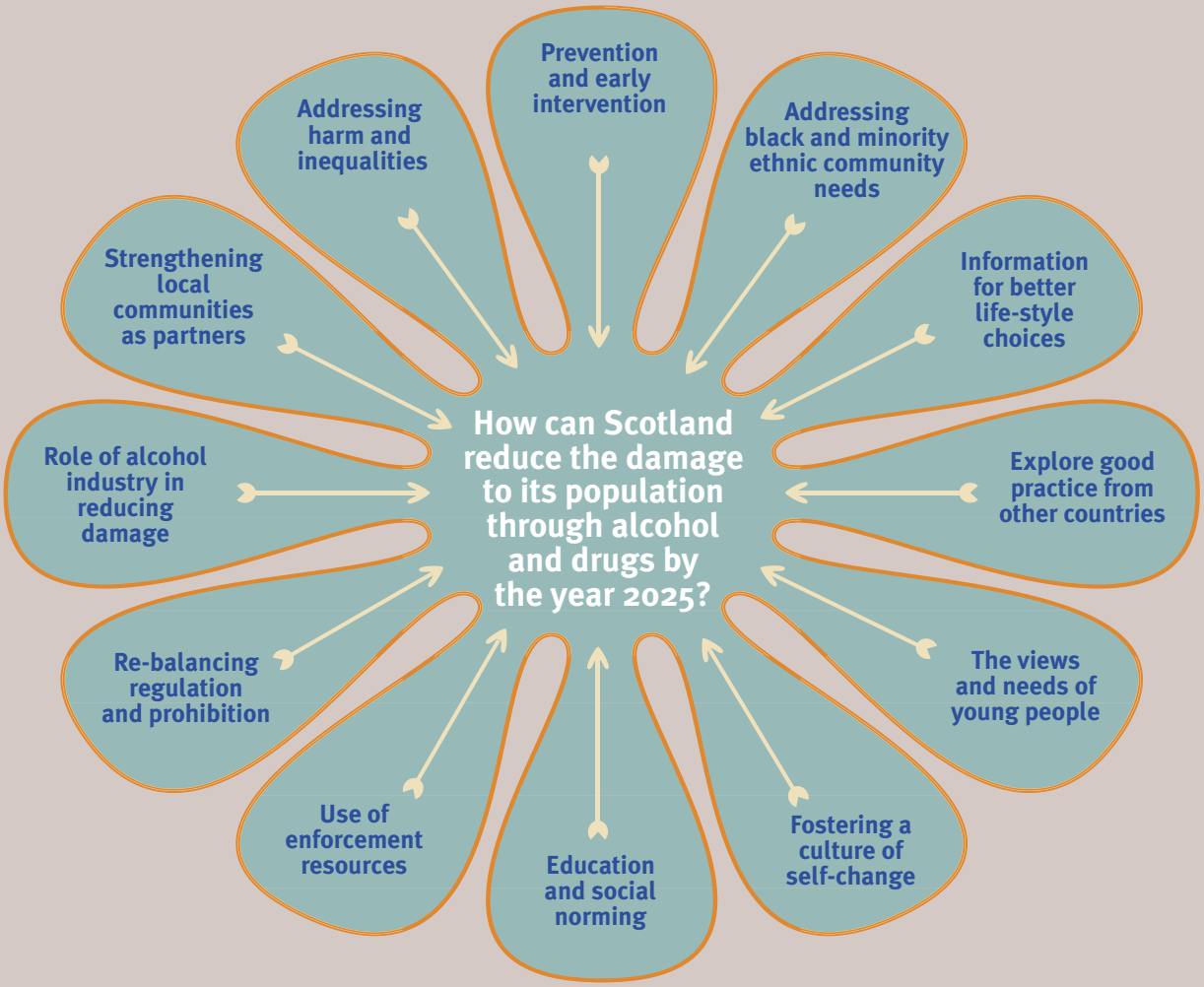
Scotland's Futures Forum

# 12 Dimensions of a manageable problem: **A collection of expert views**




This report is a companion document to the Report, ***A Question of Architecture: The Structure & Design of 21st Century Alcohol & Drugs Policy, A Systems Mapping Approach to How Scotland can reduce the damage to its population through alcohol and drugs by half by 2025***, published by Scotland's Futures Forum

This and other reference documents can be viewed at www.scotlandfutureforum.org along with the project FLASH site.

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**Foreword**

In early 2007, Scotland's Futures Forum considered there to be 12 dimensions to the project question, 'how Scotland could reduce the damage to its population through alcohol and drugs by half by 2025'. It then set about looking for experts both nationally and internationally, who could speak, discuss and debate with the Forum their work, evidence and approaches.

This referenced collection of lightly edited presentations forms part of the evidence base for Scotland's Futures Forum project findings. While care has been taken to represent the views of the speakers, this cannot be guaranteed, given the nature of the editing process.

Each chapter provides a lightly edited version of the main presentations made throughout the year. Each is accompanied by PowerPoint slides and referenced, available at www.scotlandfutureforum.org

I am hugely grateful to all the speakers who engaged with the Forum during this project.

Frank Pignatelli CBE
Chair, Alcohol and Drugs 2006/7 Project Board

## June 2007: Getting a Life: Alcohol, Drugs and Early Years

### Alan Sinclair, The Work Foundation

### Context

Arguably, we don't officially know how to reduce the harm caused by alcohol and drugs. In some sense, there is a collective view in Scotland that alcohol and drug abuse is part of being Scottish, it is part of being young, it is part of being a man. These are worrying perspectives.

There is a range of issues we confront – unruly behaviour in school, knife crime, alcohol and drugs abuse, obesity and anti-social behaviour in our communities. These are seen as enormous problems. However, another way to think about it is to see this catalogue of problems as one problem, just manifesting itself in different ways. It is the problem of poor or problematic early years just expressing itselfin different outcomes.

### The size of the task

The topic for Scotland's Futures Forum's seems very achievable - to halve the damage caused by alcohol and drugs by 2025. However, the statistics tell an interesting story. The rates in the abuse of alcohol and drugs show an amazing engine of growth. By 2025, we could have increased from about 1% of the Scottish population being badly affected by drugs to 2 or 3% being badly affected[1]. While, at best, there may be a slightly slower rate of growth, in trying to reduce the problems by half we may really be looking at a 100% or even 200% reduction, simply to get half the number of people we have today. So, the ambition of this target is significant.

### Alcohol and drugs - prevalence and harm

The alcohol and drugs industry is big business. The alcohol industry is estimated to be worth about £3.5 billion in Scotland[2]. On top of this, the largest part of the informal economy is made up of the trade in illicit drugs.

From alcopops to crack sellers, we know that the alcohol and drugs industry is inventive and ambitious in holding onto and expanding their market.

The general population has more disposable income now than ever before[3]. In most markets demand goes up when people have money. Alcohol is 62% more affordable now than it was 25 years ago[4].

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[1] McKegany, N. 2006, 'The lure and the loss of harm reduction in UK drug policy and practice', *Addiction Research & Theory*, vol. 14, no. 6, pp. 557-588.
[2] NHS National Services Scotland. 2007, *Alcohol Statistics Scotland 2007*, Available at: http://www.alcoholinformation.isdscotland.org.
[3] Ibid.
[4] Ibid.

## Urgent need for a new direction

There is an urgency in terms of the harm and pain that alcohol and drug abuse causes.

- Given the prevalence and the growth rate in alcohol and drugs usage, it is clear that if we do nothing, it is not being too dramatic to say, we can expect the problem to be twice or three times as large in 20 years' time[5].

- We have to think about how, as a society, we can afford to look after so many people in the future suffering from alcohol and drugs and how we will deal with all the consequences that flow from this.

- The economic future we face collectively is actually a very precarious one. In the next ten years we will be playing in a much more open world economy. In the last 10 years the world's labour force has doubled as a result of China, Russia, India and Brazil joining the world market[6]. However, the amount of investment available has roughly stayed the same[7], which begs the question, 'where do we in Scotland fit into that world?'. Employers are already looking for softer skills: the ability to talk and listen to clients, to work together, to work with customers and solve elementary problems. In many cases, the very people who suffer from drug and alcohol problems are the very people who will not have the softer skills employers are looking for. Our labour market may become much tougher.

## Don't hitchhike on roads without cars!

We need a serious sense of direction to determine how we are to respond to this picture. In trying to get a hold on the alcohol and drugs issue, we must not go down roads that don't yield results. There are a lot of tempting roads, a lot of temping prospects, but policy makers and others must find roads that will give us substantial results in confronting the problem we face. We have to understand the scale of the change that we are required to make. It will not be a symbolic change, but a category shift.

## The territory

The territory we are in today is both **nurture** and **genetics**. We also need to consider free will, choice, deprivation and regulation. All of these things have an effect on alcohol and drug consumption and harm. However, the significant territory to look at in terms of substantial change is nurture.

Working properly with young people will help to steer them through a world full of dangers, helping them make more of the right choices. We can help children develop the attitudes and the resilience that will help them make the right choices about the use of alcohol and drugs.

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[5] McKegany, op. cit.
[6] Freeman, R. 2006, 'Labour Policy in the Global Economy: Going Beyond Orthodox Reforms', Available at: http://theworkfoundation.com.
[7] Ibid.

**The importance of early years**

There is very strong evidence of the benefits of getting early years right. In the US, for example, the Nurse Family Partnership[8] works very intensively with low income, disadvantaged mothers, helping develop better prenatal care, more sensitive care for the child, help with planning future pregnancies and help in finishing education. Although this intervention programme runs for only two years, there has been clear evidence of benefit to these children when their lifestyles have been looked at 15 years later[9]. These include 44% less drug abuse by mothers, and 55 days a year with less alcohol consumption on the part of 15-year-old children[10]. This intervention has helped these children find a better route.

In 1962, in black inner city Michigan, the Perry Pre-school initiative targeted 123 children with IQs of less than 90[11]. Half were assigned to a control group and half to a programme group. Those in the programme group were given high quality support and stimulation in their play for five half days a week for two years. There was also a one and a half hour home visit each week.

A comparison between the control group and the programme group showed the following:

| | Programme Group | Control Group |
|---|---|---|
| Use of sedatives / tranquilisers | 17% | 43% |
| Use of marijuana | 48% | 71% |
| Use of heroin | 0% | 9% |

The programme group had 68% fewer arrests for drug dealing and they were 63% less likely to be habitual criminals[12].

This was a programme set up specifically to improve the educational outcomes of children born to fail. Its impressive results have been recognised by the US Department of Health as one of 25 programmes across America with an award for 'Exemplary Substance Abuse Prevention'.

Other important projects with sound evaluations have demonstrated that providing appropriate care to children and helping parents develop their skills as parents are hugely powerful. This is not about learning to read and write. It is about children having an adult who gives them sensitive care, provides stimulation and encourages their play. Again, the evidence from such early interventions, even in the first two years, has shown real changes in behaviour in later life, particularly in relation to a

[8] Olds, D.L. et al. 2007, 'Effects of Nurse Home Visiting on Maternal and Child Functioning: Age-9 Follow-up of a Randomized Trial', *Pediatrics*, vol. 120, no. 4, pp. e832-e845.
[9] Ibid.
[10] Ibid.
[11] Scweinhart, L.J. 2005, *The High/Scope Perry Preschool Study Through Age 40*, Available at: http://www.highscope.org/.
[12] Ibid.

reduction in abuse of alcohol and drugs and reduced entanglement with the criminal justice system[13].

**'Children are a reflection of the world in which they develop'**

In the womb, from 20-weeks-old to birth, there is a large and rapid increase in the size of the brain. Once born, a child's brain is like a growing sponge. The more exercise it gets, the more it develops and the more it takes shape.

**How do children develop?**

- Attachment is hugely important, knowing that someone is out there looking out for you. This is very important in the early, sensitive years.

- Empathy is important too. Unless a child learns empathy by being looked after, encouraged and loved, it is very hard for that child to show empathy.

- The ability of children and adults to regulate their hormones is critical in managing behaviour. If the hormone level is wrong, children are more likely to display fearfulness, depression and be more predisposed to alcoholism and aggression. One of the most important unbalancing times is while the child is in the womb and results from 'stress' caused by alcohol, drugs and physical violence. The other critical period for regulating hormones is in the first few years of life, where sensitive care provides life-long benefits, while the absence of good care creates a permanent problem.

Providing a healthy early years period for our children is within our powers. If the will exists, policy makers and practitioners can design and implement the right type of practices. If we do not invest in the early years, we inhibit young people's ability to develop friendship and empathy - things we all value more than possessions. If we do not invest in early years, we sacrifice young people's hope and ability to shape their future.

"He who has a why to live can deal with any how". This is very important for those who choose not to take drugs and in helping those who do to stop. This is the territory we are in with alcohol and drugs. We need to give young children the equipment to cope with optimism, pessimism, fear and well-being.

A study by the Home Office[14] shows the predictive factors for drug abuse are:

- parental control
- family cohesion
- parental monitoring
- peer drug use
- drug availability
- genetic profile

[13] Karoly L.A., Milburn, M.R. & Canon, M.R. 2005, *Early Childhood Interventions: Proven Results Future Promises*, RAND, Santa Monica.
[14] Home Office. 2007, *Predictive factors for illicit drug use among young people: a literature review*, Available at: http://www.homeoffice.gov.uk/rds/pdfs07/rdsolr0507.pdf.

- self-esteem
- the rate of risk to protective factors
- hedonistic attitudes

Most of these factors cluster around how people are brought up, how they are looked after.

**Getting on the front foot**

The early years agenda is a positive one. There are many concrete examples of things that can be done for improvement, such as:

- helping children be children, but also helping parents be parents
- supporting children in forming a secure attachment
- having family and friends who give meaning and purpose
- exposing children to positive things that happen in our wider communities

**Scotland – a great place to take the children on holiday!**

The biggest rate of return on investment in education is in the early years. James Heckman, the Nobel prize-winning economist, has painstakingly analysed the long-term data sets and shown that the returns in education in the early years are dramatically greater than in the late teens or early twenties[15]. If we ensure early intervention in policy then we can make progress. For example:

- We can invest financially in early years: there is nowhere near enough investment at present. We invest heavily in tertiary education but nowhere near enough in early years. The balance is topsy-turvy.

- We can support parents by starting more children's centres. These are nothing new: there are 3,500 about to be established in England[16]. The Jeely Piece Club in Castlemilk is a great example.

- We can learn from pedagogues. Perhaps we need to learn from those countries at the higher end of the well-being charts in Europe. Perhaps we should bring help into specific homes and play areas, for those under-seven where there is an insufficient development plan. This can all help children develop as children.

- We can promote a good home learning environment.

- We can build on the provision of paid nursery time. It's good to see more paid nursery time being made available in Scotland - this is a good start, but only a start.

[15] Heckman, J. 2006, 'Investing in Disadvantaged Young Children is an Economically Efficient Policy', Available at www.ced.org/docs/report/report_2006heckman.pdf.
[16] The Department for Children, Schools and Families, Sure Start, Available at: http://www.surestart.gov.uk/aboutsurestart/about/thesurestartprogramme2/.

- We can recognise that a serious ten-year childcare strategy is needed for Scotland to match at least the English or Irish strategy or to go beyond and embrace some aspects of the Scandinavian model.

**The economics of investing in early years**

Major robust studies with control groups have shown a rate of return of between 3:1 and 7:1 when the child reaches the age of 21 years[17]. This equates to an annual rate of return of around 16%[18]. The studies that continue to monitor participants beyond 21 years of age show that the benefits continue to flow throughout the lives of the people recruited to the programmes[19]. The biggest savings are in:

- criminal justice – less criminal activity in teens
- health – less drink and drug abuse, less use of mental health services
- education – better responsiveness to the education system
- employment – more people in work, reduced numbers claiming welfare

**Conclusion**

Early years should be a priority. We do not have any strategy in Scotland to make it so. There is, however, in England, Wales and Ireland.

To make headway towards the overall question that the Forum is asking, we need an alliance of people concerned about health, education, criminal justice and the economy. Only by working together and investing in early years will we see a net benefit for us all.

It is not all the government's role. Good parenting is a cultural phenomenon that must be developed and that relies on the responsibilities of the wider community. As individuals, as a community and as a society, we all have a role to play.

If we do nothing, the alcohol and drug harm we face in 2025 may be at least twice what it is now[20]. The challenge is great and urgent morally and economically.

Both theory and an evidence base approach tell us that investing in early years works. Helping children to get the right foundation in life makes moral and financial sense. Approached on the right scale, a shift to creating a country that has good early year practices will give us a country of citizens capable of resisting the traps of alcohol and drug abuse.

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[17] Sinclair, A. 2007, *0-5: How small children Make a big difference*, Available at: http://theworkfoundation.com/Assets/PDFs/early_years1.pdf.
[18] Ibid.
[19] Scweinhart, L.J. 2005, *The High/Scope Perry Preschool Study Through Age 40*, Available at: http://www.highscope.org/.
[20] McKegany, N. 2006, 'The lure and the loss of harm reduction in UK drug policy and practice', *Addiction Research & Theory*, vol. 14, no. 6, pp. 557-588.

**Chapter 2**

**Substance abuse issues in a multicultural Scotland**

## A Theoretical Discussion: A Race Equality Dimension to Drug Users' Services[21]

*Neville Adams, Honorary Senior Research Fellow, City University, Research Associate, T3E based at Middlesex University*

The main areas to consider in framing a theoretical discussion are:

- Europe
- the race equality framework.

# Europe

The EU Drugs Action Plancovers 2005-2008. The strategy itself does not mention any specific equality dimension.

The first T3E project, undertaken approximately 10 years ago, looked at how race equality was being pursued in five different European countries with regard to drug services. It was based on a similar survey covering all areas in all countries. The results showed race equality to be very unevenly developed across Europe. However, on the ground, drug service agencies were informally active in race equality, although not formally monitored. Exceptions did exist. For example, the Netherlands had formal policies, formal legislation and, as a consequence, much more race relations work was evident.

Ten years on, T3E is involved in another project, Democracy, Cities and Drugs. This project looks at how, at local city levels, local drug policies can be developed, involving relevant stakeholders, and how this evidence can be fed back at the European level. The difference over the intervening 10 years between the two projects has been the emergence of a common equalities legislative framework. Nevertheless, today, the same pattern persists in relation to race relations across the board in Europe; the issue is unevenly developed, marginalized, and there appears to be reluctance to talk about race or anything to do with minorities.

Much of the co-ordinating work around anti-discrimination comes through the Directorate for Employment, Labour and Social Affairs. There, civil society has a key role to play in making anti-discrimination rights effective. This is done through advocacy as well as awareness-raising activities with individuals, specific groups and the wider public, who may be potential victims of discrimination.

**Key Race Themes**

[21] During his presentation Adams preferred to talk about race equality and used 'race' in its broadest social construct sense.

There are, of course, key race themes in the United Kingdom, which emanate from Europe. In terms of the needs of visible minorities, they tend to fall somewhere between the cracks of treatment and the criminal justice service and, in some cases, access to services comes through the criminal justice system. Sometimes people are misdirected, sometimes they are misdiagnosed.

There is also a need to be mindful of stereotypes posing as needs in relation to race relations, particularly stereotypes about particular communities. For example, there seems to be an attitude of 'they look after their own', or 'they don't want to access drug services'. This is often based on a lack of clear primary research and not speaking to the communities themselves.

### Citizens or citizenship?

In Europe, we talk about citizens in a general sense as people who have a right to access services. Citizenship in race relations is a big issue in the United Kingdom at present.

There are particular concerns about asylum seekers and refugees, particularly in the way in which they simply cannot access services. A key theme running throughout race relations in the United Kingdom is one which considers race relations in terms of progress by keeping the numbers down. That has been repeated in the UK time and time again and is being played out currently with those seeking asylum. How can services be provided to asylum seekers if there is a legal bar preventing them from accessing them? There is no easy answer, but it is an important point for debate.

Another issue across Europe and in the UK is an underdeveloped equality infrastructure. This is particularly true in relation to drug services. An underdeveloped equality infrastructure in many organisations makes it very difficult to address the issue of race equality and this can be reflected in terms of the quality of the services that are provided.

### Marginalisation

In the UK, and in Europe, the term 'minority' does not lend itself to correcting that. It has often been an add-on, not considered meaningfully as a mainstream topic for discussion.

## Race equality framework

### Drug services

There are three points to be made in relation to drug services:

- Services should be able to identify and meet the needs of the most marginalised. If they do not, then there is something fundamentally wrong with the service. In terms of work around race equality, one of the key issues is that this is not a minority issue; it is not a marginal issue. Race equality is very much like a barium meal – you could run it through the organisation and it would point out all the problem areas.

- The public sector, which has a remit in the provision of services and has an enormous range of employees, should be of the highest anti-discriminatory standards.

- Local communities, particularly marginalised communities, should be actively involved in the development and provision of services. User involvement is a key theme that should be evident in all areas in the provision of services.

**The anti-discriminatory legislative framework**

We should not pursue a legalistic interpretation of equalities, but the legislation should provide a minimum baseline for action. There is quite a broad range now of anti-discriminatory measures in legislation.

Legislative measures have largely come about because there has been a struggle to secure them – race relations, women's equality, sexual orientation – the timeline goes back centuries in some cases. What is new is that governments have only recently, in terms of the overall history, wanted to do something positive about it.

While in the 1970s and '80s, equalities were seen in voluntaristic terms, we now have a fairly comprehensive legislative framework covering race equality, women's equality, disability, religious belief, age and sexual orientation.

**Moral or business arguments**

One of the false distinctions made in the past was that the case for equality could be made as either a business case or a moral argument. In a sense, with the new legislative framework in place setting out what society expects, part of the moral argument has now been won. The business case provides a certain advantage for getting organisations to take on equalities, but it is not a stand-alone argument.

It has been argued that discrimination is regulated when it is connected with sex, gender reassignment, marriage, civil partnership status, race, colour, ethnicity, national origin, or nationality, but not usually when it is connected with immigration status, disability, sexual orientation, religious belief or age.[22]

Discrimination connected with other characteristics – in particular, social or birth status, wealth, social class or immigration status – is not so regulated. Poverty, both abject and relative, remains a feature of UK life, notwithstanding our collective wealth. Asylum seekers and migrant immigrants are hounded and vilified by the press. Part of the problem is that a general equality obligation is not founded in law.

**Inclusive participative engagement**

[22] O'Cinneide, C. 2007, *United Kingdom Country report on measures to combat discrimination*, Available at: http://ec.europa.eu/employment_social/fundamental_rights/pdf/legnet/ukrep07_en.pdf.

If you want to find out about need, you need to talk to people and that cannot be done, for example, on the basis of saying they are hard-to-reach communities. To say that is a cliché – there is no such thing as a hard-to-reach community, only hard-to-access services. We need to change that balance.

**Summary – service development**

Some key points in relation to service delivery:

- There is a need, in terms of implementation structures, for better transfer from policy to the frontline
- Better accountability processes mean moving away from the financial management of accounting systems
- Stakeholder involvement needs to be improved. This means not only communities and senior management but frontline workers as well
- A proper race equality guidance framework is needed. A few of these already exist; ENTA, the Home Office and T3E have produced very comprehensive guidelines
- Cultural competence – we prefer to talk about race equality and anti-racist service practice and tie that to democratisation. At the end of the day, it is about making a service as responsive as possible to differing needs and being able to respond to them properly. That has more to do with communities making claims for certain things and being able to resolve those claims fairly and equitably without reference to race or any other kind of stereotype
- There is a need for more review and evaluation involving stakeholders

## A service delivery view of equalities

*Jac Ross, Corporate Inequalities Manager, Greater Glasgow and Clyde Health Board*

By way of context, the Scottish National Alcohol Plan defines the equalities groups as "a range of different groups, reflecting diversity in race, disability, sexual orientation, language, social origin and religion that may experience inequality or discrimination."[23]

A definition of institutionalised discrimination, adapted from the report on the Stephen Lawrence Enquiry, is:

"(T)he collective failure of an organisation to provide an appropriate and professional service to people because of their race, gender, disability, age, sexuality, faith or other characteristic. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people."[24]

### What we know

We know that reported drug use in black minority ethnic (BME) communities is less than in white communities in Greater Glasgow and Clyde. However, we know that the patterns and trends, methods and quantity of consumption are similar. It is believed that drug use is increasing within BME communities.

We know that BME communities, for the same range and complexity of reasons as white communities, use drugs because:

- they are bored
- they want to do something exciting
- they are doing something that their peers are doing
- people are disenfranchised from society
- there are interactions with poverty

We also know that BME communities have poorer access to services. There are barriers in language, barriers of trust in services and barriers of perception (perceived as 'white', services that are seen as 'not for us' by the communities). People from BME communities are less likely to use services. Anecdotal evidence suggests that people from some communities wait until they reach crisis point, particularly relating to alcohol, before presenting themselves at GP services.

### 2025 - A futures focus

[23] Scottish Executive. 2002, *Plan for Action on Alcohol Problems*, Available at: http://www.alcoholinformation.isdscotland.org.
[24] Greater London Authority. 2005, *The GLA equality and diversity policy statement*, Available at: http://www.london.gov.uk/gla/.

What would 2025 be like in an ideal world?

- Our services would be accessible
- Our services would be culturally competent - all staff would be competent in intervening appropriately, where necessary
- There would be black specific services to accommodate specific need
- Treatment options would be culturally appropriate and we would know what they were
- The needs of a diverse community would be considered when designing services
- Services would be seen as available to everyone
- There would be trust between the services and the communities they serve
- Language would no longer be a barrier to accessing services
- The fear of being stereotyped by service providers would not be an issue
- The links between structural issues such as poverty and racism in addictions would be well understood and used to drive our prevention agendas
- Media messages would reflect the needs of and represent diverse communities
- Upstream activity would increase to reduce the number of BME people using drugs and alcohol as a consequence of social isolation and stress.
- Poverty and unemployment in the black community would be as low as in white communities.

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Why is it not like that now? After all, we have had the Race Relations (Amendment) Act[25] for a substantial length of time. Evidence from service workers in the addictions field in Greater Glasgow and Clyde suggests:

- There are not enough resources to work with the black community
- It costs too much to provide services at this level
- The necessary skills don't exist to work within the black community
- There is a lack of understanding of the issues
- Service providers are too busy doing their day-to-day jobs

We strive for cultural competence, but what is it? It means that time should be spent to know and understand the communities being served better and to put that knowledge to use in delivering services. It becomes about detail.

- If only I knew who ate halal and what that was about
- If only I knew why people prayed at certain times and what that was about
- If only I knew why certain women did this and other women didn't do that

At the core, we need to recognise and accept that our services reflect a society of discrimination and challenge that. We need to put the legislation, and our compliance with it, at the centre of our services. Often cultural competence becomes a tick-box exercise. It needs to go deeper. We need to think of ways to help communities access services better, communities that might think, for whatever reason, that these services are not for them.

[25] Race Relations (Amendment) Act 2000.

This is not an issue about setting up specific services, across the board, for BME communities; this is about developing confidence and skills in staff in delivering services to the BME communities. We need to integrate a diversity model into the planning of our services. We need to start by saying, "how do we actually plan our services?", and "how do we plan them to make them inclusive to all?".

We need to design our services as flexible and responsive to all because we have a changing population. Just when you think you have it right in terms of cultural competence, they go and change the population. If only the population would stay the same! If only everybody used the same drugs all the time! Our population changes in lots of ways: the drug using pattern changes, the ethnicity of our population changes. So what we need are services that are able, at their core, to be flexible and responsive.

We need to reject the notion that we treat all service users the same because we don't. Treating all service users the same means that your ethnicity doesn't matter, your gender doesn't matter, that being brought up in poverty doesn't matter. Of course, the reasons people take drugs are individualised. Taking a blanket, colour-blind approach to treatment is not good enough. At present, people are getting a service that we have made up for some 'neutral person' who actually doesn't exist.

If we were designing an inclusive model from scratch, what would it look like?

- We would ensure that the BME communities' issues are represented in strategy and policy drivers
- Much research has been done and questions are being asked about BME communities as the service is being developed. We would have BMEs represented from the start
- Equality would be built into the core of the service, not bolted on and then seen as an extra burden on staff to implement
- A training plan would be in place for staff
- Better monitoring of ethnicity would exist
- A lead practitioner for BME issues should exist in each of our services to try and link across good practice
- There is a need to develop outreach and community engagement to promote services because people from black communities need to know that the services are there for them and that the services when they get there will be appropriate for them
- People should be encouraged to use services
- Resources should be available to promote the services appropriately

## A view on the Polish migrant experience

*Zosia Wierbowicz-Fraser, Chair, Inverness Polish Association*

**This last section has been lightly edited and is reproduced as a personal, moving account of the experiences of some Poles living in Scotland and some of the barriers to accessing services.**

Thousands of Poles have come to Scotland and they have brought their habits with them. The only cure for loneliness, isolation, being cut off from services, from accessibility, from being stigmatised as a drunk or a druggie is through booze. It is part of our culture. Vodka is dirt cheap: the last time I was in Poland, you could buy vodka in roadside kiosks at 20p for half a litre. Just think what you can do with a couple of litres.

So Poles come here and they find that their earnings are considerably higher, but they are working in mindless, conveyor type jobs. We have people who are studying for PhDs who are processing fish 11 hours at a time. We have people who are construction workers or who are washing the floors in Tesco who used to run their own building firms. We have high-powered consultant medics, high-powered intensive care trained nurses and dentists who cannot get a job. I have to congratulate the NHS because they have made a move into producing written information on how to register with a doctor. However, as far as accessing services, it is pretty well impossible unless there are maybe a handful of people like me who have both Polish and English and can understand the spirit and pride of a Pole.

