his expertise is constantly sought by policymakers keen to shape a fairer agenda, relating to Black and Minority Ethnic groups. He is in the useful position of being held in high regard by service users as well as 'officialdom': he recently collected an award for which he was nominated by ex-gang members, whom he had helped transform into a dynamic voluntary organisation, committed to helping others out of drugs and crime.

Twenty-eight-year-old Mir's own story reveals why he is passionate about his role in helping others to fit into society. As a teenager growing up in Stoke, he hated school and felt the education system did little to offer him any sense of belonging or ambition. Being an Asian lad in a white working class school made him feel like 'the pink poodle', he says. He was picked on by lads who went on to join the BNP, was stereotyped because his dad had a corner shop, and pointed in the direction of becoming a taxi driver by teachers who didn't seem to care less that he showed great promise at sport – particularly tae kwon do, in which he competed for the British junior team.

For the most part, school was 'a horrendous experience' he says. 'I didn't do well. I had all kinds of problems with teachers and it was a nightmare growing up. I was written off and had bad reports.'

Initially leaving school to work in a restaurant, he hadn't forgotten the buzz of succeeding at something he was good at. While working as a postman and fitness instructor to support himself and help with family bills, he applied to study sport, gained a BTEC in sports science, and emerged from college with an award for outstanding achievements, before heading for Manchester Metropolitan University.

Becoming an achiever unlocked many possibilities for Mir, straightening out his purpose in life. But his varied experiences along the way have given him a keen radar for the disaffected – particularly young people who could use strong mentoring to help them find their positive potential in society, instead of being drawn into the 'wrong crowd'.

'Drug use is on the increase in minority communities because many are poorly housed in inner city areas,' he says. 'Combined with poor education and lack of job opportunities, it's not hard to see why many young people are feeling socially and economically excluded. High birth rates and a burgeoning South Asian population of under-21s means problems can only get worse, unless we get a handle on this.'

'Getting a handle on this' means more than just approaching the 'usual suspects' – community leaders and those who shout the loudest. The issues underpinning South Asian communities are complex, which is why Mir and colleagues work with the ethos that 'communities know their communities best'. He explains that 'instead of parachuting in academics and professionals to stir things up', they work at getting to the grass roots. Only then do they get beyond the view of many professionals that 'Asians don't do drugs' to find that, in actual fact, the statistics come from them not accessing services. The problems often run deep within communities, to be submerged by stigma and family shame.

A recent programme with the Department of Health meant engaging with hundreds of community organisations around drug prevention, education and treatment. Talking to BME groups within the substance misuse field then took the dialogue further, engaging with thousands of community members about issues that concerned them. Using local networks makes sure they find those who need help: 'ex-users, ex-offenders, prisoners, women, families and carers – all the diversity strands'.

Talking to services, Mir finds there is often 'a lot of good will out there, a lot of passion' to engage with BME communities. 'But often it's not converted to action.' He seeks not just to bat away rhetoric and steer away from a 'tick-box approach' but to make sure user involvement is properly harnessed. He insists that meaningful engagement has to run through commissioning, planning and decision-making to get long-term results.

'It goes beyond doing the bare minimum to comply with equality legislation. Services need to embed their strategies for reaching BME clients as part of core business planning,' says Mir. 'Issues need to be performance managed as well, whether it's by government or regionally by the NTA. There has to be accountability around race and diversity.'

Accountability has to go hand in hand with understanding need, and Mir has had insight to some of the complex issues embedded within South Asian communities in the UK. Unable to accept the stigma of drugs in the family, some parents would be closed to any thoughts of treatment here. Through his contact with Kamlesh Patel's research, Mir came across instances where parents had flown their children back home to Pakistan in the hope that removing them from British culture and influences would 'cure' them of a drug habit: 'They thought the culture and religion back home would make them come off drugs. But obviously that's not the case because they're much more easily available and cheaper over there. So they would come back much worse.'

Other horror stories, such as parents locking their children in their rooms, even chaining them to the bed to stop them from taking drugs, speak volumes about the alienation experienced by some of the migrant generation and a failure in British society to connect with them. Parental panic can be exacerbated by

language barriers, which often extends to a poor knowledge of drugs, their legal status and their effects.

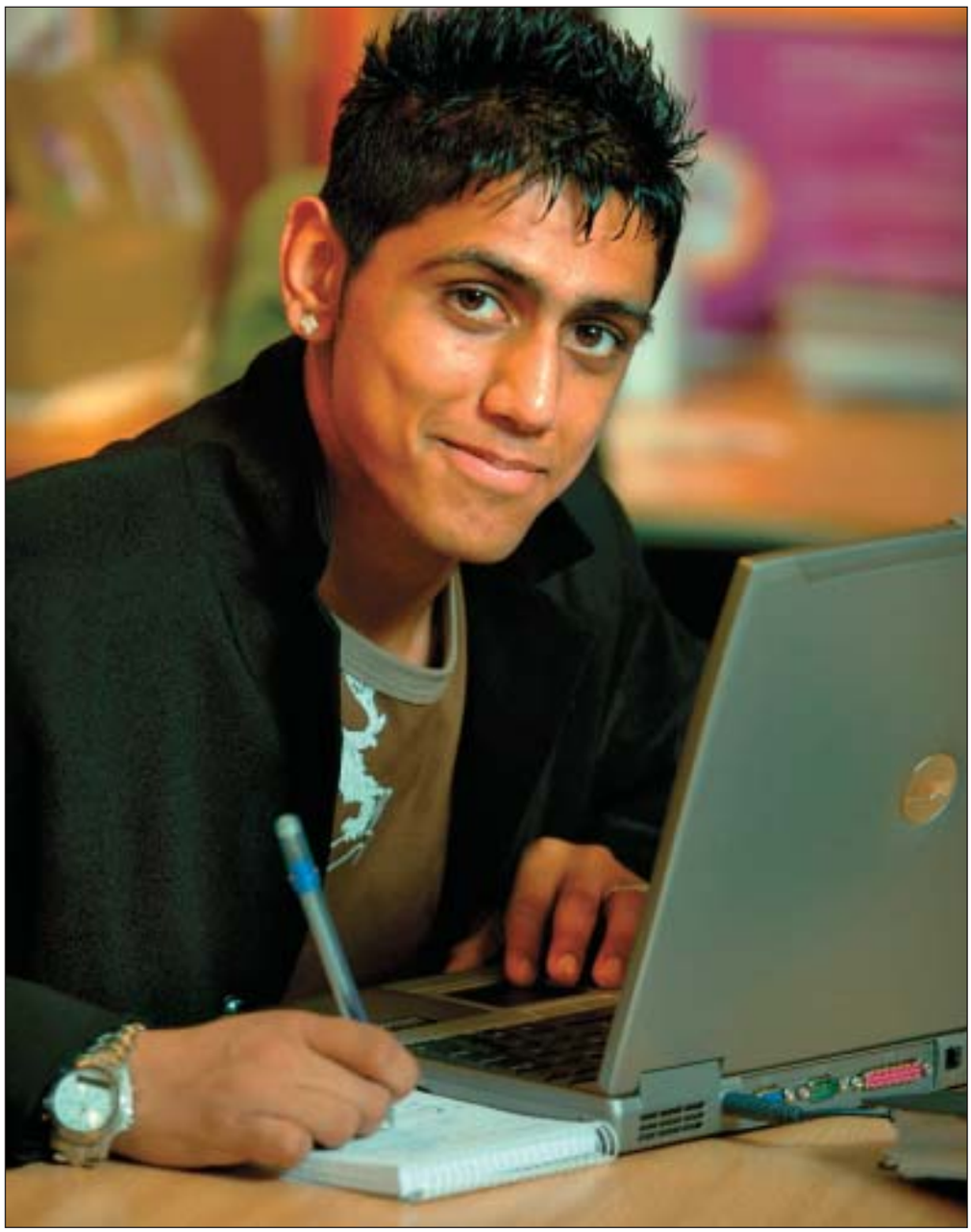
Such examples also underline why it is crucial for all services to make themselves aware of basic cultural rules and taboos, so they can start to bridge the knowledge gap and get people into appropriate treatment, according to Mir. He illustrates this through explaining that 'halal' (meaning permissible) and 'haram' (not permissible) don't necessarily relate just to food. Muslim communities are likely to regard methadone as haram, and might also see harm reduction measures such as needle exchanges as not being compatible with their belief system. Knowing this will make sure drug workers are more likely to offer residential rehab, counselling and psychotherapy as more acceptable options.

