

Druglink

REPORTING ON DRUGS SINCE 1975

- Cannabis farms
- Stop and search
- Law reform
- Recovery

Message in a bottle *The state of the nation*



Leeds Addiction Unit

in collaboration with the University of Leeds School of Healthcare

Addiction Studies

BHSc (Hons)
Graduate Diploma
Diploma of Higher Education
Certificate of Higher Education
Community Treatment of Substance
Misuse

Enrolling now for

September 2012 & February 2013

Programmes and modules combining theory, research, policy and practice are available by **distance learning** or **attended taught sessions** at Leeds Addiction Unit

Modules include: Motivational Interviewing • Research • Cognitive Behavioural Coping Skills • Harm Reduction • Psychopharmacology • Child Bearing Drug Users & Child Protection • Dual Diagnosis • Criminal Justice • Social Behaviour & Network Therapy •

phone **0113 295 1330**

or email

lau@leeds.ac.uk

www.lau.org.uk/training

Short courses, accredited programmes and stand alone modules
We also offer courses tailor-made for your group or organisation. Contact us for details

Leeds Partnerships 
NHS Foundation Trust


UNIVERSITY OF LEEDS

Substance Misuse Personnel

Permanent • Temporary • Consultancy

Supplying experienced, trained staff:

- Commissioning
- Service Reviews
- DIP Management
- DAT Co-ordination
- Needs Assessments
- Project Management
- Group & 1-1 drug workers
- Prison & Community drug workers
- Nurses (detox, therapeutic, managers)
- many more roles...



Call today: 020 8987 6061

Register online:
www.SamRecruitment.org.uk

Solutions Action Management
Still No.1 for Recruitment and Consultancy

Druglink

Through a glass darkly

Most people will agree that alcohol is being sold far too cheaply especially by supermarkets. Charities and health professionals have welcomed government commitment to introduce a minimum price per unit of alcohol. Not surprisingly, the industry has reacted with scepticism that this will tackle the real problems of our drinking culture, especially for those with alcohol dependency, claiming that it will be primarily 'responsible drinkers' who will be affected. Supporters of minimum pricing point to research which does suggest that consumers will respond to higher prices by moderating intake, so that over the longer-term there are projected savings for society in relation to health, anti-social behaviour and so on.

However, the research is inconclusive on what sort of drinker is likely to modify their drinking based on price and so the health and crime gains remain notional. More likely, the main beneficiaries at least in the short-medium term are going to be the drinks industry and supermarkets with increased profits and the government through higher tax revenues. But there is one move that could help those at the poorest end of society such as homeless street drinkers – and that would be to entirely ban super strength cider and lager. There appears to be no reason to produce 7% plus cider or lager other than to attract the very people least able to cope with it. Such a move could prove legally tricky, so an alternative might be to increase taxation to such an extent that the price becomes prohibitive.

Harry Shapiro

Editor and Director of Communications/ Information

Druglink is sponsored by Ansvar Insurance and The Brit Trust for 2012



DrugScope
Prince Consort House
109–111 Farringdon Rd
London EC1R 3BW

Telephone
020 7520 7550
Email
info@drugscope.org.uk
Web
www.drugscope.org.uk

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

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

SUBSCRIPTIONS
Subscription for the year (six issues): £55
To subscribe call
020 7520 7550

DRUGLINK STAFF
Editor Harry Shapiro
Editorial Assistant
Ruth Goldsmith
Online Jackie Buckle
Book Reviews Editor
Blaine Stothard
Director of Communications and Information
Harry Shapiro

ADVERTISEMENTS
Email:
harrys@drugscope.org.uk
The inclusion of an advertisement, flyer or free sample in Druglink does not imply any endorsement of a particular product or service by DrugScope or Druglink.

Design
Helen Joubert Design
helenjoubertdesign.com

Print Holbrooks Printers
Ltd, Portsmouth PO3 5HX

CONTRIBUTIONS
Druglink welcomes letters and other contributions. Send direct or contact Harry Shapiro
Email:
harrys@drugscope.org.uk

Material published in Druglink does not necessarily represent the views or policies of DrugScope

© DrugScope/the author(s). All rights fully reserved. Requests for permission to reproduce material from Druglink should be addressed to the editor.

ISSN 0305-4349

News

- 2 **Doubts raised over 'government' document**
- 3 **Tony Newton 1937-2012**
- 5 **Misuse of Drugs Act under strain**
- 6 **Reactions to Alcohol Strategy**

Features

- 8 **COVER STORY: NEVER THE BRIDE**
With the Alcohol Strategy having little to say about treatment, what does the future hold?
By Trevor McCarthy
- 12 **Druglink Interview**
Noreen Oliver, CEO of BAC O'Connor and Chair of the UK Recovery Group.
Interview by Harry Shapiro
- 14 **Weeding out the dope**
What is the current state of play with cannabis farms in the UK and can the police cope?
By Harry Shapiro
- 16 **Stop and search**
It is more than a decade since the Macpherson report highlighted that institutional racism had eroded community trust in the police. What progress has been made since?
By Caroline Oubridge
- 18 **Strange bedfellows**
The debate over drug law reform often throws together those whose views are otherwise polar opposites. By Marcus Roberts
- 20 **From addiction to recovery: twelve easy steps?**
Recovery champions can sometimes give a false impression about recovery. Nic Sheff was pulled up on this by an angry listener.
- 4 **Inside DrugScope**
- 22 **Reviews: law reform;**
Sigmund Freud; dual diagnosis
- 26 **Research: drug education**
- 27 **Factsheet: PMA/PMMA**
- 28 **Drugworld diary**
Neal Richardson, Charing Cross Hospital



■ Dutch cap hash

A judge in the Netherlands has upheld a new law that will ban foreign tourists from smoking cannabis in 'coffeeshops'. The ban has been introduced in the three southern provinces closest to the Dutch border with Belgium and Germany and will go nationwide by the end of the year. Those who wish to smoke will have to show valid Dutch ID or be in possession of a 'weed pass', a move currently under discussion.

However the Chair of the Union of Maastricht Coffeeshop owners, one of the areas immediately affected by the ban says he will defy the ban on selling to non-residents. The coffeeshop owners say that if the ban is not overturned, they will appeal to the European Court of Human Rights on the grounds that they are being forced to discriminate against people on the grounds of where they live. However, an expert in European law interviewed by the BBC said this was unlikely to succeed because cannabis smoking is an illegal activity.

In a separate development, the Dutch have reclassified cannabis with a THC content above 15% as a more dangerous drug.

■ Estonian overdose surge

Estonia has one of the highest overdose rates in Europe, a dubious honour fuelled by a boom in deaths caused by a synthetic heroin product called fentanyl. The drug, nicknamed 'China White', first appeared on the streets ten years ago during a heroin shortage. But so powerful is the drug, around 100 times more potent than morphine, that once users tried it, for many there was no going back. But with potency comes significant risk. Half a teaspoon of the caramel-coloured powder could kill at least ten people according to the Estonian Forensic Science Institute.

Doubts raised over 'government' document

The Coalition document *Putting Full Recovery First – The Recovery Roadmap* has caused much consternation within the sector.

Despite being covered in departmental logos, its appearance differs markedly from similar policy documents. Neither the recently published Alcohol Strategy nor the original 2010 Drug Strategy documents carry any departmental logos at all; they are simply badged 'HM Government'. The Alcohol Strategy carries clear publishing details showing that it is published by The Stationary Office with ordering details including an International Standard Book Number (ISBN) – all the hallmarks of an official publication. The 2010 drug strategy document has fewer of these features, but does have an ISBN. The Roadmap has none of these.

The document was presented to the Inter-Ministerial Group (IMG) on Drugs chaired by Lord Henley, the Home Office drugs minister. One of those who attends the meetings, David Burrowes MP, Parliamentary Private Secretary to Cabinet Secretary Oliver Letwin, another attendee, was quoted in *The Guardian* (24 April) defending the document saying it was not the product of "government diktat", but from a 'collaboration' with charities and service providers".

As a partner with Recovery Group UK in the Recovery Partnership, one of the charities named in the document was DrugScope. But in a statement to *The Guardian*, CEO Martin Barnes made it clear that DrugScope does not support the document where it departs from the official Home Office 2010 drug strategy

He said "DrugScope welcomed and continues to support the considered approach to treatment and recovery as set out in the government's drug strategy, published in 2010. The strategy states unambiguously that recovery is an individual, person-centred journey and – while becoming drug-free is the ambition – there is a role for medically-assisted recovery.

"Despite being referenced in the Recovery Roadmap document, DrugScope...do[es] not support or



David Burrowes MP:
defends Roadmap

endorse where it clearly differs from the drug strategy and the government's commitments to an integrated, evidence based and balanced treatment system'

Other organisations like Release, Transform and the National Users Network were signatories to a letter sent to Lord Henley expressing their concern that the focus in the document on 'full independence from any chemical' represented a unitary treatment goal that was 'unethical, arbitrary and ineffective' and that the Roadmap undermined evidence-based harm reduction interventions with a consequential threat to public health. The signatories also noted that by stating, 'ultimately payment [to service providers] will be made for full recovery only' there was a risk of discrimination against those who could not achieve this outcome. The letter concluded that the document 'represents a profound misunderstanding of the lives of people who use drugs, the complexity of their problems, and the services that work with them.'

Tony Newton

1937-2012

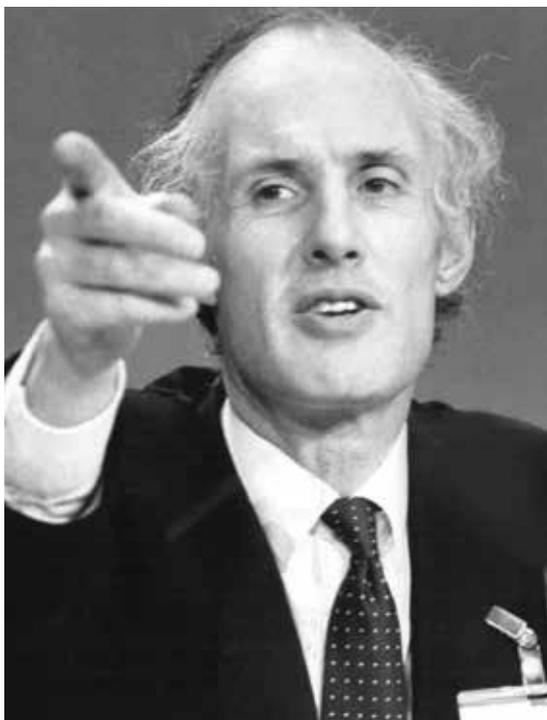
Jeremy Sare

Lord Tony Newton died in March aged 74. He was the Conservative member for Braintree, Essex for 25 years until 1997 when he became a life peer. Throughout his career he showed a considerably more progressive outlook to social policy than many of his ministerial colleagues.

His fifteen-year-long ministerial career included two years as the health minister in the mid-eighties (1986-8) during the tabloid panic over HIV/AIDS, dubbed, at the time, the 'Gay Plague'. In 1988, the Advisory Council on the Misuse of Drugs had produced a fairly radical response to the problem *AIDS and Drug Misuse* written largely by (Baroness) Ruth Runciman. Although the report recommended embracing, to a great extent, the new harm reduction philosophy, the ACMD found highly valuable allies in Tony Newton and his Secretary of State at the old DHSS, Norman Fowler.

There were many in the Cabinet who found the very concept of needle exchanges highly unpalatable and politically problematic, but Newton and Fowler were able to convince them (and Mrs Thatcher) this was the policy of a responsible Government. Newton showed a degree of political courage to win over the social conservatives in Parliament and the media. The £50m advertising campaign which followed (Don't Die of Ignorance) was, with the report, acclaimed worldwide and has subsequently become very influential in many countries.

The harm reduction approach has resulted in the UK having one of the lowest rates of HIV among injecting drug users in the world and it should, at least in part, be credited as one of



Tony Newton's finest achievements. He also secured from HM Treasury £10m compensation for haemophiliacs infected with HIV. Ruth Lister, of the Child Poverty Action Group, described him as, "the best health and social security minister of the Thatcher years".

By the time of John Major's government (1990-7) Tony Newton as Leader of the House, brought together the first cross-departmental Drug Strategy in 1995. For the first time, there was a much broader responsibility for the drug strategy shared across government rather than being exclusively 'owned' by the Home Office going right back to the first Dangerous Drug Act of 1920. He later became President of DrugScope.

Tony Newton was always a 'One Nation' Tory and was a reminder of the pragmatic and compassionate side of Conservatism.

Per-U Turn

A key plank of the new Peruvian drug strategy is to ramp up the forced eradication of coca, a tactic President Humala promised not to do when he was on the campaign trail in the growing areas last year. The government says that with the number of hectares of coca to be eradicated set to increase year on year to unprecedented levels, coca output will be cut by 30% by 2016.

But like Bolivia, coca growing is legal in Peru in recognition of the centuries old tradition of coca chewing.