These are real facts, these are the real people. I have begged Highland Council, I have begged the NHS, I have begged the social services, the housing department – I am sick and tired of saying please help us, please stretch out a hand and put in place some kind of infrastructure that will allow the Poles to show you what they are capable of and give back what they have acquired through working in this country.

We are proud people, we are ambitious. We don't want to take charity. We are here to make a good life for ourselves and our families and to show the Scots that we really can do as well as they can, if not better. And this is where our pride comes in. Employers often stereotype the Polish and may think 'Pole equals slave labour and minimum wage'. Poles do not feel they are understood. They are not going to come to you as a Pole and say 'I have got a problem'. They are not going to talk about alcohol abuse - I drink like all my friends drink. I don't have a problem. One guy I found out had 15 empty bottles of vodka in his bedroom and that was three days' worth of drinking. He doesn't feel he has a drink problem. He doesn't see that the outreach services from NHS Highland and the various counselling systems are for him because they are in English. There are not enough of us with good enough English who can give up our lives to help people like that. We don't have a massive drug problem yet. I am scared that our young people will pick it up because they are seeing the Scots kids taking part in this.

But booze is another issue altogether. The Poles drink like fish. It is part of our culture. We eat funny food. We eat beetroot soup which is wonderful, we eat

marinated herring, we eat huge quantities of everything and at every course; Christmas Eve is our big festival, one of them, and we have 12 courses of food and every course is followed by vodka. Nowadays, we have become more civilised in this country, we just drink wine but over there it tends to be vodka because it is most readily accessible - it always has been. It was the same in Soviet Russia. Getting Poles to admit that they have a problem is a huge difficulty. Getting them to access housing services is well nigh impossible.

Has anybody seen the Highland Council's application form for housing? It is hugely complicated. The same with the Inland Revenue. I have asked Inland Revenue workers to come and talk to the Poles. We have an open meeting once every month where the Inland Revenue could come and talk in general terms about how to fill in tax forms and what is required in this country, but they refused. They wouldn't give me a reason.

For Job Centre Plus, you work through an internal interpreter service. You book an appointment with an interpreter, who is somewhere in the central belt, to get a national insurance number. So you speak by phone to somebody, and you try and make yourself understood in Polish to a Pole who very often doesn't know what you are talking about but who is supposed to be trained.

Our access to services of any kind is well nigh impossible. It is easy for me. I was born in this country. I know how the systems work, but for a Pole coming in from Poland it is extremely difficult and more so if you have a sexual problem or a health problem. If you have got a personal emotional problem or an intimate sexual problem, it is hugely difficult to talk about it to a doctor through an interpreter. Poles would rather curl up and die. So they phone Auntie or somebody in Poland and they get the medicines that they had three years ago sent across. That is how it is done. It is not a fault of the NHS – they have done what they can. But it is the people themselves who feel stigmatised.

So Poles are frightened and, for that reason, they are scared to approach services, because if you are approaching services it means you weren't listening during the classes that you should have been listening to, you weren't paying attention.

Poland is bound hand and foot to the Mother of God. The people are poor. No matter how hard you work in Poland, you are never going to make it. So what I want from you is help in setting up some kind of drop-in centre.

This was prompted when I was called as a translator to Rigmore Hospital a couple of days ago to a guy who was brought in as an emergency admission, into A & E. He was a serious alcoholic. He hadn't been drinking, but he was so bad that he couldn't make himself understood. He was sacked three times for being drunk in his job. His friends had abandoned him because they were frightened that because of their association with him they too would be sacked. This is quite common amongst employers, as well as amongst landlords. You step out of line once, you complain once too often, you turn up drunk or you are a friend of the drunk, you get sacked. Why? Because there are 10 other Poles waiting to jump into your shoes. So you can afford to be choosy: as an employer you can exploit these people just as you can if you are a landlord.

This Pole said to me, “Do you know what I really need? I need to sit down somewhere in a corner of this room and talk to some Poles that understand me”. So I am asking for your help; to help set up a drop-in centre where they can access online drugs information, online self-help groups. Where we can help them get back their self-esteem. Where they can start their own businesses. We have huge numbers of qualified trades people who ran their own companies in Poland which fell apart through financial difficulties. A meeting place for Poles here in Scotland is much needed: a place where they can meet others like themselves, get back their sense of self-worth and start to behave as they want to and be accepted as Scots.

## Chapter 3

## Public Information and the Hierarchy of Harm: Are People Getting the Right Messages?

# Section 1: Based on the comments of Dr David Shewan, Research Director, Glasgow Centre for the Study of Violence, Glasgow Caledonian University

### The context

In this subject, it is important to talk not only about reducing drug-related harm and alcohol misuse, but also reducing drug use and alcohol use.

While the hierarchy of harm index[26] is a very handy reference, it is, of course, only that. It cannot unpick the wider context in which substances contribute to their use or misuse.

For example, in Cornton Vale Prison, there are very high levels of drug use,[27] very high levels of destructive behaviour, including self-harm. However, the overwhelming impression from Cornton Vale, and the prisoner population, is that of difficulties with mental health and all kinds of social and personal problems which they arrive at jail with. It may also be that drug use increases at that point (when problems increase).

It is important to recognise the range, depth and scale of drug-related problems associated with drug use, which will affect people in different ways. This is the case at an individual level, as well as at a social or economic level.

There is recognition of the seriousness of drug use and misuse. People get hurt using drugs, which has tragic effects. However, most drug use is not like that, and it can be argued that most drug use is relatively non-problematic.

While the *Lancet* article[28] is a very good piece of medical writing, there are problems with the way it baulks at tackling the issue of people's personal choice and people's personal responsibility in using all the drugs in the hierarchy.

### The media and the wider debate

In terms of the media, drug use seems to move back and forth between being something of interest and something of concern. Of course, there is the celebrity interest, but actually most headlines revolve around the impacts of drugs and alcohol misuse, poverty, crime, health, suicide, domestic abuse and sexual offences. We cannot simply ignore this context and focus on particular drugs to the extent that we

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[26] Nutt, D. Et al. 2007, 'Development of a Rational Scale to Assess the Harm of Drugs of Potential Misuse', *Lancet*, 23 March 2007.
[27] Scottish Prison Service. 2003, *Nursing Services Review,* Available at: http://www.sps.gov.uk.
[28] Nutt, D. Et al. 2007, 'Development of a Rational Scale to Assess the Harm of Drugs of Potential Misuse', *Lancet*, 23 March 2007.

can forget things such as 14-year-old mothers. To lose sight of the wider social context while we debate a hierarchy of drugs would be wrong.

**The pharmacentric view**

The medical approach is as useful as any other. However, we have to remember that this approach puts chemicals, or indeed a plant, at the centre of how we understand drug-related behaviour. According to this model, drugs would make people do things that they would not normally do. This is not necessarily the case. The idea that drinking alcohol makes people violent seems to be gaining some acceptance recently. There is a desperate urge to find a substance that makes people do things that they don't usually do.

When we examine the characteristics of the individual user and the immediate and broader setting in which the drugs are used, we start to see the interactions much clearer than we would with a medical model. We would expect the philosophy of medicine to oppose that of social science. They contradict, not entirely, but they contradict in one crucial aspect: looking at the drug itself and making that the focus of what happens next, giving it those properties, those causal rights.

**The Barlinnie example**

Barlinnie Drug Rehabilitation Project was set up in 1996-1997. Barlinnie Prison has had more than its fair share of heavy drug users and problematic drug users. In his project, the Governor, in collaboration with external agencies, picked and trained his most suitable staff for the project. They committed time and resources to setting up the project, but it folded within months. It did so because, while prison staff talked with prisoners about drugs very quickly, they did so in a very matter-of-fact way. The difficulty and the burden for this project, and something that staff, prison management and the Scottish Prison Service could not sustain, was in dealing with prisoners' tales of childhood abuse, serious mental disorder and tales of self-harm which had never been described to anybody before. The issue of drugs quickly fell away from the agenda.

**Conclusion**

Of course, the answer is to provide all sorts of support, treatment and intervention programmes for people who are in trouble with various aspects of their lives, including drug use. However, we must move away from looking only at somebody's drug use to the broader issues. Investing much more in understanding and treating mental health would be a very good step.

The hierarchy index is very easy to use. However, can anyone say whether depression should be higher than anxiety disorder? That sort of comparison would probably be viewed as rather tasteless and unhelpful.

The things we are doing we should be doing better. It can be argued that the Misuse of Drugs Act[29] has probably served its purpose and we are better off without it. When

[29] Misuse of Drugs Act 1971.

we talk about harm we could talk about the harm involved in arresting people for their drug use, for their drug possession. We could talk about the harm to people, who are otherwise law-abiding, productive, valued members of society, in putting them in jail and giving them a criminal record. These are harms which may not be covered in *The Lancet* article and which should be raised.

## Section 2: Based on the presentation of Dr Peter Rice, Consultant Psychiatrist, NHS Tayside

### Context

Achieving the target of reducing damage by half over the next 20 years can only be done by work at a population level. While work with individual clients is effective – and cost-effective – there would have to be an enormous amount of work with individuals in order to achieve this target on a one-by-one basis. The capacity of alcohol services in Scotland does not currently allow for this. It is unlikely that work of the type reflected in *The Lancet*[30] paper is going to help us to reach the target either.

One of the problems of the hierarchy of harm approach in *The Lancet* is the half-hearted attempt to place drugs and alcohol in the same context. *The Lancet* paper says that tobacco and alcohol were included in this ranking of the serious use of drugs because of their extensive use, producing reliable data on the risks and harms. However, the paper states that "direct comparison of the scores for tobacco and alcohol are not possible". Alcohol and tobacco are thus being used here to elucidate some of the issues concerning illicit drugs. That is an inadequate and unsatisfactory way to look at alcohol. It is a recipe for perpetuating the poor relation status which has been so prevalent in discourse on substance use.

We need to look at alcohol and tobacco as substantial problems in their own right, which need responses in their own right, particular to their place in society. Using alcohol in the drugs discussion may be helpful in finding bearings, but alcohol should not simply be used as a kind of make-weight in a process which has its main focus on illicit drugs.

### Long-term health impacts

The Forum's project question is how to reduce alcohol-related damage in Scotland by half within the next 20 years. Is that achievable? The most reliable indicators we have to allow comparisons are health data on hospital admissions, rates of alcohol-related diseases and deaths. This type of harm has doubled in the past 10 years[31], so achieving this goal would mean us turning the clock back just a decade.

These increases in alcohol-related health harm are taking place at a time when Scotland's health generally is improving. We are seeing falls in both heart disease and

[30] Nutt, D. Et al. 2007, 'Development of a Rational Scale to Assess the Harm of Drugs of Potential Misuse', *Lancet*, 23 March 2007.
[31] Based on figures from ISD Scotland (SMR01) and GRO(S) (mid-year population estimates).

cancers[32] [33], so alcohol is becoming an increasingly significant contributor to poor health in Scotland.

It's important to recognise that our use of, and attitudes to, alcohol aren't fixed. They change a lot over time, and it is a myth to suggest that Scots have always been heavy alcohol users. Because excise duty has been collected on alcohol for a long period of time, we have consumption data which goes as far back as the 1690s. What we see are very high levels of alcohol consumption in the pre-industrial revolution and a marked fall in alcohol consumption at the start of the twentieth century, followed by a rise from the 1950s until the present day, with a marked increase in alcohol consumption from 1970 through to 2005.[34]

Over time, in terms of consumption, the relative proportion between beer, spirits and wine has not changed much, but wine consumption increased in the 1970s.[35] In recent years, cider has been the big growth drink, particularly for young people. The cider industry is the fastest growing part of the alcohol industry. Affordability is likely to be a big factor in this. The duty that is paid on a bottle of 7.5% cider far less than that paid on 7.5% beer. This allows strong cider to be marketed as a cheap drink and, in my experience, white ciders have been the drink of choice among those with the most serious alcohol problems for the past 10 years.

A major frustration in analysing drinking trends is that consumption for excise duty purposes is analysed on a UK-wide basis. The localised data which producers and retailers collect, which is extensive, is not available for analysis.

**Alcohol and age**

Scottish alcohol-related harm, based on hospital admissions, suggests men drink more than women do and go into hospital at about three times the rate that women do.[36]

Young people's admission rates are actually falling, but admission rates for the over 45s are rising. For instance, in Ninewells Hospital, Dundee, in 2002-03, 130 people under the age of 24 were admitted with an alcohol-related diagnosis compared with 132 over the age of 65[37]. This trend is consistent across Scotland. There are more people over the age of 65 coming into hospitals with alcohol-related intoxication harm than people under the age of 24. This group is now starting to be known as the "saga louts", those older people who are running into increasing problems with their drinking.

**Alcohol and deprivation**

[32] Scottish Executive. 2006, *Health in Scotland 2005*, Available at: http://www.scotland.gov.uk/Publications/2006/10/30145141/0.
[33] Scottish Executive. 2004, *Coronary Heart Disease and Stroke in Scotland Strategy Update 2004*, Available at: http://www.scotland.gov.uk/Publications/2004/12/20325/47432.
[34] HMRC. 2007, *HMRC Statistical Factsheet on Alcohol Duties*, HMRC, London.
[35] Ibid.
[36] Based on figures from ISD Scotland (SMR01) and GRO(S) (mid-year population estimates).
[37] ISD Scotland. 2005, SMR01.

While we do not fully understand it, there is a heavy weighting in alcohol-related deaths towards the most deprived groups. Men have death rates almost five times higher in the most deprived parts of our community than in the wealthiest parts of our community.[38] That is hard to explain because it is not reflected in alcohol consumption patterns across society. Wealthy men drink more than men in the poorest categories and, in particular for women, there is a strong association between income and alcohol consumption. The basic science tells us that cirrhosis of the liver is mostly due to the amount you drink over your lifetime, so why emerging Scottish deprivation data does not fit with that pattern is something that needs more public health and basic science research. It may be to do with the way data is collected, but it is hard to imagine that would explain the discrepancy on its own.

**Scotland's place in the world**

However, the fact remains that Scotland's liver cirrhosis rates for men aged 45-64 rapidly took off from the early 1990s onwards.[39] What is interesting is that this pattern is not the same in other countries.

Scotland appears to be in a particularly bad position, so when *The Lancet*[40], arguably the single most important medical journal in the world, says in a leading article that Scotland is in a uniquely bad position with regard to cirrhosis of the liver, we need to stop and take notice. For instance, looking at Australian measures of alcohol consumption and alcohol deaths and alcohol hospitalisations from 1990, you see that the number of deaths from alcohol-related illnesses is slowly falling.[41] The trends that we have seen in alcohol-related harm in Scotland are not universal. In fact, the UK, and in particular Scotland, appears to be out of step with Western Europe and other developed countries.

Why might that be? The World Health Organisation undertook a major piece of work four years ago called 'Alcohol: No Ordinary Commodity'.[42] It looked at the factors that influence rates of alcohol-related harm in the community, split into six broad areas:

- pricing
- availability
- safe drinking measures like service and safer glasses
- treatment interventions
- regulating ads and promotions and information, such as school-based education
- labelling on products.

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[38] Scottish Executive. 2005, *Scottish Health Survey 2003*, Available at: http://www.scotland.gov.uk/Publications/2005/11/25145024/50251.
[39] Leon, D.A. & McCambridge, J. 2005, 'Liver cirrhosis mortality rates in Britain from 1950 to 2002: an analysis of routine data', *Lancet*, 6 January, 2006.
[40] Ibid.
[41] Chikritzhs, T. Et al. (2003), Australian *Alcohol Indicators, 1990-2001; patterns of alcohol use and related harms for Australian states and territories*, National Drug Research Institute, Perth, Western Australia.
[42] Babor, T. et al. (2003), *Alcohol: No Ordinary Commodity. Research and public policy*. Oxford, Oxford University Press.

Falling prices and easier availability were found to be the most important drivers in the amount of alcohol-related harm a community faced. Safer drinking measures, such as server training and good public transport home, had a mid effect, as did treatment. Regulating advertisements and promotions had very little effect as a stand-alone measure. The most popular intervention – increasing information, including schools-based education – consistently appeared to have had a low effect.

There are some particular types of education and information driver processes that are perhaps a little more effective than others. In Scotland, the Scottish Association of Alcohol and Drug Action Teams (SAADAT) is continuing work with Health Scotland to look at a process called 'media literacy'. This project is aimed at helping young people in particular develop resistance skills to various kinds of alcohol promotion. That seems to have a rather better effect than the 'this is bad for you' kind of message. Despite the lack of evidence for effectiveness, we currently have a lot of enthusiasm for product labelling as a harm-reduction measure.

**Labelling**

Labelling as a harm-reduction measure is unlikely to work. Since the introduction of strength labelling of alcoholic drinks in the UK, stronger drinks have increased in popularity. The most popular beers are now 5%. Wines have drifted up from 9% or 10% volume to 12%, 13% or 14%.

This does not support the suggestion that knowing the strength makes people drink 'more responsibly'. On the contrary, it suggests that strength labelling increases alcohol consumption as people focus on 'getting their money's worth'. It would be helpful if there was open access to the sophisticated sales data held by producers and retailers.

Perhaps the best we can hope for in labelling is to try to put the strength into some kind of context. For example, 'a man drinking this can of super strength lager will be consuming his safe daily limit'. In my view, it would be a serious mistake to think that strength labelling or information on alcohol unit content will reduce alcohol-related harm.

The affordability of alcohol has increased by 50% over the period since 1980.[43] While the price of alcohol relative to other goods has not changed much during this time, in affordability terms, people have become more prosperous, meaning alcohol is much more affordable.

In Australia, there is a rather different pattern. There, the excise duties on alcohol are tied into average income so the cost goes up automatically. Nobody wins or loses votes in Australia by freezing alcohol duties. It is not a political decision, it happens automatically. This has led to prices keeping pace with incomes. In the UK, alcohol is not just becoming cheaper, it is becoming very much cheaper in particular settings,

[43] Office for National Statistics. *Focus on Consumer Price Indices*, Available at: http://www.statistics.gov.uk/cci/nugget.asp?id=181.

and especially in the off-sales trade and in supermarkets. Arguably, these are the places now driving alcohol sales.

**On- and off-sales trade pricing**

At the start of 2006, the *Sunday Mail* ran an article looking at how prices have changed in alcoholic drinks between 1976 and 2006:[44]

- a 37p can of lager would have cost you the equivalent of £1.36 in 1976
- a bottle of gin which now costs £8.50 would have cost you £30
- a bottle of vodka would have cost £30
- a bottle of wine would have cost £14

However, in pubs a pint at £2.20 would have been about £2.96. There is not such a big difference in the on-sales trade, therefore, but a considerable fall in the real cost of alcohol in off-sales trade – and that has an effect on overall alcohol consumption.

**Prohibition**

If we were to come up with an intervention which produces the effect of reducing alcohol consumption by half, cirrhosis deaths by a third and domestic violence by 90%, we would be pleased. These were the results of US prohibition, which is now regarded as a great failure. While many assume prohibition failed, in public health terms, it worked very well. The history of prohibition and temperance in the US and the UK has been widely misrepresented. In public health terms, they had considerable success and were popular among many in the community.

In Scotland, the temperance movement was part of a drive towards social improvement and political emancipation. During the Licensing (Scotland) Bill debate in 2005, Wendy Alexander reminded the Parliament that Kier Hardie, the founder of the Labour Party, stood on a platform of home rule, proportional representation and temperance[45]. The first two have been achieved, but has the third?

**Conclusion**

How do we reduce harm by 2025? Work with individuals and families needs to continue. However, these efforts will be drops in the ocean compared to the big, cultural, broad population trends that need to be addressed. The arguments that harm and alcohol use do go together are powerful. There is no silver bullet solution to sort out those who have problems with alcohol, leaving everyone else free access to alcohol. No community or country in the world has managed to do that.

Other countries have faced these problems recently, but they have dealt with them much better than Scotland. Scotland needs to learn from its history and it needs to learn from other places.

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[44] 'Our Booze is Cheaper than Water', *Sunday Mail*, 15 January 2006, p. 1.
[45] Scottish Parliament, Official Report 16 November 2005, Available at: http://www.scottish.parliament.uk/business/officialreports/meetingsParliament/or-05/sor1116-02.htm.

## Section 3: Based on the comments from Dr Laurence Gruer, Specialist in Public Health

### Context

In the first section, it was argued that the harm from illegal drugs is perhaps exaggerated and there is a need to focus on the underlying problems of people. In the second section, a case was made that the harm from alcohol has been under-emphasised.

This section will look at some advantages from the hierarchy of harm compared to the present system.

The Misuse of Drugs Act in 1971 was designed to be a rough A,B,C of classification of harm to health and also social harm. It includes in the highest classification of harm (Class A) heroin, cocaine and ecstasy. Class B, which is supposed to be intermediate, contains amphetamines and barbiturates. Class C includes cannabis and benzodiazepine tranquillisers. What it does not cover are the two very common and powerful legal drugs, tobacco and alcohol.

### Hierarchy of harm

David Nutt and Colin Blakemore et al[46] have tried to reassess this whole system to bring, in terms of policy, a way of classifying these psychoactive drugs that may be more contemporary. They have devised a three-level scale based on three different aspects of drug-related harm:

- the physical harm that drugs cause to the bodies of the people who are taking them
- the notion of dependence or addiction, the extent to which drugs distort people's decision-making processes and make drugs something that they have to use on top of everything else
- the broader idea of the social harm that drugs cause to the individuals involved, to their families and to communities

They looked at physical harm and divided that up into three different components:

- the immediate effect of the drugs, what they do in the short-term: making you drunk, making you vomit, making you develop delusions – all sorts of things that happen straight away
- the chronic effects that happen over a longer period of time when someone is taking drugs over months or years, and how it affects the body in numerous different ways
- intravenous harm, which they particularly singled out: the effects that injecting drugs into your body can bring about in a fairly distinctive way, focussing on

[46] Nutt, D. Et al. 2007, 'Development of a Rational Scale to Assess the Harm of Drugs of Potential Misuse', *Lancet*, 23 March 2007.

things like blood-borne viruses, HIV, Hep B and C; and also the effect of an overdose, where the drug comes straight into your brain and can knock you for six in terms of stopping you breathing, stopping your heart beating and causing death immediately

Then they looked at dependence and they came up with three different dimensions to dependence:

- the intensity of the pleasure that it causes, when you love the stuff so much you want to come back to it again and again
- the psychological dependence, where you find that the stuff is so important to you that you really have to have it
- the physical dependence, where something actually happens to your body so that if you don't have these drugs then you start feeling so unwell physically that you feel obliged to have more of them.

Then they looked at three different dimensions of social harm:

- the harms to society of people going around intoxicated by drugs
- a range of other social harms that might relate to things like violent behaviour, neglect of children, the break-up of marriages and financial problems
- looking at the cost of the health care system and the wider social care system of looking after people who have fallen foul of the drugs

They then used these ultimately nine dimensions of harm to see whether they could devise a scoring system 0 – 4, where each of these nine variables would be rated by experts of various sorts. The aim was to see whether there was some consistency and consensus that could be arrived at. Two groups were involved in this exercise. One was a group of addiction psychiatrists and the other was a mixture of people with backgrounds in pharmacology, biochemistry and sociology. The exercise included a range of different ways of looking at drugs from different perspectives.

They found pretty broad agreement between these different experts. They looked at a total of 20 different drugs and they ended up by averaging all these scores to come up with a single for each drug. They then used this data to devise a league table of different drugs which can be compared to the current classification system.[47]

At the top are two Class A drugs (heroin and cocaine), but then in the top 10 there are a number of other drugs which are lower down in the Misuse of Drugs classification or, in the case of alcohol, at number 5, and tobacco at number 9, which don't appear at all.

In the 11 – 20 section, cannabis appears at the top, followed by solvents, which aren't currently classified, and then ecstasy, at number 18, which is currently right at the top in Class A.

[47] Misuse of Drugs Act 1971. Details of the classification are available at: http://www.homeoffice.gov.uk/drugs/drugs-law/Class-a-b-c/.

The 'scale of harm' certainly gives some justification as to how it was arrived at. While recognising the view that the present system is irrational, there are grounds for believing that the new systems is, from a scientific view, more rational and consistent.

**Implications of a new scale for reducing harm?**

The new scale certainly takes account of the volume of harm that different drugs cause. It has already been argued above that perhaps the amount of harm caused by illegal drugs might be exaggerated and the amount harm caused by alcohol is insufficiently emphasised.

Another drug which features is tobacco, with currently about one quarter of the adult population in Scotland addicted to nicotine. It comes out as number 3 in the index of harm in terms of dependence and, according to a recent study that my organisation carried out in Scotland, 24% of all deaths are attributable to tobacco.[48] So there is a correlation between tobacco's ranking and the volume of harm, in terms numbers of people and the seriousness of the consequences for them.

Alcohol is associated with a large degree of violence. Whether the violence might have happened if people weren't drunk is a matter of opinion perhaps, but there is a very, very strong association with alcohol. About one in three prisoners in Scotland have serious alcohol-related problems, probably a little bit less than those who have hard drug problems. Heroin is associated with a very high proportion of all property crime in the UK, as well as most fatal drug overdoses and most blood-borne viruses. It is certainly very appropriate to argue that if heroin becomes a legal drug, you would not get nearly so much property crime. But in the current scheme of things it is the cause of a huge amount of social harm.

Cannabis is Scotland's most popular illegal drug at the moment and, interestingly, it appears that the prevalence of use among young people has been declining somewhat in the period since it was reclassified from B to C. It is also apparent that there is a rising number of people coming into drug services who have cannabis dependence as their main drug problem. There may be a decline overall, but there seems to be a hard core of people who are becoming really quite heavily dependent on, and harmed by, heavy cannabis smoking.

**Options for reducing harm**

The range of options to reduce drug-related harm is relatively limited; the sky is not the limit.

There is the possibility of (i) changing the legislation, (ii) changing the taxation regimes and (iii) changing the regulations (a very large part of how drugs of various sorts are currently dealt with in society).

Moral codes, in various parts of the world, determine the level of drug misuse. It is interesting that in many of these situations it tends to be particularly among women

[48] NHS Health Scotland, ISD Scotland and ASH Scotland. 2007 *An Atlas of Tobacco Smoking in Scotland*, NHS Health Scotland, Edinburgh.

that drug misuse is remarkably low. For instance, in China there is a huge disparity between men's and women's drug use. This is often driven by a moral code. Moral codes can work in some senses, but they come with other societal issues.

Public education can play a significant part in trying to help people to realise what they might be doing by using drugs. Can professional training be used to make people better able to deal with the problems when they arise? There are a number of health and social care interventions that can be deployed, either to prevent certain harms taking place, such as needle exchanges for tackling HIV and Hep C, or to help people overcome their addiction before it gets too bad. There is also a range of safety measures which can be put in place such as replacing glass with plastic in pubs.

There is a significant amount of evidence on what can work. It is interesting to see that with the two legal drugs, tobacco and alcohol, most of the evidence around success, in terms of reducing harm, does tend to come as a result of increasing control, increasing the price of tobacco and increasing the restrictions on how it is marketed. This works alongside getting through to people how harmful tobacco is.

In terms of alcohol, there is a lot of information about what works, and it tends again to focus on control: increasing prices, restricting the market, enforcing drink driving laws. There is also a clear place for public education through successful initiatives like 'don't drink and drive'. However, this can only go so far. Looking at the vast number of kids who are drinking at a very young age, it is clear that despite the general sense that alcohol is bad for you, the message doesn't really seem to get through.

With heroin and other injected drugs, specific needle exchanges certainly have worked in cutting down HIV, but not necessarily Hep C. Methadone has proved to be, in certain cases, the most cost-effective of all health care interventions and rehabilitation, provided it is done properly. It does help significant numbers of people come off drugs altogether, but not really as many as one would like.

So there are a number of ways in which evidence shows that, if things are done properly, comprehensively and with sufficient resources, then they can reduce harm.

**What doesn't work?**

Neither prohibition on the one hand nor a totally free market on the other is the answer. It is doubtful that in today's society you can realistically ban something like alcohol. Nor can you contemplate liberalising the way in which drugs are used. Somehow a middle way must be developed between these two extremes to give us a balanced approach, a better balance than we have at the moment.

**So where do we go from here? Seeding the discussion**

Are we going to advocate more or less or different legislation and controls from those that we have at the moment? And, if so, where will we focus our energies? Are we going to advocate more education in schools, more public information? We are currently exposed to an unrelenting river of information every day. The amount of

public information that we can squeeze in is obviously limited, so if we are going down that road, how are we going to proceed?

- Can we somehow develop some sort of cultural evolution or revolution?
- Can we go back to the temperance days?
- Can we mobilise people in a moral crusade against these drugs – is that feasible in today's society?
- Can we get back to the basics of professional training so that clients are better able to pick up the problems when they arise?
- Can we use more health and social care interventions?
- Can we deal with underlying problems so that people don't feel the need for drugs?

In a sense, these are all on the menu, different possibilities that we have to consider. I don't think there are many other options. We have to find some way of judiciously rearranging how we go about doing things in order to reduce harm.

Is there a less harmful middle way? If so, how do we identify it and what do we do to get there?

## Chapter 4: Alcohol and Drug Treatment: Up Close With Holland

## Based of the presentation of Vincent Hendriks, Senior Researcher, Parnassia Addiction Research Centre and Central Committee on the Treatment of Heroin Addicts

In terms of the project question, the Netherlands has perhaps some answers. However, obviously, there is no single answer to something as complex as addiction. There are many countries struggling with very similar problems to Scotland.