'Services and treatment need to be compatible with their belief system. Most people are aware now that in the workplace we need to provide halal food. It should be the same concept with the health and social care field,' says Mir.

'Halal and haram come up with Muslim communities. With other communities it might be about finding ways to tap into spirituality,' he adds. The agenda is all about respect, leaving the 'them and us' behind, and making sure every experience of treatment is a positive one.

Through recent project work, Mir has been faced with the question 'how can we recruit a diverse workforce'? His answer illustrates the whole point he is making about achieving progress through the most direct route. 'I said from the outset, do we need to recruit a diverse workforce – or is it a workforce that can see the needs of a diverse client group? Although it's good practice to have a diverse workforce, ultimately you want the best people in the job.'

In other words, don't shelve a diversity policy because you think you haven't got the people to put it in place – make the best of the resources you've got. As Mir emphasises: 'Some people say it's about Asian workers working with Asian clients; Black workers working with Black clients. It's not. It's about existing workers having the skills to work with our communities.'



'Unable to accept the stigma of drugs in the family, some parents... had flown their children back home to Pakistan in the hope that removing them from British culture and influences would "cure" them of a drug habit. They thought the culture and religion back home would make them come off drugs. But obviously that's not the case because they're much more easily available and cheaper over there. So they would come back much worse.'

'There is no money to commission anything new, and criteria for what we can commission are now so tightly defined by the NTA et al that about the only thing we can consult service users on is what colour to paint the front door. So, we are expected to spend local taxpayers' money and time on setting up a process that can only lead to those consulted being ignored. Outstanding.'

Oh so glib

It is easy to see why Mr Hayes has attained the level he has with such a wonderfully illustrated example of why we need these 'wretched' NTDMS forms – his argument is plausible and to many makes perfect sense (*DDN*, 26 March, page 7) . However he, along with many others in the hierarchy of decision-makers, seem unable to grasp the point that we, the poor maligned workers are trying to make.

No-one is denying the need for statistics, no-one is denying the need for justification of funding or employment; what is being said is simply, we cannot do both. You, the government, have access to computer records, you the government have access to numerous other statistics. Surely without burdening the very people who are to actually support the vulnerable ones you, the government, can use the existing computer records that are churned out by the forest and make justification out of this?

My second point is that we work with a number of professional individuals who are experiencing a 'vulnerable' time. These people come to us for a confidential service and do not want, under any circumstances, the government to know of their problems. Maybe this is paranoia, maybe this is justified, but in Mr Hayes' world I can no longer see people who are not willing to sign the NTDMS consent form, as I will not get paid for it. Could Mr Hayes possibly enlighten us as to what we do with these people, because in my role as a social worker, I sense I may get a few complaints by this stance.

With the impending new document TOP [Treatment Outcomes Profile] – oh goody, when I close a case now I have five documents, I think, to complete. I'm not sure anymore if that's true – it's now Wednesday and that may change by Thursday.

We are beseeching Mr Hayes in rather a forlorn fashion, as we know the world of bureaucracy will win – but just how many staff have/are becoming disillusioned by the likes of Mr Hayes?

Name & address withheld

Not so glib

I'd like to respond to Paul Hayes' excellent and humourous riposte to the complaints about NDTMS – I completely agree with everything he says. NDTMS is essential and should certainly be augmented with a system of outcome monitoring (although he does neatly illustrate that the real purpose of all this is to enable the PM to look good on telly).

For many years millions of pounds have been poured into drug treatment only to fund ineffective and poorly organised services, which often only delivered active individuals' own idiosyncratic versions of treatment according to their own moral, medical or religious views.

I do have some reservations about the amount of data collected and its intrusive and personal nature. Having been through various, very effective, health treatments including eye and arterial surgery and depression, I have never had so much personal information extracted from me by the state. But completion is voluntary, so no-one seeking treatment needs to give it up.

However, there is still an enormous amount of work to be done to bring logic, rather than politic, to bear on the bureaucracy in this field. Consider the following situation. In the DAT area where I currently work, we are being encouraged by Regional Government Office (RGO) to spend local council taxpayers' money on conducting a needs assessment of young people in the area. Of course, this is good practice. But the funding to deliver services has, this year, been cut by 15 per cent, and next year by a further 26 per cent. There is currently a significant unmet need among this most vulnerable and fruitful client group, particularly in relation to unhealthy and high-risk levels of alcohol and skunk consumption.

So, instead of using all available funds to deliver direct services, we are under pressure (which both RGO and NTA routinely, and quite cynically, refer to as 'support') to further reduce the funds available and divert them into the profits of a private IT consultancy company, actively promoted by GO staff.

The need is clear and obvious, there is no need for an expansive and long-winded assessment, and all we will gain from this expense is to change one box on an RGO monitoring return from amber to green and to illustrate the widening gap between the funds available and the need – a situation of which we, and our local YPs and their parents, are already painfully aware. At a recent briefing on this matter and the changes to NDTMS for YPs, I sought clarification from the NTA YP Treatment lead. I asked him: 'So what you are saying then, is "less money and more monitoring",' to which his refreshingly honest response was a straight 'yes'.

Furthermore, we are also expected to demonstrate that we are involving YPs in commissioning decisions when, in reality, there are no new commissioning decisions being made. We are now in the position of having to cut all the peripheral services commissioned from the output of previous needs assessments, consultations and government directives.

There is no money to commission anything new, and criteria for what we can commission are now so tightly defined by the NTA et al that about the only thing we can consult service users on is what colour to paint the front door. So, we are expected to spend local taxpayers' money and time on setting up a process that can only lead to those consulted being ignored. Outstanding.

Finally, the aforementioned cuts are designed to shift the responsibility (*ie* blame) for services from the national government to the local council – an overtly political act. The local council is now in the ludicrous position of having to fund a post whose primary responsibility will be to lobby the same council for funds to make good the shortfall created by the cessation of Department of Health funding. The post will cost more than the funding cut. 'Is that logical Captain?'