So why the hard line? A clue can be found in the comments of the reformist drugs chief Ricardo Soberon who was replaced in January by the more conservative Carmen Masias. Soberon told the media that drug policy had been 'hijacked' by those working in the interests of external forces. Masias worked for more than 20 years for the US-backed anti-drugs group Cedro which promotes coca eradication.

Insider trading hits AA

The US Securities and Exchange Commission has filed a law suit against Timothy McGee, a member of Alcoholics Anonymous who used confidential information given to him by another member to turn a profit of \$300,000.

McGee's buddy began complaining about the problems of overseeing the sale of his insurance company to a larger firm.

The stress piled up on his friend, causing him to relapse, while McGee continued to pump him for more information.

McGee then used this knowledge to buy \$400,000 of stock in his buddy's company, turning a quick and substantial profit when the merger went through.

This is the first time that the government has ever found AA confidentiality to be binding in law, at least on the financial side. There was a famous case in 1994, when an AA member shared details of a double murder he had committed, but this was found to be outside the so-called shield law that for example, protects journalists from having to reveal sources of information.

New DrugScope report: Building for Recovery

As part of our work for the Drug Sector Partnership, we have published a new report *Building for Recovery*. The key messages of the report are:

- Support for the commitment to recovery articulated in the Drug Strategy 2010, where recovery is described as ‘an individual, person-centred journey, as opposed to an end state’, and stated that recovery will ‘mean different things to different people’ (including a role for ‘medically assisted recovery’).
- A recognition of the value of ‘drug free outcomes’. However, we believe in an inclusive vision of recovery that doesn’t associate it with a single end state. Recovery requires balanced, integrated and evidence-based services that respond to the needs, assets, motivations and priorities of service users at every stage of their ‘individual journey’.
- A belief that social integration is at the heart of the recovery vision. People affected by drug and alcohol problems have often experienced trauma, victimisation and abuse, poverty and exclusion and have many problems to deal with. They cannot rebuild their lives if the roads into society are closed to them. This is about tackling inappropriate and negative attitudes to people in recovery as well as about making resources available.

We note that recovery should include health and public health interventions. The Drug Strategy 2010 identified ‘preventing drug related deaths and blood borne viruses’ as one of eight best practice outcomes.

We are concerned about the potential for local disinvestment and the impact of a wide range of policy and structural reforms on the implementation of recovery, particularly against a backdrop of financial austerity and significant cuts in local authority budgets.

We call on national Government, Public Health England and local authorities to keep faith with and build upon the vision of recovery in the 2010 Drug Strategy; to ensure that innovation in health and public service reform is balanced with evidence-based approaches and the highest clinical standards; to keep under review the impact of other policy change on the recovery ambition (for example, payment by results and welfare reform); and to ensure that there is sufficient investment in every local area (including in areas like housing, mental health, family services and employment support) to provide our sector with the necessary tools and resources to deliver recovery-orientated services on the ground.

Read the full report at www.drugscope.org.uk/POLICY+TOPICS/BuildingForRecovery.htm

DrugScope set to benefit from unique fundraising scheme

DrugScope has signed an agreement with Chris Knott Insurance whereby you can help us raise funds by asking this charity-friendly broker for a quote.

Simply ask them for a quote for your car, home or business insurance. Mention DrugScope and Chris Knott will donate 25% of their earnings to us if you go ahead with the cover. What’s more, they’ll donate again, every year that you stay with them.

Earnings example: On a car insurance premium of £300, Chris Knott will earn £42.30 of which DrugScope will receive £10.58. This is payable for the life of the policy i.e. if you renew the next year, DrugScope receives the same percentage again.

Neil Franklin, MD of Chris Knott Insurance says “We’re delighted to be offering this scheme to DrugScope – I have personally been following their

work for some time and can say I’m inspired by their expertise and the valuable contribution they make in the drug field. The least we can do in response is help generate some funds for DrugScope through this insurance scheme for supporters”.

DrugScope’s Harry Shapiro, commented “this opportunity for members and supporters to benefit from a potential saving on their annual insurance bills while raising money for DrugScope is most welcome”. Chris Knott Insurance offers this scheme to a number of charities with local hospices and regional Air Ambulances the latest organisations to sign up.

Call Chris Knott Insurance FREE on 0800 917 2274 and mention DrugScope. Alternatively call 01424 200477 which is cheaper for mobiles.

NEW DRUGS STRAIN OLD LAW

It isn't just drug reform organisations that question whether the Misuse of Drug Act can cope with the flood of legal highs. By Jeremy Sare

The Home Affairs Select Committee's inquiry on drugs recently included enlightening and amusing evidence from comedian and former addict Russell Brand.

There was a time when such committees restricted formal submissions to austere academics and hard-bitten coppers. Nevertheless the message appears to be the same: the current drug law cannot cope with the modern demands placed on it.

For years now, some drug charities have been suggesting the Misuse of Drugs Act (MDA) 1971 was unable to respond with sufficient agility to a world of drugs never envisaged when the Act was passed. The introduction of Temporary Orders last year has made the law respond much more rapidly but that is not satisfying every stakeholder's expectations. In the wake of the emergence of many new club drugs and so-called legal highs, there is realisation from traditionally conservative quarters that the legal method of controlling new drugs needs re-examining.

The Advisory Council on the Misuse of Drugs (ACMD) published *Consideration of the Novel Psychoactive Drugs* in October last year. Among its "practicable options" the Council suggested, "moving the responsibility for the supply...to the vendors...to prove such substances are neither analogues of current medicines nor products harmful to consumers in their intended form."

The view of senior police appears to be more flexible than the Government's about the efficacy of the MDA. In its submission to the Home Affairs

THE MDA DOES NOT ADEQUATELY ADDRESS THE CURRENT SITUATION WHEN 40-50 NEW COMPOUNDS EMERGE EACH YEAR

Committee, the Acpo drugs committee questioned the effectiveness of "adding inexorably to the list of illicit substances" as an effective way of changing behaviour and prevalence. It doubted, "the extent to which legislation can realistically be used to address active choices being made by (predominantly young) people".

Acpo concurred with the UK Drug Policy Commission's conclusion that alternative legislative options could be deployed to shut down legal high suppliers. There is enough consumer protection law and trading standard regulation to stop these enterprises trading by demonstrating their 'produce' is not necessarily safe and potentially harmful to its customers.

But these laws sound a little weak, when contrasted with the image of the traditional drug raid. Using consumer law would also hand some responsibility for drug policy to other departments including the Department for Local Government and Communities which the Home Office would certainly resist.

Dr John Ramsay, toxicologist and director of the Tictac Communications drugs database at St George's medical

school said, "The Misuse of Drugs Act was conceived at a time when the emergence of a new drug of abuse excited toxicologists. It does not adequately address the current situation when 40-50 new compounds emerge each year. We badly need a review of all the legal instruments at our disposal; the criminal law, consumer protection legislation, medicines regulation and resources to enforce them. Attempts to deter drug use solely by control of the supply has never been successful even before the advent of the internet, electronic money transfer and international courier networks. We need to concentrate our efforts on informing consumers and hopefully reducing the demand."

The situation on new drugs and the potential threat to young people's well being is rapidly evolving. The EMCDDA report on legal highs published in April 2012 showed a doubling of the numbers of internet suppliers of these new psychoactives.

But faced with this problem, the Home Office's response remained resolute about the MDA as the legislative vehicle to counter drug misuse, "The UK is leading the way in cracking down on new psychoactive substances by banning them while the harms they cause are investigated. Our strategy is to keep drugs off the streets and punish the dealers."

■ **Jeremy Sare** is a freelance journalist

Alcohol strategy: fizzy or flat?

Governments often use Friday afternoons to push through initiatives when fewer MPs are in the House. Presumably, the alcohol strategy qualified because of the controversial decision to introduce minimum pricing for alcohol. What isn't debatable however, is that the UK has an unhealthy relationship with alcohol. A 25% increase in alcohol-related deaths since 2001 is just one of the more shocking statistics that means that according to a recent YouGov poll, 40% of us associate Britain with the word 'drunk'. So what about the strategy itself? *Druglink* sought the responses to the strategy of interested organisations, and identified four key themes. By **David Ader**



MINIMUM PRICING

Dr Vivienne Nathanson, *Head of Science and Ethics, British Medical Association*

It is encouraging that ministers have put forward a national strategy designed to tackle the serious problem of alcohol abuse that wrecks thousands of lives and costs the NHS millions of pounds each year.

The decision to tackle the affordability of cheap alcohol and the availability of multi-buy discount deals is a step in the right direction.

Dr Peter Rice, *Royal College of Psychiatrists lead on the Alcohol Strategy, Scottish Health Action on Alcohol Problems*

The acknowledgement of the link between price, consumption and harm is very important. This was not

previously as well acknowledged by the Government as it was by health professionals, and this change is very welcome.

Price is the most important factor for long-term health harm, and minimum pricing is thus the most important aspect of the strategy.

Emily Robinson, *Director of Campaigns, Alcohol Concern*

It's great to see the Government's commitment to minimum pricing. The government has kicked the discussion off at 40p – though it has been made clear that price per unit is open for discussion. We would see this set at 50p per unit to be the most effective at bringing change, and it is to be expected that there will be vigorous lobbying by the drinks industry for a lesser figure, as well as a likely legal challenge under EU competition law.

Sainsbury's official statement

We do not support minimum pricing. It would unfairly affect the vast majority of our customers who buy alcohol as part of their grocery shopping and drink responsibly.

We do not believe it will tackle alcohol misuse. There is no simple link between price, consumption and alcohol misuse. Countries that have the highest alcohol taxes and highest prices are also ones where alcohol misuse is a problem.

ALCOHOL AND THE COMMUNITY/ COMMUNITY SAFETY

Chief Constable Jon Stoddart, *ACPO lead on alcohol and licensing*

The growing trend for 'pre-loading' means that young people are often drunk before they even enter a bar. By the time they hit the streets at closing time they are more likely to get involved in crime and disorder or injure themselves or others. I welcome any new approach that will help reduce the availability of cheap alcohol, give communities a greater say over licensing in their area and reduce pressure on the police.

Jeremy Swain, *Chief Executive, Thames Reach*

In my view there is a real danger of services supporting people with substance misuse problems giving the impression that we are extremely concerned about the care and rehabilitation aspect of addressing alcohol misuse but much less bothered about the impact on local communities caused by drink-related violence and other disorder.

Emphasising responsibilities towards local communities is the best way of heading off the watering down of this strategy by the drinks industry which

will seek to return us to a failed strategy based on labelling of products and education on the impact of alcohol. These contributions are important, but nothing is as important as the shift in behaviour which will be achieved through delivering on changes in pricing based on unit cost.

Vivienne Evans, *Chief Executive, Adfam*

The strategy doesn't address the needs of all family members affected by problematic alcohol use and the devastating impact this can have on spouses, partners, parents, siblings and adult children. We will be looking for further opportunities to draw attention to these family members' needs, and how alcohol recovery services could go some way to support whole family recovery.

ALCOHOL DEPENDENCY AND TREATMENT

Simon Antrobus, *Chief Executive of Addaction*

The strategy includes information on the forthcoming ring-fenced Public Health Grants, but within these, there is no dedicated funding for alcohol treatment. There needs to be.

It is estimated that there are over 1.5 million dependent drinkers in the UK who require specialist support. But without this dedicated funding, services such as ours will struggle to deliver that support.

Karen Biggs, *Chief Executive of Phoenix Futures*

This isn't a strategy that aspires to address addiction and it would be dangerous to think it did. Of the 32 pages of strategy, 3 paragraphs are concerned with recovery.

The strategy for me highlights the major risk for the sector in the coming years. That the transfer to public health will divert funding from services delivering specialist recovery to the most vulnerable groups, to services that address broader lower intensity public health messages. It is difficult for me to see how this strategy will touch the

lives of those entrenched chaotic alcohol users that we take into our services every day.

Selina Douglas, *Director of Substance Misuse Services, Turning Point*

In particular, the Government should be focusing on reducing alcohol-related harm by identifying those who need help. This can be achieved for example by putting trained specialists in hospital A &Es. Around 1.6 million people in the UK are dependent on alcohol but only 8 per cent of this figure - 140,000 people - are in some form of treatment.

We would like to have seen the strategy include more advice around which treatment approaches are considered to be the most effective, including advice around innovative integrated approaches across all the different tiers of treatment, as well as greater integration with drug treatment.

Dr Peter Rice, *Royal College of Psychiatrists lead on the Alcohol Strategy, Scottish Health Action on Alcohol Problems*

There is little mention in the strategy of treatment services, and the number of early interventions needs to increase. Priority for interventions ought to be on a par with other major public health interventions such as breast cancer screening and vaccinations.

Only 1 in 18 of people with alcohol dependency are in treatment, so there is a huge unmet need. A change of gear is needed in the scope of alcohol services, and these services need to be rolled out at a national not merely a local level. Whilst pricing is the correct place to start, the second phase must be treatment.

'HIDDEN DRINKING'

Chris Sorek, *Chief Executive of Drinkaware*

We are concerned that while young adults sprawled on pavements after a night out on the town grabs headlines, the Alcohol Strategy does not include measures to tackle the worrying trend of Britain's hidden binge drinkers. Recent ONS statistics confirm Drinkaware's evidence that 25-44 year old working professionals are drinking more heavily

and more regularly than young adults.