I want to tell you about:

- the prevalence and the coverage of the treatment system in the Netherlands
- the scope of the treatment system in terms of the facilities that exist
- what treatment is offered in the Netherlands
- what the most recent trends and treatment demands are concerning cocaine, heroin, cannabis and alcohol-related problems
- three innovative programmes that started in the second half of the 1990s concerning evidence-based treatments and research to improve addiction care in the Netherlands
- medically prescribed heroin

**Prevalence of regular use in Holland**

It is striking that, for the two substances we allow as a society – tobacco and alcohol – the treatment system offers the lowest provision. The coverage relating to heroin and cocaine treatment is quite high – one of the highest in Europe.

There are 10 million regular drinkers of alcohol in our country, where we have a total population of 16 million inhabitants. There are an estimated 350,000 people with alcohol dependency, of whom approximately 10% go to treatment each year.

There are an estimated 60,000 regular cocaine users, half of whom are addicted. There are 18,000 in treatment and the majority of these 18,000 who apply for treatment are crack addicts.

In total, the addiction care treatment system includes 18 clinical facilities, sometimes part of a psychiatric hospital, and 10 outpatient treatment facilities. The addiction care treatment system has become a big business with 4,000 full-time equivalents working in addiction care. It is estimated that there are 65,000 patients who are reached by the treatment system each year. The majority of these are treated for alcohol addiction, but a substantial number are treated for primary drug problems, mainly heroin and cocaine.

**Expenditure relating to addiction services**

The total estimated spending in Holland on services is about 550 million Euros per year, of which 42 million Euros are spent on prevention, 278 million per year on

treatment and about the same amount on harm-reduction. Of course, there is a lot of overlap between treatment and harm-reduction. That compares to about 1.6 billion Euros per year in law enforcement, which includes costs to the justice system and police, and the costs of limiting the supply of drugs entering the country or being produced. It also includes compulsory treatment of people referred to treatment through the justice system.

If you look at the spending in the Netherlands and in Scotland, taking into account the different population size, the Netherlands has four times the level of alcohol- and drug- related expenditure, and spends twice as much on addiction treatment.

**Treatment options**

The Netherlands has quite a comprehensive treatment system including a range of options from long-term abstinence-oriented treatment, for example, in therapeutic communities, or residential treatment. It also has all kinds of harm-reduction measures, including needle exchanges, employment training, day and night care facilities and drug-user rooms. Of course, there is also methadone maintenance, which is still the best proven medical pharmacological treatment of opiate addiction by far, and heroin maintenance. Heroin maintenance is only targeted at a limited group of opiate addicts who previously failed on more usual treatments, for example methadone.

Treatment is voluntary in most cases. Those who commit multiple criminal offences can be directed by the court system to compulsory referral for treatment.

Each approach is offered by the Parnassia Addiction Research Centre under one roof. There is a psychiatrist, drug user rooms, therapeutic communities, detox facilities, in-patient housing for addicted mothers with children, and also heroin maintenance programmes. Even within one organisation, quite a comprehensive treatment service is offered.

**Treatment demands**

From 1994 to 2005, the heroin population treatment demand remained quite stable. This population, while stable, is chronic and ageing. There is a low incidence of new cases. The average heroin user in the Netherlands is 40 years old.

However, between 1994 and 2005, there was a big increase in treatment demand for cocaine-related and cannabis-related services. With an average age of 24, those seeking cannabis services have the lowest average age. There are many adolescents in this group, which has led to the development of special treatment programmes based on family therapy for cannabis dependent adolescents.

**Drug-related deaths**

In Scotland, in 2006, there were 421 drug-related deaths due to overdose. In the Netherlands, there were 122 drug-related deaths in 2005, 60 of which were opiate heroin use related, 23 for cocaine and 39 for other substances.

What is very important to note is that the route of administration of heroin in the Netherlands is predominately smoking from aluminium foil and not injecting. This obviously prevents transmission of diseases like Hep C, B and HIV, but it is also directly related to the low number of overdoses.

In the second half of the 1990s, there were three major innovation programmes in the Netherlands which were very influential, both in terms of research and in terms of the addictions treatment system.

- **Scoring Results** started in 1990 and is still working to improve the care to addicted people on evidence-based principles. This involves referral of patients to certain types of treatments best suited to them, but also involves a view on the cost-effectiveness of the treatment option.

- **Stimulation Programme of Addiction Research** had a total budget of 23 million euros and is a programme which our research community is still profiting and benefiting from. Much of the research has been conducted around the generics of addiction and randomised controlled trials. This is really cutting edge, with studies looking at different aspects of career addiction, not only from the perspective of what this means for drug and alcohol policy, but also from the perspective of what this means for the way we attempt to treat and support people.

- **Randomised controlled studies** directly financed by the Ministry of Health looked into the efficacy of high versus low doses of methadone. In the Netherlands we had a long tradition of much too low dosing with methadone. These studies showed that the highly effective dose really starts at 80 milligrams of methadone per day for most patients. These studies also showed that anaesthesia did not add anything to the efficacy of detoxification: it has more side effects and it is more expensive, so the conclusion of the study was not to continue detoxification and anaesthesia. These studies were designed to improve the treatment practices based on routine outcome assessments implemented within the clinics and give feedback to the treatment services about their effectiveness.

In developing these innovative programmes, across the board in the Netherlands, the service agencies recognised that things had to improve; there was a national recognition of that. The major objective of the first programme was to redesign the intake and referral process on the basis of evidence-based criteria. As a result, a stepped care system was introduced. This allowed the matching of the patient to the type of treatment from which they would benefit most. Traditionally, studies have shown that only a very limited number of matching information variables exists. This programme involved referring patients on the basis mainly of cost-effectiveness to the lowest intensity of care from which you still expect sufficient results. This meant a low investment of money and the patient did not go into unnecessary intensive treatment. If it was felt that the lowest intensity care was not sufficient, they would be moved to the next step. There are four levels of intensity based on the stepped care model, which is a now a nationally implemented protocol. In terms of proper evaluation and cost-effectiveness, this programme is a good alternative.

At least 35 protocols have been produced with a guideline handbook. Evaluation has shown a high degree of acceptance and implementation of this programme, which was

only possible because it was felt to be a necessary national effort. This was a major breakthrough in the Netherlands. There was a shift from old addiction care models to modern addiction care, not based on hypothesis and models, but based on scientific evidence. It included not only abstinence-oriented measures but also measures to minimise harm, reducing risk both for the person in the direct environment and for society as a whole. This system blends a psycho-social approach with a pharmacological approach.

Very importantly, this programme was not based on isolated care, but on a much more integrated and co-operative care system between mental health, the justice system and the addiction treatment services.

**Controlled medical prescription of heroin**

In 1996, there were an estimated 28,000 heroin addicts, of which around 60-61% were in treatment. Of these, about three-quarters were in methadone maintenance treatment. Various surveys and studies investigating this methadone population showed that approximately 38% were integrated, did not use illicit heroin, were regulated, had good social integration and did not commit crime. However, a group comprising 23% were extremely problematic, illicit heroin users, often combined with crack cocaine use, and were repeat criminal offenders. This latter group, who had not benefited sufficiently from the available treatments offered (methadone, detox, therapeutic communities) became the target group for heroin treatment. This was a specially selected, limited target population.

The primary objective of the study was to test the effectiveness of one year of a combined pharmacological intervention of methadone plus heroin compared to the usual treatment with methadone alone. The study then looked at:

- the effectiveness in terms of what happens to illicit drug use
- what happens to the medical status of the group
- both physical health and mental health
- the level of social integration in terms of reductions of criminality, i.e. the level of integration and communication with the non-drug using population in society.

A cost-effectiveness study of both treatments was also conducted. The medical ethical board were concerned that people were effectively being condemned to a lifelong treatment with heroin maintenance. They also wanted to see what happened if the treatment stopped. This resulted in a special procedure for some people to stop the heroin maintenance programme in favour of traditional treatment options. Only people who deteriorated in the period after termination of the heroin treatment had the possibility of restarting the programme for the following year. This is still in place today.

**How did we define success?**

Success was judged to be if the 'responder' showed at least 40% improvement in physical or mental health or in social functioning compared to the start of the treatment with heroin. It is important to note that improvement in at least one of these

three areas should not be achieved at the expense of serious deterioration in another, such as an increase in cocaine use. (It was suggested that if you give heroin to people in treatment and they need cocaine too, they will probably spend their money on more cocaine.)

Heroin treatment was viewed as a medication study, so it meant that two medications had to be developed: a medication whereby heroin could be injected by people who usually injected heroin, but also medication that could be smoked or inhaled by people who usually smoked heroin, which is by far the majority of users in the Netherlands.

**Results of the study**

For the injecting group, according to the criteria set, 32% were deemed to be successful and responded favourably to methadone, compared to 57% who responded favourably to heroin treatment one year on. This represents a 25% higher success rate for heroin maintained patients. For the smoking group, according to the criteria set, there was a 23% increase in the success rate for heroin patients.

It can be observed, from a clinical viewpoint, that improvements in the two months following the termination of the heroin treatment fell away. It can be argued that the improvements of heroin maintained patients are linked to continuation of treatment in the majority of cases. It is not a temporary treatment for most patients.

**Cost analysis**

A cost-effectiveness study was published in the *British Medical Journal* in 2005[49]. In direct medical costs (for example, the costs of the medicine, the treatment premises and the staff), heroin maintenance is much more expensive compared to the associated costs of methadone maintenance. This is largely because of the security and staff-related costs in providing heroin three times a day.

What can also be argued is that the higher costs of heroin maintenance were more than outweighed by the benefits from a societal point of view, for example in terms of costs associated with crime, property crime, criminal damage, the resources of the police and the legal system.

In terms of cost benefits, there are net savings from a societal point of view.

**Conclusion**

Heroin-assisted treatment is an effective option, but it is limited to the group of chronic treatment-resistant heroin dependent patients. It is practical, with no medical side effects. It reduces public disorder. In the neighbourhoods where objections were raised initially about the programme, this rapidly disappeared.

[49] Dijkgraaf, M.G.W. et al. 2005, 'Cost utility analysis of co-prescribed heroin compared with methadone maintenance treatment in heroin addicts in two randomised trials', *British Medical Journal*, vol. 330, pp. 1297-.

The beneficial effects are linked to a continuation of treatment and, although heroin treatment is costly, more importantly, it is cost-effective in treatment terms and from a societal point of view.

In the Netherlands, from December 2006, heroin was registered by the Medical Evaluation Board as a medication product, in both its injectable and inhalable forms. It is restricted to the same target group of approximately 425 patients. The government has granted the possibility to extend the number of treatment places to a maximum of 800 in a total of 20 treatment units spread throughout the country.

There is a need for good treatment coverage, which is an issue for Scotland too. Good treatment coverage can be achieved with a comprehensive system, which includes different treatments for different patients, at different phases of their addiction career. There is often a clash between people who adopt only abstinence-oriented treatment and those who adopt only harm-reduction treatment, but they are both very much part of the same continuum. Any physician, in either addiction field, will first try to cure the disease. If that does not work, as an alternative, a physician will try to alleviate symptoms. The same is true of diabetes or hypertension or other chronic diseases. Addiction is a phenomenon, it is not a disease, but it shows so many parallels with other chronic phenomena.

An acceptable quality of life can be obtained through a comprehensive treatment system, even in an ageing population of chronic addicts.

## Based on the comments of Victor Everhardt, Head of the Prevention Unit, Centre for Prevention and Brief Interventions, Trimbos Institute

This presentation will look at the workings of the Dutch system and the gaps within the treatment system, highlighting especially the heroin trial which started with scientific research at the national level. I would also like to mention, for reflection, another treatment option, or at least a harm-reduction option, which was created in the Netherlands.

I don't know what your experience is here in Scotland, but in the Netherlands things started at national level, like the heroin trial. However, a lot of good work has been done at grassroots level in the Netherlands, starting by trying to work with the people who are out there and using drugs. How, for instance, did needle exchange programmes start in the Netherlands? Just by changing needles at grassroots level. Was there any evidence that it would work? Should we have proved it beforehand, or should we have worked through stages when installing this kind of method? Drug consumption rooms started at the same time.

In the Netherlands, we have the feeling, from the health perspective, that, first of all, we have to prove things: we have to have evidence before we can start things. Look at the heroin trial: first we had to have proof. If we look at the justice and home affairs interventions, they start, they're good. We start with a problem and work with the problem. So, in the Netherlands, there is a lot of debate within the health sector on the issues when we are just starting. For instance, with drug consumption rooms, you are thought to be giving up on people because you are allowing them to use in this

specific room. First, they want to see evidence, but that is too difficult; you can't always have evidence before you begin working.

Drug consumption rooms started off in the 1990s at grassroots level, and what have they become? They are facilities under the administration of an official organisation where drug users can administer their pre-obtained drugs in relative peace and quiet under the supervision of trained staff. They started just as a room with somebody offering the opportunity to use drugs. How did this starting point develop into this system? It is because, in the Netherlands, we like to take a pragmatic approach to the starter group. Long-term addicts, multiple problems, street drug use and poor physical state[50] – that is what we saw, and we considered how to work with them.
Drug consumption rooms are one way of getting in touch with users and one way of getting them into the treatment system. It is the first step, but at least we can try to work with them.

With drug dealers and drug tourists on the street, what should we do? What should be the reaction of the health authority? What should be the direction of the town council? In the Netherlands we opened up a consumption room in the basement of city halls. That is one way of working with the problem. I don't know what the way of working is within the Scottish context, but we tried to be pragmatic, and this is at least an example of a pragmatic approach.

In other cities, people were trying to open up more facilities of this kind. Of course, the judicial authority said, "Is this allowed? Do we want to have this kind of thing? What do health authorities at national level think about it?" The next step in this process is the Ministry of Health coming in. They see what is being done at the local level where the problems occur; they see that people are trying to deal with the problems. Of course, you have to have a national debate on the issue and, of course, you want to have proof that it will work in the end, but you should continue the work, not stop it and first have to obtain proof. That was the Ministry of Health's way of thinking in 2002.

There are some benefits for public health. We see that there is a decrease in public nuisance – that is always a big argument in the Netherlands. If you can prove to the health authorities that your new intervention will result in a good reduction of public nuisance, you win the argument most of the time within any political context. The pragmatic approach from the Ministry of Health is that if they don't allow drug consumption rooms, if they don't have them installed in a proper way, we will end up with illegal shooting galleries with all the associated negative side effects.

In 2001, before the Ministry of Health had this official policy, we already had 20 drug consumption rooms. Nine local communities had installed them, addiction care was already involved and the number of daily visitors was 29 in 2001.

After that, you see an increase in all the factors, the number of drug consumption rooms, the communities that are involved, and so on. This is because, if the national government has given approval, the more communities or local authorities will take

[50] Bransen E, van't Land H and Wolf J. (2004) *Gebruiksruimten in Nederland. Trends and ontwikkelingen 2001 – 2003*, Trombos, Utrecht.

up this kind of issue. Addiction care was getting more daily visitors over the threshold, and the number of the drug consumption rooms also increased.

The objectives included the reduction of public nuisance (that is a very important one), the reduction of health risks and risk-taking behaviour, and improving the quality of life (not being out on the street any more, but coming into safe surroundings, with medical supervision, a hot meal, a cup of coffee and some bread).

These are the perspectives that made it work: the public order debate, social integration and medical care.

These are the principal criteria for admission to drug consumption rooms:

In 2001, people of the minimum age of 18 made up just below 50% of those using the drug consumption rooms; the number of people in this category using drug consumption rooms went up. In 2001, 60% of those using drug consumption rooms were homeless; that figure also went up. The number of clients in some way known to the health care authorities also went up slightly. Clients should be registered with the council which is offering the drug consumption room. This number went up dramatically because a lot of town councils didn't like the idea of drug addicts from other cities coming to their area to roam around the streets and cause nuisance. It was a major drive in 2001, but it became less important in 2003.

What types of areas are there within drug consumption rooms? There are, of course, smoking and injecting areas, but in 2003 there were injecting only areas (this was the main target group), smoking only areas, and, in 46% of the cases, there was a common room where clients could just have a quiet time.

What kind of services are provided within drug consumption rooms? A needle exchange, medical aid, sandwiches, recreation activities – all kinds of things. These are the first, low threshold ways of dealing with the drug addict. The whole idea behind the drug consumption rooms is that you make initial contact with drug users and try and get them into your treatment system. That they should end up in the treatment system should be a logical follow-up to getting them into the drug consumption rooms.

There was an emphasis on rules because there was a lot of debate in the selected neighbourhoods due to the fact that people were very reluctant to have drug consumption rooms in their own neighbourhood. Once the Ministry of Health backed the whole system, all kind of rules were put in place. This created a better atmosphere in the neighbourhood. A lot of local authorities were involved in drug consumption rooms, not only the medical or health authorities, but also the judicial and police authorities. There were all kinds of agreements between them and the neighbourhood, and some rewards were given to get those drug consumption rooms installed.

The big question then was: we have these facilities, but has the target group been reached? From this research we could say 'yes', and the number of visitors also increased. For example, in Utrecht, a city in the middle of the Netherlands, there are 410 homeless drug users. Three hundred of these homeless users have a pass to the drug consumption rooms and 220 of these are active visitors to the drug consumption

rooms. This means you are reaching 75% of the whole population that you are targeting. That 75% of them are actually making use of the drug consumption room is, I think, a very good way of working. Of course, it is not a success in every town; you have differences. In Rotterdam, only 12.5% of the target group have been reached. Within the Netherlands there are different ways of working with drug consumption rooms, and whether they are a success or not depends upon the backing of the authorities.

It is difficult to maintain the admission criteria and to keep them at a high level because it is easy for users to give their pass to anybody who is seeking a quieter environment. On the other hand, to get the general support of the neighbourhood, you need to stop the influx of drug users from other areas coming into the town. This means that you have to be strict. That is why the residency permit is necessary, but how do you get drug addicts to keep their permits in good order?

We also want to have more emphasis on getting drug users to the next step without losing them, and that is what we should work on. That is the difficult part. We have them, we have good contact with them, but now we want to get them more integrated into the system itself – and how do we do that? These are questions that we are working on in the Netherlands.

There is always a big debate on opening hours. Should drug consumption rooms be open 24 hours a day, 12 hours a day, during the day time or not? If they are not open, then the drug use could be transferred to the streets; but within certain neighbourhoods opening up 24 hours a day is also not suitable. There are always debates, but best practice from different towns should help us learn how and in what way we should deal with this kind of challenge.

Are drug consumption rooms also contributing to the nuisance reduction that was the major drive in getting them installed? From research in 2001, Vincent Hendriks found that cities with drug consumption rooms had reduced levels of drug use in public. In 2003, 80% of the pass holders in Rotterdam used drugs less in public[51]; and, in Utrecht, 48% of the pass holders reported less loitering about because of the drug consumption rooms and only 20% still preferred to use drugs in the street[52]. This means that drug consumption rooms have contributed to nuisance reduction.

What are the discrepancies between what the authorities are doing and what the clients would like them to be doing? Maintaining order is a very important issue, and so are the distribution of food and drinks and housekeeping. The most frequently reported needs of the clients are facilities for personal care, medical aid by a nurse and dental care. There are discrepancies between what is offered and what is asked for, and that is another challenge we should meet in the coming years.

**Conditions for success**

[51] van der Poel A., Barendregt C. & van de Mheen, D. (2003), 'Drug consumption rooms in Rotterdam: An explorative description', *European Addiction Research*, vol. 9, pp. 94-100.
[52] Hulsbosch, L. Et al. 2004, *Gebruiksruimten in Utrecht: evaluatie van een nieuwe voorziening*, Trimbos, Utrecht.

If you look at the experience we have had in the last few years, the conditions for success are:

- Successful contact with the target group – you have to know how to reach them and where they are
- Consensus about the objectives and the target group among the authorities who are involved with them
- Consumption rooms can't stand alone, but should be embedded in local policy and should be embedded within the treatment system itself.
- You should have good agreement with the police and public prosecutor, otherwise you will be working contrary to each other.
- Availability and accessibility of health care and welfare facilities for long-term addicts.
- The availability of trained staff is also very important because of the needs of the clients.
- Co-operation with interested groups and the target group.

With these conditions, we know that it could work – that is the conclusion that we can draw from our own experiences.

There is always a big dispute about whether you can do this when you look at your own legal condition, because you are opening the doors to people who are in possession of drugs, which is an illegal act. Within the Netherlands, we can solve this kind of issue fairly easily because we have the Principle of Discretionary Powers. This means that, of course, it is an illegal act, it is an offence, but the public prosecutor can always waive prosecution of offences. The public prosecution in the Netherlands has written guidelines on how to deal with this issue. Within these guidelines, it says that if the drug consumption rooms are operated by a local health authority and supported by the town council, you can waive prosecution. I don't know if waiving prosecution is an option within the Scottish context. I know that it is not an option within the German context, or the Swiss, but they argued in a different way. They say: okay, we have the UN conventions[53], which do not allow possession of drugs, which should be a criminal offence within the country. But, they argue, the conventions have opened up opportunities to install proper demand reduction policies within our own national framework, and harm reduction is not an inferior demand reduction strategy, harm reduction is part of a good demand reduction strategy. The use of drugs as such is not governed by the UN conventions, and you get a legal argument that, because of this, possession for personal use is also not governed by the UN conventions. You can argue that drug consumption rooms are a sound medical practice, and you can draw the conclusion that drug consumption rooms are not contrary to the UN conventions.

We are not the only country to have installed facilities of this kind; as I mentioned before, Germany, Norway, Switzerland, Portugal and Spain have also done so. The legal conditions and possibility that they are contrary to the UN conventions are highly disputed in the international context, but at least Germany, Switzerland and the Netherlands are hammering on about the fact that it is sound medical practice and that

[53] United Nations Single Convention on Narcotic Drugs (1961), United Nations Convention on Psychotropic Substances (1971) and United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).

harm-reduction is part of a demand reduction strategy and should not be seen as something different.

That is the context from an international perspective. There are other countries thinking about this option. I don't know if it is an option for Scotland. I can't say, but I do think that we in the Netherlands, with this intervention, have created another opportunity at least to have a low threshold intervention aimed at getting into contact with drug addicts, getting them into the system, working with them and not leaving them out on the street.

*Expert Seminar - Everybody is Doing It?*

*Organised by the Scottish Association of Alcohol and Drug Action Teams (SAADAT),*

*in partnership with Scotland's Futures Forum,*
**held on 22 October 2007**

**Wes Perkins**, Professor of Sociology and Anthropology at Hobart and William Smith Colleges

My job today, as I see it, is to give you an overview of the social norms approach, what it is about, some of the research that has been done, some of the theory behind it and some of the evidence of its effectiveness.

My research and the development of this approach began many, many years ago, focused on the young adult population, typically 18-24 year olds. Most of the research early on was focused on college and university students, in part because that is conveniently where researchers often begin their research, in looking at a lot of different types of issue, because their subjects are right at their back door. However, in this instance, with regard to alcohol use and abuse, it is quite a pertinent population because in most societies, certainly in the States and here in the UK as well, 18-24 year olds are a primary target for concern about alcohol abuse, and university students are often at the high end of some of that usage and its associated problems.

Since then, our research has moved into larger state-wide and community focuses; it has also moved into lower grades, into primary and secondary schools, with younger age groups. So, if you are working with different populations, different age groups, I think what I have to say is also of relevance, and I will show you some information about that as well.

And, finally, this approach – while focused historically and, still today, heavily, on alcohol use and abuse – is applicable to concerns about substance use in general, and applicable to concerns about other kinds of problem behaviour. We are working now in sexual risk- taking, bullying issues and so forth, and also some of that has been moving over to the UK in some of our work.

So, there is a broad range of applications for this approach, although I am going to be talking mostly about alcohol today.

When we think about prevention strategies and what we really need to have effective strategies, more and more of the argument today is focused on the need for science-based prevention strategies. And when we talk about science-based prevention strategies, we are really talking about the need for two things. Those are, firstly, good theoretical reasoning – what is the theory behind it and does it make any sense? – and, secondly, good data – is there evidence? Do we have good data collected? Is there

evidence that this strategy, or whatever strategy one is using, is working? And, consequently, a lot of our traditional strategies break down along one of these two lines: either the theory behind it doesn't really make sense, even though our gut tells us to do it; or we keep thinking it makes sense, but there is no real evidence out there that it is working.

So we'll think about this when I move on to talk about what we do traditionally and then why the social norms approach is different from that. Traditionally, at least in the US and I think I am speaking for what happens in the UK as well, I would say that most of our focus has been on what I would call health education. And it has been health education of the sort that says "Let's teach people, especially young people, about the effects of alcohol and other drugs, about the pharmacology of how they work". Whether it is to a very young child or as we move up through the school system, we have been saying "Let's teach them; let's educate them about how alcohol, drugs and other substances affect the body", with the assumption then that having a more educated population, we will have less risk-taking.

Unfortunately, the research today – certainly in the US, and everything I have seen elsewhere – is absolutely unequivocal on the point that this type of traditional health education alone does not reduce risk behaviour. We can have a population that is very educated about how alcohol and drugs in general work, and it doesn't really reduce risky behaviour. Don't get me wrong: I am not saying that to be educated is a bad thing. I am a full-time faculty member, and I teach a course on alcohol use and abuse with a biochemist. We co-teach a course, and we spend a lot of time talking about the biopharmacology of alcohol and how it works on the body, and so forth. However, we don't believe that that information alone is going to reduce risk-taking, because students, for the most part, are in a peer-intensive environment where peer influences drive their behaviour, while traditional education – the health education of the sort I have been talking about – is based on a model of rational choice: that individuals will get information, read through it all, sort through it and come to the right answer – that is not how people operate. They look around and see what everybody else is doing, what other people are talking about, what other people are thinking, and they make their choices – at times, choices that are in opposition to their own best interest.

When health education does not work by itself, we turn to a more extreme type of strategy, which I call 'health terrorism', and health terrorism is literally to scare the health into people. If I can scare the health into you, then surely that will reduce risk behaviour. What is all that about? I have got to tell you then about all the awful and bad things that are going to happen to you if you drink, or if you drink heavily, if you use various drugs, and so forth. I have got to tell you all the bad things as a way to get you to avoid them. What are some examples? In the US, there are a couple of classic examples, where we see a poster like this. It is only beer, but it is laid on its side with a syringe at the end of it as an attempt to scare young people away from drinking. There is a lot of fine print on the poster that gives information about the beer having alcohol in it. But that is not the point, that is not what they are trying to do anyway, and pharmacological information in itself has a limited impact, as we have said. The attempt here is to scare. Needles are scary – most of us don't like getting shots or injections – and here it is also associated with things like heroin use, and that is much scarier for the population. But how many young people drink a beer and immediately experience a feeling like a heroin rush? That doesn't happen and, consequently, this is

a really false message; and most people realise that and recognise it right away. Another kind of scare message is something like this: “Chugging can kill”, with an attempt at trying to reduce the drinking games that occur among young adult and adolescent populations. Chugging contests, at least in the States, are very popular, like all kinds of drinking games.

Tragically, it is true that, each year, after chugging contests, we hear reports of deaths. Someone falls off a roof or out of a balcony and kills themselves; someone consumes such large quantities that they go home and go to bed, and don’t wake up ever again. However, the number of deaths that occur as a result of chugging or drinking games compared to the number of people that participate in them, is very, very small – and therein lies the problem. We are trying to tell people to avoid a behaviour by saying, “This is going to happen to you”, but it really happens to only a few people. Their deaths are tragedies, but it happens to relatively few, and people will say, “It probably won’t happen to me”, and they are right. We are using a behaviourist psychology of rewards and punishments. The strategy of rewards and punishments is built on the notion that people will avoid punishments. And it is true people will avoid punishments: if they put their hand on a hot stove, they burn their hand and they never touch it again because they know what is going to happen to them. We can learn vicariously: we see somebody else burn their hand on a hot stove, so we don’t put our hand on the hot stove – we don’t all walk around with scarred hands as a way of learning not to put our hands on stoves. We can learn that, but the fundamental point is that, when somebody does put their hand on a hot stove, it burns them every time, and we make that connection quickly because we are real smart; other animals maybe aren’t that smart, but we can do that. So the notion with scare tactics is that we can learn vicariously, and if we show the bad and awful things that happen to other people, we will pick that up and learn from it and not do it. But we are showing them things that don’t happen that often; most of the time, they don’t happen. And when health terrorism doesn’t work, we scratch our heads and we say “What should we do?”, because young people say “Show us blood and guts that will get us to stop”. And it doesn’t work, and we scratch our heads, and we say “Let’s make it scarier”, and so we try to portray the most horrific, terrible event – carnage on the highway in a traffic crash or gross destruction – and it doesn’t work. Making it scarier makes it even less probable that it will happen. So it is not an effective strategy, if you think about the theory it is based on, which requires a close connection between reward and punishment in the action itself.