DAAT YP Lead, name and address withheld

Standing on the beach

I've always thought Paul Hayes was pretty expert at appeasing his political masters by marvelling at the quality of their new clothes. Now he has taken it to

another level altogether and I agree with the comments of the drug and alcohol manager (same page) insofar as it is difficult not to discern a certain attitude towards service providers that comes through the pretend interview device employed by Mr Hayes in his construction of what is, in my opinion, a largely specious argument.

It would be easy (and fun) for me to respond in the same 'imagine the scene' way. How, for example, could Jeremy Paxman possibly be interviewing the new Prime Minister in the run-up to a general election? Only after the election, surely! However, I'll avoid further temptation because the issue of obsessive monitoring is a serious one, and it goes far beyond Mr Hayes' justification of NDTMS.

What I will do is enthusiastically refer Mr Hayes and, I hope, anyone interested in reading about how bureaucratic micro-management wastes money and gets in the way of treatment, to the findings of a special investigation by Nick Davies, one of this country's most respected journalists. See 'How Britain is losing the drugs war' (www.guardian.co.uk/drugs/davies). From where I stand as a practitioner, the waste and inefficiency highlighted in that article are even more evident today.

Of course we have to be accountable Mr Hayes, and a certain amount of monitoring can improve efficiency. But when bureaucrats talk of 'treatment outcomes', experience has taught me to be wary: quantity is seldom a reflection of quality and I doubt that your definition of what constitutes treatment would be the same as mine or my clients'. I have no objection to monitoring things if I know it leads to a real improvement in services, but I don't think it has. And, more importantly, most of the drug users I have spoken to lately don't think it has either.

We need to count the big things to test whether current policies are working, not get obsessed by minutiae. When I have to prove to you that I'm standing on a big beach by counting every grain of sand, things have gone too far.
Prison and community drugs practitioner, name and address withheld

Acid request

I am writing a book on the social and cultural history of LSD in Britain (Cyan Books, 2008). I would be very interested in hearing from any *DDN* reader who has information about any aspect of the LSD scene in Britain: opinions, experiences, news clippings, involvement as a dealer, LSD and free festivals, LSD and the military, LSD and psychotherapy, LSD related photographs and artwork, LSD 'personalities' etc.

I want the book to be the definitive history of the subject, so please get in touch if you have any knowledge or information whatsoever.
Andy Roberts, andy@darkstar.fsnet.co.uk

Email your letters (up to 350 words) to Claire Brown, editor: claire@cjwellings.com

Shifting the focus of alcohol policy

A collaborative venture between international agencies aims to turn alcohol policy in a different direction, presented through a new book, *Drinking in Context*. **DDN** was at the launch.

'Alcohol policy should be the art of the possible,' said Prof Gerry Stimson, at the launch of a new book, *Drinking in Context*. As lead author, Prof Stimson said we could come up with imaginative ways of changing drinking culture.

The book challenges traditional policy approaches to alcohol. A collaborative venture between the International Centre for Alcohol Policies (ICAP), the International Harm Reduction Association (IHRA), the World Federation for Mental Health (WFMH) and the Institute de Recherches Scientifiques sur les Boissons (IREB), it argues for a pragmatic approach, based on 'what is possible and feasible'. This means recognising that 'people do and will drink', and focuses on minimising harm for drinkers, those around them, and society as a whole.

'The conventional view of alcohol policy is to regulate and restrict, not to deal specifically with harm,' said Marcus Grant, president of ICAP. The new approach would be to target resources at people at risk, addressing specific needs at community level.

To do this effectively, the book looked at the need for effective stakeholder partnerships. Effective collaboration needed the active participation of government, health authorities, producers, retailers and consumers, and debate had to take place within a climate of respect for different views. Acknowledging that many consumers enjoyed alcohol as part of a balanced and healthy lifestyle, doing no harm to themselves or others, would push resources towards targeted interventions for those whose drinking had become problematic.

Steering away from one-size-fits-all approaches would be the only logical way forward, said the authors. Interventions needed to take account of different cultures and 'at risk' groups, and could not rely on pre-fabricated solutions. The authors also emphasised that no intervention to reduce alcohol-related harm could be expected to be successful entirely on its own – which was why stakeholder collaboration was so important.

Launching the book at the House of Commons gave opportunity for debate. Gaye Pedlow, alcohol policy director at Diageo, said there were many different perspectives, depending on whether you were talking to a major alcohol company like Diageo, or a small local producer or farmer.

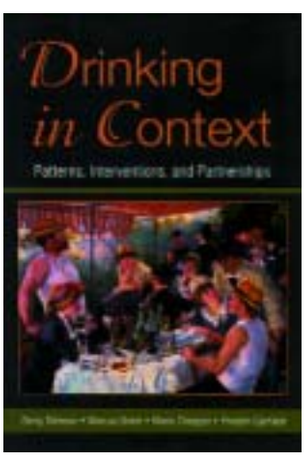
'Living in this very real world means recognising that many different groups have something meaningful to contribute,' she said. 'We need aspirational and achievable targets and a sustainable way in the long term. Consumers want to see companies acting responsibly.'

Jack Law, chief executive of Alcohol Focus Scotland, said that targeted initiatives should include looking at how parents' drinking influenced young people: 'We should be looking at the way we behave and contribute to their alcohol use.'

The book explored working in partnership and Mr Law said there had been effective progress in Scotland, such as interventions from community pharmacies, initiatives around drinking environments, and the introduction of mandatory server training. 'Partnership doesn't mean everyone should agree, but we can maximise the impact of interventions,' said Mr Law. 'We're looking for the best skills and knowledge... this book adds to the lexicon of our potential.'

Marie Choquet, research director of INSERM, the French National Institute of Health and Medical Research, said understanding why people drink was not about a linear approach: 'We have to look at home, family and culture.

'The approach needs to be more global – and also more positive,' she said, endorsing the book's ethos that alcohol policy should move away from relying on restrictions and regulation and towards long-term public health and wellbeing.



Drinking in Context: Patterns, interventions and partnerships; edited by Gerry Stimson, Marcus Grant, Marie Choquet and Preston Garrison; March 2007. Published by Routledge, price £31.

Seeing past the smoke

With an estimated 1,100 million regular smokers in the world today and one related death every 10 seconds, tobacco is one of the world's most used and most dangerous drugs. **Ann McNeill** and **Jamie Bridge** suggest how harm reduction philosophy could replace the usual global 'quit or die' response.

In recent years, there have been many successful interventions and campaigns around the world to reduce or prevent tobacco consumption. In the UK, price increases, marketing bans, sales restrictions, warnings on packaging, nationwide smoking cessation campaigns and services, and education in schools have helped to gradually reduce the prevalence of cigarette consumption. It is anticipated that new smoke free legislation across the UK will have an additional impact.

However, there is still a significant population in every country who are either unable or unwilling to stop smoking, and they are often people from the most deprived areas or groups. In the developing world, where the epidemic is still at an early stage, the toll of tobacco-related mortality and morbidity will be unprecedented for years to come in many countries; if current smoking patterns continue across the world, an estimated 10 million people will die every year as a result of their habit by 2020. Something has to be done to reduce the harms faced by those who continue smoking – we cannot simply disregard and condemn them.

To address this issue, the International Harm Reduction Association (IHRA) took a strategic decision in 2004 to broaden its scope from illicit drugs to all psychoactive substances, including tobacco and alcohol. Harm reduction is an approach widely applied to illicit drug use, which explicitly accepts the continued use of substances, and aims to reduce the associated harms. For illicit drugs, this can involve providing sterile injecting equipment, safe substitute treatments, outreach and peer support, or advice on how to use drugs as safely as possible. For tobacco, however, this approach has received little attention to date.