Sandy Jerrim, *Project Manager, QIPP Alcohol, NHS Southampton*

The strategy points at dealing with night-time drinking, and it points at retail and industry, but it doesn't look enough at the country's general drinking culture. There is a lot of focus on 'bad guys' - binge drinkers associated with violence and aggression, using valuable A&E time - and little attention to other areas such as drinking levels among different socio-economic groups, including higher economic groups who drink more regularly than lower socio-economic groups. There is a risk of demonising certain groups and failing to address the bigger, but less visible issue around professionals.

Mike Pattinson, *Director of Operations, Crime Reduction Initiatives*

The strategy places great emphasis on 'young people's' drinking and much of it is based around controlling their behaviour. It is not until Section 5.12 that any reference is made to adult misusers of alcohol - with the alarming projection that 70,000 people will die over the next 20 years of alcohol related illnesses. The media-driven focus on young people and alcohol seems to have led the strategy to being somewhat unbalanced in this respect.

James Morris, *Alcohol Academy, and editor of Alcohol Policy UK (www.alcoholpolicy.net)*

I don't think the strategy entirely ignores the issue of more hidden drinkers and alcohol dependency, but it certainly could have been given further exploration and commitment. We still need to significantly increase overall treatment capacity, and in particular improve its effectiveness in meeting different levels of needs. A big issue I feel is really about reaching less severely or non-dependent drinkers who require less intensive treatment or very brief psychosocial treatment. There are many people out there who are highly functioning, with families and jobs, but because of this they won't see themselves as dependent or needing "treatment".

■ **David Ader** is a DrugScope intern

NEVER THE BRIDE

Trevor McCarthy argues that the Government's new alcohol strategy still leaves alcohol treatment as drug's poor cousin, but suggests Public Health England could be the driver to reprioritise substance misuse treatment.

Alcohol services looking for hints of improvement in the new alcohol strategy are probably still looking. Chapter 5: *Supporting individuals to change* includes precisely nothing about specialist treatment. The only reference to anything resembling specialist treatment comes in one small paragraph; "... Funding through the Public Health Grant will allow local authorities to commission Identification and Brief Advice, which is proven to be effective in reducing the drinking of people at risk of ill health, and specialised treatment for those with greater needs. Alcohol liaison nurses within A&E have been shown to reduce re-presentations and may in future be co-funded by Clinical Commissioning Groups alongside Local Authorities."

For the alcohol strategy to work, it needs to take a whole population approach to alcohol – and for that, you need to engage the whole population. Politically this has not been popular. The fingers of Special Advisers (SPADS) are all over the alcohol strategy.

The ideology underpinning the alcohol strategy is all about blaming drinkers for their alcohol problems. The individualised approach to people who may cause problems to others denies the contribution of marketing, availability and licensing laws, for example.

In fact government alcohol and drugs policy does not really focus on the direct needs of people with problems at all. Alcohol and drug treatment is almost always justified by the amount of money it will save the NHS, the criminal justice system or local authorities. Treatment may also be justified on the basis of reducing anti-social behaviour. Treating drinkers and drug users is a means to

desirable ends. Benefit to the individuals receiving treatment is rarely if ever the policy rationale. It is not about people with problems having a right to treatment.

Most drugs for alcohol treatment like Acamprosate are not in patent so pharmaceutical companies lack incentive to push them. Naltrexone manufacturers do not even seek a licence in the UK for treating alcohol problems even though it is recommended by NICE.

So in the virtual absence of direction from the strategy; what should alcohol treatment comprise? Before Labour's 2004 alcohol strategy there was no evident requirement for local areas to provide alcohol treatment, yet everywhere had some. There would usually be an advice centre and a community alcohol team: a mix of voluntary sector and NHS services. The first comprehensive analysis published in 2005 found those local arrangements delivered insufficient capacity.

Contrary to popular myth, civil servants spotted the acronym before the Alcohol Harm Reduction Strategy for England (AHRSE) was published. Like its 2007 successor, *Safe, Sensible, Social* and the current document, AHRSE was biased toward prevention; a whole population, public health approach.

The drugs strategy has been based on the analysis that most drug-related harm is perpetrated by dependent, illicit drug users: hence a focus on getting dependent users into treatment.

Alcohol is not illegal and alcohol strategy is different. The harm experienced by dependent drinkers, and others directly affected, is significant. However, the Prime Minister's Strategy

Unit 2003 interim analytical report found most alcohol related harm is associated with drinkers who are not dependent. Consequently, treating dependent drinkers was not the priority.

Drug targets have been to get two thirds of dependent drug users into treatment; an aim that has been fully funded, centrally. For alcohol the aspiration has been 15% of dependent drinkers in treatment at any one time. This calculation was based on one Canadian paper published over twenty years ago. And the treatment is not funded either centrally or fully. Spot the difference?

Models of care for alcohol misusers (MoCAM) and accompanying publications, including the *Review of effectiveness of treatment for alcohol problems* published in 2006 gave guidance on commissioning treatment systems and evidence based interventions. But with next to no money backing up the publications, rhetoric was the main implementation strategy.

In most areas of England drug commissioning teams took on alcohol, with the familiar results that accrue from ridiculous levels of re-commissioning for no discernible benefit. The main result of this churn – displacing provider agencies and disrupting existing partnerships – is never accounted for. It is not clear that alcohol outcomes or delivery of best practice, evidenced based interventions have improved. However, the NDTMS data collection system has kicked in for alcohol and data was a key element driving improved drug treatment.

The commissioning processes which spawned large regional and national voluntary sector providers are also affecting alcohol treatment, narrowing



the multi-disciplinary aspect of local systems.

When I joined the alcohol field the Community Alcohol Team (CAT) included psychiatry, psychology, psychiatric and general nursing, occupational therapy and social work. GPs were supported by the CAT in prescribing for community detoxification. Services were delivered in home and community venues, augmented by an Alcohol Advice Centre and a specialist hostel supporting controlled drinking as well as abstinence.

Now alcohol psychologists are rare. Occupational therapists are long gone. Psychiatrist-led services are replaced by GP-led services. There is no evidence that removing psychiatry from the mix has improved or would improve systems. Commissioners have acted to strip out some professional expertise and experience on the basis of unsubstantiated tenders from those large voluntary sector providers who are making an argument for their own organisational advantage

PEOPLE IN FRONT LINE ROLES FIND IT DIFFICULT TO ASK ABOUT ALCOHOL. MOCAM INSISTED ALCOHOL IS EVERYONE'S RESPONSIBILITY; NICE CONFIRMED THAT. SO THAT IS A MAJOR PROBLEM FOR THE ALCOHOL STRATEGY

Commissioners fail to specify what multi-disciplinary services should comprise. Some tenders from the voluntary sector-led consortia maintain there is no need for (expensive) psychiatric input. Once expensive elements are eliminated there is no

guarantee they will ever return. Where Commissioners believe GPs with Special Interest are equivalent to psychiatrists they literally buy into narrowing alcohol provision.

The expansion of GP engagement in local drug treatment systems was surprisingly straightforward. Many GPs responded and have been intrinsic to the development of effective and penetrative, normalising drug treatment. The GP medical role is a good fit for treatment systems and congruent with their work in other specialisms. Drug treatment prescribing: medically assisted withdrawal or maintenance has well established evidence based protocols. Accompanying talking therapies are not delivered by GPs. Drug users go to specialist drug services where they are assessed; the subsequent GP role is straightforward, well bounded (and paid). Crucially, GPs are supported by well resourced community drug services.

Alcohol is different. Drug users are a relatively small segment of the



population whereas people drinking above recommended levels make up a large proportion of GP lists. National Service Frameworks (NSFs) were NHS priorities with Primary Care typically in the gatekeeper role. NSFs included mental health; coronary heart disease; older people and diabetes. With the national cancer plan, dual diagnosis guidance and the suicide prevention strategy, GPs were in the front line delivering multiple overlapping strategies. All should have routinely included alcohol as part of holistic Primary Care assessments. That didn't happen.

Identification and Brief Advice (IBA) is mentioned in the new alcohol policy. The rationale of the DH alcohol team was that GPs are put off by technical terms like "assessment" and "intervention". Assessment and intervention implies time and GPs are (and say they are) time-poor. A vast amount of work previously delivered in hospitals has been devolved to Primary Care; a trend that continues. In a literature search of the alcohol research evidence base IBA will turn up no results. Tools and techniques claimed for IBA are assessment, brief interventions and treatment in the literature. Here's everything you need to know about IBA. NICE don't mention it. At all. Not once. Because NICE is all about the evidence – not about spin. IBA was a cuddly alternative to Assessment and Intervention. And of course it fundamentally misses the point.

It is normal for front line professionals to avoid routinely asking about alcohol – even when alcohol problems are implicated in their service users' and patients' problems. People in front line roles find it difficult to ask about alcohol. MoCAM insisted

IRONICALLY, THE REVILED HEALTH AND SOCIAL CARE BILL MAY INADVERTENTLY ESTABLISH AN ENVIRONMENT WHERE ALCOHOL TREATMENT AND INTERVENTIONS ARE PROPERLY COMMISSIONED

alcohol is everyone's responsibility; NICE confirmed that. So that is a major problem for the alcohol strategy.

Yet the shared-care model has begun to resolve wide spread reluctance to raise addiction issues. Still not all GPs engage though, and there are many more people with alcohol than drug problems.

Integrated, well resourced, responsive drug treatment systems, make referral easy and offer GPs (and other professionals – notably Probation) a clear role. The result: more people in treatment and increased engagement with wider partnerships of professionals. Some money sweetened the deal for GPs but appealing to their better professional nature was crucial. It wasn't about time. It was about having a role in a responsive system that supports professionals and users.

So, why not make alcohol work easier? Establish well resourced multi-disciplinary systems with clear referral routes. When front line professionals have begun routinely screening and assessing service users and patients they need somewhere to send the drinkers they find and experts to inform their

interventions. This is what works in drug treatment.

Ironically, the reviled by many Health and Social Care Act may inadvertently establish an environment where alcohol treatment and interventions are properly commissioned.

There are two potential drivers. Aligning NHS and social care outcomes makes sense for alcohol investment. Perhaps even more important will be the active involvement of Directors of Public Health who were marginalised during the centralised expansion of drug treatment.

Alcohol is a top three issue for Directors of Public Health (after smoking and obesity). DPHs respond to data and evidence. Having them centrally involved in commissioning alcohol treatment offers a real prospect that alcohol will become a priority. NICE alcohol guidance will inform commissioning and *Screening and Intervention Programme for Sensible drinking (SIPS)* found that Primary Care should screen everyone for alcohol: targeted screening – which most GPs preferred – missed 40% of at risk drinkers.

Despite the Health and Social Care Act's unwanted and unwarranted de-nationalisation of the NHS it may offer hope for alcohol. The commissioning Health and Well Being Boards and Public Health England might just act on the evidence and guidance, putting resources into alcohol screening and assessment and expanding treatment as recommended by NICE and implied in MoCAM

Public Health are ideally placed to implement policy because policy is to drive down alcohol problems at risky levels of drinking below dependence criteria. And they understand the logic of knock-on effects. The NICE public health guidance on alcohol (Tier 1 & 2 guidance for the most part) states that the capacity of specialist treatment should be increased to meet the anticipated increased demand from successfully identifying more people with alcohol problems by introducing widespread if not universal screening

I'll drink to that.

■ **Trevor McCarthy** is an independent consultant and trainer



DrugScope

DRUGSCOPE CONFERENCE

**A question of balance:
delivering an inclusive
treatment and recovery
system**

Tuesday 6th November 2012

Connaught Rooms, Great Queen Street, London WC2B 5DA

For preliminary programme and booking form
go to: [www.drugscope.org.uk/documents/
conference2012.pdf](http://www.drugscope.org.uk/documents/conference2012.pdf)

**BOOKING
NOW OPEN**

Noreen Oliver



Regarded as a standard bearer for residential rehab and seen as an unapologetic advocate of abstinence-based treatment, nevertheless Noreen Oliver has been making a significant contribution to building bridges across the ever-fractious drug treatment sector. Interview by **Harry Shapiro**

Following on from Mark Easton's BBC report in 2007 on treatment outcomes, a huge gulf appeared to open up in the sector, an ideological struggle between harm reduction and abstinence which served to underline the tensions and divisions that have bedevilled the drug treatment world. Do you see any signs of improvement?

There are still some fragments sitting outside, but I think things have improved significantly. I think the field realised that this was an old worn-out debate and actually I think the field has never been encouraged to work together and even more importantly to recognise the important part that each section of the treatment field plays – and the gains to be made both for providers and service users from having a joined-up integrated system.

I think the Recovery Partnership has played such a significant role in bringing everybody around the table, to reduce the fragmentation and for the first time have a direct voice to ministers

through the Inter-Ministerial Group. You only have to look at the attendance at DrugScope's CEO forum meetings to see the sort of support the field has been giving and the comments from well-known major providers supporting the Recovery Partnership to see the impact that it has.