So health terrorism doesn’t work. And when health terrorism doesn’t work, we rely heavily on social control, which is focused on rewarding or punishing people for following rules and regulations. We establish a lot of policies, controlling access to alcohol for example: how you can get it, at what age, where, and so forth. We also work on rules and regulations concerning restrictions about not only age limits, but also places in communities and venues, and so forth. This is important to some extent. Obviously, if we threw all the rules and regulations out, problems would arise. And, I think, we can come up with creative, additional rules and regulations and policy that may make sense, reduce harm and be effective. But the problem sometimes is that we think we can just legislate our way out of a problem. That is, if we just create enough rules and regulations, we will be able to avoid the problem, but the experience is frequently one of backlash, particularly with young adolescent and young adult populations. If we just clamp down and create a rule or regulation, there are ways to

circumvent or get around those rules. They can get other people to get them the alcohol. We can find other ways to address the problem. For example, in the US, if we ban kegs in the quadrangles among university populations, alcohol moves to the halls of residence; and if we can ban it in halls of residence, more and more of it moves to private, off-campus settings. We push it around like a game, with our rules and regulations, frequently without reducing the actual use or usage levels.

Likewise, we can ban alcohol, and we can have heavy restrictions in younger age populations, but if we are not also addressing the demand – or perceived demand – among younger people for drinking heavily, then our rules and regulations, by themselves, will not get us very far. We can't put all our eggs in the one basket, as the expression goes, of legislation alone.

So we move to social norms, and this is a different kind of strategy because it is based on very different assumptions. These first three have been based on rewards and punishments and rational, individual self-interest. I can rationally choose what I am going to do best; I will avoid being punished and, consequently, I will behave in accordance with the rules – and yet that doesn't seem to be solving the problem. A social norms strategy operates from a different starting point, and the starting point here is that humans are group oriented, that we are largely influenced to conform to peer norms. Now, that is nothing new, that is not something I invented or the field of social norms invented. There are 50 to 100 years of social science research demonstrating that peer influence is the – or one of the – most powerful influences, that we are group orientated. We are very much herd animals, we operate in accordance with peer influence. That is, you and I are doing what we are doing here today because of peer expectations. You are dressed as you are, you are sitting here politely as you are, not because these are your unique biological tendencies. If that were the case, probably half of you wouldn't show up, half of you would have your feet on the chairs, be spitting in the corners, or whatever. But we have a sense of priority, of what is normatively expected, and when I talk about norms, I am talking about what the majority of the group or the community or the population does. Normative behaviours – we sometimes call them descriptive norms and also attitudinal norms – are what the majority of the group believes is appropriate or right. Sometimes they are called injunctive norms, that is, attitudinal norms. Whatever most of the group thinks is appropriate and whatever most of the group actually does: those are the norms as I am using the term.

Where the social norms approach cuts in is that it asks the question: "Well, what about the *perception* of peer norms?" We know that norms are very influential: at all ages, we are behaving in accordance with the group in large part, but are we behaving in accordance with the group or are we behaving in accordance with our perceptions of the group? Are those one and the same, or are those different? That is where this research began. It really began with research I was doing 20 years ago now and we were collecting data on college and university students. We began with a study that we did on my campus where we had over 1,000 students in the study, highly representative of the university as a whole, and we were asking a whole series of questions about alcohol use and attitudes. This is just one example: we were asking "What is your attitude with regard to alcohol use?" and gave them options from "You should never drink" to "It is okay to drink, but never get intoxicated", "Occasional intoxication is okay, as long as it doesn't interfere with academic or other

responsibilities", "Occasional intoxication is okay, even if it does interfere", or "Being frequently drunk is okay" – all the way from the most restrictive to the most permissive. We asked students what their attitude was and explained that it was an anonymous survey. We actually had very few students saying that you should never drink. There are abstainers, but they are relatively few. About 90% of students in the US consume alcohol: 80% nationwide, 90% in the north-east region where we were doing this research to begin with. The vast majority of students said either that you should drink, but never get intoxicated, or that you should certainly never drink to the point of it interfering with academic or other responsibilities. We had 81% fall into that first set of responses. About one out of five in that study (19%) said it is okay, even if it does interfere, or that frequent drinking is okay. One out of five. But what we also asked in that same study, which was unusual at the time and is still unusual today in most studies, is "What do you think everybody else is going to say? What do you think is the most common, the most typical attitude here at this school? What do you think it is going to be, regardless of your own attitude, whether it is 'you should never drink' or 'drink all the time and it is great, and get drunk and it is fine'? Regardless of what your attitude is, what do you think most others are going to say?" In that particular circumstance, which we call the perceived norm, we had only 37% get it right; only about one third could accurately identify that most others were going to fall into those first three categories, and we had almost two thirds who thought that most others were going to express an attitude that was far more permissive than the actual norm. That is what I mean by the misperception of the norm, which is fundamental to this approach and really drives this whole strategy. We saw this huge discrepancy between the actual norms and the perceived norms.

Now, that discrepancy wasn't just a result of this one question. We asked all kinds of questions, such as "How much do you drink? How often do you drink, and in what context?" and, whatever the actual norm was, the perception would sometimes be two or three times in excess of the reality. I did it several times at our institution and got the same results; it wasn't just a one-time, strange event. Other schools that picked up on this research began finding the same thing.

So, we went back and asked the question: "Why might this be important?" Our traditional approach to peer influence with regard to alcohol use and drinking or substance use in general is to focus on how actual peer norms influence personal use. If all my friends are drinking, is it going to influence me, and how I drink and how much? We had a lot of talk about watching out for who you hang out with, who is in your neighbourhood, how much is going on at your school, how much your peers are doing and what they are doing – those factors are going to influence you. That is all true, no question; there are a lot of data supporting that.

If you are a young person going to a party where lots of alcohol is being consumed, where everybody is consuming, playing drinking games, and you walk in the door and people are handing you drinks, handing you that second or third drink and saying, "Come on, engage in the drinking game", you're likely to consume more than you would otherwise. You're likely to take that first or third or sixth or eighth drink. Wherever you are in the continuum, you are likely to be pushed along a little further.

However, there is another important piece that is traditionally left out of this perspective, and that is the perception of the peer norm; and, as we just saw, that is

not the same thing as the peer norm itself. There is only a vague connection between what is actually going on and what I might think is going on. Yet, we are finding out more and more that what I think is going on is the most powerful part of the peer influence. So, if I walk into that party or social gathering thinking everybody there is going to be drinking, everybody is going to be drinking heavily, everybody expects me to engage in that drinking game, then I am much more likely to take that first, second, fifth, eighth drink and be pushed along because of what I think everybody is doing and is expecting of me, regardless of its truth. And therein lies the problem – or much of the problem.

Are these misperceptions so pervasive? I am going to give you some examples and take you through a variety of examples of research demonstrating these misperceptions.

Ten years on from that first research, we were starting to do a lot of research examining perception versus reality. In New York State, with about 5,000 college and university students from 20 institutions, we found that the actual norm among students at the time was drinking twice a month, with 5% drinking daily. However, when we asked these same 5,000 students about their perceptions of their peers, 89% thought that the typical student was drinking at least weekly but, most importantly here I would say, 25% thought daily drinking was the norm. Now, remember that 5% *are* drinking daily, but about one quarter of the students thought daily drinking was done by the majority. That is where the huge disconnect was. Very similar patterns have also been found with regard to tobacco. More than half the students at the time were not using tobacco, and that has come down dramatically. A quarter of the students at the time were using tobacco daily, but 94% of students thought that tobacco use was the norm among their peers, and two thirds thought daily use was. Similarly with hallucinogens: 91% of our students had not used hallucinogens at any time during the academic year or in the last 12-month period. So, no use was clearly the norm, yet 61% of students thought the typical student in their population was an hallucinogen user – a tremendous disconnect between reality and perception. With regard to cocaine, 5% were using it and 95% were not. So, in that instance, it was very clear that not using cocaine was normative behaviour, and yet 61% of students thought that the typical student in their situation was a cocaine user.

I am not saying that, therefore, we don't have to worry about cocaine use. Cocaine is a very serious, destructive drug and it is a big problem: 5% of students in the New York State, which is a very populous state, with a tremendous number of students, means a lot of people are using cocaine. It is a big problem, but it is far from the norm. And we disconnect those two things: we don't distinguish the problem from the norm and, in losing perspective on what the norm is, we lose one of the most powerful agents for producing enhanced health.

Fast forward another 10 years and you have a study published in 2005, where I looked at college and university students across the US. It is the largest study to date: 72,000-plus students were in this study, 130 schools were in the study, and we again asked several kinds of questions. We asked them how much they were drinking at parties and social occasions, bars and so forth, and asked them to estimate what they thought everybody had consumed most commonly and what they were drinking. We had a whole variety of types of school across the nation because we have a lot of social and

demographic variation in religious beliefs, racial patterns, etc. There were some schools where drinking one or two drinks was most common. Most typically, on average, it was three or four and there were some schools where drinking five, or even a few where six, was common. But, no matter what the actual norm was on their campus or in their student population, they commonly overestimated what their peers were drinking.

Compared to what the norm in their local situation actually was, 15% underestimated, mostly by one or two drinks, so there were some people who actually underestimated the situation. A little less than 15% got it right, but that meant that 71% overestimated – and almost 40% were overestimating by three or more drinks. So, in a campus setting or a school setting where having two drinks was the average, most students were thinking everybody else was drinking five or six. And, in a campus setting where the average was four or five drinks, they were thinking that everybody else was drinking eight or 10 – that is the kind of pattern we see.

Now, you may think that that is just the US, and all Americans are crazy and they can't estimate anything correctly. However, we are now seeing studies from other places. The most recently published is a study of 18-25 year old college or university students across Canada; and in the same kind of questions, we saw the same kind of pattern, virtually the same result. A few underestimated (about 10% underestimating), 14% got it right and, in this instance, over three quarters were once again overestimating. So, Canadians couldn't get it right either.

We had a smaller study in New Zealand showing the same thing and, recently, a study of university students at Paisley University here in Scotland was published in the *Journal of Studies on Alcohol*, and it showed exactly the same pattern and how powerful those misperceptions are in predicting one's own personal behaviour.

It is not just among college and university students, it is also what we are seeing in wider populations of research. We did research in the state of Montana, for example, where only about one third of 18-24 year olds were in some form of higher education, and most of them were in community settings across the state. What we still found in a representative study there was that men, when they did drink, would consume on average three drinks per occasion. A drink, as I am talking here in US measures, is a 12oz beer, a 5oz glass of wine or a shot of liquor and mixer drink, which all have the same amount of alcohol in them in the States. But they thought their male peers were having seven drinks on average. The women were having two drinks on average, but they thought their female peers were having five on average. This is not to say that there weren't some men consuming seven drinks and some women consuming five drinks or more, but they were in the tail of the distribution, not in the centre of the bell curve. That is the fundamental point here: where we perceive the centre of curve to be versus where it really is.

That same study was also looking at drinking and driving, because the state of Montana – like most of the US – has a very serious problem with alcohol, which corresponds with alcohol-related crashes, and drinking and driving. In this instance, 20% of men who were drinking and driving were having two drinks and driving within the hour; and consuming two or more drinks and driving within the hour can raise one's BAC (Blood Alcohol Concentration) levels up to a risky point. About 12%

of women were doing that. However, we asked people to estimate what percentage of their peers they thought had done that. They thought 60% of the men had done so and about 42-43% of the women. Again, 20% of men and 12% of women doing that is a very serious problem. It is a major killer of adolescents and young adults in the US. It *is* a very serious problem – but it is not the norm. Yet it is frequently perceived to be the norm, and those who are doing the drinking and driving think they are just like everybody else. And, what is even more perverse, most other people out there who don't drink and drive think that the drinking drivers are the norm, so they reinforce or enable the risky behaviour of others.

I have one last example from young adult populations. This is a study of about 2,500 university students in a state in the north that looks at protective behaviours. That is, how you reduce your risk of harm if and when you drink. About 60% say they only drink with people they know, 55% say they watch out for their friends, 55% use a designated driver or have someone who doesn't drink along with them if they are going to be drinking and have to ride in a vehicle home. About one quarter of them eat before they drink and keep track of their drinks, and about 15-20% pace themselves. They don't all use the same strategies, but what was most striking – and is always the case in all the research that we have found – is that when asked to estimate what percentage of others are using these protective behaviours, they grossly underestimate it. It is the mirror image of what I have been talking about. Risk behaviours are overestimated, while protective behaviours are underestimated compared to the norm. We would want everybody to use a designated driver if they are going to be drinking and riding in a vehicle afterwards, and the fact that only 55% are doing so is a tragedy. However, they do that thinking nobody else does so, and there, again, is a problem.

Let's turn to younger ages. We have been doing a lot of research using anonymous online surveys in younger, middle and high school populations across the US, and we have collected data now from about 90,000 students, scores of schools and in states across the country that are demographically very different. I am just going to give you a few examples. In a study of sixth to eighth graders – that would be about 11-13 years old in our system – we asked about their attitudes with regard to tobacco use. Clearly, the majority do not approve of tobacco use ever: 87% said it was never a good thing to do. Clearly, the norm is a good, healthy belief attitude for the vast majority of them. However, when they were asked what they thought everybody else was going to say or what would be most typical, 60% said they thought most of their peers would say they disapproved of tobacco use, and that is a good thing. Most actually got it right, but 40% still got it wrong and thought most of their peers were going to say it was okay.

When we moved up in grades to the ninth to twelfth graders, who would be about 14-17 years old, the pattern we saw was the following: 71% still say it is never a good thing to do – still clearly the norm, but the norm has been eroded from what was 87-89% before in the sixth to eighth grade. It is the same school system, so it has eroded some. By the time they get to the high school grades, less than a quarter could get it right that the majority of their peers don't think it is okay. So, perceptions early on begin to erode and get very myopic.

In a survey grid we show the responses given by ninth graders, who are about 14-15 years old, when asked about their drinking patterns for themselves and what they think others are doing; and the representation here is the norm for these ninth graders. The majority don't consume alcohol at all in the ninth grade. This study was done in a region of our country with heavy alcohol consumption, and the majority of ninth graders – 14 year olds – were not consuming alcohol at all. However, they thought their friends were averaging one drink; they thought students in general in their grade were averaging two; they thought the males were consuming three drinks on average and the females were consuming two; and they thought that juniors and seniors – those who were two and three grades ahead of them – were on average drinking four, when the truth about the juniors and seniors whom we studied was that they were consuming on average between zero and one drink. They thought the drop-outs were drinking seven or more – drop-outs always get a bad name – and they even thought that the athletes in their school were consuming on average at least one. Again, there's gross distortion of reality.

Pick another school: this example is a high school, with 14-17 year olds, in the Midwest. I picked this one because almost everyone participated. There is no question about having a representative sample or not as we had virtually a census. That is to say, the study is based on over 1,100 students, 96% of the entire student body in this large high school. We asked, and this is just one example, one set of questions: "How many drinks do you have, if you have consumed alcohol at all, at parties and social gatherings?" Here is the pattern.

What we saw there was that almost 60% didn't consume alcohol. The norm was not to consume alcohol at those ages. About 40% were spread out all along the continuum, with about 15% drinking six or seven drinks at parties and social occasions at that age. A very serious problem and a very serious health risk, but it is not the norm. However, once again, when asked "What do you think would be typical among all of your peers here in this school?", only 5% got it right: only 5% said the majority here don't drink. Only 5%. The rest had some level of misperception, spread along the continuum, with almost 30% thinking that the norm was to consume five or more drinks.

Just as an example, I've picked another school, in the south-west, in Arizona. Almost 1,600 students – 86% of the entire student body – were present and took the survey. The norm is not to use tobacco: almost 80%. But here is the picture of perception: almost half think that the majority of their peers are using tobacco weekly. It's a similar picture with alcohol. About half never use any alcohol and the rest are spread out along the continuum, but there are massive misperceptions once again.

Looking at the use of marijuana and other illicit drugs among the 14-17 year olds, the point, again, is not that there is no problem, but that the fundamental, underlying problem is the massive misperception of how many and who is doing it. If peer influence is so important and people think all their peers are doing this, isn't that driving much of the actual behaviour?

One of the most guarded pieces of information in adolescent and young adult culture is those who are not drinking or who are drinking moderately. That is one of the most guarded pieces of information that we are being able to get out only through

anonymous surveys and make public, as nobody in the culture would want to talk about that publicly because that would be an embarrassment.

There are two indisputable findings in the literature: the first is that the peer norm is one of the strongest predictors of personal behaviour – social science has known that for decades and decades; but the other indisputable finding now is that peer norms about substance use in general are grossly misperceived in the direction of overestimated use and exaggerated permissiveness in terms of normative attitudes. The research shows that, whether we are talking about alcohol or other drugs, whether we are talking about regions, sizes, programmes, actual norms at the schools, there are still misperceptions in all circumstances. These misperceptions are there in sub-populations of youth. It is not just whites, it is not just Africans, it is not just Asians, it is not just the honour students, it is not just the school athletes – whatever their social demographic category, they misperceive their sub-group. There are differences in actuality among sub-groups, but they misperceive the norms for their sub-groups and they misperceive for their youth population overall.

These misperceptions are also there in what we call state-wide populations; they are not just restricted to schools, they are there widely in communities. They are there whether we talk about attitudes or use; they are also there in terms of policy support. Remember, one of the things we said earlier was about policies being limited and not being very effective. One of the reasons, we would argue, that policies are limited in their effectiveness is because there are misperceptions about those too. That is, young people think routinely that most others don't agree with the rules and regulations. Now, there are some policies that most people don't agree with, and there are some that young adults and adolescents do agree with, and they are typically the policies that are focused on reducing harm and risk of harm. The majority do agree with them, but they don't think that anybody else agrees with them, so they may not practise them as much: they may not comply, they may not help security officers and authority figures enforce the policies, but they don't think anybody else supports them, they remain silent.

So, back to theory. Why these misperceptions?

The causes of the misperceptions really come from three levels. The first has to do with psychology, what we call the mental attributions process. I am not going to give you a whole lecture on psychology here, but the basic point is that, when we observe other people's behaviours – psychologists have documented this for some time now – we tend to think those behaviours are more common than they really are. We tend to think the behaviours reflect their dispositions and what they do most regularly, because we don't know them very well and we have got to make some kind of guess or judgement – subconsciously, if not consciously – whether this is characteristic of them or not. If I see you doing something and I don't know if it is characteristic of you or not, and I don't have any other way to conceptualise it as I don't see you in another context, I tend to think that that is what you do all the time.

We make what is called a fundamental attribution area in the mind. The brain plays tricks on us and, as we are all doing that frequently, we tend to think that those behaviours that we observe in others, e.g. occasional intoxication, is something people do all the time.

The second level is that of memory and conversation. We remember things that are most vivid and most extreme, and that is what we talk about a lot. People who get intoxicated – those are usually very vivid, very memorable. It could be the person who is the extreme introvert and gets up on the table at a party and starts singing and dancing around, and everybody is looking at this person saying "I can't believe that person, who is normally an introvert, is doing this". Everybody talks about it, and everybody laughs about it, and it is a big joke.

Or it could be sad or disgusting: somebody at the party gets sick and passes out on the floor next to everybody. We remember that, we talk about that. It could be very frightening: somebody in an inebriated state gets into a fight, attacks you or a friend. You remember that. But, regardless of where it is on the affect continuum, from very funny to very sad, disgusting, frightening, we remember it and it gets talked about and that talk becomes our vision of what is normative.

How many times do you hear a young person getting up, coming downstairs the morning after a party and saying "Boy, I can't believe how many people were sober last night"? Your mild kind of embarrassed chuckle is exactly the same response that I get in the States whenever I say that. It sounds very strange, and we can't imagine it, and yet it is the statistical reality: the majority of people are sober. We have now been able to document this. All kinds of surveys and also anonymous BAC testing in youth populations and young adult populations show that the majority of individuals at the younger stages don't drink at all. And of older adolescents and young adults, the majority are sober any night of the year, in any state, any school, any region – always the case, but we never talk about that.

We have just a few words to describe not being drunk – sober, abstain, moderation – but we have thousands of words for intoxication because that is what we talk about and that generates our image of what is normative.

The third level is the cultural level. The entertainment industry, whether it is movies like *Animal House*, or MTV shows or the equivalent shows over here that are emphasising youth and heavy alcohol consumption, and certain forms of advertising may do the same thing, but it is not just the commercial industries that are contributing to these misperceptions, it is the news: 'If it bleeds, it leads'. What we hear about are the 3% who are using the new designer drug or the 5% who get into a big fight after the game in an intoxicated state – that is in the news. Or the 20% in some study who have been identified as clinically at risk. We don't hear in the news about the 97% who have never used the designer drug, who have never got into a fight after a sporting event, or about the 80% who are not clinically at risk – they are not perceived as interesting.

Those risk behaviours in the minority group get talked about in the news and, as we talk about the stories once again, we don't remember the statistics, we just remember that there are a lot of people using designer drugs, a lot of people getting into drunken fights after football games, and a lot of people are at risk ("Oh, the majority, most young people are doing this today"). That is the way news reports get talked about in the end.

And, finally, health advocacy organisations do their part to contribute to the misperceptions because what they are doing is – understandably – trying to generate interest in the problem, trying to get more people involved, trying to get more funds to address the problem. So, they are talking about the problem, about all the people who are doing this or that, or are at risk, or are exhibiting this behaviour. They are publicising that, talking about that, but the problem there is that the message is going out not just to those targets who might be political legislators or funding agencies or people who will work with them as allies to address the problem. It is spreading out to everybody and, consequently, as we see, talking about the problem leads people to believe that the majority have the problem. As they talk about the problem and they see people getting concerned and coming on board with them, the discussion generated by health advocacy organisations takes on a life of its own, and it is almost as if we think talking about the problem is the solution to the problem – and it is not. It is understandable, and we have to demonstrate need when we are asking for a grant or trying to get more political backbone, but talking about the problem is not the solution to the problem.

One last thing about this kind of news reporting. There was a big article about this conference in *The Herald*, and actually I thought it was pretty good. Usually, with reporters, you worry about what they are going to say and whether they are going to report you correctly. The text was great, in the sense of reporting the social norms approach. I don't know if you saw it; it was a big two-page spread. But there was a picture in the centre – you know the media has to do this all the time – with five guys sitting around a table with about 40 or 50 empty beer bottles there, as a way to catch people's attention. This is the problem.

So what are the consequences of these misperceptions? There is what I call a 'definition situation' that produces a 'reign of error' – not a reign of terror, it is a reign of *error* – that we are controlled by our misperceptions and, as such, it becomes a partially self-fulfilling prophecy. We think everybody else is doing it, and we go along with it. For example, you sometimes hear that there is going to be some weather event and think "We had better go to the store because everybody is going to go to the store and buy up all the goods"; and you get down to the store and there is a huge, long line, with everybody buying up the goods. Why was that the case? Because everybody thought that everybody was going to do it, and it becomes a self-fulfilling prophecy in part.

So, actual use and abuse increases in the wake of these misperceptions. Layers of misperceptions compound: I will engage in excessive behaviour because I think all the rest of you are doing it and so expect me to; and you see me doing that, and I become your confirmation of your misperception and, at the same time that you are pushed along, you may occasionally engage in risky behaviour that you wouldn't otherwise engage in; I see you doing it and you become my confirmation – and the whole thing snowballs.

Opposition is discouraged from speaking out; interventions by others decline; people are less likely to turn off the tap if a party is getting out of hand, to take the keys away from somebody who is about to drive after drinking if they think nobody else thinks it is a problem; they are less likely to intervene in a potential date rape situation where

one or both people are intoxicated if they think nobody else thinks it is a problem or cares about it.

Whatever the problem or risk, if I don't think anybody else is going to care – or even if I care equally about it – I am less likely to intervene, I become a bystander. So, misperception has reinforced the bystander phenomenon. And then we are mired down by the fact that the vast majority of people are carriers of the misperceptions, and I use that term in the disease model sense because the misperceptions are a virus, they are contagious, and we pass them around in conversation. Young people moving up through grades and in schools are trying to figure out what is going on if they move into the next level in a school. They are looking around, trying to figure out what the norm is, what everybody else is doing. Most of the older students are responsible, but they say "I don't do this, but, yes, everybody else here does".

Many of those who are trying to figure out how to behave are infected with the virus of the misperception, which has an effect on their own behaviour. You can have all kinds of students who are role models in their own behaviour, but if they have the misperception, and in a conversation they say, in a proud role model way, "I don't do this, but everybody else does", they have done more damage than good. That is a problem.

And it is not just the young people themselves. We have found that teachers in schools, administrators, health educators, parents – everybody – is a carrier of these misperceptions. They misperceive as badly as the students. It is not enough just to target young people; it is not as if we get smarter when we get older. We all misperceive as badly, and carry on that conversation.

How do we translate that into a prevention strategy? The model is one where we identify the actual versus the misperceived norms. We so often just identify the problem and talk about it, but we have got to find out what the levels of the problem are and what is perceived, provide extensive exposure to actual norm messages, telling the truth frequently with credible data about what the actual norms are. This leads to less exaggerated misperceptions, which, in the end, will lead to less harmful and risky behaviour. That is the model. It is a very simple one. It is almost embarrassingly simple that I have been talking about this, and going around the country, and writing books and articles for so long. It is a very simple process, but it is one which is a fundamental paradigm shift from the vast majority of what is done in the prevention world.

What are some examples? This can be done in a variety of ways. Most commonly, it is done through print media campaigns. What might this look like? Here are just a couple of examples.

In a university student population, here are a couple of posters making the point. Very different from those scare posters you saw before.

- The first poster is from HWS, my own institution: Hobart William Smith. Most HWS students, when they party, drink one to four drinks or do not drink at all. You will remember that the perception is that everybody here is drinking seven, eight or nine drinks. The poster dispels that myth.

Most of the students (87%) never caused property damage as a result of drinking. The notion is that everybody breaks things or destroys something at a big party at some time, so we are very tolerant of others, and we often end up paying for the costs of the destruction by others. We are trying to dispel that, saying "No, most people don't do that, most people don't get into an intoxicated state that leads them to do these things".

Something like three quarters do not engage in sexual activities as a result of drinking. Now, you may say, as the negative side of this that we typically try to flip back to, that means that 28% are engaging in unintended sexual activity as a result of drinking and that is a serious problem – and indeed it is. But what is the perception out there? If you ask, it is: "Oh, yes, almost everybody gets drunk and hooks up on the weekend" – and 'hooks up' is the vernacular for having sexual relationships in our setting. That is the distinction. This comes as quite a surprise.

- The second set of posters is from a campaign for high school students, where the majority don't consume. For older students, the message is moderation; for younger students, the message is just a statistical reality, it is not preaching and it is not telling them what they should do, it is just telling them what the situation is. For the younger ages, it is abstinence in terms of alcohol. So what does this mean? Four out of six in the last month have not used alcohol. Four out of six. There are just a couple of ads, again very different from the scare messages.

- A third example is a poster from a tobacco campaign in the state of Montana. This was targeting 12-17 year olds to reduce initiation in tobacco. It is a dog cell, so we put a dog in the picture; but, most importantly, it is just getting the message out that 70% don't use tobacco.

Public service announcements can also do this. What we are doing is normalising the truth to empower the vast majority who don't drink and continue to put pressure on those who do to stop.

Other strategies include peer education programmes, getting peers to talk about their peers, about what the norms are, rather than preaching down to them about scare tactics. They also include school orientation presentations, which you can bring to counselling interventions. If you are going to break down denial counselling interventions, you can't just tell somebody they have a problem. How are they going to identify that they have a problem? They really need to know where they sit in relation to everybody else, so providing normative feedback about what most people are doing is a very important step in that process, which is part of social norms interventions.

Doing it in curriculum infusion, going beyond traditional class education and providing electronic media is important as well. Those are all the strategies.

The last question is: "Do we have any evidence that it works?" I know I said that being science-based is an important part of this approach. Data are testing the theory. I am just going to give you a few examples.

First, we have correlational studies showing dramatic connections between perceived norms and personal behaviour – perceived norms are the strongest predictor. Beyond correlational studies, we have intervention experiments, where, in brief, high-risk populations will be identified, and we'll do brief interventions, dosing them heavily with normative information about what most peers do and think. We'll then go back three or six months later to see what the effect is, showing the positive effect on those who got the normative information versus the traditional information.

In my own institution, we have done intensive experimentation. In the first 18 months of stopping our traditional programme and doing intensive social norms messaging through the variety of strategies I mentioned, perceived heavy drinking went down 15%, reasons for drinking – to get drunk, to break the ice, to relieve anxieties – all went down dramatically. Drinking to get drunk nationwide actually went up a few percentage points during the same time period. We were taking the pressure off students; they didn't feel so much that they had to drink in social situations when they realised that not everybody else was doing it or drinking heavily. Heavy drinking at parties and bars went down 15%; frequent heavy drinking went down 21%. There were massive reductions in the consequences of heavy drinking as a result.

These were not just the results at our institution. I looked at five schools that tried this experiment out intensively, stopping their traditional programming and doing a social norms intervention intensively over a two-year period. These were all over different two-year periods, but all took place during a time period when, across the US overall, high-risk drinking had not gone down at all.

What was the reduction in terms of heavy drinking? My institution had a 21% reduction. The University or Arizona had a 21% reduction. Western Washington had a 20% reduction, as did Northern Illinois. This is important, because they are demographically very different. We are a highly selective private school in the north-east; Western Washington on the west coast and Northern Illinois on the east coast have a lot of first generation students, a lot of students coming from working-class, blue collar backgrounds. Demographically, it didn't matter: when they were told about their own local norms, it had a positive effect.

Here are the results of the high school project for which you saw a couple of posters earlier. Over a two-year period, consumption of five or more alcoholic drinks in a row went down dramatically. Tobacco use went down as well.

Here are the results of that experiment with the dog cell on the poster. They looked at the counties and went back eight months later. In the counties that had a heavy dose of social norms, there was a 10% initiation in tobacco use. Among all of those who had not used tobacco before, 10% had started using it: it was a bad day. In the counties where they didn't get the social norms message, however, 17% started using. So, having a heavy dose of social norms messaging cut the initiation rate almost in half.