The premise behind the tobacco harm reduction approach is that most tobacco use is underpinned by a dependence on nicotine. However, it is not the nicotine that causes most of the harm but rather some of the other 4,000 constituents of cigarette smoke, of which 60 are known carcinogens. Drawing an analogy with illicit drug use, the cigarette is the equivalent of the 'dirty syringe'. Consideration therefore needs to be given to separating the drug from the delivery system.

Cigarettes are the most dominant global tobacco product – highly engineered and sophisticated devices designed to deliver nicotine efficiently to the human body. They are also the most dangerous, and eventually kill about half of those who regularly use them. Although there will never be a truly 'safe' cigarette, it may be theoretically possible to design slightly less harmful cigarettes.

However, very little attention is paid to what goes into the cigarette and what comes out of it – the cigarette is virtually unregulated. One exception to this (highlighted in the IHRA collection – see box) is 'reduced tar' cigarettes, which are deceptively marketed in many countries as 'mild' or 'light'. Cigarette manufacturers often comply with tar reducing legislation by making cosmetic changes to their products, such as adding more ventilation holes to the filters, which provide limited benefits for smokers. Many smokers turn to these brands rather than quitting but then alter the way they smoke in order to compensate for the reductions in nicotine, by taking more puffs, deeper puffs, smoking right down to the butt, or by covering the holes on the filters. While these cigarettes pass the standard machine-operated regulatory tests, they fail to account for the associated behavioural changes, and it is widely accepted that these products have had limited (if any) positive impact on public health.

In the spirit of harm reduction, the tobacco industry and tobacco regulators are negligent if they do not do all within their powers to make cigarettes less harmful for continuing tobacco users. This may include designing cigarettes with a reduced propensity to cause accidental fires, regulating smoke constituents, or changing harmful ingredients that are often added for taste or smoothness.

One alternative to cigarettes is smokeless tobacco, which is currently used around the world in a range of forms – from the high-risk (and largely unregulated) smokeless products used across South Asia, through the fermented and medium-risk products in the USA and Canada, to the much lower-risk (and more highly manufactured and regulated) products used in Sweden. There is a growing recognition that the latter product in particular, which is generally known as 'snus', is significantly less harmful than smoking (but not harmless). There are also products which heat, rather than burn, tobacco – such as 'Eclipse', which is marketed in the USA as a safer alternative to conventional cigarettes. Whether these products could play a role within a tobacco harm reduction strategy has been the cause of much debate within the tobacco control community.

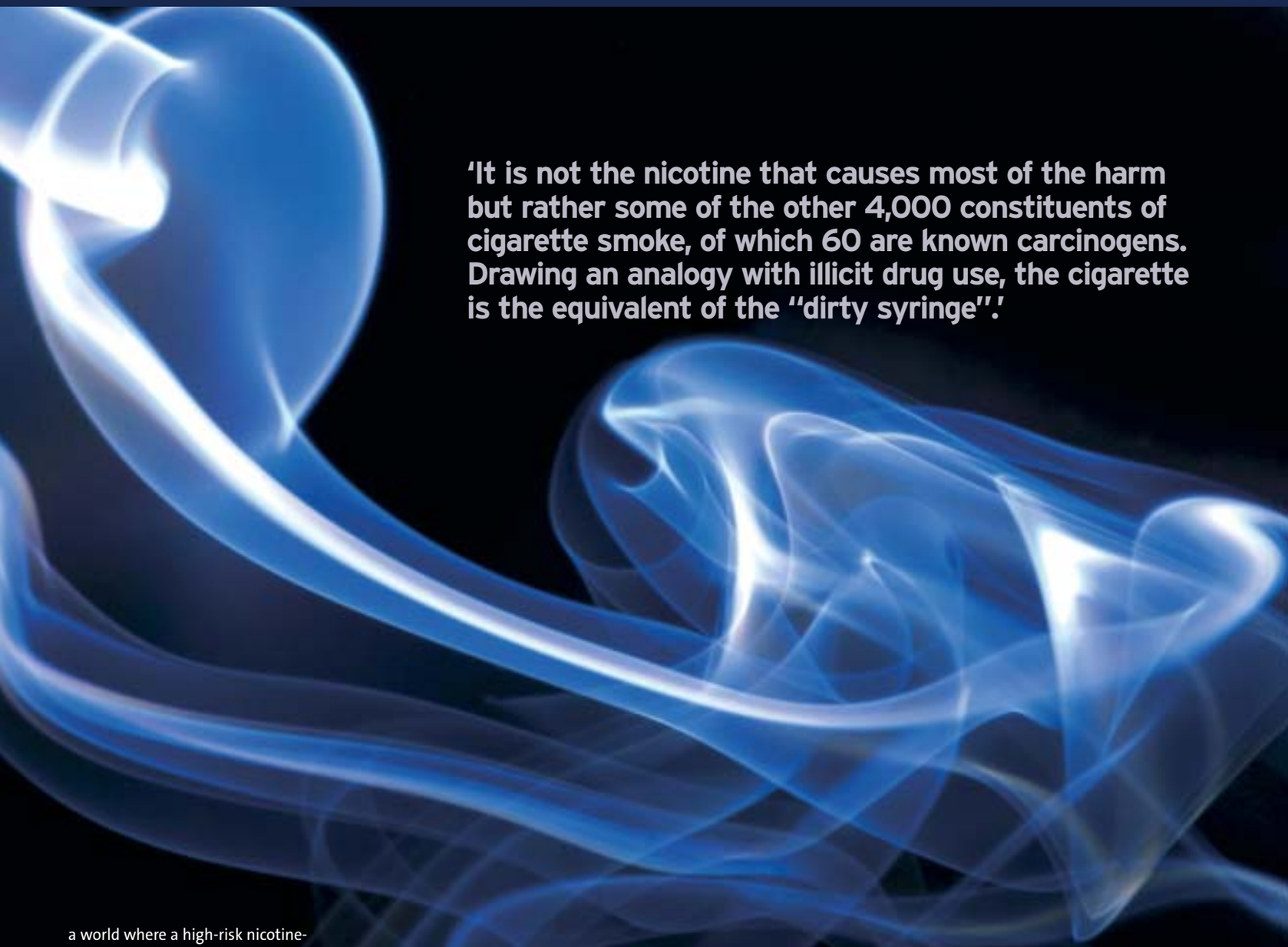
Some tobacco control experts argue that smokers need to be informed about the different options available to them and the associated levels of risk; only then can they make informed consumer choices. However, Sweden is currently the only European country that allows the supply of snus, thanks to special dispensation from the European Union – who have outlawed smokeless tobacco in the rest of the continent. Significantly, Sweden currently has the lowest rates of lung cancer and cigarette mortality in Europe and is the only European nation to achieve the World Health Organisation's target for reduced *per capita* cigarette use.

On the flipside, some experts argue that the availability of less harmful tobacco products will simply draw attention away from the tried and tested tobacco control strategies, maintaining people's tobacco use when they would otherwise have quit.