To anybody not familiar with it, the politics at the centre must look very confusing; the Recovery Partnership, the Recovery Group, the Skills Consortium, the Drug Sector Partnership and so on. As well as being a leading light in the Recovery Partnership, you are also Chair of the Recovery Group. Has the Recovery Group done its job?

That's an interesting question. I would say no, the job isn't done – the job being to find a home for residential rehab providers and to play a large part in supporting everything that happens at the end of the treatment journey. And that is more than just rehab; there are emerging recovering communities and

it is important to demonstrate to rehabs that they have a role in that as well.

There was always a misconception about the role of the Recovery Group. We had the whole range of people sitting round that table; the vice-chair is Steve Hamer from Compass who mainly provide harm reduction services. But there were people sitting round the table looking at others and thinking 'what are you doing here. I thought it was all about rehab'. My opening statement was that ministers have this view that we cannot work together and we are all going to them with different ideas of what treatment is and different ideas of what works – when the answer is that it all works depending on where the individual needs to be.

So would it be misleading to say that you were stalking the corridors of Whitehall making a special case for rehab.

It was certainly part of what I was doing, and I was making the case for abstinence-based services because I

don't think clients have been given enough choice – but only ever as part of an integrated system. This is what I said to *The Guardian* back in September 2010 (reads):

"As an advocate for abstinence, Oliver might be expected to defend this option to the detriment of others. On the contrary, she refuses to be drawn into a dispute that she says, is not only divisive, but misses the point. Abstinence is not about telling all addicts that the only way to 'move forward' is to stop suddenly. She says, 'it's about providing choices' Any limits on the prescribing of methadone would she says, be the 'antithesis of individualised care' and 'may actually put lives at risk'...The first treatment an addict receives is about 'stabilising the chaos', and if that means something other than abstinence, so be it'.

You have been to those meetings of the All-Party Parliamentary Group on Drugs where providers and supporters of residential rehabs have turned up to ambush whatever minister has turned up, complaining about empty beds and trying to get additional funds from the centre. What's your view on all that?

Any organisation or group that comes together as an 'attack dog' is going to isolate themselves. If you are a provider, you have a responsibility to see what you can do to change both on behalf of your staff and the service users.

Residential rehab is seen as a last resort or an add-on, but it isn't just the treatment system that has built that brick wall, we as residential providers have built this brick wall as well. There are huge opportunities at a time when the system is changing. Rehab providers have always viewed themselves as sitting outside and crossing their fingers that somebody will be referred to them. Somebody said to me a few weeks ago 'oh well, it's different in your area because you've got everybody on board.

Our drug services don't want to work with us'. I said, 'hold on, somebody didn't just come in and wave a magic wand – we went to the drug service. If you are saying that you've got a Tier 3 provider in the same road as you (which was the case), why have you not gone to them and explained your service and what you can deliver, how people from your service could be recovery champions for those in the Tier 3 service.? So it is a joint responsibility here. If you say 'send us your clients' then you have divided the system. They are not anybody's clients, they are part of a whole system. And you have to accept where it is appropriate for people to move forward and where it isn't.

When some of the smaller providers found out about the work of the Recovery Partnership, they wanted to come to the table, to be a part of this. The Recovery Partnership has a sub-group looking specifically at residential rehab. We are planning a communication sheet to all providers to tell them about the work of the group: producing an easy guide to rehab for commissioners, service users, parents and carers and also looking at quality standards, which also links into the Skills Consortium, in terms of the qualifications that people can expect of the staff working in rehabs.

Every tender these days has the word 'recovery' in there somewhere, like it used to have HIV/AIDS or Crime Reduction. Is there a danger that in an attempt to rebalance the system, we go too far, get carried away with the ideology of recovery and throw the methadone out with the bath water?

I pray that isn't the risk. If we start saying to people, 'you've got six weeks left on your script', we're in trouble. As much as I might advocate for abstinence because I have seen the difference in the lives of many, many people, it is all about a balanced treatment system. For any one individual the big changes in

life might come through a reduction in crime, reduction in blood borne viruses, their relationships, housing and a reduction in the script. I regard all those as major steps forward. What is not a step forward is somebody on a high level maintenance dosage who is getting no psychosocial support.

There is a huge responsibility on the part of DH and the NTA to focus on commissioners, to stop them rushing into things, like 'OK everybody has to be on time-limited scripts' otherwise we've got a lot of problems on our hands. Unfortunately we do have a lot of commissioners who don't have a lot of experience of the sector. They don't actually understand the treatment system. There is a responsibility for commissioners to spend at least a day in each service. They haven't moved away from micro-management and they often build walls between themselves and providers. Here in Staffordshire, we have a provider board and we invite the commissioners in so they can answer questions. Even as taxpayers we have a right to question what they are spending public money on and why.

The NTA have been champions for treatment at the centre, held the political line on funding, brought more people into treatment, yet they have come in for a lot of criticism and in particular being accused of being 'anti-rehab'. Are you glad they are going?

I think they missed some key opportunities in trying to bring about a more integrated system; the sector could have been brought together much earlier. They have been around since 2001 and in all that time, they focused too much on one part of the system. Which is sad because having worked with some of the key individuals recently including Paul Hayes, if this had been happening five or six years ago, we really could have changed the system.

Weeding out the dope

It's five years since *Druglink* last covered the phenomenon of cannabis farms, during which time the national picture has changed considerably and in the process put police resources under considerable strain. By **Harry Shapiro**

On December 20th 2011 Trevor Bradley was jailed for five and a half years for conspiring to produce and supply cannabis. He was part of a five strong gang that ran a number of cannabis farms from premises in the Greater Manchester area. In 1997, Bradley had been jailed for fourteen years for supplying ecstasy across Merseyside. Trevor Bradley is the father of Kirk Bradley, who, at the time of his father's sentencing, was on the run from a firearms charge. Kirk was the leading member of a gang who acted as 'enforcers' for other gangs in the Merseyside area, He was subsequently caught in Amsterdam and convicted in his absence in March this year.

The involvement of domestic criminal gangs is just one aspect of the changing face of commercial cannabis growing in the UK, but one of the most significant because it indicates that commercial growing has become embedded in the UK, part of mainstream criminal activity which will not be easy to dislodge. Never before has the UK had inland drug production on this scale and it presents a huge challenge to the enforcement agencies both in terms of strategic response, time and money.

There has always been a level of home grown cannabis cultivation in the UK, but primarily restricted to personal use or social supply including those growing cannabis for medicinal purposes both for themselves and for a small circle of fellow sufferers.



It was in 2000-01 that cannabis cultivation became more commercially organised and widespread following a wave of largely illegal immigration from North Vietnam to augment the legitimate community who had been

settling here since the mid 1970s. This new group sought to replicate the highly lucrative cannabis trade their Canadian counterparts had built up in British Columbia. This they did, quietly at the margins of criminality, keeping the whole enterprise within family groups or using other illegal immigrants to tend the farms in order to pay off debts of £15-20,000 paid to those who had secured their entry into the UK.

It wasn't until the police launched a nationwide crack down on cannabis farms called Operation Keymer in 2006 that some hint of the extent of the trade became apparent. The public were introduced to the idea of ordinary suburban houses being gutted and transformed into cannabis farms, where thousands of pounds worth of cannabis was being grown under powerful lighting using electricity stolen through a Heath Robinson tangle of wiring and junction boxes. Landlords and letting agents were warned about well-spoken Vietnamese businessmen looking to rent houses; utility companies about looking out for unusual spikes in energy consumption from residences; and neighbours, postmen and the like, about houses suddenly being blacked-out, strange comings and goings – and weird smells. Cannabis farms were turning up in sheds, lock-ups, greenhouses and on more industrial sites. The police could hardly keep pace with the number of premises exposed as cannabis farms; as with most sorts of crime, the more

they looked, the more they found. The number of farms discovered has soared since 2007/8 from 3000 to 7800 in 2010/11. And while Vietnamese (and to a lesser extent Chinese) gangs are still in the driving seat of production, they are by no means the only game in town. The Trevor Kirby gang is just one example of how cannabis production has moved from a niche criminal activity to just another arm of a generalised British criminal portfolio. It would appear that domestic criminals are moving into the cultivation business as a way of maximising profits from the trade, because they have always been key players in the distribution chain: the Vietnamese tend to stick to what they know. A sign of possible closer ties between cross-cultural gangs was presented at a recent Association of Chief Police Officers (Acpo) conference on cannabis cultivation held in Newcastle. One constabulary reported that there was a time when cannabis farms would be booby-trapped for fear that local gangsters would break in and steal the plants. But no traps had been found for nearly two years, suggesting in that area at least, different criminal groups had come to an understanding.

After a move to larger, more industrial growing spaces, Acpo report that the gangs are now favouring a move back towards residential properties to spread the risk across an area, an indication that police are having an impact. One officer from Scotland told *Druglink* that Vietnamese activity in his area was in decline as they have an aversion to being arrested and possibly deported. Some growers go to extraordinary lengths to conceal their activities. *Druglink* heard of one case where four shipping containers (anything up to forty feet long and ten feet high) were entirely buried underground, accessed only by a trapdoor in a caravan located in the middle of a field.

But having established that there is a substantial drug trade worth millions of pounds annually, the police are faced with the problem of what to do about it other than what is known as 'tip and skip'. This is essentially visible policing on the ground; a farm is located and the police go in, seize the plants and then strip out all the equipment and throw it in a skip. They may find a Vietnamese or Chinese gardener on the premises, but more likely police will bust into an empty house, although on one occasion, when police went back several hours later to a farm to strip it out, they found

a gardener still hiding in a tiny cupboard. Often there is no attempt to try and link a single location with others in the area or perhaps immediately outside the local Basic Command Unit (BCU) and here is where structural problems in policing emerge.

...CANNABIS PRODUCTION HAS MOVED FROM A NICHE CRIMINAL ACTIVITY TO JUST ANOTHER ARM OF A GENERALISED BRITISH CRIMINAL PORTFOLIO'

The operational template is known as the National Intelligence Model (NIM) which divides operations up into three levels; in this case level 1 would be a typical local 'tip and skip' operation; level 2 would be an operation involving officers across the Force area while level 3 operates at national and international level. But argues, criminologist Daniel Silverstone in his 2010 article in *Policing*, when you are dealing with Vietnamese gangs, this model 'runs into reoccurring problems because [they] tend to operate at all three levels simultaneously. For example, the 'cannabis factories' appear at level 1, but they might be situated in various BCUs and they are managed by personnel who move themselves and the crop swiftly across forces as the market and evasion from local law enforcement dictates'. Silverstone goes on to point out that level three comes into play too, because proceeds are repatriated to Vietnam and the gardeners are trafficked in from overseas.

An example of what can be achieved using intelligence to transcend the potential limitations of the NIM was presented at the Newcastle conference by Cheshire Constabulary. Fans of *The Wire* will recall the episodes where Lester Freamon was able to provide proof of conspiracy by tracking mobile phone calls. This is precisely what the Cheshire police in 'Operation Penne' set out to do. They linked suspected growers with letting agents, in locations across the country. After several months work, the arrests were made and key players successfully prosecuted.

And overall at a national level, the value of this kind of work is

acknowledged. In the wake of the decision to reclassify cannabis back to Class B, 2008 proved something of watershed for the strategic oversight of cannabis cultivation. Acpo publicly stated that in general 'there is now a continuum of harm caused by serious organised criminality that runs from our neighbourhoods to the national and international levels. This requires a continuum of effective policing response'. The National Policing Improvement Agency published an operational handbook on dealing with cannabis farms while Acpo appointed an officer to lead on this and established a Commercial Cannabis Cultivation Working Group(CCCWG).

However, it is precisely strategic intelligence-led policing that is suffering because of the 20% cut imposed on the police across the board – and the evidence suggests that drug enforcement will take one of the biggest hits. In its 2012 'Problem Profile' for cannabis cultivation, Acpo revealed that only City of London police failed to find a cannabis farm on its patch out of 49 UK forces while the estimated street value of the cannabis seized was in excess of £200m. Yet Acpo also reported that 'tackling offenders for commercial cannabis cultivation is not considered a priority by most UK Police Forces, due to competing demands with more importance given to the supply of Class A drugs. The dismantling of cannabis factories is still primarily seen as a short term solution, with missed opportunities for further investigation into potentially linked factories'.

This underlines the problem identified by the UK Drug Policy Commission (UKDPC) in their 2011 report, *Drug enforcement an age of austerity*. UKDPC reported that drug related policing expenditure and activity was expected to decrease at a faster rate than other activities – and in particular longer-term proactive intelligence work like that carried out by Chester Constabulary would fare the worst. In fact 15% of the respondents noted they had little if any funding allocated to drug activities at all.

The police face a double whammy – a trade whose roots run deeper and wider than ever before (where the internet has made the purchase of seeds and equipment easy for amateurs and professionals alike) and, despite more strategic oversight of the problem, dwindling financial resources to weed out the dope.

Stop and search

Ineffective, unfair and racist are just three of the criticisms levelled at police stop and search powers. Thirteen years after the spotlight of the Macpherson report, **Caroline Oubridge** reports on the status of this controversial tactic.