This wasn't just a one-time deal. This is an example from my own institution. Most students had moderate attitudes over a five-year period. We weren't trying to change that, but we were trying to get people to recognise that the majority had moderate attitudes, to change the misperceptions. We steadily increased accurate perceptions and steadily decreased high-risk drinking, the heavy drinking.

Also, there are liquor law arrests, trouble with the police to consider. It wasn't just in self-reporting: we saw arrest rates going down over the same time period in the local community.

There is a 10-year experiment at another institution, where, the first year they were doing traditional programming, the heavy drinking and injuries actually went up a few points. They stopped that and started messaging about the two norms and, with the exception of one year where there might have been some event or big publicity thing going on, the perception went steadily down, self-reported heavy drinking went steadily down and injuries went down.

When is this most effective?

- Most importantly, when you have a clear, positive norm message, when you are getting the message out about what the majority do – that is a positive behaviour – and you are not mixing it with images of people having passed out on the streets and litter associated with the problem all over the place. We do that at times to get people's attention, but it doesn't convey what is normative.

- When it is based on credible data. It has to be based on real data from the community, competing scare messages have to be absent, and the dosage has to be high. It is dosage, dosage, dosage. You can't tell people about the norm just during alcohol awareness week, and then walk away for the year and think people are going to go "Oh, I get it. Most of my peers don't engage in this" and believe it. You can't tell people in a short message "This is the truth" and expect them to change their perceptions dramatically. You have to have heavy dosing over a period of time, using many strategies to get the word out. What I'm talking about here is a student population, but if it is a community, it is the same point. We have to get the word out, not only to the people who are most at risk, but also to those carriers of the misperception in order to reduce everybody's misperception, so we don't have bystanders as well.

If we do all of these things, that is where we see the studies and experiments that have had the most dramatic positive effect. You tell the truth – a very simple message, based on credible data – you tell it frequently and you let the truth do its positive work.

**Dave Zucker**

I am going to talk about tobacco use from the experience that we had with a campaign in the state of Florida. The time period I'm going to be talking about is 1998-2000, so let me just set the context.

In 1997, the state of Florida received money from the settlement that was made between several states in the US and the tobacco industry. The tobacco industry was sued for several hundred million dollars and the state of Florida was the first state to actually receive the cash. The Governor of the State of Florida at the time, Governor Chiles, decided that he would allocate most of that money to a youth prevention campaign. The state of Florida put out a request for advertising agencies and public relations agencies to respond to this offer to develop a campaign targeting youth tobacco use in the state of Florida. The PR agency that I work for responded, along with an ad agency based in Miami, and we went into this without any real scientific behaviour model in mind. We approached this as the marketers that we are.

The ad agency had almost no experience in public health of any kind, but the state of Florida, and Governor Chiles in particular, said: "You know what? This is a really tough issue to tackle. No one has ever tackled this very effectively, so let's bring in some fresh thinking from the private sector and see what they can come up with" – and that is basically what we started with.

The state of Florida had very clear and precise objectives laid out for their programme, which is actually refreshing for those of us working in the marketing business because we don't often get such nice clear objectives from our commercial clients. It was refreshing to have this, although a bit daunting, because they were looking for a reduction in tobacco use from 1998 to 2005 amongst middle school students from 17.7% to 8.5%, and amongst high school students from almost 30% down to 20%. So, daunting objectives.

The second objective had to do with environmental tobacco smoke or second-hand smoke: they wanted to see a reduction in the exposure of these young people to environmental tobacco smoke as well, by relatively significant amounts.

Those were the two key objectives of the programme.

I am going to talk about it from the marketing prospective: the goal; the environment that we were facing; our strategic approach; the programme and the results that we were able to see after two years. This was Governor Chiles' own personal vision. In fact, when we were awarded the contract, he called us to the Governor's mansion in Tallahassee and sat us down and said: "I only have one thing that I am going to tell you to do. You guys are great at what you do. I am not going to meddle in your affairs. You know you have got my full support, but you *will* involve young people from day one. This is their campaign. They will own the campaign – that is the only way we are going to make this work." And they wrote that right into the language of the contract.

They also had a vision going in that this needed to be a very comprehensive multi-faceted programme. It wasn't just a media campaign, just an advertising campaign or

just a grassroots effort, it was really a multi-faceted approach with significant funding. We had about $20 million just for the first year of the programme to execute it in the state of Florida. That is along the lines of a major commercial product being launched, so there was a really significant marketing budget behind the programme.

The three priorities that they gave us were:

- to reduce and prevent youth tobacco use
- to deglamourise tobacco use
- to reduce youth exposure to second-hand smoke.

When we entered into this in 1998, teen smoking was up by 73% in the decade prior to that year, and 90% of people who were smoking had started before the age of 18. So, that was the reason to target people under the age of 18 for a prevention programme.

Tobacco marketing was very aggressive. Tobacco companies spent $286 million in the state of Florida – compare that to the $20 million that we had – and their advertising was clearly very effective. Their branding was very effective in enticing young people to try this product and, once they try it, obviously to get hooked on it. The tobacco companies had been very, very good at positioning their brands as being hip, rebellious and independent, which is really a great magnet for a teen audience; and prior to this effort, all the existing anti-tobacco campaigns in the US were really pretty much following the health terrorism line: "If you smoke, you will die". And when we went and started to talk to young people in Florida around the development of this programme, that is the first thing they came back with. We had them do drawings and focus groups and creative idea sessions, and there were lots of skulls and crossbones and black lungs. Part of our process in working with these young people, who we really treated as if they were our clients, was to help to educate them in what had not worked and some potential ways that they might consider for their programme that would be different from what had been done in the past and try to get them off that very natural place where you head to: "Don't smoke or you will die"

We had a teen summit at a resort area in the centre of the state of Florida. There were 650 teenagers who had been identified by local school districts, who all came together for this three-day summit. The purpose of the summit was that we had to come out of this with the first two TV ads that had to go on air the following week. That was the kind of pressure we were under. We used those three days to work with these teens, to talk to them, to throw around some ideas that we had going into this.

It is clear that teens love and identify with brands. It is one of the ways that they start to express themselves and start to associate with their peer group, through the brands that they wear and the brands that they use. Brands are very powerful and teens are high consumers of pop culture. At the time, the Internet was still at a relatively early stage so it was having some influence, but certainly not nearly as much as today. TV and other forms of media are highly influential on teen culture.

'Generation Y' – the 13-30 age group – places a high value on authenticity and integrity. They grew up very, very high consumers of media and they are much attuned to manipulative marketing tactics. I don't know if you've noticed here, but the

advertising and marketing industry in general has really had to shift strategy. The tone of a lot of the advertising now is very different from what it had been targeting my generation. They don't buy the BS as easily as we did, and so you see a lot more reality. The whole growth in reality TV is maybe the ugly side of this trend and this drive towards wanting authenticity.

Teens are rebellious, they always have been, and they are searching for ways to show that they are in control of their lives. Cigarette smoking is one of the ways that they were saying that they were in control of their lives, especially because all the adults had been telling them that it is bad for you and you shouldn't be doing it. So, guess what? "I am the one in charge of myself and I am going to smoke, even though – especially because – you are telling me it is bad for me."

In starting to talk about some of the messaging that was out there in past campaigns, the teens really looked at that all as preaching. Anything that was coming out of a Government agency was preaching, it was a bunch of do-gooders, and they really turned off to it. Teenagers – and I am sure this is true across all cultures – feel pretty invulnerable, and so to try to get them sensitised to any issues that have to do with health effects is very, very difficult.

Cigarette smoking represented an expression of choice and independence, and the tobacco industry had started to fight the anti-tobacco movement by positioning smoking as almost part of the American right to freedom. We don't tell people not to do something there. It is a legal product and therefore it is in keeping with the American spirit that we should be marketing tobacco.

At the teen summit, they did react very strongly. We took quotes and scenes from some of the tobacco industry testimony in front of Congress, where they were saying, for example, "Tobacco is not addictive". We exposed the teenagers to some of the excerpts from internal memos where they were actually talking about targeting young people. The reaction of the teens at the summit to those messages was very intense and they were getting very emotional about the fact that they didn't want to be lied to.

Prior to going into this, just as an interesting aside, we at the ad agency were thinking that we were probably going to go in the direction of a brand called 'Rage' because we were assuming that the reaction to this was going to be just pure anger: "How dare you do this to us, we are going to rise up and get out on the streets and we are angry". But when we sat down and talked with these young people, the reaction wasn't like that. It was more, "We are not so angry, we just want the truth, just don't lie to us. We will figure it out ourselves, just tell us the truth". It became clear that the anger thing was more appropriate to the baby boomer generation; I was harking back to my days of protesting the war in Vietnam and these young people in this generation weren't feeling it that way. They were much more attuned to: "Don't lie to me, tell me the truth and let me figure out what is right".

As far as a strategic approach was concerned, we wanted to reposition anti-tobacco and really did come at this from a branding perspective. We felt that in order to fight the very effective branding that was coming from the tobacco industry, we had to create a brand that could represent rebellion and give teens a way to express their independence; that could light a spark to a movement where teens would reach out to

other teens, where there would be a horizontal influence. There are many, many more tools available to us today around this concept of horizontal influence with all the social networking online. Back then, we didn't have much of that at all, so it was actually more of a grassroots peer-to-peer aspect of the programme. However, we knew that that was going to be very important in establishing a norm and changing the perception of the norm, establishing a norm that said: "Hey, look, there are a lot of young people here in Florida who are saying 'no', they don't want to be lied to, they don't want to be manipulated and they are ready to stand up to the tobacco industry".

Involving youth effectively in all aspects of the campaign was obviously a very important part of the strategy. Also, a particular challenge very relevant in Florida was making sure that the campaign resonated effectively with all the various ethnic groups that we had to work with, particularly with African Americans and the Hispanic population in Florida.

We were also going to be putting out some very controversial messages. We were a little bit nervous even though we had the full support of the Governor, but here we were using Government money to spark a rebellion amongst young people against an industry that, in fact, was selling a legal product and knowing that we could face strong opposition and perhaps have the plug pulled if we didn't build political and community support as a key piece of this. We used research throughout to refine and revise our messaging.

To sum up: the strategy would be to reposition anti-tobacco, to create a brand to replace tobacco brands in teens' lives and give them a way to rebel. A brand that would be as present in their lives as tobacco brands are; that would match the favourite attributes that they are looking for in a brand; that would make the act of not smoking just as rebellious as the act of smoking; and that would appeal to 'at risk' teens, not just the student council members, the members of student government.

This is all rooted in the idea of tobacco industry manipulation. First of all, we needed to make sure that we were giving teens the facts and the knowledge that they were asking for, what they needed in order to believe in the brand that we were marketing to them. The product that we were offering was facts: facts about what the tobacco industry was doing; facts about what tobacco does; and facts about the marketing with which they were being targeted. The idea was to help teens deconstruct the lies and the myths that were being propagated by the tobacco industry and to direct their natural instincts for rebellion towards the industry itself.

Coming out of this three-day summit we changed our minds along with the help of our 650 teens and shifted our brand idea from 'Rage' to 'Truth'. Teens can wear it, they can watch it on television, they experience it, they talk about it, they believe in it: it is a brand like any other brand. The point is very much about saturation. Whatever the message is, you are fighting powerful forces and powerful cultural norms and you really need the kind of support behind a marketing programme, not just media but grassroots gear. I will show you some examples of T-shirts and hats, and really bring this brand to life in a very compelling way. Events, as well, were created in ways to attract young people, attract even 'at risk' young people and bring them into this movement, bring them into the Truth brand.

We established a group that teens could belong to through their schools called SWAT (Students Working Against Tobacco); they came up with that name themselves. They would then be responsible for planning local advocacy events, local concerts tied to the Truth brand; they were the arms and legs and spokespeople with the media for this campaign. The tobacco industry actually found it very difficult to attack this because the spokespeople were 16 and 17 year old, very eloquent, intelligent young people. It is very tough for a tobacco executive to go one-on-one aggressively against a smart, eloquent young person.

For the additional challenge of needing to ensure that the materials and messages were relevant to all ethnic groups, we brought in speciality agencies that came from those communities and made sure that, through our advertising media buying, we were reaching the influential members of those communities effectively. Again, talking about building support for these controversial messages, using the youth spokespeople was a critical element. We also advertised in local newspapers that did not reach the teens themselves but reached the parents, teachers, educators and other influential people in the community. We also needed to get at the second-hand smoke messaging, which was an adult-targeted message, through traditional media vehicles and especially through minority media in the state which, as a side benefit, also bought us political support. It is one of the realities of working in the States, that the minority-owned media are very powerfully tied to the minority politicians, and if you don't give money to the minority-owned media, you find it very difficult to get the support of the minority politicians. That's just the reality of working, especially in a state like Florida.

We did lots of research, qualitative and quantitative, looking at the changing tactics of the tobacco industry, really looking at them as competition, tracking everything that they were doing as we would in any kind of normal commercial marketing campaign.

I mentioned some of the gear that we developed. This was just about a cool brand named 'Truth' that happened to be about anti-tobacco industry manipulation and the young people all knew that because they were exposed to all of these messages. But they could wear this gear and wear it in any way that they chose. We continued to refresh the gear in all kinds of very creative ways, different versions for young girls as opposed to young boys. Again, a really full product line in support of the Truth brand.

Moving on to some of the events and appearances that we had. One example is the Truth truck, which says on the side: "Purveyors of fine unfiltered facts". That truck travelled around the state and we had young college and university students manning that truck. We would pull up outside a high school football game and just blare music, not talk and not preach but hand out the Truth gear. And, again, teens would immediately associate that with the anti-tobacco message and we could engage them in dialogue, but with a light touch.

I won't go into a lot details about the minority aspects of this, but it was an important component of it. On the Hispanic population, in particular in talking to parents about second-hand smoke, we understood, through our research and through working with community partners, that appeals related to their role as protectors of their family were a very important and compelling message for them. One example was a slogan:

"Your children's death is in your hands"; and this was a very forceful message which was targeted at adult parents of kids in that community and in the African American campaign.

The SWAT advocacy events were very evocative and very controversial themselves and one in particular that the young people organised was called "Put your money where your mouth is". In this, they were attacking Philip Morris spending $100 million to promote its charitable, philanthropic efforts as a company, and confronted tobacco executives. We actually had a representative of Brown and Williamson come to an event and sit in front of these kids and take their questions. It generated a huge amount of press coverage.

On to results. We saw significant tobacco use decline amongst both middle school and high school students: 40% middle school, 18% high school – that is reduction in smoking – and those figures are based on tobacco use in the last month of the campaign. We were also able to demonstrate a correlation between exposure to the advertising and the likelihood or not of using tobacco.

We were also looking at the degree to which Truth was becoming a part of youth culture. Again, it was very important to look at other brands that were high on youth's radar and we saw Truth was clearly in the 'in' column. SWAT was on the way in, not in as strong a position as Truth at this point, but it was getting there.

Overall, what the strategic framework really looked like is that we looked at youth and focused on changing youth attitudes, primarily through the marketing campaign, the SWAT organisation and education in school that was focusing on industry manipulation messages and health effects for the much younger kids. We worked on reducing exposure to environmental tobacco smoke through a marketing campaign targeting adults through SWAT and through partnerships with local communities. The SWAT partnerships were also working on local community-based advocacy to make sure tobacco products were placed behind the counter and not displayed next to candy where they had been, for the most part, but that was again driven by the young people themselves.

If I had to say what drove success:

- It was certainly the political will which was there. When Governor Chiles left office and the brother of our current President took office, the campaign ended – draw the conclusions yourselves. It's only just now – just within the last month – that the state of Florida released an RFP looking at trying to reinstate the Truth campaign, but at a much lower level of spending. The money was actually all shifted out of anti-tobacco and put into other things.

- Audience engagement was obviously a very important piece of the success of the programme. Authenticity, both in terms of the Truth brand and what it represented, the strategy and also the fact that the young people really felt that it was coming from them. We did focus groups and would show them the Truth ad. We would say: "So where did these ads come from, who is behind this campaign?" Interestingly, they never said it was the state of Florida or any government agency. They would say: "Well, I'm not really sure, I don't know,

maybe it is like older kids, like college kids that are doing this". It was tremendously successful from our perspective that they did not associate it with a government agency. We also had the perfect villain in the tobacco industry and you know that is much more difficult when you are dealing with alcohol use because there is responsible use of alcohol, but there is no responsible use of tobacco.

- The compelling brand that we created and a marketing budget that is at par with major consumer brands.

## Scotland's Future Forum

## Client Empowerment and Self Change - 6 December 2007

## Thomas Horvath, Practical Recovery Services

SMART Recovery is a free support group which teaches a self-empowering approach for abstaining from any type of addictive behaviour. I live and work in La Jolla, San Diego, California.

As an organisation, SMART Recovery was founded in the United States in the early 1990s as a non-profit corporation, and it is primarily operated by volunteers. We do now span the globe, but we are mostly in the United States, and we operate groups in a variety of settings. In addition to providing this free self-empowering approach, our primary job is to promote choice in recovery.

The programme: abstinence for any type of addictive behaviour, including activities such as gambling, sexuality and shopping. I want to differentiate SMART Recovery from the dominant model in the US, which is Alcoholics Anonymous, with the 12-step approach, which I know is here but is not nearly as dominant.

Another way to describe this programme is that it is an intersection. There are empirically- supported approaches to addiction treatment that are not necessarily self-empowering, at least on the surface – I think they all are in some way. We focus on the self-empowering part and, then, what will work in a support group. If it requires a professional, then we would talk about SMART Recovery therapy, and I expect our discussion period to focus probably more on SMART Recovery therapy than on SMART Recovery itself.

There are four aspects to the context out of which SMART Recovery arose, and the first of these is diversity. Race, colour, gender, religion, age, national origin, veteran status, sexual orientation and physical disability: this is a list of categories that the American Psychological Association will not allow you to discriminate on if you are placing an employment ad. It is a fairly traditional list. Some of these categories are legally protected in the US and some are not. But when we look at treatment, then we have another list of variables, including socio-economic status, that will obviously have a profound effect on how someone would respond to different kinds of treatment interventions; and then, when we are looking at addictions specifically, I think there is an even broader list.

What we know now, and we will come back to this point probably a number of times, is that the majority of recoveries are those which occur naturally, that is without going to a support group or seeking professional treatment. Let me be clear about this. If I line up 100 people who drink too much, what happens to them is probably anybody's guess; but if I line up a 100 people who have recovered from drinking, then well over half of them, possibly as many as 75% or more, will have recovered essentially on their own, again without support groups or treatment. That doesn't mean that they

really did it on their own, because they just found other ways of engaging social support.

The goal that people have ranges anywhere from total abstinence to what would be considered classic harm reduction: continued use at the same level but with greater safety. There are now many treatment approaches available and these approaches, at the very bottom, take several orientations, such as motivational enhancement or skill-building; and there is also what I have termed passive change. I have now seen a number of clients for other reasons who come in and tell me that they changed their drinking problems by going to acupuncture sessions or having energy healing sessions, something that we don't normally associate with recovery, but it seems to have worked for them in that individual case.

Based on my clinical experience, the vast majority of people come to treatment because they are in pain and want to get out of pain, and one of the jobs of the clinician is to transfer their motivation over towards building a better life. So, what they begin with – avoiding trouble or getting away from trouble – now becomes approaching a better life. But sometimes people come because they have just decided there is a better life out there and they want it.

There are, of course, many levels of problems and many co morbidities that one can have. It was once written about syphilis, before it was well understood, that if you knew syphilis, you really understood all of medicine because it presented in so many different ways. I believe that if you know addictive behaviour, you will probably know clinical psychology or your related field because of the many different ways that it presents.

Some people need to transform their lives almost entirely in order to overcome an addiction, and other people need to make only very minor changes. Some people go and get a lot of social support, and others seem to do it mostly on their own. We have had a number of clients in our treatment centre who keep their treatment secret from their friends and family which, of course, they are allowed to by law, and it is very important to them that it should be completely confidential. A relatively small percentage of people go to support groups, perhaps a third.

Speed of change: this is one of the bugaboos in the field. Some people seem to take nearly forever or, unfortunately, they die first; and, at the other end, people change very quickly. There is very little predictiveness from what I can see.

There are now medications and complementary medical interventions that seem to help some people.

My point is that, when we talk about addictive behaviour, we are talking about a very broad range of problems and a very broad range of solutions. SMART Recovery will address only a small percentage of the people who have addiction problems, but I think that is true for any particular intervention or approach. We need to have a very diverse system of services and options available for people.

The second part of the context out of which SMART Recovery arose is other support groups, and the primary support group, at least in the United States and overall worldwide, is Alcoholics Anonymous.

Here are aspects of the AA programme which, to its members, are often cited as being the most important elements, and to those who don't want to go to AA, they are some of the primary reasons why they don't want to go: acceptance of powerlessness, belief in a higher power, acceptance of the label 'alcoholic', lifelong group attendance and being aimed at severe problems. By characterising SMART Recovery as a self-empowering approach, we are trying, in a positive way, to describe the difference quickly to people. Although, interestingly, in the US, with many people, unless you dramatically say, "this is a very different programme from a 12-step approach", they still don't seem to understand that, because the 12-step model is so dominant in our country. As an organisation, AA has been phenomenally successful. The fact that its effectiveness remains unknown is remarkable. The first evidence that 12-step-based treatment might be effective wasn't published until 1996, which is also remarkable.

I believe that the ultimate justification for support groups is not scientific evidence but whether people attend. In absolute numbers, AA is a very large success, because there are a million and a half to two million members. Relatively, its success is also limited. If I stick with the US figures, there are perhaps 20 to 60 million Americans with drinking problems, depending on how severe you want to look at the problem, but only one to two million AA members – clearly, it is a minority solution. So, most won't go and, of those who go, most don't follow through.

There is room for lots of other approaches and, in fact, there are now a number of alternatives although, collectively, they are still perhaps 5% the size of AA. The oldest of these is Women for Sobriety, which began in the 1970s. SOS (Secular Organisations for Sobriety) started in the early 1980s; and then Jack Trimpey, a social worker in California, founded Rational Recovery. Rational Recovery no longer offers free support groups; it is now a for-profit treatment centre and has relationships with SMART Recovery, which I will come back to. SMART, MM (Moderation Management) and Life Ring all began in 1994. Of this list, only Moderation Management is supportive of either moderation or abstinence, the rest are abstinence groups.

I did a phone survey almost 10 years ago and, from what I can see, the results really haven't changed. I have been in San Diego since 1985, specialising in a non-12-step approach to treatment, and I speak at every opportunity I can. I have been very active in trying to promote the idea that there are alternatives to treatment. In the phone survey, when we spoke to people who answered the phone in addiction treatment centres, we gave them a little story. We said, "I have got a girlfriend, and she needs help, but she refuses to go to AA. I looked you up in the phonebook because you provide alcohol treatment, so you must know what else is there." Nearly half said, "Oh, there isn't anything else" and the other half said, "There is other stuff, but it is no good". So, 8% got the answer right – that there are alternatives and they might be helpful – and that is probably not a bad sample for the entire US. Amazing.

Then there is an entire body of scientific literature which forms the foundation of SMART Recovery. In SMART Recovery, we do not view addiction as a disease. I

recognise that these are very controversial issues in some areas. I also believe that there is no point in arguing with somebody on this point – most people seem to have their opinions about it for themselves: "my problem is a disease" or "it is not a disease". Therefore, SMART Recovery would be a good choice either for someone who wanted to learn specific relapse prevention skills, even if they viewed addiction as a disease, and it certainly is the first choice if you don't view it as a disease. Most people have, if not a diagnosable co-occurring disorder, probably a sub-clinical one.

There are treatments that, at least in studies, seem to work. How they work in the real world is a separate question but, in any event, all of our services probably ought to be oriented around promoting a naturally occurring process. Treatment should not get in the way of natural recovery. First of all, do no harm; and, then, how could we supplement that naturally occurring process?

The book I turn to – and there are other places to turn – is Hester and Miller's *Handbook of Alcoholism Treatment Approaches: Effective Alternatives*[54]. I don't know if a fourth edition is going to be forthcoming now that Bill Miller has retired, but he had reviewed all the randomised controlled clinical trials for addictions, or alcohol treatments specifically, published in 2002. To summarise: there were some medications, cognitive behavioural treatment, some aversion therapies, brief intervention, and motivational enhancement. There are fewer than 10 treatments that have a very strong empirical base. If there were a book that would be the bible of addiction treatment, this would be one of the nominees because it reviews that entire literature.

The literature on drug treatment has caught up significantly, in terms of number of studies, and has largely similar findings, for example, the US National Institute on Drug Abuse. These are a few of the principles from the 13 principles that they list[55].

The first statement – 'No single treatment is effective for all individuals' – is important. What they are trying to say, but they won't come right out and say it, is that 12-step isn't the only solution – but this is a more diplomatic way of saying it. As a US citizen, at the moment, I have many disagreements with my Government, but one of my disagreements, in this particular area, is that they are not taking more of a leadership role in broadening the diversity of options available for people.

We go on to include the role of medications and the importance of looking at co-existing emotional and mental problems. I can say that in my treatment centre the vast majority of time and sessions with clients is spent on other issues. My sense is that there is only so much time that you can talk about motivational enhancement and coping with craving, and the rest of the time you are talking about anxiety and depression and trauma, relationships, communication skills and so forth, and that is where the majority of time goes.

There are now a few studies of SMART Recovery. One of these was published by Penn. It was federally funded, with the substance abuse and mentally ill population,

[54] Hester, R.K. & Miller, W.R. 2003, Handbook of Alcoholism Treatment Approaches: Effective Alternatives, Allyn & Bacon, Boston.
[55] National Institute on Drug Abuse. 1999, *Principles of Drug Addiction Treatment: A Research-based Guide*, Available at: www.nida.nih.gov.

and it compared a SMART Recovery oriented day treatment programme with a 12-step oriented day treatment programme. I think one of the interesting findings of the study was that, as she wrote, 'The 12-step programme might not have survived if they hadn't made it more client-centred and user-friendly. They had to back away from the traditional, confrontive approach that is used in the US-based 12-step treatment at this time.' One approach wasn't better than the other, which was an adequate finding for the time, since 12-step is the predominant route in the United States.

I imagine you will all have seen the Stages of Change model before. This notion that we need to target interventions to a client's stage of change just makes complete sense once it is finally introduced into the field, but we didn't have a language for this, I think, until this model was introduced some years ago.

There has also been an important legal context for SMART Recovery and alternative support groups in the United States. The US Constitution was adopted some years after the Revolutionary War – I think it was 1787. Then, some years after that, came a group of amendments – the first group of 10 amendments to the Constitution, which I always take to be a significant fact because, for as fine a document as the US Constitution is, they immediately had to amend it 10 times – and those amendments in the US are known as the Bill of Rights. The First Amendment guarantees freedom of speech, the press and freedom of religion; and the freedom of religion sentence is usually referred to as the Establishment Clause: 'Congress shall pass no law respecting an establishment of religion nor prohibiting the free expression thereof'. On the basis of that Establishment Clause, the courts in the US have now ruled repeatedly that, because for practical purposes AA is like a religion, it is illegal for the Government to require someone to attend. This may seem like an unusual idea to you, but it is very common for a judge to sentence someone in the United States and, if alcohol was related to the crime, the sentence will include attendance at AA meetings. This is now starting to change because of various rulings.

The highest court in the US is the Supreme Court, but underneath it there are Circuit Courts of Appeal. Five of these Circuit Courts have now made virtually the identical ruling: that AA attendance – mandated AA attendance – violates this Establishment Clause. The most recent ruling, in September 2007, changed the situation even more. The case involved a parolee in Hawaii who was a Buddhist and who objected to attending 12-step- based treatment, which the Salvation Army was offering. His parole officer ordered him to attend, he refused, and they sent him back to prison, where he died. I don't know the circumstances but, apparently, they were enough to consider the possibility of damages, and his estate sued the parole officer, saying, "You shouldn't have ordered him to prison for that reason". The parole officer came back and argued, "Okay, I understand it now. I shouldn't have done that, but I am a Government employee and I am granted qualified immunity in my role as an employee"; and the Ninth Circuit said, "No, because you really should have known this: the case law is extremely clear. You were not granted qualified immunity". The case was therefore remanded back to the District Court in Hawaii to determine what damages, if any, the parole officer might be held accountable to. When I have spoken in the last two months to groups of Government employees in San Diego on this ruling, you can hear a pin drop. I expect we will get some very rapid change now that money has been added to the consideration.

The rulings go back to 1996. The Second Circuit's ruling *was* appealed at the Supreme Court, which declined to hear it. With five Circuit Courts ruling in the same direction, it is now quite unlikely that the Supreme Court would overturn this decision. Nevertheless, it will probably take years for this to be fully implemented.

We have looked at four aspects of the context out of which SMART Recovery arose. To review these: we need to have a diverse range of options, support groups, treatments and modalities for change. We do have some other support groups now. The scientific findings are there. We need to have at least one support group that would seem to be relatively consistent with them. One advantage of having SMART Recovery available is that, if you are offering evidence-based practice, both for addictions and/or for anxiety and depression or the disorders that commonly go with addiction, you can put a client who is in treatment also into a support group that is very consistent with what you are doing in treatment. Of course, support groups are sometimes the only thing that people use, and that is fine too. I don't know the exact state of Scottish law, but, at least in the United States, somebody can completely avoid violations of the Establishment Clause by referring someone to SMART Recovery.