There are also harm reducing alternatives to tobacco itself, such as the increasingly diverse range of Nicotine Replacement Therapies (NRTs). These include such products as nicotine gum, patches, nasal spray, inhalators, tablets and lozenges, and are widely available for purchase and prescription. They have no known long-term adverse health effects and are therefore potential substitutes for cigarettes that address the nicotine dependency underlying most tobacco use for people who cannot stop smoking.

In a harm reduction regime, NRTs can have a key role to play in reducing the levels of death and disease attributed to smoking, and can be used alongside existing efforts to help people stop smoking, prevent people from starting, and reduce the harms that non-smokers face through passive smoking. However, NRTs are relatively expensive, largely unavailable to smokers in the developing world, and much more tightly regulated than cigarettes – even after the licences on these products were recently relaxed in the UK. If an NRT was ever developed which could match cigarettes in terms of nicotine dose and speed of delivery, it would probably not be allowed on the market.

Unfortunately, these regulatory barriers are typical in the clouded world of tobacco and nicotine policy –



'It is not the nicotine that causes most of the harm but rather some of the other 4,000 constituents of cigarette smoke, of which 60 are known carcinogens. Drawing an analogy with illicit drug use, the cigarette is the equivalent of the ''dirty syringe''.'

a world where a high-risk nicotine-delivery mechanism (the cigarette) can be widely available, relatively inexpensive and largely uncontrolled, but potential harm reducing alternatives are either banned outright across the continent (smokeless tobacco) or restricted to cessation attempts only (NRTs).

Many public health and tobacco policy experts argue that a single, combined regulatory framework is needed for all tobacco and nicotine products. Having such a policy in place would create a level playing field where cleaner nicotine products could replace cigarettes as the dominant form of nicotine delivery.

As with harm reduction interventions for any psychoactive substance, the key factors are information, choice, coverage and accessibility. None of the products or interventions mentioned in this article are designed to stand alone – they should all be seen as part of a collective approach that sits alongside cessation, prevention and exposure-reduction strategies (in the same way that harm reduction for illicit drug use can sit alongside demand and supply reduction approaches). If smokers cannot be convinced to quit, they could at least be encouraged to reduce the risks that they face (and the risks that other people face) with the help of products such as long-term NRTs (and possibly the availability of regulated smokeless tobacco products) in the UK.

Ann McNeill is a Professor in Health Policy and Promotion at the University of Nottingham; Jamie Bridge is the Communications and Project Development Officer for the International Harm Reduction Association.

Researching the case for tobacco harm reduction

This month, IHRA launches an online collection of the '50 Best' key documents on tobacco harm reduction (funded by the Open Society Institute, and part of a series of document collections on the IHRA website). The aim is to provide a free resource centre to highlight the evidence base, reasoning and justification for tobacco harm reduction.

By providing a free online collection of key documents and resources, IHRA hopes to improve international awareness of tobacco harm reduction approaches. The collection is aimed at anybody interested in this field – including policymakers, advocates and smokers themselves. The collection demonstrates how the harm reduction ideology can be applied outside of the traditional illicit drug remit. It also shows how the current tobacco policies and strategies are failing a significant proportion of smokers and condemning them to potentially reducible risks.

The '50 Best' collection on tobacco harm reduction is now available and fully searchable on the IHRA website – www.ihra.net. In addition to this and the existing collection ('HIV prevention and care for injecting drug users'), IHRA also plans to launch further '50 Best' collections in the near future, including 'Alcohol harm reduction' and 'Policing and harm reduction'. For more information, please contact Jamie.Bridge@ihra.net.

In 1967 Release arrived on the scene to champion human rights and offer the first national drugs helpline. Forty years on, we invite executive director **Sebastian Saville** to explain why the organisation is as passionate as ever about making sure drug users are not unfairly treated by the law.

Release: needed then – needed now

Release celebrates its 40th birthday this year and will be holding an anniversary conference in June. Helping Release celebrate will be its founder Caroline Coon along with illustrious speakers including Helena Kennedy QC, Ethan Nadelmann, Simon Hughes MP and Simon Jenkins. This event also coincides with the approaching end of an important phase in drug policy. Both the United Nations and the UK government launched major drugs strategies in 1998, and these are up for review next year.

The UK's strategy is probably more pragmatic in tone than that of the United Nations. As embodied by its drug control organs at least – for these are often out of step with its broader humanitarian project – the UN has consistently argued for the most restrictive interpretation of the drug control treaties to which the international community, including the UK, is signed up. The lead agency for drug control operations, the Vienna-based UN Office on Drugs and Crime (UNODC), has attempted to limit the setting up of global harm reduction measures and to expunge all mention of harm reduction from the UN's public documents.

The Blair government, meanwhile, has been willing to countenance various harm reduction practices, and has enabled more imaginative drug treatment ventures such as the provision of heroin to addicts, albeit on a small-scale trial basis. Treatment places have been greatly expanded, and the quality of treatment, while remaining subject to geographical variability, has undoubtedly improved. At the same time, however, we have seen the focus of treatment shifting away from public health and therapeutic imperatives and towards crime reduction, which is now the driving force beneath drug policy.

There remains the uneasy perception that this crime reduction agenda is itself a response to the media's appeals to the lowest common denominator. We are all familiar with the headlines…

What price civil liberties?

The crime reduction strategy has engendered an authoritarian response, placing security at such a premium that perhaps too many of our freedoms are sacrificed to maintain it.

An unprecedented volume of legislation has been introduced by this government, aimed at producing a society of 'respect'; the ASBOs and the DTTOs, the DIPs and the squads of security guards intent on denying access to our malls to anyone under 30 who happens to be wearing a hooded top. Our prison system is fit to burst, with some 80,000 people locked up.

We are in danger of going beyond the 'respect' agenda and into one that seeks instead to replicate the conformism of an imaginary golden age of decency, to which some hark back. There are of course interlocking relations between drugs and crime – but not in the way that the tabloid mindset and its accompanying easy answers like to assume. We cannot punish our way out of this situation; building more prisons is not the solution. We are in danger of building such a great security super structure that we will all wake up one day to find ourselves inside it.

Invisible plagues or plagues of the invisible?

A scan of contemporary healthcare leaves one feeling equally uneasy. Estimates for the number of

people infected by the hepatitis C virus in the UK range between 200,000 and 600,000, with perhaps 80 per cent or more of these being infected via injection of illicit drugs. The World Health Organisation has described the global situation as a viral time bomb set to go off. There are 70,000 living with HIV and the trend is rising, as is the trend for sexually transmitted infections generally. Among the very poorest people in the UK, the homeless, tuberculosis has returned. There were more than 8,000 cases in 2005.

It is well known in the drug treatment field that the Home Office now estimates that there are 300,000 'problematic drug users' too; men and women who are supporting heroin and/or crack cocaine habits by recourse to crimes of one sort of another.

The overlap between all of these populations is a close one. Poverty, marginalisation and criminalisation are the crosscutting issues that grip them.

Release in the present

The 'crime reduction agenda' has meant that civil liberties and public health have increasingly taken a back seat in drug policy. This provides the current context for Release's ongoing aim of offering both practical help to individuals in their dealings with the legal and drug treatment systems and seeking to have their voices heard in the formation of government policy.

There is often a dilemma for those involved in making efforts to humanise drug treatment and influence policymakers. It consists of whether to accept the parameters set on debate by the present government (and its predecessors), and thereby help individuals here and now; or to attempt to change the bigger picture by campaigning to change government policies. According to the NTA, the government wants drug users to engage with the treatment system, and to be involved in the design and delivery of policies. On the other hand, it most certainly does not want them to demand rights, and to seriously raise the issue of regulating drugs in alternative ways.