Police stop and search tactics were criticised by the 1999 Macpherson Inquiry into the murder of Stephen Lawrence, reforms were made and things have improved, right?

Not quite, in fact the disparity highlighted by the inquiry, that black people are more likely to be stopped than white people, has increased as have the overall number of stop and searches.

In 1997/98 black people were 5 times more likely to be stopped than white people. By 2009/2010 the figures were 7 times more likely for black people and twice as likely for Asian people.

Recent analysis by the LSE and Open Society Justice Initiative has shown that these figure rise sharply when police use 'section 60' powers, which allow people to be stopped and searched without reasonable suspicion. In 2011 a black person was 29.7 times more likely to be stopped and searched under section 60 than a white person. The figure was 7.6 for Asian people.

"It's disappointing that we still have an increase in the disproportionate use of stop and search", says Kam Gill, spokesperson for campaign group Stop Watch. "But it's not surprising given the problems with race relations experienced by the Met and other police forces."

The Macpherson report blamed racist targeting by individual officers for disproportionate use of the powers, but thirteen years on, after much scrutiny and reform can this still be the case?

Home Office research suggests two other possibilities: that the 'on the street' population who are available for searching are more likely (due to a range of factors) to be of a certain age, gender

and ethnicity and that searches tend to occur in geographic areas with a greater concentration of people from ethnic minorities.

These are the arguments put forward by Metropolitan police Chief Superintendent Victor Olisa. He points to the example that two section 60 orders authorised for Westminster in one month (after officers heard that members of a Congolese demonstration had a machete) will skew the disproportion figures considerably. "The challenge for us is that we don't get the opportunity to put the stop and search figures into context. We always appear defensive, always on the back foot."

NO ONE IS
CHALLENGING THE
IDEAS THEY THE
[POLICE] APPEAR TO
HOLD THAT BLACK
PEOPLE ARE MORE
LIKELY TO USE THAN
WHITE PEOPLE

Rebekah Delsol, from Stop Watch and the Open Society Justice Initiative is not convinced by such operational arguments, "The data is so stark now there is no way to deny that there is a problem...officer decision-making is playing a role here."

The Equality and Human Rights Commission's 2010 report 'Stop and Think' reviewed the use of the

powers in England and Wales. It found that geographical patterns in the disproportionate use of stop and search have persisted over many years and that similar or neighbouring areas will often have very different results, which cannot be easily explained.

With such a history of controversy and the steady increase in its use, it is important to ask does stop and search work?

Critics of the powers frequently point to the fact that nationally only around one search in ten leads to an arrest. However supporters argue that stop and search disrupts and deters crime rather than simply detects it. Rhetoric around its value often mentions police being active (and being seen to be active) in keeping people safe.

Overall there is little research evidence about the efficacy of stop and search. A study published in 2000 by the Home Office found that searches reduced the number of 'disruptable' crimes by just 0.2 per cent. It also found that because searches concentrated on users rather than dealers, and cannabis rather than class A drugs they were unlikely to substantially undermine drug markets or influence drug-related crimes.

Roughly half of all stop and searches are for drugs and most arrests are for drugs, mainly cannabis possession (making up a third of all arrests for drug-related crime). However, there is no clear evidence as to how many arrests go onto charge or caution.

When asked about efficacy Niamh Eastwood, Executive Director of Release points to the low arrest rate for drugs, but moves swiftly to highlight the



undermining effect that disproportionate use of the powers has on police relations with young people generally.

“Just last week we had an 11 year old who was stopped at a bus stop; the police drove by, smelled cannabis so decided to stop and search him. The experience was really distressing for him and has left him feeling fearful towards the police.”

The experiences that individuals have during searches can have a profound effect on their attitude towards the police. As Niamh points out, “If a young person is concerned about potential violence in an area, why go to the police if your relationship with them is poor?”

Searches carried out in public can be a humiliating experience. Many young men, particularly those from black and Asian communities, feel they are being stopped and searched simply because they fit a general stereotype. Being the subject of suspicion can lead to hostility and people want to be given a good reason for the stop.

Suspensions are at the heart of stop and search. Actually that should be reasonable suspicions or rather “an objective basis for an officer’s suspicion” relevant to the likelihood of finding something during a search. Guidance explicitly states that reasonable suspicion can never be supported by personal factors alone such as age, race or appearance.

However, when it comes to drug use, Niamh Eastwood feels that police officers are poorly informed, “No one is challenging the ideas they appear to hold that black people are more likely to use than white people.” She cites Professor Alex Stevens’ analysis of Ministry of Justice data, which revealed that black men are nine times more likely to be stopped and searched for a drugs offence

than a white person, despite surveys showing that levels of drug use between the two groups are on a par.

Rebekah Delsol suggests that using the smell of cannabis as grounds for reasonable suspicion is an easy option compared to the level of evidence needed for searches on other grounds. “Cannabis possession shouldn’t be counted as a sanction detection. This currently acts as a perverse initiative to criminalise young people, it would be really positive to move away from stop and search for possession and to target what people care about.”

Sanction detections rates are used by the Home Office to judge the performance of police forces. The 2004 reclassification of cannabis laws gave officers the ability to quickly generate a sanction detection by issuing a cannabis warning slip to people caught with small amounts of cannabis. Since the change cannabis seizures have doubled, largely through street level detections of small amounts of the drug.

The Met’s Victor Olisa defends the practice as valid and proportional, “Rather than putting people through the criminal justice system for low-level possession, cautioning deals with them at a street level.” However the Met has announced that it plans to halve failed drugs searches, shifting resources away from random drug stops to searches focussed on finding weapons and preventing violence.

Concerns about police time spent on bureaucracy have led to changes in how stops are recorded. Since March 2011 police forces have been able to choose whether or not to record ‘stop and account’ (stops that do not lead to a search) and to reduce the information recorded on stop and search forms including the name and address of the

person stopped and what the outcome was.

The need to record stops, whether or not they resulted in a search, was a key recommendation of the Macpherson report. Campaigners are concerned that these changes will make the police less accountable for who they stop and why. A handful of forces, including the Met, have decided to continue recording stop and accounts.

External scrutiny can help to redress community unease. Most police forces stop and search data is reviewed by police authorities and community monitoring groups. Forces in West Yorkshire and Suffolk have taken that a step further.

Started in response to a 2008 finding that black people were 8 times more likely to be stopped than white people in Ipswich, the Suffolk Stop and Search Reference Group checks through anonymised forms from stops on black and minority ethnic people. “If there is a pattern, such as forms not filled in properly by the same officer, the group can identify that there is a training need,” says Joanne Bennett from the Ipswich and Suffolk Council for Racial Equality.

In West Yorkshire monthly panels of local people and police look at hate crime investigations and stop and search procedures. Stop and search forms are randomly sampled and scrutinised. “The panels can ask for a report on anything they are not happy with, if they need further clarification they can ask officers to come to the panel to explain their actions, which is a very powerful thing,” says Detective Chief Inspector Steve Thomas of the West Yorkshire Police.

Later this year the public will be asked to elect Police and Crime Commissioners for each police force area in England and Wales outside London. The posts are part of the coalition government’s localism agenda and are intended to “provide stronger and more transparent accountability of the police”. Campaigners point out that recent changes will make it more difficult to do this for stop and search.

Police stops are a highly influential point of contact between the police and the public and the disproportionate use of stop and search is still a significant issue. As Niamh Eastwood concludes, “At the end of the day the police are there to support and protect the whole community. If they are alienating one section of that community they are failing in their job.”

■ **Caroline Oubridge** is a freelance journalist



As Mark Twain's mate and fellow writer Charles Warner observed, 'politics makes for strange bedfellows' – and none stranger than in the world of drug law reform. By Marcus Roberts

As Peter Hitchens and Kathy Gyngell lined up to give evidence to the Home Affairs Select Committee (HASC) inquiry on drug policy on 24 April, the battle-lines seemed to be assuming a customary form. Liberalisation of drug laws is widely assumed to be a progressive left(ish) cause that is opposed by right wingers. So we are accustomed to hearing the arch-social conservative and *Daily Mail* columnist Peter Hitchens expressing the view that, far from being time to end a failed 'war on drugs', it is time to begin one (properly), and it is no surprise when Kathy Gyngell sends out a chilling warning to *Daily Mail* readers that the 'pro-drug lobby never sleeps', expressing her concern that arguments for decriminalisation are even being considered by a parliamentary committee. *The Spectator* – an impeccably rightist magazine – provided a clear statement of this anti-reform position in its editorial on 3 March ('Bad Habits') declaring that 'a policy of partial legalisation has been pursued behind our

backs for many years. It is this that has failed, not prohibition'.

Meanwhile, the 'lobby that never sleeps' would appear to have progressive, left liberal credentials. The HASC inquiry has been heavily influenced by a report from the 'Global Commission for Drugs' (June 2011), which called for an alternative approach to the 'failed war on drugs'. Signatories included some of the world's leading human rights campaigners – for example, Kofi Annan (former UN Secretary General), Asma Jahangir (former UN Special Rapporteur) and Ruth Dreifuss (former President of Switzerland). This report was followed by a pro-reform event in the House of Lords in November 2011. One of the only attendees from the Commons was Caroline Lucas MP (Brighton Pavilion), pictured above, who is the first Green to sit in the British parliament.

In the media, while the *Daily Mail* provides a platform for drug policy conservatives and its own Melanie Phillips, the chief organs of the liberal press are increasingly vocal champions

of drug law reform. For example, *The Observer* has devoted two editorials to the topic in the past six months alone. The most recent, on 8 April, followed an interview with President Santos of Colombia in which he called for a review of global policy in the light of the devastating impact of current policy in Latin America. *The Observer* urged Barack Obama, 'to embrace a wide-ranging discussion to include a range of options which would then be investigated in an evidence based approach'. An earlier editorial (13 November 2011) asked 'must we rely on big business not our leaders to pave the way when it comes to tackling a narcotics industry that is ravaging Latin America?', concluding that 'Milton Friedman was right, 20 years ago, when he said: "if you look at the drug war from a purely economic point of view, the role of government is to protect the drug cartel. That is literally true'.

This prompts three reflections that blur the borders in our mapping of the ideological and political underpinnings of drug law reform.

First, it highlights the extent to which recent debate has been provoked and shaped by calls from senior politicians from Latin America for a debate on the 'war on drugs', in the light of its appalling impact in their countries, including murderous drug cartels, civic corruption and environmental devastation. But we shouldn't assume that the sort of law reforms that are sought by reformers in consumer countries will necessarily be of any help in addressing the problems of producers – for example, decriminalising cannabis would be largely irrelevant to Latin America, decriminalising cocaine could make things worse. Nice people may take drugs, but nobody with a concern for the plight of Latin America should be using cocaine. Similar issues were explored by Ed Vulliamy in *The Observer* on 24 July 2011. Speaking of his experiences at Ciudad Juarez on the US-Mexico border 'where drugs are legal for personal use and easier to obtain than soft drinks', he says that he developed a problem with the current lexicon for talking about drug issues in countries like the UK, with the stress on 'recreation', rather than 'despair and desperation'. 'This view of drugs as stimulating entertainment may hold true of Camden Lock in London and the capital's West End clubs', he concluded, 'but not of São Paulo or even the valleys of south Wales, let alone the US-Mexican border'.

Second, the near catastrophic losses of Britain's economy to currency speculation in the early 1990s have proved an unexpected boon for advocates of drug law reform. It was on 'Black Wednesday' that international financier George Soros reputedly netted around a billion dollars, which has helped to fund his philanthropic interests in drug law reform (which has benefited from the legacy of another fantastically rich American, John Paul Getty Jnr). The world of finance has distinguished representation on the Global Drug Policy Commission, notably in the form of Paul Volker, the (Democratic) former Chairman of the US Federal Reserve. Another signatory to the Commission's report was George P Shultz, who served as Ronald Reagan's Secretary of State, and previously as US Secretary to the Treasury in the Nixon administration.

And, of course, the HASC inquiry heard from 'big business' when it opened with evidence from the Virgin boss Richard Branson. Mr Branson spoke for decriminalisation along Portuguese lines and in favour of experimentation with alternative legal regimes. Whatever

motivates his interest in drug policy it does not appear to be a particularly detailed engagement with current policy contexts. He admitted he had not looked at the UK Drug Strategy prior to appearing to give evidence. This is not to suggest that drug law reformers from business or finance backgrounds are driven in a direct way by business interest, but only that their engagement may reflect perceptions, principles and priorities that are distinct from those of other reformers – for example, they may be particularly influenced by the fact that drug prohibition is exceptional, and may appear anomalous, from the point of view of free-market and consumer capitalism.