The primary document in SMART Recovery – the Purposes and Methods Statement – is just two pages long. There are only four numbered statements in it, and the first of these is 'We help individuals gain independence from addictive behaviour' – any type of addictive behaviour. 'Gain independence' is understood to be more than just abstinence, but reorienting your entire life to a healthy lifestyle of well-being and productivity and good relationships. Freud once said that a healthy person should be able to love and to work – and that is still a great formula for looking at your life.

In the second numbered point we then have four bullets and, collectively, they are known as the Four-Point Programme: 'We teach how to: enhance and maintain motivation to abstain; cope with urges; manage thoughts, feelings and behaviour; and balance momentary and enduring satisfactions.' The last two are the self-management points. These are not 'steps'. These are four aspects of recovery that we believe everybody is going to need to pay some attention to, but to some points more than others. So, of course, you are not going to change without some level of motivation to change, and you will probably need to cope with urges or cravings – we use the terms interchangeably, but I know some people do distinguish them.

Managing thoughts, feelings and behaviour at this point is primarily from a cognitive behavioural perspective.

Balancing momentary and enduring satisfactions. One of the examples I often use with my clients is that everybody knows that you need to save money for retirement and your old age; but if you put all of your money into retirement, you would die of starvation in about a week, so that wouldn't be a good choice – you really do need to balance. Unfortunately, for our participants, typically the balance is weighted far too much in the other direction; and they understand that, but at least they are happy to understand they can have some momentary satisfactions, and then we just look at some other ways to get them help. I often tell people: "There is nothing wrong with getting intoxicated, but let's just find some other ways for you to get intoxicated, get high, that don't have the side effects of the methods you are using now".

Many people think that SMART Recovery is a cognitive behaviourally oriented group, and that is true for the moment. We may not be here to see it, but I expect in 100 years, the SMART Recovery programme will look somewhat different, perhaps dramatically different, because the evidence base is going to change. We purposely wrote this programme to allow it to evolve, and I will show you some of the directions we are thinking about currently.

I would say the biggest evolution we have had in 13 years so far is that we have increased the motivational components of the programme on the evidence that motivational enhancement therapies have seemed to be effective. We do encourage people to stay involved with us. One of the masterstrokes of the structures of AA is that you are not supposed to ever leave the organisation, and that is an excellent way to build an organisation over time. Our philosophy has been 'Get what you need and graduate'. It is an organisational disaster because we constantly need to pull new people in, but we are trying to balance that and stay true to our philosophy. We are actually looking to start partnering with some outsiders from various other organisations because our biggest problem is finding meeting facilitators. Our participants really do graduate, really do move on – which is what we want them to do – which is why a certain amount of Government support wouldn't be a bad idea either.

In addition to the four steps, the four points of the SMART Recovery programme, we teach a set of nine tools. We are not going to go into the detail now, we can discuss them later. Our big focus recently has been to simplify the programme, not to make it more complex because, particularly in the early stages of recovery, people are easily overwhelmed.

We have recently put out a very basic meeting outline. Meetings can be 60 minutes or 90 minutes – that is up to the facilitator. There is a two-paragraph introduction that is read and then a quick check-in. If this were a SMART Recovery meeting and we have 50 people in here, more than 50 people, I would say, "We are going to do a quick check-in. Because there are so many people and we want to get around the room, everybody gets to say one word. Fraser I will start with you and we will just go right around the room." Then I would ask for volunteers for the extended check-in, and we would limit that to two or three people. We used to refer to this as 'working time', but it intimidated people that it was a bigger task than they wanted to take on, so now we just talk about an extended check-in. Fraser Ross is SMART Recovery Scotland and started the organisation here. If Fraser were going to do the extended check-in, I would say, "What do you want to tell us about?" and it might be a problem with his work or his neighbourhood or whatever, and then we just go around and do several people like that and, in the discussion, attempt to introduce perhaps a SMART Recovery tool or two to start to show someone how SMART Recovery could be helpful in their situation.

That is the bulk of the meeting. As most self-help groups do, we pass a hat and ask for donations, and then we do the check-out. In this group, because of its size, you might only get to say one word; if it was a smaller group – eight to 10 members is the ideal size for a SMART Recovery meeting – I would allow longer for this than the check-in because, if I am facilitating the meeting, I start to get some feedback about what was

meaningful to people and that will shape what I do in the meetings ahead. So this is about as simple an outline as we think we can get by with.

I wrote an article for our newsletter and said, if you are a beginner facilitator, these are the things you need to focus on: the discussion needs to keep flowing, you can't let one member dominate the discussion; and it needs to stay focused on addiction issues, there has to be some connection. You can talk about work: if your typical way of dealing with work stress is to go to the pub afterwards and then to drink too much there, then work becomes a relevant issue under point three 'Identifying and solving problems'; but if it is completely unconnected, then they belong in another group. We would try to accept whatever a person was saying – this is not a meeting primarily about confrontation – but we would offer a more rational or scientific perspective if it seemed appropriate to do that.

Let's do a little bit of history. Our initial groups were called Rational Recovery Groups, and they were started in the late 1980s by Jack P Trimpey. He pulled together a Board of Advisers, which met in Dallas, Texas in 1991, and that group was incorporated in 1992, at the time as the Rational Recovery Self-Help Network. We had a name change in 1994, when the Board decided to end the relationship with Trimpey because he was moving in a direction that we didn't want to go in. At the time, we all wanted an evidence-based support group, and he was heading off in a new direction, so we simply changed our name and invited the support groups in existence at the time to either affiliate with us or to stay affiliated with Trimpey. As of 2000, he stopped offering support groups altogether, and we have no further connection with him. We got a grant from the Robert Wood Johnson Foundation in Boston, and we started offering annual training conferences in 1996. We began an International Advisory Council in 1998 – Dr Linda Sobell is one of the members of that Council – and the Council graciously allows us to use their name as an additional source of credibility and, from time to time, they review our documents and make suggestions about what might be improved.

A major change for the organisation was in 2000, when we began to outreach for non-recovering facilitators. We are the only support group that I know that does this. This has been a very interesting development, I think, because the role of a facilitator in a SMART Recovery meeting is relatively demanding, and it is demanding in two ways. You need to know something about those nine tools and those four points, and we actually have a training programme that involves four 90-minute conferences calls, plus about 10 hours of reading and viewing a video. So, that is a certain amount of time commitment, but even more demanding than that is the role of actually facilitating the meeting.

I was a soccer referee at one time. For me, facilitating is not difficult because, as a professional, I have a lot of training; but when I first got on the soccer field, I wasn't prepared for the parents of a six year old to be screaming at me the way they did. There is a certain level of personal authority you have to have to be a good referee or to be a good SMART Recovery facilitator, and many individuals in recovery just don't feel they have that. My latest angle on this has been to approach (I don't want to name the organisation) an organisation that claims to offer its members – and it does – some leadership development opportunities. I said to them, "If you will partner with us, we will give you a leadership development opportunity that you probably won't

have. A SMART Recovery meeting is filled with individuals who can be whiny, irritable, demanding, self-centred, not seemingly capable of listening to anybody else, and so forth – and that is on their better days. So, if you can manage a group composed of these individuals, you can probably manage almost any business meeting, and it would be a great training opportunity." We are hopeful that we will start by partnering with this rather large organisation, and we have some others in mind, and that we will accomplish several things: we will get more facilitators, because that seems to be the biggest bottleneck for expanding the organisation, and I think we'll demystify some aspects of addictive behaviour because as 'normies', as they are called, start to get to know addicts and alcoholics – terms, to remind you, that we don't use – they will start to realise that these are just regular people who have a particular set of problems. So, on both counts, we are excited about this possibility.

InsideOut is the SMART Recovery prison programme, correctional programme, which was developed with some federal funds and tested, I have forgotten what the comparison condition was, but it was shown to be equally effective, and it is now in use in some US prisons and in Scottish prisons and in Australian prisons; and, in one state in the United States (Arizona), it's the dominant mode of treatment. We expect that to continue as well. It has been very well-received by the inmates.

We have a very simple structure. People come to meetings, which could be on the internet, or they purchase our publications. We have meeting facilitators. Facilitators are supported by, advised by, volunteer professionals, volunteer advisors. I'm the volunteer advisor for San Diego County. In some areas, we don't have an advisor, so they would come through somebody in another locality. It is often me: I am a volunteer advisor to localities throughout the United States. Fortunately, once people get going, after a few months, they typically don't need a lot of support in that way.

Our central office is near Cleveland, Ohio, near the Great Lakes. Half of those on our current Board of Directors are addiction professionals and the other half have some other occupations. All have had a long-term relationship with the organisation. Then we have the International Advisory Council. We are very, very grateful that these individuals have agreed to become affiliated with us.

We have a few publications. The Yellow Recovery Handbook, which is in the second edition. The first edition came out in 1994, and it was radically rewritten in about 2004. We have a Facilitator's Manual, a newsletter, a recommended reading list, and there is a great deal of free information on the website. We kept Trimpey's book on the recommended reading list. By calling it *The Small Book* he is making a pointed reference that it is not AA's *Big Book*.

We have a number of internet meetings now, but I am hopeful that we will have them 24/7. You can log on to the website. There are generally 50 people on the message board at any one time, but if you want to connect with somebody, you have to do it by posting a message as opposed to an interactive meeting.

We are starting to experiment with some specialised groups. Our normal idea has been that it is beneficial to mix coke users with alcoholics, with meth users, with gamblers because they start to be able to rise about the problem and see "I have cravings, say, for heroin, but I don't have cravings to use slot machines; but he is

talking about the cravings in the same way that I talk about cravings; maybe I could learn to manage these". This does seem to happen. However, there does seem to be a role for team groups, and we have started to experiment with some sexual addiction specific groups only. I think primarily there because there is much greater shame for most of the participants associated with that addiction than with some of the others.

We have had a number of celebrities in addiction treatment lately in the United States. At least in US grocery stores, you can't get through the checkout counter without seeing headlines in the tabloids about Lyndsey Lohan or Britney Spears, or whoever, so people understand that there is addiction treatment out there and that people go to it.

We have continued to support research. We have had a few studies done, and we are always looking for someone who would like to use our participants as subjects, and they are generally quite happy to comply. I expect we will continue to grow. I have already talked about facilitators as leadership trainees, and we hope to expand that as well.

One of my very, very part-time activities is to help teach leadership at the University of San Diego; and the distinction between leadership and authority is, in our school, a very important one. One way to say it is that the authority figure is someone who does things right and the leader is someone who does the right things; an authority is someone who is an expert on a known body of knowledge, and leaders are those who are helping organisations craft new solutions for which solutions are not yet known.

When you manage a SMART Recovery meeting, you are not actually a leader, you are an authority figure. You are managing a meeting according to specific guidelines for how that meeting is to be run, but you need a certain level of confidence to do it.

We are having an increasingly international presence. Stealing a line from this side of the world, I wrote a President's Column a few years back in which I mentioned that the 'sun never sets on SMART Recovery' because, at that point, we had reached Vietnam and Uzbekistan.

Mindfulness is under some discussion currently as a possible addition to our programme because there is emerging data that mindfulness Eastern techniques applied in specific ways might be a useful addition for treating a number of problems.

When I look to the future myself, I see three different ways in which our programme might change. There has been a much greater emphasis in the basic clinical psychology literature on the role of emotion. Amazingly, psychotherapy has primarily focused on cognitions thinking and behaviour, but there has been relatively little direct discussion about emotion. The December 2007 issue of the *Clinical Psychology* journal of Division 12 of the American Psychological Association is an entire issue devoted to emotion. We will see what emerges there in terms of helping people have greater emotional awareness, managing their emotional expression, regulating their emotional experience. That is one area.

Another one – and this seems like an old-fashioned term – is 'willpower training', but I am referring to the social psychological experiments of Roy Baumeister and others.

These have some very interesting findings that suggest that willpower is a kind of energy reserve and that it is relatively easily depleted. They make the analogy to exercising. If I have just worked out and had a hard work-out, I am, until I recover, actually weaker, for a few hours at least; but if I work out regularly, I will gain strength. They have put people in rooms where they have plates of radishes or plates of chocolate chip cookies, and then had them stay in the room for a while before coming on to do some of their task – and the subjects have no idea, as it is often the case in social psychology experiments, what is actually going on. They have discovered that people's capacity to risk temptation in the next room with something else is significantly more depleted if they are sitting there in a room full of chocolate chip cookies than a room full of radishes. I heard Baumeister talk a while ago, and he said: "I now have even reassessed things like swear words. We don't have this any more. It used to be that there were all these words that everybody knew, but you couldn't say them in polite society, so it would come into your mind, and then you would have to suppress saying it. I think that is a kind of willpower training that we don't get to have any more." It led me to thinking that maybe, at least in our treatment, every client who comes through the door might be put on some sort of willpower training regime right from the first day. This very easily could be exercise, since many people with addictions don't exercise very much – some do – but that would be, as we say, 'killing two birds with one stone' because they need the exercise also and they would overcome that resistance each time.

I think one of the things that disgusts the general public about severe addiction – and if you work in the field you have seen this – is that it would be quite common for someone who has got severe addiction problems to, say, open a candy bar and drop the wrapper on the floor because he didn't want to make the effort to walk 12 feet to the wastebasket. It is that kind of loss of willpower to do the right thing that does in fact exist. For some of these people, just getting out of bed in the morning starts to become a major ordeal, so we need to reverse that. How we would work that into a self-help format, I don't know. Maybe just everybody in the organisation would have some sort of willpower development project. We will think about it.

I haven't fully formulated how to do this, but when we finally get a better handle on adult development, I think it will have the same impact on the field that the Stages of Change model had, where we start to recognise that your level of cognitive complexity restricts how you are going to understand your addictive behaviour. Think about Robert Kegan's work in *In Over Our Heads: The Demands of Modern Life* or the kinds of developmental levels that Ken Wilber talks about in his *Theory of Everything*. You can understand things only to the maximum level of your cognitive complexity; and, by analogy, if you keep making action stage interventions for somebody who is in contemplation or precontemplation, you are not going to go anywhere; and if you try to explain addiction at one cognitive level to somebody who can only understand at another cognitive level, you have a problem. That is going to be a very difficult thing to work into a support group context. We haven't even worked it into treatment yet of any type, so there is a lot of work there to do.

Just to remind you, there is a paradigmatic example of this with five year olds from Piaget. You take a short, wide glass filled with liquid and you pour it into a tall, thin glass. The child watches you, but the level of fluid in one glass is lower than the level of fluid in the other glass. When you ask which glass has more fluid, up until a certain

age, they always say the tall, thin one, even though they have seen you pour it. I understand that there is an exception to this if it is a particularly desirable drink for the child, say orange soda pop, then they understand it is the same thing; other than that, if it is just water, something about being higher is more is something they can't get beyond. So, we have got to figure out how to do this with adults, because adults keep developing through adulthood. In fact, Kegan has suggested that the reason that we live so long now may be that we have the opportunity to develop into what he calls 'fifth order consciousness'.

If we go to a very big question – What is the purpose of life? Darwin would say survival. Aristotle, writing in the *Nicomachean Ethics* in about 350BC, would say happiness, however we get there. And then we look at addiction, and we find that those two things actually go together. If you think of ourselves in our hunter-gatherer days, pre-civilisation, 11,000 years ago or more, when you were having fun, meaning you were eating, having sex or experiencing the love and affection of those around you, you were also surviving – those two things went hand in hand. In the contemporary world, when you are having fun, there is a very reasonable chance that you are killing yourself – and that is the transition into civilisation that we have not figured out how to manage.

Food, sex and attachment are three related, but separate, innate motivational systems; whether status or prestige, power or stimulation are as well, I am still thinking about that and reading literature. I do think of media stimulation as a pretty powerful source of addictive behaviour. I remember, a few years ago my parents came to visit, and my dad asked what time the paper arrived in the morning. "Well, Dad," I said, "I don't get the newspaper" and he said, "That's okay, I'll watch the news on TV". When I said that I didn't have a TV, he was surprised. I quit watching TV a long time ago, and my life improved immeasurably, but he was clearly having a withdrawal reaction, and I finally figured out where he could go and purchase a paper in the morning. He and my mother needed this level of stimulation. You see it with people walking around with earplugs, managing this. My own particular view – this is not SMART Recovery now but my own particular view – is that addictive behaviour is increasing, because we have so many different ways now to be addicted. In the US, two thirds of the population are overweight; we have increasing non-prescription use of pharmaceuticals. It raises the question "How are we going to tackle these problems?" because, so far, we have been dealing with them on an individual basis. We are going to try and increase the level of self-control or willpower in individuals, and that seems to be necessary if we are going to have a free society. We do know that prohibition probably doesn't work, but is there a public health way to manage this? Do we outlaw fast food restaurants, for instance? It doesn't seem likely that we would do that. So these are some of the considerations I will keep in mind as we try to shape the SMART Recovery programme in the years ahead.

From a public policy perspective, of course, if you can have people in free support groups versus paid services – that is obviously a costs saving. I did some rough calculations. For under £100,000 per year, there could be a very thriving SMART Recovery organisation in Scotland, actually throughout the UK, because they are basically funding two people and everything else is volunteer.

I have talked about encouraging partnerships, and we are going to continue to do that.

## Linda Carter Sobell, Nova Southeastern University

What I want to do today is give you an opportunity to learn some new clinical techniques that you can use with your patients right away. We are going to do some role plays and as this is a big group we can do this by breaking into dyads. There is a motivational interviewing strategy card supplied because when you are trying to learn new tools sometimes it is hard to, so about a year ago I came up with these cards and they have actually become very handy in doing these motivational interviewing workshops.

It would take eight hours or two days to go through this. We have got a very streamlined programme for you, it is not going to be that you have got a full exposure to MI but you will have a handful of four or five techniques, ones that you can go back and start using tomorrow.

What I want to do is maybe take about ten minutes to walk you through an understanding of what motivational interviewing (MI) is in terms of its tone, its focus, and how it got developed.

Basically what we are talking about is learning how to construct a conversation with somebody so that you can influence their receptiveness to consider changing a risky or problematic behaviour. I don't specify alcohol, drugs or smoking because what you will see in a moment is that motivational interviewing has become a common currency in healthy mental health. So whatever the problematic behaviour maybe: getting rid of a spouse, working with a child whatever, it may be flossing, alcohol drugs. Whatever the problematic or risky behaviour is we can work on it.

A lot of what we do in the addictions field is doing that but is not to evoke resistance. You want to have happy campers and how we do this is through a different interactional style. This is not a therapy, in fact if you were psychodynamic or if you are cognitive behavioural or if you have a family orientation you can layer this on. All it is intended to do is to help you work better with patients to help them increase their understanding of what is going on and increase their willingness to consider changing.

So how do you approach them? You have heard Tom talk about not using certain kinds of words like alcoholic and drug addict and that is what we mean here – presenting information in a non judgemental, neutral context about the risks of continuing behaviour or the benefits of changing. You will understand about what the language means. We are going to do a short role-play around the language issue and the tone. The language is really critical because if I say for example, "How many years have you had an alcohol problem?" versus, "Tell me a little bit about your alcohol use?" You hear a difference. OK. And if somebody is a little bit shy or uncertain about considering changing which one do you think they would feel more comfortable with talking to me about, the first or the second? OK.

And you will see that as we go through here there really is a reason behind all of this. We heard somebody talk about evidence based. There is a rationale behind all of what we do here. I am not going to go into the science part of that; there is lots of it,

references for it. Just to let you know a little bit about my own background. I am a scientist practitioner meaning what I do has an evidence base but I also see clients in my clinic and I also train doctoral students. So I think I have a real grassroots feel for what we are doing.

Who is it for? Patients too are ambivalent about changing. There are a lot of patients who come in that want to change right away – that is not what we are talking about. But what you are intending to do is to build rapport. Now why would you want to build rapport? You want to build rapport because the more the empathic nature of the conversation, the better the outcomes, the happier the person is, the more they are likely to comply so that if this group rated me as having higher rapport empathic feel versus this group, who do you think would have better outcomes?

So what we are intending to do is to construct this conversation so that it builds empathy and coming back to that, you can understand empathy seems to be the critical thing for why people do well. That is why motivational interviewing has a lot of things that are built into it like that.

We want to get people talking about the ambivalence. We want to get them talking about the good things and less good things about their drugs. Yes I did say good things. We want to talk about the good things and less good things about domestic violence. Yes I did say good things. And you will see why. But we want to talk to them in a manner that is likely to increase their motivation for change and the reason we have both sides of the equation is because we have to make a connection. There are good things initially to problematic behaviours and you will see if we don't recognise that, that we have a disconnect or conversely we make a connection with people where they really understand. The aim here is to elicit the reasons for changing from the patient rather than me saying, "You know if you don't change your alcohol use you are going to die of cirrhosis."

There are health care practitioners and therapists that do become more confrontational. What we know is about 10%, 15% of folks do like to be told what to do. The other 90 – 85% of people do not like to be told what to do. So what we want to have happen is that we will say to the patient, "Do you know what would happen if you don't change your alcohol use." "Where do you see yourself 5 years from now if you don't make the changes that we have talked about? What would be some of the benefits of changing?" So when we say, "What would be the benefits?" We give voice to the patients because what we know is when people speak out loud about themselves that they are more likely to change than being lectured to.

Psychological studies show you this over and over again. A lot of these things got built into motivational interviewing because of Bill Miller and Steve Rollnick. If you want a definition, – it is patient centred. Bill Miller and Steve Rollnick, who are the founders of motivational interviewing pulled heavily from Carl Rogers on empathy and patient centred, but what happens is where it departs is in its directive method for listening. So it is a patient but directive method that is the difference from Rogers.

But we are listening to intrinsic internal motivation for change. You can send somebody to treatment from jail, from prison but their motivation has got to come from within because if it they are saying, "Yeah I am going to do it for my spouse,

yeah I am going to do it", – but it is not real, it is not going to change. It has got to be a real sense that they have got to do it for themselves.

The other part of the definition is that we are exploring and resolving the patient's ambivalence about changing a risky problem behaviour so we do that with the divisional balance exercise or talking about the good things and less good things about a behaviour using something called reflective listening which is basically saying it. Reflective listening is basically reflecting what you see or hear and there are a variety of ways of doing that but when you do the reflection it is like that's a big change and it sounds like you are feeling good. You are being empathic and again coming back we know that empathy, empathy, wear your empathy blanket and you will have a much better outcome, much better compliance with your patients.

Now at the beginning, let me tell you, there are no perfect therapies. It is not like I am going behind closed doors and 100% of my people are going to run out being cured. It doesn't happen that way but they will have better outcomes. They will attend more often, there is going to be increased compliance. So by and large if you are using a motivational interviewing style whatever therapy you are doing you are going to have all of those things happen versus not. We will do some role plays in how that happens.

We are going to focus on the patient's concerns and beliefs. You may be concerned about the person's xyz. Let's say they come in for something and you are concerned about their interactions with their children. You can creatively say, "So I am wondering how your alcohol use affects your relationship with your children or your spouse?" – but if they don't see it as a problem you have got to find a way to be creative. It is dependant on their concerns and beliefs because when you force somebody into talking, it is not going to work. I have already said that the big part of this that is really effective is that it gives the individuals a sense of empowerment. Now why is that important? Well what we know is that folks that have low self-efficacy at the end of treatment do not do well, do not have positive outcomes. So what we want to do and we know that most of them don't have good self-efficacy is to give them a sense of self-confidence or self-efficacy, build that in. We have that with the readiness rulers as we will show you through the rest of the day but you want to have them having the sense that they can do it. So again, we are looking at empathy having better outcomes. We are looking at self-empowerment having better outcomes. It is also a respectful way of going.

Initially motivational interviewing was developed for substance abusers because that is where Bill Miller and Steve Rollnick started working. It developed because of these three things. At the end of the week they had high drop out rates in the substance abuse field, high relapse rates and poor outcomes. The TGIF thing I think was invented for us because at the end of the week it was very difficult.

Motivational interviewing has become a common currency among health care and mental health care providers. It has gone way beyond anything that I ever thought and I am sure Bill and Steve ever thought –beyond substance abuse and into dietary and medication compliance, hypertension, insulin dependent diabetes to eating disorders to schizophrenia and to flossing. It has gone and become a common currency among health and mental health care professionals because it works and

there are about 150 clinical trials out there supporting the request for a variety of behavioural domains and patient populations.

Conceptualisation – How can we think of it? It is a state of readiness to change and it can vary from situation to situation. It has been a long day for folks. How many of you would like to go home tonight and clean wherever you live for six hours solid. So I come along and I do the white glove test. How many of you would like to do that. Really, why not? You are not very motivated, why not? Not very much fun is it, no rewards. Let me change the equation a bit.

So imagine in my pretend world you didn't want to clean your flat or place like that for six hours. If you could really pretend that I could do this, how many of you would do this for £5million? How many? OK. What happened is really what happens in lots of situations around motivation. I change the equation. It went from really not very rewarding to really very rewarding and so what happens is motivation waxes and wanes for all of us in different kinds of situations but the most important point of what I did through this is to demonstrate to you that it can be influenced by you. By how you talk, what you say and how you say it, that is what we are getting at and so you want to change the equation for the patient.

So the important part is to understand that it is a dynamic fluctuating in a modifiable state but most importantly using these kinds of techniques you can help influence the client's motivation.

Now high levels of empathy. What are the key factors? I said you express empathy through reflectability. You say, "It sounds Fraser, that you are really wanting to change but it also a struggle for you. I know you have been coming to...", and so you connect that way, it is a gigantic part of it and the reason for doing this if when I say it 'sounds like', or 'I get the sense', or 'I am understanding', what you are doing is validating that you are hearing the person and you are validating that what they are saying has a basis there. Now you are not saying that you are agreeing with them but that you get the sense that living with your wife is really difficult, I am not saying that but I am getting the sense and you are making the connection and the big part of this is that you are validating.

There are additional examples that you see so you can get the flavour of it because examples are really the big part of understanding. You want to do what we call 'change talk'. You want to get the person telling you why they should change or what will happen is they change or what won't happen if they change, where they will be five years from now or six months from now so the idea is when we are talking 'change talk', have the person give voice to the change process or lack thereof and the arguments are coming from them rather than my saying, "If you don't do this she is going to leave you." Instead we say, "We have been talking a little bit about your relationship with your spouse and it sounds like it is on shaky ground, what will happen if you don't make some of the changes she is demanding?" rather than my saying it. So the big part is getting you to think about having the patient give voice to the change process rather than lecturing. It is a very simple thing to do but it is one of the major things. When they hear themselves say, "If I don't..." it actually is one of the most successful markers when you hear them say that.

To give you an idea of the evidence base, we find that those that are doing the change talk have better outcomes so that is where we know some of the things that need to be done here.

So, for example, we say, "It sounds like you are concerned Tom about your gambling, you know what will happen if you continue at the rate that we have been talking about today", and the patient fills in whatever it may be, and you go on and then you say "and what would happen in five years time if you didn't make a change" Or in another examples you might say, "You are 55 and seem to having some difficulty breathing, what will happen in five years if you continue smoking?" You see you have got reflective listening, and you will ask, "It sounds like you are not happy" and the person might say that having to take insulin, it is not a fun thing to do and you will say, "Well it sounds like you are not happy with having to take insulin. What do you know about what might happen if you don't take it on a regular basis?" So you get the sense of what you are trying to do there.

"What would be different if you do stop or change or quit?" "How would your spouse feel about it?" There are lots of variations, you can ask any of these things. "What would be different in your life? What would you need to do to?"

Now for those of you not experienced in MI, just to repeat a little about tone. It is not judgemental, it is not confrontational, it is empathic supportive were patients can discuss the good things and less good things and that is where we are going in a moment. You know when you do this inquisitive tone we actually call it the "Colombo technique". It was named after Peter Falk in the Colombo series. He plays this bumbling detective in this rumpled raincoat and he doesn't look as if he could solve a crime in a paper bag but lo and behold he does. We do the same kind of thing in therapy a little bit but we say, "Tell me what will happen, it sounds like there are a lot of good things to your cocaine use" and then you go on, "and on the other hand you are saying that you are just starting to realise that there are some less good things. What will happen in your job if you continue using?" So you have this inquisitive kind of thing rather than laying it out in a matter of fact way.

This is another good inquisitive one for smokers. "Help me understand, you know on the one hand you have come in and we are talking about your coughing and you are having trouble breathing, we are going to do the respirator test and x-ray but on the other hand you are also saying that you have been a smoker for 20 years, tell me why you think that cigarettes are not part of the costs." So you put the discrepancies out there because typically if they have had a long-term cough it is going to be part of that.

Two key components to motivational interviewing: it is your style, it is how you come across - the delivery, and then the content, what you say. I started out by saying, "Now how many years have you had a drug problem? Do you mind if we talk a little bit about your drug use?" and that language, the style of language comes in there and these two things are critical for influencing the receptiveness to consider changing. So MI style is using the empathic non-judgemental, confrontive supportive manner (how you say it) and the content (what you say).

For a different example, look at flossing. If your dentist says, "Do you floss?" when you are in the chair. Now you know you should floss so what do you do? You lie, and you say "Yes". And not, "No I really don't, I don't have time and those things are awful." So what is happening? It is a confrontive thing, yes/no and you know that it is supposed to be good for you. "You know Mr. Smith we have been talking a little bit about your oral hygiene there, tell me what are some of the good things about flossing? and they might reply with one or two things. If you get what are some of the less good things then you can counter with, "Well it is not for most people, but you know we have got some of these new floss sticks and I am wondering if you are willing to give it a try?" So there are lots of ways to go about this but you stay away from these dead end questions which are confrontive and judgemental.