However, it is becoming increasingly apparent that more and more mainstream groups now readily accept that many of the harms associated with illicit drug use are in fact caused or exacerbated by the present legal system, rather than the drugs themselves. It is Release's policy, therefore, to act on both levels: to provide information, assistance and advice to drug users and their families and friends, while engaging with the government in an attempt to move policy in the direction of evidence-based harm reduction strategies. The independence necessary to speak the truth to those in power comes hard won and the price is the constant struggle to maintain the funds to stay open.

So, colleagues, let's make sure our 40th birthday conference, at the fabulous Hampstead Theatre, is packed to the rafters on 18 June 2007. It will be a great day out and you will be helping us carry on with our much-needed work.

Book a place at the Release conference by calling Jacqui Olliffe on 020 7749 4044 or by visiting www.release.org.uk

Q

How do people without 'formal' drugs work experience gain a chance of being employed in substance misuse services, despite having ten years personal experience with a user who is a close family member and having a Level Two NCFE Certificate in Drug Awareness Studies?
Maria, by email

Valued contribution

Hello Maria,
I work as a lecturer in mental health nursing at Bell College in Dumfries in Scotland on the pre-registration course. Drug and alcohol use/misuse is key to many issues covered within the course, both in theory and practice placements. People who enter the pre-registration course with experience of working with dependency – either formally or as in your case, informally – bring a valuable contribution and experience with them.

On qualification, many mental health nurses work with people who have substance misuse problems. Many clinical areas have contact with people who use drugs and alcohol or indeed have other dependency issues, and it is an area that some mental health nurses choose to specialise in.

The course itself is three years long and is demanding with regards to assessments, both in theory and practice. The clinical placements are varied, but each offers a wealth of experience within the context of their purpose. Not all are linked with dependency and no guarantees are given with regards to employment at the end.

Nursing colleges and schools usually offer a non-means tested bursary and many offer degree pathways as well as registration to the Nursing and Midwifery Council. Entrance qualifications are usually five O' levels /grades/standard grades (or equivalent) at grade C/3 or above. (This includes entrance to the universities!) Many students in mental health are mature – the oldest I have come across was 54 years old – and the starting age is usually 17 years old, depending on the institution where you study.

For advice look up your local university or nursing college and they will explain in greater depth and detail.
Joe Brown, Dumfries
For advice and information visit our website www.bell.ac.uk or call +44 (0) 1698 283100

No shortcuts

Maria,
My first suggestion would be to take a Certificate in Counselling Skills. These courses are inexpensive, run over about 30 evenings in one year and are widely available in local colleges (with additional financial/learning support available as required). Anyone interested in listening to and supporting clients with an addiction or any other issue would enjoy the course and would not find the workload a burden. It is a good place to start and discover whether a role as a professional listener is for you.

Secondly, you say you have ten years' experience with a close member of the family as a drug user. This can be a very distressing experience for family members. It is important you have had the opportunity to resolve any painful emotions in a support group or personal counselling or therapy. This ensures you can comfortably empathise with clients who may have recently used substances.

There is no shortcut to gaining drugs work experience before being employed by 'substance misuse services'. The field is as competitive as the work is satisfying. All the people I have met as paid workers in agencies, however well-qualified, started as unpaid volunteers. I would recommend joining a local agency with good training, support and supervision for volunteers. This will provide you with a good knowledge and skills base and provide an invaluable reference to help gain your first post, as well as the confidence to do so.

Personally I believe it is best for addiction workers to ultimately become qualified counsellors. A counselling diploma enables a professional to be self-aware, adhere to ethics and boundaries and to have the solid skills base needed to support and promote change amongst the client group.

Good luck. I have found addiction clients in general to be sensitive and creative and the psychology of change in addiction is a very exciting therapeutic area.
Annette Catherine, by email

Persistence and patience

Hello Maria,
I have a personal history of heroin addiction for 13 years, I have a diploma in counselling, a certificate in youth work, I train professionals in self-harming – and I have difficulties gaining a full-time post.

I think that personal experience and qualifications do go a long way. Just keep looking and I'm sure something will come up. Is there a Turning Point drug and alcohol centre where you live? They are very empathic towards people who have experienced life. I gained a casual support post in Chester, which I hope will be of value when I find the right job for me. But be aware that organisations do stigmatise substance misusers, and if you have a criminal record for drug offences this can also bring judgement, even if the conviction is spent.
Good luck,
Clare, by email

Reader's question

I work as a Methodist Minister in post-industrial areas of South Yorkshire/North Nottinghamshire, where there are many people coping with drug issues. I am looking for a course that will begin to equip me to help such people in a practical way. Can anyone point me in the right direction?
E Mackey, by email

Email your suggested answers to the editor by 1 May for inclusion in the 7 May issue.

The freedom to be addicted

Freedom and addiction may look like opposites, but are in fact polarities that feed on each other, says William Pryor.

Whether it touches our lives directly or not, addiction is a price we all pay for living in freedom. Not any old idealistic freedom, but the liberty championed by politicians of every hue in the 21st century. A double-bind freedom that might seem to be at the other end of the corridor from addiction, but its being hoist as the fundamental good of modern times leaves many staring into an abyss with nothing to be free for, no place to be free, no aspirations to cherish, no sense of who or what it is that has been set free.

And yet, and yet, in this empty freedom it is impressed upon us that we are free to choose whether to take the stuff, to do the things to which we become addicted. This is where the myth of 'addictive substance' arises – how else can we explain that, up to a certain point, we are apparently free to choose what we take or do, but after we have crossed that river, we become slaves. It must be the stuff what done it.

In this mythology, addicts are not free. They are slaves, trapped at the other, the dark end of the passage, in portable prisons built from the stoned highs around which their addictions revolve. But a special kind of medical slave to whom we can give treatment – at best, a get-out-of-jail card, at worst, a furnish-the-jail-with-more-comfort-and-stability prescription. Freedom and addiction may look like opposites, but are in fact polarities that feed on each other.

It's hard to challenge the dogma of liberty beloved by neo-con right and new labour alike: it confuses freedom from oppression with the notional freedom to act that individual selves are thought to have. These two ideas have become interchangeable, but are in fact utterly different.

Few would say oppression is a good thing – we all want to be free from it. But then the other freedom is thrust upon us. We will make you free to be yourself, to enjoy the fruits of capitalism, but we're going to have to watch you with CCTV cameras that tell you to pick up your litter. You are free to drink whenever you want, to gamble as recklessly as you like, but not to indulge in things we have come to regard as evil; heroin for example. It's a liberty thoroughly qualified, but only for your own good. It's a liberty thoroughly confused, a double bind, a conflicted *cul de sac*, but it's all we can think of. When you seek refuge from this dead end, becoming addicted can seem an attractive option; at least it does away with choice. The politicians' liberty has no value in and of itself, because the self that is free, the individual that would assert its rights, is an empty thing.

'What's the point of being free if that freedom gives you nothing and leaves you all alone in that nothingness? If existential angst is the overriding experience you are free to go through, then the simplicity, certainty, comfort and even the imprisonment of the addict's life are going to look attractive.'