IF YOU LOOK AT THE DRUG WAR FROM A PURELY ECONOMIC POINT OF VIEW, THE ROLE OF GOVERNMENT IS TO PROTECT THE DRUG CARTEL (FRIEDMAN)

And this brings us, thirdly, to *The Observer* reference to Milton Friedman, the free market economist who advised Reagan and inspired Thatcherism. Friedman spoke at a drug policy reform conference in Washington in 1991, declaring that 'the war on drugs is a failure because it is a socialist enterprise'. He concluded with two key points. First, that it was a mistake to challenge 'prohibition' in the name of alternative forms of state regulation, nothing short of the free market would do. Second, that 'we are likely to make more progress against drugs if we recognise that repealing drug prohibition is part of the broader problem of cutting down the scope and power of the government and restoring power to the people ... the reason to end the war on drugs is also the reason to end the socialisation of medicine, the socialisation of schools and so on down the list'. In other words, and running directly contrary to left liberal opinion, the reason for legalising drugs is also a reason for withdrawing all public funding from health, education and so on and leaving them entirely in the hands of the private sector and the free market. Nor has Friedman been an isolated voice on the libertarian right. The Cato Institute, a US libertarian think tank, has called for drug liberalisation and the leader of the US Libertarian Party, and its presidential candidate, Gary Johnson, is an honorary member of

the *Drugs Policy Alliance*, which supports law reform.

More recently, advocacy of drug law reform has emerged as an important theme for libertarians within the US Tea Party, such as Ron Paul, pictured left, a Republican member of the House of Representatives from Texas, who recently commented that 'someday we're gonna awake and find out that the prohibition we are following right now with drugs is no more successful, may be a lot less successful, that the prohibition of alcohol was in the twenties'. An article by Harvard economist Jeffrey Miron (himself a libertarian advocate of drug legalisation) on the 'Tea Party and the drug war' concluded that this is an issue that divides social conservatives from libertarians within the Tea Party. He concluded that 'if the Tea-Party believes in its principles, it must choose a libertarian path on drug prohibition'.

As Peter Hitchens and Kathy Gyngell played out their accustomed roles in the UK debate about drug law reform in their evidence to the Home Affairs Select Committee, they helped to set the 'left'/right' compass for drug policy in a familiar and cognitively soothing way. Scratch below the surface of the current lobby for drug law reform, however, and one finds a curious and unstable political and ideological eco-system. There will be those who will see this as a coalition of those who 'get it'; whatever their political divisions the liberal left and the libertarian right are united by the fact that they have followed through evidence and argument on drugs to a logical conclusion. It is interesting in this context to note that Milton Friedman argued at that 1991 conference that it was a basic intellectual error to consider drug policy as 'a special case to be discussed in terms of specific issues associated with drugs', when actually it was about broader political issues, and particularly the appropriate relationship between the state and the market. Should the reform lobby ever move on from calling for 'mature discussion', 'impact assessment' and 'evidence based debate' to detailing specific proposals for reform, it is likely that these repressed differences will make their way rapidly to the surface – particularly between those who want reform but favour close state control and regulation and those who would be inclined to let the market rip.

■ **Marcus Roberts** is Director of Policy and Membership at DrugScope. Material for this article was also developed by **Laurie Hare Duke**, DrugScope intern.

FROM ADDICTION TO RECOVERY: TWELVE EASY STEPS?

Nic Sheff, an American who gives lectures on his recovery from methamphetamine addiction was confronted by an angry listener who said he made it sound so damned easy. And it made him think.

Since the publication of my first book, *Tweak*, four years ago, I've been travelling around the country speaking to different groups and organisations about addiction and recovery. I've spoken at high schools and colleges and at fundraisers for big name rehabs like Hazelden and the Caron Foundation. Usually these events consist of about a 45-minute share of my basic story, followed by 15 minutes of question and answers. And, for the most part, the talks I give are all fairly similar and the questions people ask are pretty similar, too—although of course, the specific details tend to be different.

Recently however, I was speaking at an event on a Native American reservation just a few miles outside of Saginaw, Michigan when an older man from the community stood up and asked me a question that made me have to re-think my entire presentation.

He was shouting and I could see that he was angry. Not with me, exactly, but with addiction in general. He spoke about watching his kids and then his grandkids struggle with this disease. And

then he went on to say that he listens to people like me speaking about how bad things were and how the drugs destroyed our lives but then suddenly we seem to jump to talking about how we're sober now and how we are all happy and everything. What he wanted to know was: how did we get from being strung out and miserable to being happy and sober? How did we get from A to B? I wasn't totally sure how to answer.

I know that for some, getting from A to B is a fairly straightforward process—which isn't to say that it's easy. Though perhaps it's easier to explain. They use drugs and destroy their lives, then they go to AA, where they get a sponsor, take commitments, work the steps and go on to live lives that are happy, joyous, and free. But that wasn't the way it worked for me.

I'm envious of people who got recovery like that. I remember back when I was first getting clean, I was in a Sober Living house and going to meetings with these kids my age, and a lot of them are still sober today. They followed that path and it worked for them. I was the one

that continued to fuck up over and over and over again.

I went to AA just like they did and did everything that was suggested, but then I still went out and relapsed. Maybe I just didn't do it right. I don't know. And there's no easy explanation for what finally worked for me. Every time I thought I found the answer, I'd end up relapsing again.

At one point, I went to this new agey treatment center in the desert and spent a lot of time talking about childhood trauma and releasing the memories from my body and stuff like that. I did Eye Movement Desensitization and Reprocessing (EMDR) designed to alleviate the distress associated with traumatic memories and Somatic Experiencing and got into blaming my parents. I did meditation and got in touch with my feelings and then I thought, "Okay, awesome, I've fixed myself now."

But then I went out and started drinking so much that I was soon waking up in the morning and downing mini-bottles of flavoured vodka 'cause they



were only 79 cents on sale from the local liquor store.

After that, I pretty much decided I was done with rehabs and AA but would try outpatient and just good old-fashioned therapy and psychiatric medication.

But here's where I did something different: in the past, I'd always gone to whatever psychiatrist was recommended to me. I decided that this time, I would try to find one that I could relate to and respect. It took some time and I met with four different doctors, but I finally did find someone who was young and super knowledgeable about addiction. She got me on different meds and I started seeing her once a week.

That was also the first time I'd ever tried outpatient, and the program I'd enrolled in here in LA seemed like it had really started working for me. When I'd been in inpatient rehabs before, I'd get close to the other clients when we were in there together, but as soon as we got back out in the real world, we'd discover how little we actually had in common. But that didn't happen with outpatient, probably because we incorporated what we were doing together into our daily lives, rather than make it our entire lives. And as a result, the friends I made there are still some of my best friends today—nearly five years later.

So that's it then, right? Outpatient and psychiatry, the magic combination? Is that what I should tell that old man on the reservation? Actually, no. Because I relapsed again.

I HAD TO HAVE FAITH.
NOT IN GOD, BUT
JUST FAITH THAT IT
COULD AND WOULD
EVENTUALLY WORK.
AND IT HAS.
FOR NOW, ANYWAY

My ex-girlfriend had a bottle of Vicodin left over from the time she broke her arm, and I thought one couldn't hurt me. Three bottles later, I had a pocket full of cash and was heading downtown to go cop heroin when I suddenly, and inexplicably, had some sort of moment of clarity—or however you want to describe it. Basically, I just saw how I was about to throw everything away that I'd worked so hard to get. I saw how my life was going to spiral completely out of control again and I was going to lose everything and destroy myself and I thought, "No, no, I don't want to do this again. I don't want to go back to the bottom again." And so I didn't.

I went home and called my doctor, got on Suboxone and just basically locked myself inside for a week. And that was it. That was my last relapse. I've been sober ever since. Over four years at this point. So what's been the difference? What's gotten me from point A to point B? How do I answer that old man's question?

The only thing I can figure is that I guess it must have all kind of worked. That is, I don't think it was any one treatment that got me sober. But each one gave me a little more by teaching me more about myself and my disease and recovery. None of it was a waste. I kept falling but eventually I started to learn how to not fall so far down, and how to pick myself up a little sooner. It was a lot of trial and error. I had to find out what fit for me and what didn't.

Because there is no one answer for anyone. We are all different. What worked for me may not work for you, and vice versa. So I guess I just had to be open to trying—and then trying again.

Of course, a lot of it is luck, too. I have plenty of friends who fell down and never could pick themselves up again because they overdosed and died. So to simply say it doesn't matter how many times you fall because you can always get back up isn't exactly true. People die from this disease. It happens all the time.

But what I want to tell that old man in Michigan and what I want to tell anyone who hears my story in the future is that really, getting from point A to point B is, like I said, all about trying. Trying. That's it. I had to try. And I had to be open. And, yes, I had to have faith. Not in God, but just faith that it could and would eventually work. And it has. For now, anyway.

**This article first appeared in
The Fix, 23 February 2012.**

Double trouble

Many people with drug and alcohol problems also suffer severe mental health problems. So how useful is this book for clients and families struggling to cope?

Reviews

■ **Jennifer Harris** is a chartered clinical psychologist with the Addictions Services, South London and Maudsley NHS Foundation Trust.

First published in 2006 in North America, Daley's book is based on 30 years of clinical practice and research. Drawn from workbooks, it aims at an audience of 'clients and families', to educate, provide hope and practical suggestions to individuals with dual diagnosis and their families. Service-users commented on an earlier version of the book.

While it describes the key features of common anxiety disorders it mainly focuses on two particular mood disorders – depression and bipolar affective disorder. Readers wanting more information about recovering from alcohol misuse and social anxiety or PTSD, or polydrug use and personality disorder, may not find the level of information they are looking for.

The early chapters outline the scope of the book, emphasising the dual-diagnosis/co-dependence aspects and the role of alcohol. The coverage seems best fitted to a professional readership, and concerned or affected parents and families may find their needs better met from other – UK – sources, where information leaflets and pod-casts already exist.

There is a useful summary of indicators and effects, of substance dependence and mood disorders, but some of the treatment options referred to are US specific and unlikely to be relevant to UK readers.

Later chapters have more to commend them and fill what appears to be a gap in the market. The book encourages individuals to take responsibility for and an active approach to their recovery. Chapters four to eight describe the recovery process through its various stages, detailing some of the factors and influences which can assist progress towards recovery. These include motivation, personality, relationships, building support systems. Much of this text is relevant and valuable, but practical summaries or conclusions are sometimes lost in the text. Some

of the strategies discussed are not well-linked to the initial description of the processes and stages involved in the recovery approach. The chapter on medication is a useful idea but readers need to be mindful that these treatments may not all be available in the UK. As a clinical psychologist, I particularly welcome the chapter on feelings, which commendably summarises strategies – drawn from CBT and 12-step philosophies – relevant to dual recovery in a useful format.

'Building a support system' deals with an area

where clients and families have a need for more coverage and information. Many of our clients find this a significant challenge after years of feeling isolated and stigmatised. There is an emphasis on formal support systems but no coverage of less- or in-formal sources of support that might be developed through involvement in leisure activities, peer mentoring, volunteering and education.

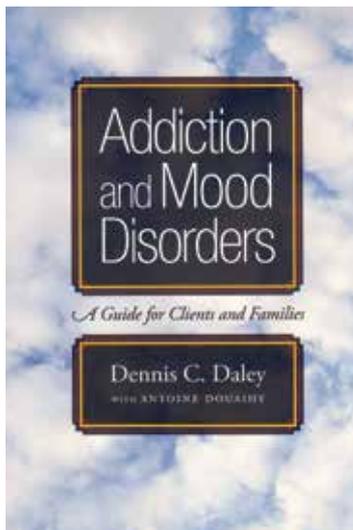
There is helpful coverage of 'relationship traps.' Some inclusion of places where families can seek support – family therapy, AdFam, AlAnon – and where clients and families might access support groups specific to the mood disorder would have been useful.

Subsequent chapters examine the impact of dual diagnosis on families. 'Working with your family' provides a rationale for family involvement in treatment in order to best support the recovering individual, reduce distress for family members and minimise the risk of impact amongst children. It includes a list of warning signs in children's behaviour which indicate a need to seek assessment. 'Changing your Lifestyle' is a short but useful chapter that advocates recovery tools to be used on a daily and weekly basis, setting goals, handling debt and the 12 steps of Dual Recovery Anonymous. (UK readers can identify local meetings at www.dualrecoveryanonymous.org.)

'Strategies for Self-improvement' covers changing thinking and self-defeating behaviours and includes spirituality and self-comforting strategies. 'Maintaining gains over time: relapse prevention strategies' suggests relapse prevention ideas such as recognising and dealing with triggers; it advocates writing a relapse prevention plan that is shared with others – but would have benefited from including an example plan.

As a clinician working with individuals with mental health and addiction issues, it is helpful to be able to feel confident in recommending self-help materials; and to know that they are pitched at an informative and accessible level. My overall sense is that this book does fill a gap in the literature for clients and their families. It is well-informed and offers some valuable suggestions for dual recovery.

However I would level some criticisms at the editing. This book reminds me more of a textbook than one for clients and families, and requires a certain degree of literacy and concentration to make the most of. I would have liked a more accessible and engaging style of writing and for the text to be presented so that readers might access key points more clearly. Some of the prevalence data, treatment options and website links relate to a Northern American population and need adapting for UK use.



ADDICTION AND MOOD DISORDERS: A GUIDE FOR CLIENTS AND FAMILIES

Dennis C Daley with Antoine Douaihy
Oxford University Press, 2006
£ 28.00

All in the mind

The author uses Freud's psychoanalytic approach to 'analyse' Freud himself and poses the question: was Freud in denial?