Another example, "Why are you still smoking? We talked about that it is not good for you last time." OK so that is confrontive and judgemental. A better approach would be to say, "It sounds like since we have talked you are still ambivalent about quitting. Tell me what some of the barriers have been since last time?"

What I want us to do is to do two short role plays of 90 seconds with the two short scenarios that I have. They are intended to have you compare and contrast two ways of interacting. One is an MI style and one is a non-MI style. What I have done is I have chosen smoking for demonstrating the scenarios because it is just an easier one to have people think about.

The first role play is 90 seconds and we are going to divide into twos and I want one person to play the health care practitioner or the therapist and the other to play the patient. Decide that and the person who wants to be the health care practitioners or therapist raise their hand and we are going to give you this, don't let the patient see, OK?

Now we are in our defined roles. This isn't very hard but it will demonstrate something to you on both levels. Now what I want you to do is health care practitioner there are two role plays, role play one and role play two only do role play one. Do not pass go until I tell you to. Patient health care practitioner / therapist you have to read the questions as they appear. Now I know there is a method to my madness so just put up with me for this point? Patient you can answer any way you want. Then we will evaluate how it felt from both the patient perspective and the health care practitioner. On the slide is a description of the patient. The health care practitioner is seeing the patient for a routine visit and the practitioner notices that on the medical form or assessment form that they indicated that they are a smoker. The patient is 25 years old and married and has smoked for 10 years which is not unusual somebody starting at 15. They smoke about a pack a day and this is the important part of it patient as you are interacting. Eventually they plan to quit because they know it is not good and everything and they see those awful warnings on the pack but they are not worried about smoking and it is not causing them any particular problems at the current time. So does that make sense?

Now here is what we are going to do. I am going to give you 90 seconds to do this so patient answer in any way you want, health care practitioner just read the message as it appears and then I will stop you and ask you how it felt.

What I want to do is to take about six health care practitioners and in one word how did it feel and Fraser is going to write this down so I will yell back at him. One word how did it feel?

Defensive
Bossy
Righteous
Aggressive
Short
Closed

Now about a half dozen patients in one word how did it feel?

Confusing
All of those
Crap
Accusations
Bossy
Disinterested
Confrontational
Bristled

Now we will leave those to sit for a minute and we will go to the second role play. We are going to do the same thing again just take about 90 seconds keep the same roles as you had, again health care practitioner therapist read the questions as they appear, patient answer in any way you want after the 90 seconds we will do the same thing. How did it feel? OK Go.

In one word about half a dozen health care providers / therapists. How did the second role-play feel?

Friendlier
Helpful
Interactive
Positive
Interesting
Non-Judgemental
Heard

Half dozen patients – how did it feel?

Understanding
Comfortable
Encouraging
Challenging (Interesting point we will come back to this one)
Listened to
Interactive
Off the Hook
Understanding

By and large what did all of those in the first role play have in common? Negative, OK. And that is interesting because it was on both sides. Negative on both sides. And again by and large in the second set, what did all those have in common? Positive. And again on both sides – OK.

Now let me deal with the challenging. It is the case that it is that we are getting the patient to do much of the work there and it is more involving but what is interesting is that you could read all of the books on MI article after article but in 90 seconds you demonstrated to yourself basically how you put all this non MI style together and this MI style together and saw how it feels. As a workshop presenter you never want to say this ahead of time because somebody in the audience is going to trip you up purposely but I have been doing this particular role play for 20 years, and it has never failed me whether it be in Spanish, French or English. The reason is why MI has become a common currency among health and mental health care providers because it does have that resounding positive feel byand large compared to the other side.

Now you are not going to kill anybody if you do a non MI thing or a closed end of question or anything but the more non-MI style that you have compared to the MI style, the more it is going to feel like it is resistance and judgemental. Conversely the more of the tools that you can put together with the MI style, the more you are going to see a more empathic relationship, the more compliance by and large, better outcomes, having the people come back in. This applies to whether it is dual disorders, schizophrenia.It is surprising to see but when you start talking to patients who have been talked down to for a long time you see these people responding better. I am not talking about running out and every problem is cured but we do see people with better medication compliance and people keeping their appointments.

So in the MI spirit what I say is, it is your choice to go on doing what you want to or learn new skills. Now just to show you something else. One other big technique of MI is to do summary statements. MI views the health care practitioner/patient relationship as collaborative. What you are looking to do is to recognise that the person is ambivalent. They are not in denial and this is my first chance to say this to you. A big word in the addictions field has been denial, denial, denial. You are sitting in my chair, you are not denying, you just don't want to do things my way, which is to change – you are ambivalent about changing. Let's think about the language. If I say you are in denial, even if I do it in a nice way compared to saying, "It sounds like your ambivalent" or, "It sounds like you are not really sure about changing" – which sounds more comforting? This is especially so if you have a resistive client. If you are saying, "You are in denial" – then, bang you hit a wall, so the language is a big concern and that is why a big key thing is to talk about a person's ambivalence, then you are connecting. They are not in denial, they do not see that themselves but you are connecting and that is why you are connecting and validating and that is why the stuff works by and large.

You are giving them information so that they can make better informed decisions. Ultimately, it is that the person is responsible for changing, even if you took the most non- MI or absence based. Ultimately they are responsible for changing.

Now what I wanted to do is to also show you, how we do two scenarios with the same patients. I am doing a lot of smoking cessation work in the State of Florida now and

we have just come out of the studio with these new ones so that is where we are going to focus – on smoking. I think it is our best work at this point. So the first scenario that you are going to see is to demonstrate a non-MI interview. It is not intended to have any MI components to it at all and the second one will and they will contrast at the same way and you can see how you feel about it.

So taking comments after the first one – how did that feel?

Dismissive
Unhelpful
Railroaded
Patronising
Confusing
Confrontational

And what do they have in common by and large?

And from the second one, it was:

Gentle
Concerned
Encouraging
Supportive
Progressive
Sympathetic

OK and what do they have in common?

We could do this with a number of other items, but in two hours we don't have a lot of time. I have open ended questions and other techniques and other scenarios but you are going to get the same thing over and over again. Whenever you see or practise a non MI style you will get the sense of it not being very comforting, it being much more negative and with the MI style it is the other way around.

What we are going to focus on now is learning and what you saw is asking for permission and that is the first thing to do. It is a respectful thing and if you think about it, whether the person is coming into your facility for alcohol use or in the case of a lot of health care practitioners, if you take smoking or alcohol use, they are coming in for something else like a cough. How are you going to get into the alcohol part so you simply ask permission. "Do you mind if we talk a little bit about your alcohol use?" What I can tell you, surprisingly maybe to you, is that when we do this 99 out of 100 people say, "No I don't mind, it's OK"

Now what happens is you are being respectful and it doesn't happen that often and they could say no and in the one case that it does happen then I will say it sounds like it is something that you are not feeling comfortable talking about this time. I can get through most of the extra one that way. Or they say, "No I really don't want to talk about it." So I counter with – "Well OK so what would you like to talk about today?"

Now what happens is you know you are not going to get somebody to talk honestly to you if you force them into talking, so asking permission "Do you mind if we talk about your relationship with your spouse; do you mind if we talk about your cocaine use?" that is the first thing, that is not a hard thing to do. If you look on your strategy card I am going to have you practise a whole scenario with whatever behaviour you want to do. So the first thing you say is, "Do you mind if we talk a bit about your….?" whatever it is hypertension, medication, alcohol use, drug use whatever it may be.

The next thing that happened in the scenario that you saw –is that it is reflected. We say, "So it sounds like you are concerned about your coughing" or whatever, "it sounds like", you reflect whatever you hear the patient saying, so when we practise that I will explain a little more.

Normalising – you know a lot of people are concerned about their alcohol use. A lot of people have had difficulty quitting, a lot of women are concerned about gaining weight or stopping smoking. One of the interesting things that happens is that if you can normalise it, it makes the person feel like they are not the only one. You can't make it up, you want to say, "We have women who are very concerned about quitting smoking because of weight gain you know you are not the only one." or, "A lot of people have made several quit attempts."

Decisional Balance – we are going to do that in using readiness rulers and we will show you how to do that and have the patient give voice.

So let's go into the questions at this point.

"Do you mind if we talk about...?" What this question is doing is communicating respect for the patients and more likely to getting them to talk about quitting.

"Tell me a bit about your alcohol use?" "Any quit attempts, how has it affected your health..." So we are going to practise this whole thing. That is what you want to say, "Tell me a little bit about …" and you will decide whatever behaviour you want to talk about and we will have you try both the patient and therapist roles.

When you are asking permission at the end, the last part is learning how to provide information to patients in a non-judgemental respectful way so that they can make better-informed decisions. We have a lot of patients in clinics that have hypertension, and alcohol elevates that, plays havoc with you so you already have hypertension and then you are drinking and the alcohol goes up and down. A lot of physicians don't tell folks that. I will say to somebody, "Do you know Mr. Smith, I notice on your medical form it indicated that you are taking some hypertension medication. What do you know about how alcohol works with hypertension? Do you know that it elevates it?" Now the person might say they know xyz, but they typically don't know a lot. You respond with, "Would you be interested in learning a little bit more?" That is the asking for permission. There is a lot of information we can give to people about a variety of things from detox to medications but you say, "What do you know about...?" "Would you be interested in learning a little bit more" and then if you are really good you whip out your pamphlet that you have prepared and say, "Well you know I have got this and we can talk about it between now and next week."

So asking permission is the first thing and it is not a hard thing, it is probably the easiest thing to do. It is your entrée and it is the first empathic touch, the first empathic feel because how many of you know four or five colleagues that typically when they are interviewing alcohol and drug abusers ask permission to talk about it? It doesn't happen and you know you might not like it but try it and what you are going to find is that patients say, "Nobody has ever..." – you will see people are just startled.

My daughter tells a story that she uses MI in all of her medical rounds and she went into talk to people about cholesterol and a lady had taken a long time and she said, "Do you mind if we talk a little bit about your elevated cholesterol levels?" and the lady looks at her like she saw a ghost. "Nobody ever asked my permission!" she said, and it does happen that way. It is really respectful. The value of it is that it is the major technique with patients at the very beginning. Once you have made a connection with the patient, you don't keep going, "Do you mind if I ask you this question, do you mind if I…" it is the first entrée. It provides the opportunity to discuss the patient's behaviour when it is not the presenting problem and it allows the conversation to continue. Because if you say, "Do you have an alcohol problem?" and you want to not have a problem and he says "No" – where do I go? It's a dead end question. "So tell me a little bit about your alcohol use. Do you mind if we talk about it?" It is respectful.

Now what happens is motivational interviewing is creating an understanding of why people do what they do but here is what I want you to think about and we are going to go into this exercise called the Decisional Balance exercise. It is often difficult to understand why people do what they do when they engage in problematic risky behaviours. How many of you have ever bungee jumped? Why would you not want to bungee jump, what do you think about people bungee jumping – anybody? Yeah it is stupid, scary, risky all those kinds of things. I was in New Zealand when I got this idea and if I had the video I could show you it. I actually have the guy jumping off and screaming and this thrill and everything then he runs back up the hill and pays another $199 to do it again and I got talking to people and it is like a thrill, just an exciting kind of thing and they would say the same, it is scary, but it is thrill. Now a lot of us are thinking 'no way', it's risky. So what happens is that it is extremely important to understand from the patient's perspective what is going on and most of the time what we see in practise is the negatives. We see death, health problems, divorces, arrests, hospitalisations you know lungs, livers and so forth. We rarely see and we rarely talk about the good things about the patients behaviour from the patient's perspective and what happens is there is a disconnect as we say in psychology with a message because good things are happening on a short term basis and if you fail to recognise that you are not communicating.

Who routinely asks about the goods things and less good things? What is your experience? Right the client feels valued and validated and that is rarely the case. Sometimes you will hear people say, "Nobody has every asked me about that" and what happens is you start off by saying, "Tell me some of the good things about your cocaine use" and sometimes they will say, "Oh there is nothing." "Oh come on lets think about this for a minute" and that is what happens they forget so you have them go on and on.

You continue with, “OK now that you have said there are several good things about your cocaine use” and you can summarise and you can reflect back it does this, this and this – “Now tell me some of the less good things.” Now language is important. You are not going to kill someone if you say, “Tell me some of the bad things” but “Tell me some of the less good things or the not so good things” is a little softer so what you have got there in this eliciting of the behaviour, the ambivalence. “So it sounds like on the one hand there are several good things and on the other hand, you are saying there are some less good things that are happening now like the arrestment and it looks and sounds like you are saying it is going to be costly, you could lose your licence and you are just starting to realise that maybe it is more costly than you thought. Where does that leave you right now in terms of thinking about changing? If we had a kind of scale good things and less good things where would you see yourself on this balancing scale?”

The person starts to think about it OK. “It sounds like you are recognising”, you have to reflect that whatever is going on and there is going to be a variety of ways that people talk to you, “So it sounds like it is starting to affect you a little bit. Where would you be five years from now if you don’t make some of those changes, or one year? What would be different in your life? What would be different if you do make some of these changes?” and what do you do when you get someone who really doesn’t want to change or is not thinking of changing? You say, “OK it sounds like you are saying that there is nothing that would make you change. Let me ask you in my pretend world, just pretend for a moment. If I gave you £5million not to use cocaine for one day, in my pretend world, what would you do? A minute ago you told me there was nothing that could do it and now you saying you can, what is the difference? What we are looking to do is to find out what the personal price is for you?” So what the decisional balance does is it allows us to really talk about what is going on with the person. We are talking about the good things and the less good things and it allows you to get them to look at their ambivalence.

You may be in a position where only you see somebody for assessment, or you are only talking to them on the phone or you have a brief interview. You can do the good things and less good things the way that I just described. A preferred way to do it in clinical treatment and the way that it has been used typically in motivational interviewing is to use the sheet that is in front of you. The sheet like with all of the material we have is available on our website. You go to online forms and you can download whatever you want to your hearts desire. Cut/paste.

But the point is if you look at the Decisional Balance Sheet here is how we would typically use it with a patient. A patient comes in for assessment and we actually want to strike while the iron is hot. So I say, “We have been talking for about three or four hours about your cocaine use and I hear you saying you know there are some good things and some less good things” and I would spend five or six minutes summarising. I continue, “Mr. Smith we kind of hit a little bit on your ambivalence and thinking about changing and I am wondering between now and next session, (you can do this at outpatient or inpatient too,) if you would be interested in exploring the good things and less good things about your cocaine use a little bit more.” At this point you have spent three or four hours with them and they are going to say yes. You lead him in to it with, “But what I have is a very brief handout, it is very easy, it takes about 10 minutes and it is going to get you to think a little bit more in a concrete

way by putting pencil to paper. It is very easy, it explains what we are doing, it gives examples of changing and what I want you to do with respect to your cocaine use is put down what are some of the benefits of changing, what are the benefits of not changing, look at the cost of changing, the cost of not changing, you know there can be overlapping things but write them down, think about them, bring in the next time and you will notice on the back page I also want you after doing that is to write down the most important reason you want to change and then if someone gave you £5million to change your cocaine use for just one day would you change and why?"

Now you might ask why I do it just for one day because my intent is to show them that they have the ability to change if the price is right and that is the kind of language that we use. What this serves as is an excellent assessment tool. They say, "Well - one of the benefits is that I would spend more time with my family." Well the therapist in me goes, "Tell me a little bit more about that, what is going on with the family" or one of the benefits, one of the costs would be, "I would have no way to relax", I would want to know what they have done before in terms of relaxing you might want to look to have some alternatives to relax. So the Decisional Balance Tool just doesn't do goods and bads, it allows you as a therapist to look at some of the things that are going on their lives and then to go and develop treatment goals. It is a beautiful treatment planning device and we didn't see it that way but it has turned out to be one of these delightful adjunctive things for us.

As you can see when I do therapy I like doing it.

We have actually been spending a lot of time in psychology talking about the B and C – the behaviours and the cognitive part. What has actually been on the horizon is psychology for a while now but not really fleshed out much. Here the word emotion is really also being referred to as affect, and affective regulation. What happens is what seems to trigger the change process in folks is what we call their emotional attachment to the drug, to the alcohol, to whatever it may be and I am going to explain that to you.

Remember they are ambivalent. Ambivalence is a critical concept but it is really the heart of the problem. If they were ambivalent then they are not going just to show up to you or they will have made the change. So what you are doing working with the heart of the problem is ambivalent. How many of you have ever made a new year's resolution? And how many of you have broken that new year's resolution. I have this thing every year, "I want to lose 10lbs", and it doesn't sound like it is a hard thing to do and it seems fairly easy and so I always say that I am not going to say it because I always say it – so one year I didn't say it. But what happens is when I did say it and it got to like the seventh day in we are out to dinner and the black forest cake looks really good and my clothes are still fitting so the motivation to lose that 10lbs waxes and wanes. Now if somebody gave me £1,000 to lose weight, I would do it. I would do it for £5,000 but the point is ambivalence. We say this to a person and it sounds like you are ambivalent. It is a normal thing. A lot of folks are ambivalent about doing a lot of things so they are not the only ones and it is very, very important to normalise so that is another thing that you are wanting to do.

So if we summarise and I will show you what we are doing about emotional attachment. Ambivalence is not a reluctance to do something. What it is, is a

psychological conflict between choosing two courses of action: "Shall I leave my wife; shall I stay with my wife? Shall I stop smoking; shall I continue smoking? Shall I take this new job in Alaska where it is cold but they are paying a $100,000 a year, or shall I go down to Florida where they are paying $20,000?" So what happens is there are conflicts in making choices. It has nothing to do with substance abuse, it has to do with making decisions and it is a normal everyday thing and the reason that it is hard is because each side has costs and benefits.

This slide shows one of the best examples of ambivalence that I could get. "Charlie, I am quitting smoking, would you please take these three packets of cigarettes from me and hide them in my apartment somewhere in the living room." Now the reason is because you are quitting but you just want them just in case, so this is what ambivalence is about, but this is what I like in understanding affect or emotion.

"Lets explore that together" that is a powerful emotion and ambivalence is a powerful emotion. I said to you earlier the words I had been using are at the heart of the problem. "Shall I do this, shall I not do this", it is very difficult to resolve and so normalising is extremely important.

Now basically what happens is, as you are talking about the decisional balance, a person is at a decisional crossroads – whether to stop drinking or whether to continue drinking or it sounds like you are at a decisional crossroads in terms of whatever the risky behaviour may be. Guthrie always says there is a third path and so you never know what the third path would be.

But basically what you are trying to do with the decisional balance exercise is help the patient explore their ambivalence and to help them consider changing and that is all that you are doing. Now you do this when you talk about the good things and less good things. Never do you have to use the word problem. Your asking them about the good things creates a safe context and then moving to the less good things and as we heard over here it allows practitioners to sound credible, talk about the good things, and validate a patient's behaviour.

For those of you that have never done it, it may be quite surprising to you and again it is going to be your choice. If you hit a chord, a connection with somebody, that is when you are going to find that you are going to do it again because it really changes the nature of the relationship.

In no way is it a quick fix at all. It becomes an assessment tool, a treatment planning tool, looking at ways to relax or if they are having difficulty in a relationship whatever it may be – there is a richness to it.

Unfortunately in a two-hour workshop a little of that gets truncated and we just try to explain it but in summary you will explain the good things and less good things related to the risky behaviour. It is addressing the patient's ambivalence about changing and your goal is to tip the scale in favour of change. A lot of times people are not aware that there are as many goods things or less good things and they come in and it allows you also to, when a person puts pencil to paper it is something that they typically haven't done before and it is a little richer than just sitting talking to them like we did in the scenarios.

Now the next thing that you are going to learn is the readiness ruler. On the back of this handout is the readiness ruler, they are also on the website. Basically the readiness ruler is something we use in addition to asking permission at the very beginning.

You heard Tom talk about stages of change well this is kind of a simple way of doing it. What we do when a person comes in somewhere at the first session is we will say, "You know Fraser on a scale from one to ten where one is that you are not ready at all to stop drinking and ten you are absolutely ready, where are you?" (and we actually had these little plastic rulers), "Where are you at the present time?". "You are at number four, OK, and where were you six months ago?" "Two, so you have gone from a two to a four in six months, what happened?" "Some more negative things are starting to kick in, maybe it is time to change." "OK what kinds of things?"

In the interests of the workshop time I wouldn't do this but here is what we are talking about using readiness rulers. You ask a person where they are – 1 is definitely not ready to change, 10 being definitely ready to change and what number best reflects where they are at the present time. We talk about this as a state measure. Remember that motivation waxes and wanes so, "At the present time where are you?" Then in the comparison way, "Where were you six months ago" – you could say 12 months it doesn't make any difference but here is what is neat whatever number they give you, you can move the conversation on, "So you were a 1 six months ago and you are still a 1 what is going on? " or "You were a 2 six months ago now you are 4 what changed?" So you are hearing some very interesting changes. "What would it take for you to maybe inch another number higher to 5, what would it take to go to a 5?" or "How did you go from a 2 to 5, what would it take for you to change, what would be the best outcome, what would be the best outcome if you do make these changes." So there are a variety of ways again. What the readiness ruler does is that it assesses a person's readiness for change, or motivation for change. If the person is at a 5 they are ambivalent and you can use that language, "So it sounds like you are kind of on the fence a little bit more than you were two years ago. "What would it take?" "How are you able to do that, what happened?"

So the value is that people are at different levels of readiness to change when they come in and we don't know why but people like to use rulers, it is a subjective thing and they can tell us where they are.

"You have been smoking for 30 years and you have this bad cough, what would really push you to think about changing – it sounds like you are really not wanting to go there right now." So you can talk all around these numbers and you are just reflecting where the person is, it is nothing more than that. So you are assessing it, it helps the patients recognise where they are and the practitioners to recognise where the patient is and allows the patient to give voice to changing. "Where are you now, where were you six months ago?" So all of the language that is built in and all of how we ask the patient to do something again is having the patient give voice. You can say "How do you feel about going from a 2 to a 3, what did your wife or spouse notice?"

Motivational interviewing requires a special type of listening of the type that we normally don't do and that is why I have never been able to effectively communicate

exactly how to explain this. It is like either having a gigantic ear or multiple ears, but it is not the kind of listening that we do when we are out here and just chatting away or at the lunch table or whatever it is a special listening. You have got to give your full attention to the person because what you are trying to do is capture affective words. If the person says, "I am really distressed", you go after the affective emotionally lain words. The reason that you go after the affective emotionally lain words is because what we know in the self change literature is that 60 to 75% of the reasons that people give for changing on their own, any addictive behaviour whether it be stuttering, alcohol, drugs, gambling, smoking – it has to do with some kind of affect. It may be that they lost their job, it may be that you know things came together but there is some kind of affective hook that is going on.

What you will see at the lateral end of today is that if you are a smoker and somebody told you that you had six months to live, in my pretend world, you have got six months to live unless you stop. What do you think you would do? So that is a pretty strong affective. But young people don't respond to this. We can say "If you don't stop smoking you are going to die of lung cancer, you are going to have this, this and this, but it is a false message it is not really going to happen to the 15 year old so it is not that kind of affective loaded kind of threat. So what you are looking to find – is what affectively is going to change.

Reflective Listening is a primary way of responding to patients and after the patient speaks the practitioner says something. "You know I get the sense that you are wanting to change but you are concerned about gaining weight." "What I heard you saying" or, "It sounds like", "It seems like", whatever is on your handout, is a brief overview. If you look at the handout under reflective listening it gives examples, "It sounds like; I get the sense that; but I hear you saying; so what I hear you saying, I get the feeling, it looks like" What you are trying to do is reflect what you see or hear and that is all that reflective listening is.

You know you can do something as simple as it sounds. You don't have to necessarily use the patient's own words. You can reflect what you are getting the sense of. "It sounds like that is going to be really difficult for you to make a career and raise five children on your own now that your husband has left you" so you reflect back and as we have heard over and over again today is what it is doing is it is being empathic because you are saying, "It sounds like" and you are also validating that you are hearing the person. This is the one part that we don't understand, we do not know why when you reflect it continues the conversation. So you are saying, "You know Mrs. Smith it sounds like now that you are in divorce proceedings and looking at your career and raising five children it is going to be difficult for you" and what the client does is to continue to talk, so you are trying to understand the situation a bit more. We don't know why it extends the conversation but reflective listening does. What basically happens is the patient doesn't come in and tell you his or her whole story right away – you kind of pull it out of them a little bit and that is what reflective listening seems to do.

OK some more examples.

"What I hear you saying is that you know that your smoking is not causing you any problems, what might it take for you to change?" "So what I hear you saying is that

you know that cocaine is not good for you but you are not experiencing any serious consequences that you are aware of - what do you know about the long-term consequences of using cocaine over the next five years?" All you are doing is reflecting back what you are seeing or hearing.

Normalising again to summarise – is another thing that is really important. It is basically communicating to the patient that the difficulty in changing is not uncommon. Others have had some experiences – many people report making several quit attempts and so forth – so it is just allowing the person to understand that they are not alone in this change process.

So to summarise again: the value of reflections and normalising are that they validate what the patients are feeling, they reflect back what the patient says, you indicate that you understand them and normalising communicates that the difficulty is not uncommon.

"What do you know about the risks of using?" and then it doesn't close any questions, so they may say "I know they are not good for me" and you reply " what specifically do you know, are you interested in learning more about " and that is how you into this, let me show you.

Often patients do have little information or misinformation about their behaviours and so advice and information is presented in a MI way can help patients make better decisions. Now if you can focus on positives it is even better and I will show you a way to do that but it is not always easy to do that, although you can say, "If you use clean needles you can avoid xyz."

Traditionally simple advice is what health care practitioners and therapists do and that is being told. Traditionally what we say is, "If you don't do this, this will happen, here are the health consequences" or "Stop using dirty needles and this will happen", so what psychologists have found in research is that the effectiveness of simple advice is very limited. Five to 10% of the people do like to be told. However, the other 90% run out of the office going. "Yeah, sure". So what happens is people don't like to be told and when we tell them they don't follow through and so what Bill and Steve went back to look at was how can we talk to people and give them information in a motivationally enhancing way.

Think about this though. Do you like to be told what days that you have off for your holidays? Would you like to be told you have to take only June 7, 8 and 15? Most people don't like to be told. Universally students also like choice in their classes and often there are times you have to take this, this and this. We know that when people are given choice, whether it be in the holidays that they take, courses they take choice in a number of other things that they are happier, they have better outcomes and are more satisfied so the question is, "Could we do this giving people choice here?". So what happens is you start out with the same thing again. You say, "Do you mind if we spend a few minutes talking about..., what do you know about how your behaviour affects your health? .." or whatever it may be. "What do you know about how your alcohol use affects your unborn child?" What do you know about how your alcohol use affects your teeth and gums?" I mean you can go in any way you want, but,

"What do you know about...", that is the first thing. "Are you interested in learning a little bit more?"

When I said people have little information or misinformation with which to make good informed decisions, smoking is one of them. A lot of times people don't stop smoking until 45, 50, 55 and what you will hear them say is "Well you know it is too late Doc, too late." "What do you mean it is too late?" "Well you know I have been smoking for 30 years and I know that it is going to kill me and I can't do anything about it. I should have quit when I was younger." "Actually, what do you know about some of the beneficial affects of stopping even at your age." "Well I don't know." "Are you interested in learning a little bit more?" I give them a booklet that the American Lung Association puts out and, in fact, look and I will have the client read it because if I read it to them I am lecturing. It says "20 minutes after quitting your blood pressure decreases, after eight hours this happens, after 48 hours this happens and so on. Look after 15 years your risk of heart disease and smoking related death are similar to those of ones that never smoke." So if you can provide positive information – that is a good thing to do.

But the value of providing information to patients in a motivational enhancing way, which I am going to have you do in the role play is that they can make better informed decisions about changing and you are asking them, "What do you know about, are you interested in learning more?" So having that person given a voice and asking permission again.

The skills that I am going to have you demonstrate in the role-play are: asking permission to discuss the riskier problematic behaviour, reflecting what the patient says, normalising it, using a decisional balance, the good things and less good things, not the formal exercise, using a readiness ruler you follow, write on that card asking them to give voice and asking permission to provide information so when we break into pairs again we will have, just for the sake of an example, you will play the patients and then you will play the client and we will do that for five minutes then we will switch patient/client role.

In two hours the intent was to be able to have you have a small skill set that you could leave here today and actually implement in your clinical practice. So we are looking at those things that are on your card. What you can do is break into pairs and each person will do what we call a brief negotiated interview with the card and the ruler. We have enough time probably to do four minutes and four minutes and then do my brief summary. So break into pairs, decide on whatever behaviour you want but tell the person what the behaviour is you are going to change and we will take 4 minutes and then I will switch. So try to go through the card, patients you can answer in whatever way you want and let's just see how it feels. Does that make sense?

## Linda Carter Sobell, Nova Southeastern University

Basically, we are talking about self-change as being a common pathway for change for alcohol and drugs or for addictive behaviours, for that matter. When we say self-change, what we mean is basically no intervention, no treatment, not a brief intervention, not a blessing by a physician, not reading a self-help book, not going to a self-help meeting. These folk change without coming to see you and I, and you will

see where we have gone with that, how that happened and why it has important clinical implications that we can translate into the treatment arena.

As you get older, you like to do a historical foray, and that is what I would like to do. Not only because I have got older, but because really the field has changed remarkably in the 30 years that I have been in it. Just briefly, we will look at where the field was 35 years ago, because there are some major changes that have occurred with respect to providing treatment services.