In parallel with the ascendancy of the self as the prime icon of belief in the last 50 years, so the dogma of liberty has blossomed. With the decline of organised religion, liberty has become as good a value as any to justify capitalist liberal democracy, a value we can shape our lives around. But it also casts a dark shadow, a dank place filled with questions, anxiety and isolation freely stirring the turmoil most people live in. What's the point of being free if that freedom gives you nothing and leaves you all alone in that nothingness? If existential angst is the overriding experience you are free to go through, then the simplicity, certainty, comfort and even the imprisonment of the addict's life are going to look attractive.

Thus it is that addiction arises from a confused notion of liberty. Yes, we must be free from oppression, but no, the freedom to be ourselves, free will, is not an absolute good! How can it be when we have no clue as to what it is that is being free? The self is a fragile construct, a story we have to keep on retelling to keep sane. Frequently it collapses under the weight of its own mythology and expectation and we seek other forms of security, stability and comfort, often those found fleetingly in addiction.

Maybe we should ask what it is to be free from addiction, to be unaddicted? A very different liberty. Oddly, it has a similar shape to the deluded state the addict achieves in his first few highs – apparent freedom from the burdens, frustrations and delusions of the self. But unaddiction, being unhooked, does not suppress, or even merely cope with the insecurities of the self, but actually embraces them in a state of being that transcends the myths of self. Though it is a construct, the self with all its stories is the source of all addiction. We are free to be addicted until we discover that to be unaddicted is to be truly free.

Albert Einstein, of all people, said: 'The true value of a human being can be found in the degree to which he has attained liberation from the self.' Unhooked Thinking explores such philosophical approaches to addiction in the belief that they are at its core.

Unhooked Thinking 2007 runs from 9 to 11 May at the Guildhall, Bath. www.unhookedthinking.com

What the science shows, and what we should do about it (part 1)

Professor David Clark starts to describe the main findings and recommendations from a major new book based on the views of America's leading clinicians and researchers of what treatment would look like if it were based on the best science possible.

Leading addiction scientists met in New Mexico in 2004 at a 'think-tank' conference to share research findings in their respective areas and discuss possible implications for treatment and prevention interventions. This conference resulted in a seminal book, which I will consider over the coming issues.

The participants in this meeting believe that while scientific research has revealed a great deal about the nature of substance use problems and how they can be prevented and treated, very little of this science has found its way into practice.

Moreover, they point out that following drastic cuts in financial support for already starved treatment and prevention efforts, the existing US intervention system is in dire straits.

Major gaps exist between what research has actually shown to be effective and what is actually practised in treatment settings. Services continue to be marginalised, stigmatised and isolated from the rest of the health care system. Consumers have very little reliable information to use in finding and selecting services, and judging their effectiveness.

Given these problems, the book editors pointed out that it is, 'not difficult to imagine starting over from scratch to envision a more compassionate, effective and cost-efficient intervention system'.

They draw together the wealth of scientific understanding from the range of topic areas considered to produce a set of ten cross-cutting principles, and then reflect on their implications with ten recommendations for interventions.

I will outline these important principles and recommendations in this and forthcoming Briefings, allowing you to mull over how relevant they are to reducing the suffering related to substance use problems in this country.

Principle 1. Substance use is chosen behaviour

Substance use is a behaviour, chosen from among behavioural options. It is influenced by the same principles of learning and motivation that shape other forms of human behaviour.

Even when substance use becomes self-perpetuating it is not unique, as it shares common characteristics with other compulsive behaviours such as pathological gambling and overeating.

The willful-choice aspect of drug use is sometimes underplayed or denied (*eg* the disease model), in part due to efforts to inspire compassionate care rather than harsh and moralistic treatment of people with a substance use problem. This has resulted in conflicting pubic opinions of whether problematic use (addiction) to drugs and alcohol is, or is not, a matter of personal choice.

'Most people who recover from drug problems do so on their own, without formal treatment. The stages and processes of such "natural" change are indistinguishable from those that occur with treatment, and are common across the spectrum of problem severity. In this sense, effective interventions facilitate and perhaps speed natural change processes.'

The science of recovery from substance use problems gives intentional change a prominent role. The scientists note: 'Most people who recover from drug problems do so on their own, without formal treatment. The stages and processes of such "natural" change are indistinguishable from those that occur with treatment, and are common across the spectrum of problem severity. In this sense, effective interventions facilitate and perhaps speed natural change processes.'

Evidence also suggests that change often involves a kind of 'click', a decision, commitment, or turnabout. This is reflected in popular concepts such as 'hitting rock bottom' and experiencing a transformational turning point. Personal commitment appears to be a final common pathway towards change.

The authors sum up by saying that there is 'every reason to treat the individual drug user as an active participant, a responsible choosing agent, and a collaborator in... treatment interventions. Furthermore, there are myriad opportunities in society to trigger and promote self-change'.

2. Substance use problems emerge gradually and occur along a continuum of severity

No-one sets out to become addicted to drugs. The process is gradual, starting with experimental use, moving on to more frequent use, and so on.

There is no signpost saying that someone has become addicted to, or dependent upon, drugs or alcohol. Addiction emerges as someone's life becomes more and more centred on drugs or alcohol. The diagnostic criteria for dependence and addiction are arbitrary cut-off points along a gradual continuum.

Society needs to be able to address problems with a wide range of severity. Interventions which are useful at one level of severity may be unhelpful or counter-productive at another level of the continuum. In general, it is easier to change behaviour in the earlier stages of substance use related problems.

3. Once well-established, substance use problems tend to become self-perpetuating

One characteristic of addictive behaviours is that they become 'self-organising' and robust. Once established they can become particularly resistant to ordinary forces of persuasion, punishment and self-control. Addressing one aspect of this self-organising system is often ineffective.

There are a variety of routes into problematic substance use. It is important to understand for each individual what is maintaining their pattern of substance use, and what components need to be addressed in order to produce stable behavioural change.

One consistent theme is that an initial period of abstinence can be helpful in destabilising dependent substance use. [to be continued]

Rethinking Substance Abuse: What the Science Show, and What We Should Do about It. edited by William R. Miller and Kathleen M. Carroll, Guilford Press, 2006

Other positions

Substance Misuse Specialist
Camden Pct – Salary band 6
Experienced health practitioner to work with families borough-wide in Camden.
Closing date: 03.05.07
www.camdenpct.nhs.uk
(click vacancies).

Project Lead for Single Point of Entry (Substance Misuse)
Pennine Care NHST
Lead on the implementation of a single point of entry into Substance Misuse Services. Closing date: 04.05.07
For more info contact Mary Hopper on 0161 604 3200.

Substance Misuse Professional
East London & The City MNHST – Salary band 6
www.elcmht.nhs.uk
(click working for us).

HAMPSHIRE DAAT
Drug & Alcohol Action Team

Structured Day Programme Service

The Hampshire Drug & Alcohol Action Team are seeking written expressions of interest from providers with proven experience in delivering drug misuse treatment services for the provision of a therapeutic Structured Day Programme Service.

The Service will provide a range of clearly defined group based treatment and intervention programmes and activities addressing the drug misuse, physical and psychological health needs, social functioning and offending behaviour of drug users.

The programmes and activities will be delivered peripatetically across the Hampshire DAAT area in partnership with existing Community Drug Teams and the DIP team in a planned and structured way with clear output and outcome measures.