David Cohen describes *Freud on Coke* as 'half history, half polemic. His book falls into three parts: Freud's use of and writing on cocaine and what this reveals about him and his work; the twentieth century development of introspective drug-use; and the current situation around the use of drugs in a socio-medico-political context.

Cohen reviews the existing literature on Freud and cocaine, limited, he says, to one title in English – Elizabeth Thornton's *Freud and cocaine* – and two un-translated titles – *Comment Freud devint drogman*, Pierre Eyguesier (a disciple of psychoanalyst Jacques Lacan), both from 1983; and *Freud und das kokaine* (1973) by Jürgen von Scheidt.) He fails to cite Mike Jay's *Emperors of dreams* (2000) which deals with the subject while Georg Markus (1989) and Hans Bankl (1992) have also written on Freud and cocaine.

Cohen's psychoanalytic approach simultaneously acknowledges the value of the approach and provides insights into Freud's own character, including some intellectual dishonesty – hence the question: was he in denial? Cohen identifies 1859 as a key analytical point in Freud's life: the Freuds' nanny was sacked and his two older half-brothers left the family home, events which can be interpreted as the basis of separation anxiety and addiction. These events in his early childhood (Freud was then three) can be seen as the origin of childhood psychological problems which later manifested themselves in cocaine use.

Freud first used cocaine in April 1884, recording that it did not have an addictive quality. His down-playing of the addictive nature of cocaine may be, according to Cohen, because Freud ingested his cocaine orally. He initially saw his use of cocaine as problem-free, and a means to gaining the success he desired in his early career.

The changes in Freud's attitude to cocaine are linked to his prescription of cocaine as a pain-reliever for his psychology teacher, Ernst Fleischl. Fleischl used morphine as a pain-killer following failed thumb surgery but became addicted. Freud thought cocaine could act both as a cure for morphine addiction and an analgesic, publishing his convictions in his 1884 paper *Über coca*. At the same time, Freud acknowledged in his private correspondence that cocaine was not the cure-all he had previously thought, a view he had come to because of the worsening of Fleischl's condition following Freud's prescription of cocaine. It is clear from his letters that Freud continued to use cocaine after 1887, the date he told his biographer Ernest Jones that he had stopped using it.

Cohen follows up von Scheidt's suggestion of the influence of cocaine on *The Interpretation of Dreams* by analysing those dreams. He identifies eight

Reviews

FREUD ON COKE

David Cohen
Cutting Edge Press,
2011
£14.99

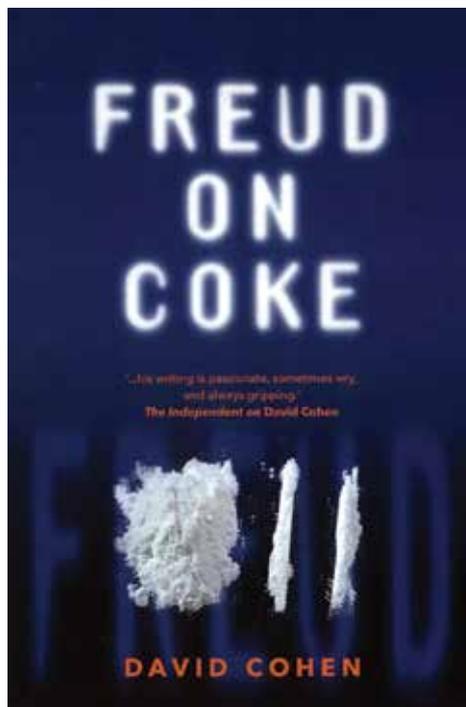
dreams, purportedly Freud's, which involve cocaine in some way. Cohen's analysis of these dreams reveals a psychoanalytical trend demonstrating the impact of cocaine on Freud's life and work, possibly contributing to his own neurosis. Freud increasingly dismissed this episode in his life as he developed his theory of psychoanalysis, and its centrality to his work remains open to debate and conjecture.

One enduring feature of Freud's involvement with cocaine is his later-life prediction, published after his death in *An Outline of Psychoanalysis* (1940) that drugs, existing and yet to be discovered or developed, would come to be used to heal psychosis and neurosis. Cohen examines ways in which the pharmaceutical industry attempted to do just this from the 1950s on – in particular, the emergence of LSD reopened the psychotherapy drug debate. This narrative is worth exploring, but Cohen's grasp of these developments and associated literature is at times inaccurate.

Cohen's psycho-analysis of Freud's relationship with cocaine is a fascinating addition to the history of drugs in writing and theory, and draws out some interesting ideas – parallels between cocaine addiction, trauma and Freud's work. It is unfortunate that his history of drug introspection appears poorly researched and reads like a late addition to the book. However, the interesting ground worked over in Freud's biographical details

certainly goes some way to reintroducing an important episode in the history of psychoanalysis, drug writing and theory.

This is an edited version by Druglink reviews editor Blaine Stothard of a review first published in The Psychedelic Press. The full version can be found at: <http://psypressuk.com/2011/03/21/literary-review-freud-on-coke-by-david-cohen/>



Does the boat float?

You could probably sink a large liner with the weight of books advocating law reform. So do these two new tomes bring anything new to the table?

Reviews

■ **Steve Rolles**
is Senior Policy
Analyst at
Transform Drug
Policy Foundation

The hundredth anniversary of the first formalised international drug prohibition treaty was recently celebrated in a resolution at the UN annual Commission on Narcotic Drugs. Other anniversaries abound; last year saw the fiftieth anniversary of the 1961 UN Single Convention on Drugs, as well as the fortieth anniversary of our very own Misuse of Drugs Act, both of which remain essentially unchanged to this day, albeit augmented by subsequent legislation. Prohibitions on the production, supply and possession of drugs have been with us for generations now, collectively assuming the banner of the 'war on drugs' (Nixon's declaration also enjoying its fortieth anniversary last year).

Challenges to drug prohibition have been a feature of the political landscape throughout this period, but have rarely bothered mainstream policy makers until relatively recently. The overarching prohibitionist paradigm, its institutions and its populist political narrative – that drugs are socially and morally unacceptable, therefore they should be banned – have become increasingly entrenched in our political culture, to a point where they are often considered an almost immutable reality of the policy landscape. Even to many in the drugs field who lean towards a reform position intellectually, prohibition has been something to work within or around, rather than a policy choice from a spectrum of regulatory options.

Yet today the prohibitionist paradigm has never been under greater pressure. After 40, 50 or 100 years – take your pick – its critique, and the debate on alternatives has finally made a decisive move into the political and media mainstream. Major media outlets from *The Times* to the *Sun* and *Mirror* have run overtly anti-prohibition / pro-reform editorials, as have high profile journals including the *Lancet* and *BMJ*. High level politicians have increasingly joined the growing critical chorus of intellectuals, academics, commentators and public figures. Last year's Global Commission on Drug Policy report (that among its pragmatic recommendations included more contentious calls for decriminalisation and legalisation/regulation), was perhaps something of a watershed, being backed by six former heads of state as well as Kofi Annan the former General Secretary of the UN. Since then a stream of sitting Latin heads of state have made similar calls – with drug reform high on the agenda at the recent Summit of the Americas that even witnessed Obama saying he didn't mind debating drug law reform and even the avowedly

prohibitionist Canadian premier Stephen Harper stating that 'the current approach is not working'.

Why this has happened now is a question for debate; it is probably a combination of the increasingly visible signs of an expensive and malfunctioning policy at a time of economic crisis, demographic changes – as the post-sixties generations move into positions of influence, and a more sophisticated and better coordinated campaign for reform from the NGO sector.

Into these shifting sands come two new books on the subject: *Legalize: the only way to combat drugs* by retired doctor and drug treatment provider Max Rendall, and *Fixing Drugs: the politics of drug prohibition* by Sue Pryce, Associate Professor at Nottingham University's School of Politics and International Relations. On the face of it these books have many similarities, both at their core, essentially offering well constructed historical backdrops and critiques of the various failings of prohibition before concluding with options and arguments for reform – and how they might be brought about.

The differences are largely in tone and commitment to a specific reform pathway. Rendall unashamedly nails his colours to the mast from the first word of the book's title and adopts a more populist style. In contrast Pryce, while sharing Rendall's central premise that the war on drugs has been a failure, is more circumspect in her approach, attempting to maintain a degree of academic objectivity, suggesting that she has opted for the narrative device of 'how would you explain this or that problem to an intelligent alien?'. While both authors make a convincing case in their own ways, the results will naturally appeal to different audiences. I suspect the deliberately measured tone of Pryce's more substantive book will prove useful for the fence sitting academics and policy makers who may be put off by Rendall's upfront flag waving – even if the text, if read, would be persuasive. Rendall's book, by contrast, may appeal more to the reform minded seeking support for their viewpoint, but who might find Pryce a tad dry and reticent.

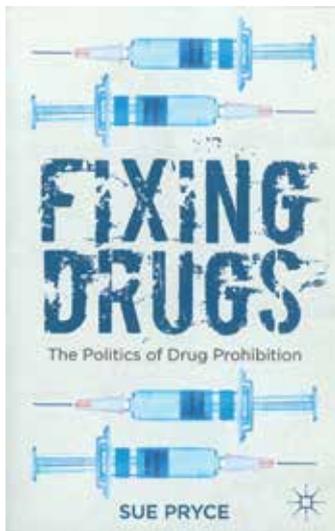
If there is a disappointment with Pryce's book it is that the level of detail and expert analysis in the excellent chapters that form the body of the book's critical narrative, including a particularly astute chapter on obstacles to change, are not matched by the two concluding chapters on ways forward. Having walked us to the door and pushed it ajar, the peek at what lies beyond is something of a let-down, and this disappointment goes beyond

Pryce's quite understandable academic caution on speculating about future scenarios. The discussion on decriminalisation of possession is cursory; only briefly considering the Netherlands and Portugal experiences, despite the similar reforms now happening in around thirty countries across the world. Even the limited Portugal discussion that is included is undermined by referencing the rather rose-tinted Greenwald CATO institute study and a muddled rapid response comment by Nigel Keegan to a BMJ paper (re drug deaths), rather than the authoritative and objective peer reviewed academic literature, most obviously by Hughes and Stevens in the British Journal of Criminology (2010).

The short discussion of legalisation/regulation practicalities is similarly inadequate. I have to declare an interest here as the author of the BMJ paper Pryce uses for the basis of her discussion. The problem here is that she appears to have read only the 2000 word BMJ paper, rather than the 200 page book is based upon (*After the War on Drugs: Blueprint for Regulation*, published in 2009, and available as a free download). Misrepresentations and misunderstandings inevitably follow, with answers to a series of questions posed by Pryce, in fact discussed in some detail in *Blueprint* – rather unfortunately left hanging.

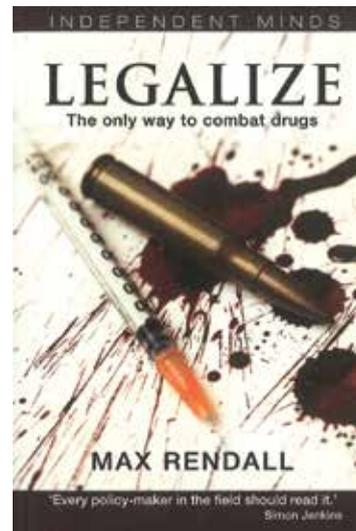
People naturally have concerns about the potential negative impacts of moves towards legally regulated markets for any currently prohibited drugs. What would have been more useful from Pryce – especially given the direction of travel her devastating critique of prohibition inevitably points to – would be to identify these risks and then consider how potential regulatory models, and the transition to a post prohibition scenario, could be managed to reduce them. Leaving these ambiguities and uncertainties largely unexplored feels like a missed opportunity and one that rather panders to the 'leap into the unknown' narrative, part of the policy inertia she unpicks so well in earlier chapters.

Rendall paints a slightly fuller picture of how reform might work in practice (also citing *Transform*), and unlike Pryce did make the effort to meet and interview *Transform* staff as part of his research. But the lack of detail is similarly frustrating. Both he and Pryce also missed a chance bring their analyses up to date with explorations of some of the informative real world developments to emerge in recent years, such as New Zealand's experience with a legal regulation model for BZP (the first such model for a non medical synthetic stimulant anywhere in the world) or Spain's



**FIXING DRUGS:
THE POLITICS OF
DRUG PROHIBITION**

Sue Pryce
Palgrave, 2012
£18.99



**LEGALIZE:
THE ONLY WAY
TO COMBAT DRUGS**

Max Rendall
Stacy International, 2011
£9.99

pioneering cannabis social clubs, now numbering more than 700, that provide an intriguing quasi-legal model for a self contained production and sales co-ops for non medical users. So despite the undoubted merits of both books, there is a sense of there being nothing particularly new or challenging here in terms of facts or analysis. It's more of a repackaging – albeit a potentially very useful one.