The service will be required to commence in December 2007.

A restricted tendering procedure will be followed with the criteria for award of the contract to be:

- Business and financial standing
- Organisations experiences of the provision of substance misuse treatment services
- Service User Involvement
- Organisational capacity & capability to deliver this Structured Day Programme Service
- Price & Best Value.

Process for application

1. Written Expressions of Interest must be received by the DAAT by **4th May 2007**
2. Upon receipt a Pre-qualification document will be sent to **ALL** interested parties to be completed & returned by **12 noon on 25th May 2007**
3. The Hampshire DAAT invites **ALL** organisations expressing an interest for this tender to attend a consultation meeting on **11th May 2007**
4. Following assessment of the Pre-qualifying document, **FIVE** organisations will be invited to tender for completion and return by 2pm on **29th June 2007**.

To register your interest please contact Richard Curtis, Hampshire DAAT, Capitol House, 12-13 Bridge Street, Winchester, Hampshire SO23 0HL.

Drug and Alcohol Strategy Manager

£42,468 - £48,777 **Ref: ACS3707**

Southend Drug and Alcohol Action Team has undergone a comprehensive restructure. As a result of this we are now recruiting to a number of exciting new posts. As Drug and Alcohol Strategy Manager you will finalise and consolidate this restructure.

Responsible for a small team of staff, your role will encompass the planning and commissioning of a full range of substance misuse services. You will provide leadership to the DAAT support team and to the Southend Treatment System. You will also provide recommendation to the local strategic partnerships and assist the partnership with achieving their targets and ambitions.

Your sound knowledge of national substance misuse strategy and treatment priorities will be essential as will your skill as a Relationship Manager.

For further information on this position please contact Mike Boyle, Interim Director of Adult and Community Services on 01702 534612.

To apply online or find out information on all our vacancies go to **www.southend.gov.uk/jobs**

Application packs for both posts are available from the Customer Contact Centre, Civic Centre, Victoria Avenue, Southend-on-Sea SS2 6ER or telephone on 01702 215000 to collect a pack. The opening hours are 8.45am - 5.15pm Monday to Friday. Please quote the reference.

New Deal applicants will be considered.

Application packs are available in alternative formats.

We are an Equal Opportunities Employer and operate a no-smoking policy.

This authority is committed to safeguarding and promoting the welfare of children, young people and vulnerable adults and expects all staff and volunteers to share this commitment. Applications are welcomed from people wishing to job share or work flexible patterns.

Closing date:
Friday 11th May 2007.

Southend-on-Sea Borough Council

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Could you make a difference?

Do you want to join a dynamic criminal justice organisation? Think Kent Probation Area.

SUBSTANCE MISUSE COMMISSIONER
Canterbury
Salary £33,232 - £37,782
37.5 hours per week

An exciting opportunity has arisen within Kent Probation Area to lead on substance abuse, including developing and implementing services, co-ordinating staff responsible for delivery, improving performance and developing effective relationships with treatment providers. Part of the role involves secondment to the Kent and Medway Drug and Alcohol Action Team in order to secure resources needed for our work with offenders.

For a recruitment pack, please visit our website www.kentprobation.org or e-mail your name and address to barbara.phillips@kent.probation.gsi.gov.uk, **quoting reference number SMC/PB098001.** Alternatively, please call our 24-hour answerphone on 01622 350645. We do not accept CVs.

Closing date: Friday, 18 May, 2007
Interview date: Wednesday, 6 June, 2007

KPA values diversity and is committed to recruiting from all sections of the community

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SUBSTANCE

Drug, Alcohol and Domestic Violence Training and Consultancy
Bespoke training tailored to your organisations needs

Substance is an association of highly qualified, independant professionals with a wealth of experience across the Social Care, Drugs, Law, Alcohol, and Domestic Violence fields.

Key personnel include Frances Potter, Greg Poulter, Rachel Hassan, Jai Hart, Ian May, Chris Newman and Kate Iwi

Contact Frances Potter on 020 8847 5437
or email franepotter@hotmail.com

Drug and Alcohol Foundation

The Drug and Alcohol Foundation is looking to recruit a **Day Programme Worker** for our addictions service day programme.

For this post we will be looking for some one with experience of working within a Twelve Step framework, a qualified counsellor or in the final year of training with previous experience of running groups with people who have addictive disorders and providing counselling to this client group. *This will be a four day per week post at a salary range of £21000-£24000 per annum (pro rata).*

The closing date for for completed applications for the above post will be Monday the 14th May 2007. If you would like more information please call the Admin Department on 020 7233 0400.

Papa Stour Project

Full Time Support Worker

Papa Stour Project invites applications from experienced individuals (or couples wishing to job share)

This is a residential post funded by SADAT. 37 hpw fixed term appointment 18/06/07-17/06/08 £15K+full- board. In partnership with Shetland Community Drugs Team and Alcohol Support Services.

We are looking for a self motivated and enthusiastic person able and willing to live as part of a small Christian-based supported housing service providing support for clients with alcohol/drug addiction in a remote small island location in the Shetland Islands.

For further information and to obtain an application pack (closing date 07/05/07) please contact:

Sabina or Andy Holtbrook

01595-873238
sabina@papastour.org
www.papastour.org

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www.SamRecruitment.org.uk

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Email: SamRecruitment@btconnect.com Or register online

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BAC O'Connor

BAC O'Connor *is a nationally recognised organisation delivering abstinence based seamless rehabilitation from detoxification, holistic rehabilitation, daycare or residential, resettlement through to independent living in self contained apartments.*

We are based in Burton on Trent and Newcastle under Lyme in Staffordshire. An exciting development for 2007 will include a new residential centre in the north f the county, which will incorporate a female only unit with crèche and childcare facilities. We are also contracted to provide DIP Resettlement and work very closely with partner agencies. Our services are designed to be both holistic and seamless and as a company we are very responsive to service user needs, holding regular consultation with our clients and their families.

Whilst our philosophy is abstinence, our programme is not based on the 12 step model, although there are some elements and we encourage support from this network and others.

We are very proud of what we have achieved in the last 8 years but as a forward thinking company we are looking for a creative and dynamic person to join us and take up the challenge this new growth brings together with continually striving for continuous improvement.

Head of Programme Delivery

You will have a substance misuse therapeutic and managerial background and be BACP or NADAAC accredited or the equivalent. Responsible for the smooth running of a multi disciplinary team we expect you to work with and further develop evidenced therapeutic programmes and oversee their delivery.

Our ideal candidate will be confident with excellent people skills and the ability to use these qualities to both develop professional working relationships with partner agencies.

We have an excellent team at both centres and believe strongly in developing people, you will therefore have the skills necessary to promote, encourage and support staff development. Service Users and their families are key to our development and the quality of our services and you will recognise the importance of service user consultation and promoting independence.

A key member of the management team you should have the necessary business experience to play a pivotal role in managing this period of growth and change. The successful applicant will also have strong organisational and problem solving skills.

Ideally you will be familiar with care standards requirements, DANOS and accreditation.

We will offer a negotiable (based upon experience and qualifications) remuneration package with a range of benefits for the right candidate.

Please send comprehensive CV to
Mrs Noreen Oliver (nee Langan), Chief Executive Officer, BAC O'Connor
126 Station Street, Burton on Trent, Staffordshire, DE14 1BX