Pryce notes in her introduction that if you are interested in the case for the status quo then read Neil McKegany's 2010 book *Controversies in Drugs Policy and Practice* by the same publisher (Palgrave MacMillan). The two are certainly worth reading in parallel as an interesting demonstration of the fallacy of academic objectivity. A similar exercise could be done with Rendall's book read alongside Philip Bean's *'Legalising drugs: debates and dilemmas'* (2010) with which it shares a certain retro charm, but little else.

But I am reminded of a book shop I once visited in the US with a section of 'liberal' political books (Michael Moore etc) on one side of the store and 'conservative' (Anne Coulter etc) on the other. People mostly pick the side of the store that suits their political persuasion and rarely cross the floor, just as we generally read newspapers we agree with to massage our sense of righteousness. While the drug debate is mercifully not split down a political left/right divide, it can still seem polarised, at least in the public media debate with its insatiable need for dialectic drama.

My suggestion – wherever you stand on the debate now – would be to read McKegany alongside your Pryce/Rendall (dare I add, *Transform*), and make your own mind up. I doubt you will emerge calling for more prohibition, but I would say that wouldn't I?



Can drug education be a class act?

Recently drug campaigning groups have been petitioning for the government to make drug education compulsory in schools. *Findings* editor **Mike Ashton** looks at the evidence for effectiveness.

Across almost an entire age group, school-based drug education offers a way to divert the development of unhealthy substance use before it or its precursors have taken root. The promise is clear, the fulfilment less so. The issues can be divided into at least two possibly interrelated domains: contradictions in principle; shortfalls in practice.

Among the first is the contradiction between the objectives of education and prevention: the former seeks to empower children to think for themselves and open up new horizons, the latter to channel thoughts, attitudes and actions in ways pre-determined by programme developers and teachers. Then there are potential contradictions within prevention programmes themselves. Some aim to limit young people's autonomy in their choice of friends and substances by extending autonomy in decision-making; to encourage conformity to non-drug use values by discouraging conformity to other young people; to develop team work and social solidarity without accepting that youngsters may express this by going along with their peers, as well as deciding not to.

The practical issue is that (perhaps because of such contradictions) impacts of drug education on drug use are usually at best minor and short-lived. But perhaps the newer 'normative' approaches (core message: 'Everybody is not doing it'), a change in objective to harm reduction rather than absolute prevention, or some other innovation, will see drug education live up to its presumed potential.

Alternatively, we may see prevention steering away from drug education and towards general early-years character development. Child development and parenting programmes which mention substances not at all or only peripherally have recorded some of the most substantial prevention impacts ever seen. The most persuasive example is the Good Behaviour Game classroom management technique for the first years of primary schooling.¹ Well and consistently implemented, by age 19–21 it was estimated that this would have cut rates of alcohol use disorders from 20% to 13% and halve drug use disorders among the boys.

Pioneering this theme was the truly seminal Dutch drug education study of the early '70s which had a profound impact in Britain.² For the practitioners of the time, it was a warning about the dangers of the dominant 'scare them' approach, but it might as well have been a lesson about the approach which outperformed the warnings – classroom discussions which simply gave pupils a structured chance to discuss the problems of adolescence.

In contrast, recent disappointments for conventional drug education include two programmes which embodied the latest thinking – the seven-nation EU-Dap European drug education trial³ and the English Blueprint trial.⁴ The former's results were patchy, the latter's, if anything, in the wrong direction.

Selected entries from the Drug and Alcohol Findings Effectiveness Bank project. For the full story with links visit: <http://findings.org.uk/count/downloads/download.php?file=DL3.php>

SOURCE STUDIES

1 Good Behaviour Game

Kellam S.G., Brown C.H., Poduska J.M. et al. "Effects of a universal classroom behavior management program in first and second grades on young adult behavioral, psychiatric, and social outcomes." *Drug and Alcohol Dependence: 2008*, 95(suppl. 1), p. S5–S28.

In their first years at school, Baltimore pupils formed teams which could earn prizes and praise for good behaviour; 14 years later many fewer young lives were marred by substance-related problems, threatened by smoking, or on track to cause serious social problems.

2 Seminal Dutch study

De Haes W., Schuurman J. "Results of an evaluation study of three drug education methods." *International Journal of Health Education: 1975*, 28(4), suppl., p. 1–16.

Barely out of the '60s and 'scare them' was the dominant response to the upsurge in youth drug use. Two young Dutch health educators put it to the test. Their seminal study caused a rethink of national policy here and in the Netherlands, but the lessons still need to be re-learned.

3 EU-Dap European drug education trial

Faggiano F., Vigna-Taglianti F., Burkhart G. et al. "The effectiveness of a school-based substance abuse prevention program: 18-month follow-up of the EU-Dap cluster randomized controlled trial." *Drug and Alcohol Dependence: 2010*, 108(1–2), p. 56–64.

The largest European drug education trial ever conducted tested whether US-style social influence programmes would prove effective in Europe. There were probably some real successes, but these were limited and may have been artefacts of the implementation and analysis of the study.

4 UK Blueprint trial

Blueprint Evaluation Team. *Blueprint drugs education: the response of pupils and parents to the programme*. Blueprint Evaluation Team, 2009.

In the British context, it was expected to decide whether an evidence-based, well structured and well resourced drug education programme could contribute to reducing youth substance use, yet the multi-million pound Blueprint study never got near fulfilling its promise.



PMA/PMMA



PMMA (paramethoxymethylamphetamine) is a Class A stimulant and psychedelic drug. It is structurally similar to methamphetamine and paramethoxyamphetamine (PMA). PMA was created in Canada in 1973 and after being linked to several deaths in Canada and U.S.A seemed to disappear from use until the 1990's. Since it has returned, it has been linked to further deaths in Australia and Canada.

PMMA is unlikely to be deliberately used recreationally due to toxicity reports, but it is more common for it to be sold as ecstasy or as an ecstasy substitute. As such, its appearance and using patterns are likely to be similar to that of ecstasy tablets. It is however possible to find PMMA in crystalline powder form with reported colour variants of beige, white, yellow or pink.

PMMA effects

- Mild euphoria
- Alertness
- Feeling of wellbeing
- Excitement
- Heightened sensations
- Dry mouth
- Teeth grinding
- Nausea
- Sweating
- Increased heart rate
- Increased body temperature
- Palpitations
- Hallucinations
- Rapid eye movement
- Muscle spasms
- Compulsive yawning

Both PMA and PMMA have been implicated in drug related deaths across Europe over the last few years. The Scottish Crime and Drug Enforcement Agency released information back in July 2011 about PMMA's presence in some ecstasy tablets and legal high products,

which can be found on their website:

www.sdea.police.uk/Downloads/ACPOS/DOC%2020110722%20PMMA%20alert.pdf

PMMA has been found recently in pale blue ecstasy tablets in Scotland where they are known as "Einsteins" which have an "E=mc²" logo. Not all batches of Einsteins have contained PMMA, some have contained MDMA so even where users have used before with no problems, this cannot be guaranteed the next time they use.

With drugs such as PMMA possibly being in tablets, negative side effects and potential of overdose are more likely. Although users report similarities to effects of MDMA, many argue that effects can feel less potent than MDMA and often the onset of effects is longer, which can result in users re-dosing and thus increases the risks. In many cases of negative side effects, dose appears to be an issue, as does poly drug use. Some sources suggest the mix with other drugs, alcohol, anti depressants or even caffeine can increase overdose potential.

According to the chemist Alexander Shulgin, a lethal dose would be more than 100mg although PMA dosages of more than 50mg are reported to be potentially lethal especially when mixed with other substances. Given that ecstasy patterns of use can involve users using multiple quantities of tablets in one session, this presents a potentially serious health risk.

Signs of an overdose could include:

- Hyperthermia (very high body temperature or overheating)
- Dehydration
- Rapid heart rate
- Increased blood pressure
- Breathing difficulties
- Seizures
- Severe nausea and vomiting

drugworld DIARIES



Neal Richardson

Alcohol Liaison Nurse

Charing Cross Hospital

I should start by pointing out that there is no such thing as a routine day for an Alcohol Liaison Nurse, as there are many aspects to the role, from client care, to staff training, to service development. I have worked at Charing Cross (a large general acute hospital located in Hammersmith, West London) since December 2007, with the post created as a response to an increasing number of alcohol related A&E attendances and hospital admissions. My background is in mental health nursing and I'm employed by Central and North West London NHS Foundation Trust and linked to the local community drug and alcohol service.

Service provision was initially based in A&E, although the work soon expanded to cover other hospital wards and clinics – to date the service has received over 3000 referrals. Most of these come from doctors and nurses, but in the past year I've also received referrals from physiotherapists, pharmacists, dieticians, sexual health advisors and occupational therapists; hospital patients can also self-refer.

My day typically begins with a visit to the Emergency Assessment Unit (A&E short stay ward) to see if there are any patients admitted overnight who might benefit from further advice about drinking. I also hold weekday morning clinics, so will check my A&E diary to see if any outpatient appointments have been arranged. Referrals from other wards can come throughout the day and I aim to see admitted patients on the day of referral whenever possible.

An important part of my role is to encourage A&E staff to screen patients attending the department by asking simple questions about quantity and frequency of drinking. Patients identified as drinking in a potentially harmful way

should then be offered brief advice and referral to me. Hospital attendance can be seen as a 'teachable moment', when patients are more likely to reflect on their drinking and respond to advice.

IN A BUSY A&E DEPARTMENT, AND WITH JUNIOR DOCTORS ROTATING JOBS EVERY FOUR MONTHS, PROMOTING IBA CAN BE QUITE A CHALLENGE

There is a substantial body of evidence demonstrating the effectiveness of alcohol identification and brief advice (IBA) in reducing drinking and associated harms and my experience endorses this. However, in a busy A&E department, and with junior doctors rotating jobs every four months, promoting IBA can be quite a challenge. The patients I see receive a brief intervention, which aims to increase motivation to change harmful drinking. This consists of assessment of the patient's drinking pattern and history, as well as questions related to physical and mental health and social circumstances. I use this information to provide personalised feedback about the risks associated with excessive drinking. I offer advice and information on reducing or stopping drinking and, if appropriate, direct towards specialist services for ongoing support/treatment. Local alcohol services are very supportive of my role and offer speedy access to treatment for patients

requiring further support following discharge from hospital.

Another crucial aspect of my role is the provision of education and training for hospital staff. Considering the impact of alcohol on physical health and the well-documented burden this places on hospitals, it is surprising how little alcohol training many health professionals have received. Formal training includes sessions on how to identify alcohol problems and provide brief advice, as well as training on clinical issues such as alcohol dependence and associated complications. Education also takes place in a less formal way during day to day discussions with staff. Around half of the patients referred to me are physically dependent on alcohol, so I'm often asked to provide advice on managing alcohol withdrawal symptoms. This can be an ideal opportunity to do some impromptu teaching and promote the hospital guidelines on alcohol withdrawal management.

Essentially, the different aspects of alcohol liaison nursing make for a demanding but very interesting job and the role plays an important part in helping address alcohol related harm. I get to see a broad range of clients, from weekend 'binge drinkers' to alcohol dependent individuals with complex physical and mental health problems. I have found it satisfying to witness the growth of the service and feedback received from staff and patients suggests the service is highly valued. General hospitals are ideally situated to identify drinkers at risk of harm, with hospital attendance offering a valuable opportunity to engage clients and encourage them to make changes to their drinking.

A person wearing a grey hoodie and dark pants stands in front of a wall of rubble and debris. The person's face is obscured by the hood. The background is a grey, textured wall with scattered pieces of wood and other debris.

DrugScope

Your annual insurance bill could help raise funds for DrugScope.

Ask us to quote for your car, home or business insurance and we'll donate **25%** of the earnings to **DrugScope** when you go ahead.

To see how much you could SAVE and to support the work of DrugScope call FREE on
0800 917 2274
quoting '117DrugScope'.

CHRIS KNOTT INSURANCE

The right choice for charity supporters

We are developing critical and academic skills in addiction professionals

This course will develop your understanding of the scientific underpinning of modern recovery-focused practice in drug and alcohol treatment.

Incorporating a range of evidence-based approaches it will equip you with broad clinical skills and knowledge of the problems that you are managing. This course will also provide you with an innovative and comprehensive framework for delivering medical and psychological treatments. The focus of the teaching will be on clinical practice, and the modules include:

- Introduction to substance misuse
- Assessment, case management and harm reduction
- Building motivation for treatment
- Changing addictive behaviours
- Rehabilitation, recovery and aftercare
- Research methodology

You can study this three year, part-time course in full to gain an MSc qualification, or in part to gain a Postgraduate Certificate or Postgraduate Diploma. You can also take most modules on a stand alone basis.

Entry requirements

You will need to have an undergraduate degree and experience of working with the relevant client group. Professional qualifications and work experience may also be taken into consideration.

Learn more

For more information including full details of all modules, fees, application deadlines and how to apply, as well as access to our on-line application form, please visit our website www.birmingham.ac.uk/treatment. Alternatively contact Susan Lowe on 0121 301 2355 or by email at treatment@contacts.bham.ac.uk or Dr Ed Day by email at e.j.day@bham.ac.uk.