Looking at the prevalence and the process of self-change and its implications for clinical treatment: what I want to do is present some results from a very large-scale, recent trial looking at promoting self-change and the public health and policy implications that it has had both for Canada, where we did the work, and for most other countries, because it will be very similar.

In 1970, what you need to understand is that the research was extremely scarce. Scientists were really not in the addictions field. Most of our knowledge derived from folk signs. And when we say 'folk signs', we mean from the folk who were there – AA, NA, those kinds of folk – but there wasn't really much to speak of in terms of a knowledge base.

Thirty-five years is not long, if you think of science generally; it has really been a short history to our field and we have made some major changes. There were very few treatment programmes in the early 1970s, and those that existed were in-patient norm, often, in Canada and the US, in a state hospital. I wouldn't want to go into a state hospital then or now – it was like a prison, a cave, six months – but that's all that existed; out-patient treatment did not exist then.

Treatment services then and now – and this is the one thing that hasn't changed – are primarily for severely dependent and, as I have been consulting, it doesn't look like it is much different here in Scotland.

Abstinence in the 1970s was the only goal for people with an alcohol problem; and motivation was something that people brought to treatment, rather than we said that they weren't ready to change, rather than inculcating motivation, as we talked about in the workshop today.

We talk about gambling as an addiction now. Gambling wasn't even thought of as an addiction until a decade ago and did not enter into diagnostic categories until very recently.
Nicotine dependence was not entered into the American formulation DSM until DSM III, so these two very critical addictive behaviours – in particular, nicotine, which has got the highest percentage of people addicted – weren't even thought of as addictive behaviour. The dominant treatment approach in the early 1970s was AA and the 28-day in-patient programme, often referred to as the Minnesota Model.

The concept of a continuum – and that is very important to understand here – from mild problem to moderate problem to severe problem did not exist. As I said, we were simply looking at the severely dependent individual, and you will see why that has got a very different flavour to it now.

Cognitive behavioural treatments did not exist at all, and now they have been adopted as the single biggest evidence-based treatment for addictive behaviours in Canada and the US, so that has been a major difference.

Brief treatments and self-change were considered heresy: forget moderation! The first brief treatment that came out in the UK, by Orford and Edwards, was actually delayed for six to seven years because they were afraid of the negative publicity. Brief treatments are again the norm; we have got briefer and briefer because what we know is more is not better.

Terms like 'problem drinker' and 'harm reduction' were not in our vocabulary, and they are in our vocabulary pretty regularly now. Addiction problems were viewed as progressive and irreversible.

Finally, recovery – and this brings us to moving on. Recovery was viewed as only possible through treatment or traditional self-help groups. So, in a way, in a short period of time – three and a half decades – the field of science has really informed us, and it has been better for those individuals that we care about.

When I said recovery was only possible through treatment, let me give you a flavour of what we are talking about. We are not just talking about a little bit of controversy. Here are some quotes. Robert Dupont, who was the ex-Director of NIDA (National Institute on Drug Abuse) in the US, in 1993, said: 'Addiction is not self-curing. Left alone, addiction only gets worse, leading to total depredation, to prison and, ultimately, to death.' So he is saying that you need to be treated.

In 1980, Vernon Johnson, in his famous book *I'll Quit Tomorrow* – very traditionalist – said: 'Alcoholism is a fatal disease, 100% fatal. We estimate that 10% of drinkers in America will become alcoholic, and that these people will not be able to stop drinking by themselves. They will be forced to seek help; and when they don't, they perish miserably.'[56] And Hazelden, *Traditional Treatment Programme* , in 2003 – so that is very recent – said: 'Untreated addiction will ultimately kill you'. So, if you were out there and you were thinking of trying to change on your own, or you were thinking "is it possible?" and you see these kinds of message, you would get the point that you are going to kill yourself if you attempt to do it on your own. That actually will lead us into the ending part, which is that the self-change process in the addictions field is the thing.

Where are we today? Several of us have talked about this. All treatments look very similar. There is a standard line in our field that is the dodo bird theory: nothing really looks any different, whether it be med or cognitive behavioural or brief treatments or AA – they all look very similar and they all have similar outcomes. Basically, nothing is better than anything else at this point. There are some bright parts, I feel, but this is not one of them. The field is really at an impasse. Do we do another controlled treatment trial of some new whatever it may be coming in? That is a question that you have to ask yourself. I would move in a different direction, but nothing seems to stand

[56] Johnson, V.E. 1980, *I'll Quit Tomorrow: A Practical Guide to Alcoholism Treatment*, Harper Collins, New York.

out. That is not to say that people don't get better – they do – but people choose different routes to change and so, what I am fond of saying, is that we have to be respectful of multiple routes to recovery. But what we do know is that the majority of people change on their own.

Now, why don't you know that? Because they don't come to see us, so that is not surprising. When we asked that question a while back, "Do they exist? Can we get them to come and talk to us?" it is not surprising that the field did not know about this because they did not need us. So, instead of continuing to look at affective treatments, what I and others have been proposing is that we need to look at the change process in general. A lot of people do change: how do they change? How do people in treatment change? We need to take a broad perspective on change – and that is not just people in treatment, but anyone who is making changes.

Today, in consulting, what we know is that the severely dependent alcohol and drug abuser constitutes the tip of the iceberg. If you think about the iceberg, you are only going to the see the tip of it, that is five to 10% of the people who are severely dependent: they are visible; we see them all the time in the treatment services. There is another 80% or so in every country, every Western society, and what happens is we don't provide adequate services for those people because they look like you and I, and we are not going to go in typically to traditional treatment programmes, especially if you are early on and don't have consequences. So, what happens is that, when we look only at the tip of the iceberg, the clinical picture is obscured: we see only the severely dependent and we see a whole different picture. It's like when you look through a telescope and, when you turn around, it is a different picture.

To complete an understanding of what is going on with alcohol and drugs and to better inform society, to have perhaps a better utilisation of health care resources, we accidentally found in that continuum from mild, to moderate to severe; and, in doing so, because the majority of people seem to change on their own, we need to understand what is now the self-change process.

Why would you want to study it? Rather than telling you why we want to study it, let me give you quotes from three or four very well-known people in the field. I had two reporters so far interview me in Scotland, and they somehow think that the US is way ahead. Actually, they are not. The major advances have come outside the US, and probably about 70% of them have come from the UK. Orford and Edwards, in the UK in 1977, both of them very, extremely bright individuals, who were way ahead of the field, tell us that we should be looking at natural forces[57]. George Vaillant, also looking at natural recovery, said a similar kind of thing[58]. Don Cahalan, the grandfather of our field, is the one who talked about the tip of the iceberg. He said: 'If you only study the tip of the iceberg your view of the disorder will be very biased'[59];

[57] Orford, J. & Edwards, G. 1977, *Alcoholism: A comparison of treatment and advice with a study of the influence of marriage*, Oxford University Press, New York.
[58] Vaillant, G.E. & Milofsky, E.S. 1984, 'Natural history of male alcoholism: Paths to recovery', in *Longitudinal research in alcoholism*, ed. Goodwin, D.W., Dusen, K.T.V. & Mednick, S.A., Kluwer-Nijhoff Publishing, Boston.
[59] Cahalan, D. 1987, 'Studying drinking problems rather than alcoholism', in *Recent developments in alcoholism* (Vol. 5, pp. 363–372), ed. Galanter, M., Plenum Press, New York.

and Robins, in the infamous Vietnam Veterans' Study[60], talked about that too. So, there are some extremely well-placed individuals, who have done very good research, who argue for why we need to study it.

Natural recovery studies are not new. The first one that I have found was in 1814, by Benjamin Rush, who was one of the signers of the Declaration of Independence. In one of his books (he was a physician), he wrote about people changing on their own, and we know that he had to do that because traditional treatment programmes weren't around then. That is the first historical one.

If you want to look at the rest of the field, there are early pioneering studies by Tuchfeld, Winick, Rozien, Fillmore or Vaillant, that whole group. They were kind of hit-and-miss and they weren't really called self-change. We called them things like spontaneous remission or natural recovery; we are now talking about self-change.

The Vietnam Veterans' Study[61] is one of the largest natural recovery studies. If you think back to what happened: we had the draft; we took young men over there; they started abusing heroin, cannabis, alcohol to a great extent; we know that they were addicted coming back. Guess what? They changed the environment – because war is not a great thing, that is my personal view – they come back, and then they are back in their other environment, and actually most of them have recovered entirely on their own. There is a 25-year follow-up study, a very impressive study.

There are also different types of natural recovery studies, with those of us who have started to look into the field for the last 25 years, and that has been my area of interest: longitudinal studies, population surveys and convenience samples, which are the advertisements that we use, and the one I am going to talk to you about.

Just briefly, before I go into that, the systematic study of natural recovery or self-change has been reviewed in two articles. We did one in 2000[62] and, at that time, we found only 38 studies that had been published from 1960 to 1997 that met the inclusion criteria. But what we find is interesting. The mean number of respondents is about 141 – that is fairly large for a clinical trial. Advertisements get about 40% of the people; about 30% are female. This is the impressive figure: the mean recovery in these studies is 6.3 years. In clinical trials, or if you are in clinical practice, if I can get somebody for 6.3 years, I am jumping with joy. This is continuous. And they did not have a minimal problem – on average 11 years. So, we are talking about very stable recoveries, the kind that we do not see in clinical practice. We are talking about every one of these people having long-term stable recoveries.

What kind of studies have gone into natural recovery? Initially, three quarters were alcohol, one quarter of them was heroin, we had a few dabbling in cocaine and one cannabis study. An interesting thing is recovery status: we do see people returning to moderate drinking, about 40% of the studies, and we are talking about very little drinking, probably less than most of my colleagues; and some limited drug use. A

[60] Robins, L N. 1993, 'Vietnam veterans' rapid recovery from heroin addiction: A fluke or normal expectation?' *Addiction,* vol. 88, pp. 1041–1054.
[61] Ibid.
[62] Sobell, L.C. et al. 2000, 'Natural recovery from alcohol and drug problems: Methodological review of the research with suggestions for future directions', *Addiction,* vol.95, pp. 749–764.

colleague of mine in Spain has done a new review and, just in a six-year period (1999-2005), we had 22 studies that have met the criteria and published. So, we do know that people are investigating the phenomenon with increasing interest and studies are occurring, and that is why we can probably make the statements that we can, because the database for self-change is very large right now. My colleague Harold Klingemann and I – he is in Switzerland – have just published a book on the process of self-change across gambling, eating disorders, smoking, stuttering, juvenile delinquency: *Promoting Self-change from Addictive Behaviors: Practical Implications for Policy, Prevention, and Treatment*[63].

Interestingly, when you start exploring, self-change is not just in the addictions field. Look at some of these things. In 1986, Toro said that most psychological problems were discussed, not with mental health professionals, but rather with the barber or the hairdresser or clergy, people like that. People would be discussing maybe their grandmother or their depression, but problems were discussed with people other than mental health professionals.

Davison has an interesting point too. He said that more Americans try to change health behaviour through self-help than all the forms of professional programmes – natural recovery. Gambling is a very new addictive behaviour, and what we have seen is that natural recovery seems to be the rule rather than the exception here. Then the thing that has surprised me. I ran into a chap who is doing a natural recovery with stutters – and again you have to believe the science – but Peter Finn has found that the majority of people who recover from stuttering do so on their own. I suspect that whatever behaviour we are going to look at, we are going to see a fair amount of self-change – that seems to make sense. Any of you that are graduate students or have graduate students, it is a superb topic for a dissertation – they are a captive audience and they love to talk to you.

Then, in a very well-known study coming out of Consumer Reports the findings were that 25% of people successfully lose weight, and 83% of those do so on their own – and that involved large numbers of people.

What are the major findings? Today, we know that there are over 60 studies of the self-change process in the addictions field. And this is the thing to pay attention to. We are not talking about fleeting recoveries: the requirement in all of these studies has been a minimum of stability, a minimum of one year. Again, if we could get that in our treatment trials, we would literally be jumping with joy.

Self-change has a very high degree of stability: 50% of the recoveries are for five years. There are only one or two studies that have looked at the relapse rate, and a colleague and I – actually, it's my husband – are going to be spending some time doing that. The point is that these are stable recoveries, and somehow these folk are doing it on their own. How are they doing it?

The other interesting thing in terms of findings – that the vast majority of moderate drinking recoveries occur outside treatment programmes – shouldn't be surprising.

[63] Klingemann, H. & Sobell, L.C. 2007, *Promoting Self-change from Addictive Behaviors: Practical Implications for Policy, Prevention, and Treatment*, Springer, New York.

Again, the return to moderate drinking is controversial. Why would they go into a traditional treatment programme only to be told that it is not possible? So, people change on their own; they change their drinking to levels that are very minimal, without consequences. Not surprising.

And I think the most important thing to get out of this, as we study the phenomenon, is that there are multiple pathways to recovery and we need to be respectful of that. It is the case that self-change is the predominant pathway, but there are many other ways that people make changes.

There are a number of epidemiological studies that I could present to you. It started with the study that we accidentally found in Canada. I spent 17 years there, that is where we started this work, but this one is now the most recent and impressive one; it's a SAMHSA study[64]. These are individuals who recovered from alcohol dependence for at least one year, so that is a pretty severe kind of situation. There are about 4,500 of them. The majority of these people were never treated. In the two Canadian studies I have been associated with, which are even larger than this, the number is uncanny – it is almost like you're making it up: 75% and 77%. Another Canadian study that came out after I left: 77%. The other two American studies had similar figures. Three quarters of the people in these large epidemiological studies recover without formal help or treatment. It is out there; it is impressive – let's not deny it and let's learn from it.

Of those 74% in the Recovery from DSM-IV alcohol dependence study who changed without treatment, 21% did so for five years or more[65]. Again, we are seeing this phenomenon of stability over and over again. Whether it be in Switzerland, whether it be in Canada, whether it be in the US, in Australia, it is there, it is a very reputable phenomenon; and, again, moderation is occurring in this population.

So how does it occur? How is that happening and what are the clinical implications? Just to give you a flavour. Harold Klingemann interviewed these folk, and these interviews took six or seven hours: these folk wanted to tell their story. If you recover on your own and you tell somebody you recovered on your own, they are going to think you are crazy and other things, they are going to tell you it is not possible; so, many of these people had never told their story. Howard Shaffer, one of the first to look at cocaine recovery and heroin, wrote in his article, 'These people wanted to talk. They said "Is there anyone else out there like me?" because they don't talk to other people about their recovery.' Harold Klingemann and I looked at this. We did a very elaborate computer analysis – very laborious, not something I ever want to do again. Years later, what we have culled it down to are four major reasons that appear to drive the self-change process. In our early study, and it appears that in the 1960s studies – except for cigarettes, which I will tell you are different – these are the major reasons. The first one: for lack of a better way of talking to you about it, we talk about a cognitive appraisal of risky behaviours. What that means is that people, when they are talking about their recoveries – and we do it in an open-ended way – tell me what

[64] SAMHSA. 2004, *Results from the 2003 National Survey on Drug Use and Health*, Available at: http://www.dhhs.gov/.
[65] Dawson et al. 2005 'Recovery from DSM-IV alcohol dependence: United States, 2001-2002', *Addiction,* vol. 100, no. 3, pp. 281-92

went on and how they were changing. Two thirds of these people talk about weighing the pros and cons of changing their behaviour, and that at one point in the change process, they kind of go "It's time to change".

What is interesting in weighing the pros and cons is that sometimes it can be the straw that broke the camel's back; sometimes it might take three months; sometimes it might take three years. The temporal perspective isn't something that we really understand, but we can tell you clearly that what seems to be going on is weighing of the pros and cons. The implication here for us was people are looking at the good things of their drug use or alcohol use and the bad things of their alcohol and drug use and, at a point in time, the scales tip – "I have had enough" – and they make a decision to change. As you see in the studies, they are all for a year, half of them for five years or more. So, the implication for us was this: if people are using a decisional balancing kind of procedure, looking at the good things and less good things of their substance abuse, let's put that into a treatment and have people do that, and maybe we can accelerate the change process. Basically, what we do for folk who come into treatment is that we have them look at the benefits of changing cocaine and the benefits of not changing cocaine. They might be able relax more, they might be able to do XYZ. Costs of changing, costs of not changing: we look at those and we talk about them in a clinical sense. It takes us to a point of assessment, to treatment planning. When we have put it into the clinical trials, and we have people evaluate it, this one comes out extremely high. People see things that they may not have seen before, and things become more salient when you put them on paper.

The decisional balance that we have put in most cognitive behavioural treatments, SMART Recovery and a number of other things actually have incorporated this kind of thinking, and it makes sense. When we make decisions, we look at the good things and the less good things. Many of us, being very good thinkers and evaluators, go through this decisional balance process around a number of issues.

The second reason driving the self-change process is actually quite intriguing, and it is something that Tom talked about earlier. We know that there is a behavioural element to the change process, and we talk about it as cognitive therapies, but what we have found in looking at natural recoveries is that the process is linked to affect-related statements. When we went through and looked at the reasons why people changed, there would be words like 'depression'; there was some affective word, some emotive word. I am going to show you what this means. Basically, it is not the rationality that drives the change process, but rather the emotional or affective content of what is going on.

If you take smoking, you will understand this. There are two major reasons for quitting smoking that we can put forth and they have a different emotional content. If we take what we call potential informational threats. What we say to young people is: "Smoking is bad for you; it causes cancer; it causes this, this, this – and you has better stop". If you are a 15 to 20 year old, how many of your friends have got cancer or decreased life expectancy? Even further, what is interesting is that with a lot of these young people's parents, who might be smoking, you are not going to see some of these deleterious effects until people are 50 or 55, so even their parents aren't keeling over. So, it is a psychological message that falls on deaf ears, it doesn't communicate

what is really happening. We are walking around saying "Bad for you, bad for you" and it has no affective component, none whatsoever.

Let's see what I mean by affective component. When we talk about, rather than potential information threats, imminent consequential threats, the single biggest reason that smokers quit – and this is the only addictive behaviour that follows this pattern – the single biggest reason that smokers quit (80 to 90% of smokers) is health. They will tell you, it is not for the other reasons; they will tell you, it is a health insult to themselves: the doctor might have told them a health insult, a spot on the lung, or a spouse has died. My father was a good example of this. My mother smoked for 30-odd years with him, and at 52 she died of smoking-related illnesses. The next day, that was it. He was looking at his own mortality and morbidity and he quit – and he was very dependent, on two and a half packs. The grim reaper is the affective hook.

So what we mean by affective consequences a long time said Linda you have . We say to people: "Would you quit cocaine for one day for £5 million?" and people say "Sure". The point is: what is your personal price? It has got to have some personal, inside kind of response.

I do strange things at night, and one of them is read statistical things. I saw these data from SAMHSA (Substance Abuse and Mental Health Services Administration), which is a major survey group that puts stuff together in the US, and this is the imminent consequential threat. If you look at women who are of child-bearing age, from 15 to 44, when you survey them and ask about their use of various kinds of drugs in the past months, and then you separate them into pregnant and non-pregnant, the difference is striking[66]. Illicit drug use – 10% of women who are not pregnant report illicit drug use in the past month, down to 4% for those who are pregnant. Cigarettes – a gigantic difference: 31%, down to 18%. Alcohol use – 53% of the women who are not pregnant reported some alcohol use in the last month and 10% for those who are pregnant. When we go on to binge drinking, it is the same thing: 23% and 4%. For heavy alcohol use, the figures are 4% and 0.7%. What is the affective hook? The baby – a gigantic affective hook, a gigantic emotional attachment. Unfortunately, this affective hook comes out, and a large percentage of women go back to smoking, not realising that second-hand smoke is actually as bad. But, this is without any kind of treatment intervention discussion, and so it is interesting. My point is: what you are looking to do in terms of clinical work is ask, on a decisional balancing thing, "What is your personal price?"

I had a woman who came in and she had young children, and I had said, "What effect do you think your heavy drinking in the evening it is going on your children?" and she said, "You know, they don't really see that much of it, in that I'm not a down-and-out drunk". So I said, "What if you just talk to them?" and she said that actually they wouldn't really know. One of the boys, who was eight or nine, however, actually started describing 'mummy's grape juice'. So she said, "It's just going to be a few years till he realises that the grape juice is not grape juice, it's mummy's wine". For her, thinking about the effect it could have on her kids was the affective hook. What you are looking for if you are a clinician is "What is your personal price?"

[66] SAMHSA. 2005, *The NSDHU Report*, Available at: http://www.oas.samhsa.gov/2k5/pregnancy/pregnancy.pdf.

We have learned that it seems to be a major thing going on and, in the psychological literature, the whole notion of emotion, emotional regulation, affect – however you want to put it – is on the horizon; and probably in another five or six years, you will see the ABCs of change: affective, behavioural and cognitive.

The third thing that we found in the natural recovery studies was behavioural monitoring and action statements. This is actually not too surprising, but what these folk who change on their own say to us is that they are engaging in a self-regulatory process, that basically they give feedback to themselves. Behavioural treatments for years have been asking for people to self-monitor their drinking and drug use, so this is not any different; but what they are telling us is that writing on the calendar how much they are drinking, that is an eye-opener. So, it is very similar to what we are already doing for people who don't do it. What we are saying is that it seems to be one of those eye-openers in getting people to give feedback to themselves.

The last reason is extremely important: that people talk about what has gone into the self- change process. What a large percentage of people who change on their own say to us is that support from significant others is extremely important in the self-change process, not just in terms of promoting it, but in maintaining it. What we do know is that when we look at self-change, when we look at AA, when we look at SMART Recovery, when we look at treatment, one of the things that is associated with positive outcomes and can cross any of those interventions is social support. The clinical implication here – a major one – is that clinical treatments need to consider social support for clients, and for those people who are down-and-out, some kind of supportive environment. Supportive environments are important.

If you take it one step further, if you look at life events literature in terms of health and illnesses, what we know is that, if you take cancer patients or those with any health problem, it is those people who have a supportive environment who somehow seem to get better with the same kinds of treatment. That is interesting, because if you get cancer, a pretty serious illness, and you have got a supportive environment, you are going to be better off than not. So, somehow, something is working, and you scratch your head and think "How does it mediate the change process?"

The four important things that can be translated into treatment from the self-change process are: the decisional balance, looking at the affective hook, looking at behavioural monitoring and, then – a very significant one – social support.

So what do we know today? To summarise: self-change is the major route to recovery for multiple health and mental health behaviours, all the way from cigarettes, alcohol, drugs, gambling, obesity, stuttering, juvenile delinquency, mental health problems. We know that it is a phenomenon that occurs across a number of health and mental health behaviours.

We know that vast numbers of people do not enter the treatment arena, do not cross the clinical threshold into my clinic or your clinic for a major reason, and that reason is stigma. Do you want to be labelled 'alcoholic'? Do you want to be labelled 'drug addict'? In new Greek what stigma means is 'mark' – they used to mark the slaves that way. It is not something that most people want to run around with. Some people

do like the label – that is okay – but that is why people don't like entering, especially that end of the continuum here, folk who look like you and I.

We also now have a much better understanding of what drives and maintains the change process. What we are trying to do now is identify mechanisms of change they are outside the clinical arena so that we can put them into treatment and into prevention, and that is where we go now.

What is happening to the masses? When I say that the majority of people do not cross the clinical threshold, what I am saying is that I don't care what studies show me, whether it is in the UK, Australia, Canada, the US, Mexico, Spain, Germany, Switzerland: 80% of the people will never come into treatment. Don't we have a problem there? We have a problem, I would say, because they are costing us a lot: cost to society, to themselves. If they will not come into treatment, what do we do? Let me give you the figures. In 2003, only 8% of people in the US who met criteria for a substance use disorder had received any services in the past year – that is pretty bad. And, of those 8%, 50% did not complete treatment, so we have a very small percentage of people who come in and then half don't even complete. For the 92% who receive no services, only 5% said that they needed treatment. They don't need treatment? They are meeting the criteria for a substance use disorder, now they are telling you "I have this and this problem". It is not that they are in denial: they often give it to you so that we can make the diagnosis, but then they say, "I don't need services". Well, they don't need the kind of services that we are offering for the tip of the iceberg.

Let me just quickly explain why we have the problem that we do in terms of convincing people that they can change on their own. When people were surveyed on whether they knew someone who had resolved an alcohol problem on their own, self-changers (50% of natural recovery people) said that they did; but, when you go down to the general population, only 14% said they knew anybody who changed on their own – and, yet, self-change seems to be the major route to recovery.

What about the perceived optimism for self-change? People say, "Tobacco, yeah, I know people who can do that": 50% say that changing cigarette smoking without treatment is possible; then it drops down to cannabis; only 31% think changing an alcohol problem can happen; and down to cocaine: we don't know about it, we don't look very optimistically on it.

What percentage of the people knew someone who had an alcohol, tobacco or cocaine problem? Ninety per cent knew people who smoked, 82% knew someone who had an alcohol problem, and 34% knew someone who had a cocaine problem. Did the person they knew deal with their problem and resolve it on their own? For tobacco, 82% dealt with it, 85% resolving it on their own. Until recently, there haven't been a lot of treatments for smokers. Some of that is not surprising, but the number of people who resolved problems on their own is higher for alcohol (32%) and cocaine (44%). So, when people don't know, they don't think it is possible and they're not very optimistic.

There are still a lot of people who don't enter treatment – what can we do to help them? We can take the treatment to them. What we are talking about is having a

message that will attract the masses. If they don't want the stigma, you want to stay away from the words 'alcoholic' or 'drug addict'. We actually took the evidence that we knew and crafted a message. Unwanted messages evoke resistance so, if we advertise for people who are alcoholic and want to change their drinking on their own, we aren't going to get them coming to the treatment – and we actually saw that in Montreal, but that is another story. They will think of reasons why they are not. To attract the audience, those people who don't cross the clinical threshold, we need to craft the message carefully. The studies tell us that it is important to avoid labels, so we don't want to see that label in the ad; we want to promise confidentiality, which is something we do in treatment anyway; and we want to send the message that many people do recover on their own.

The ad that we placed in *The Toronto Star*, up in Canada in 1996, says: 'Thinking about changing your drinking? Did you know that 75% of people change their drinking on their own? Call us for free materials you can complete at home. All calls are confidential. Sponsored by the University of Toronto and the Addiction Research Foundation.' What did we do? People responded to the advertisements; we screened them very briefly by phone for eligibility – no past treatment or help for alcohol problems; we mailed all the assessment materials out – that is why it is a mail intervention; they completed them at home, two to three hours; they sent them back to a confidential post office box; and then we sent the experimental and controlled materials to the respondents, based on their group assignment. Almost 2,500 people responded to the advertisement in that year; 1,700 met the criteria (most of the people didn't meet the criteria because they had been in treatment before, even if it was one AA meeting); and then 825 people were actually in the study (that is, returned their assessments and met the criteria). It was a very large study for a treatment researcher like me – you usually have 100.

Here is what happened. The respondents were randomly assigned to either a control group or an experimental group. The control group received two vanilla pamphlets that are available in the community. These talk about alcohol use, monitoring their drinking, reducing – two things you can just pull out off the shelf and that are freely available. Then we had the experiment. I am in love with motivational interviewing, so we thought we would provide all this motivationally enhancing feedback to them, based on the assessment materials – it was glitzy, beautiful. The hypothesis was that the experimental group was going to get better. We sent them out weekly alcohol consumption/health risk scores, all that kind of stuff, feedback ('Where does your drinking fit in?' and 'You reported drinking an average of this…'); and they were sent a decisional balance, health care information – and everything looked beautiful.

Here is what these folk looked like: two thirds are male; employed, 60%; 63% are married; 85% have completed high school; 30% have completed some university; two thirds are white collar; ethnicity, 94% are white; and the mean age was about 48 years, which is typical for a treatment trial. This is where things become different from alcohol studies: mean years drinking problem is about 11 years, but miniscule numbers of mean arrests and hospitalisations, meaning that most people don't have consequences that respond to the study. Percentage of days' drinking in the past year: they are drinking three quarters of the days, so that is quite a bit of drinking; and mean drinks per drinking day: they are drinking six – now, that is not 25 drinks like a

chronic, but six drinks per day is definitely a health risk in every country that I have visited.

Results: no significant differences between the two interventions. And when the statistician brings that in to you as a researcher and you have spent three or four years, it is not something you want to hear at all. She said, "Do you want to hear the good news or bad news?" The good news was that both groups produced significant results one year pre- to one year post-intervention. That is better than any brief intervention, better than any physician trial – we are seeing reductions.

We published the report and, for about eight months, I was really, really, troubled, walking around mumbling, "How could it be? How could it be that all that fancy motivational material had no added effect over these two pamphlets?" In fact, a research assistant of mine actually accused us of bad behaviour, and she said, "How can you just give people these two pamphlets?" What caused them to change? And at the same time I was going around mumbling this, the field also had been mumbling about all these intensive assessments that we have people do, sometimes a whole day long, even our people did two to three hours; maybe just getting people to fill out these assessments starts to make them think. Remember the self-monitoring stuff that people were doing in the natural recovery.

So what changed? What worked? Fortunately, my statistician has been with me for a long time and said, "Linda, you have the ability to understand where they changed because we had this very fancy drinking measure (which I won't go into) and we have every date." So, what precipitated the change in both groups? Is it seeing the ad that increased the motivation and thus facilitated change? Is it the brief telephone screening that triggered the self-change process leading to the change? Is it completing the in-depth assessment? All of the above or none of the above? We put our money on the assessment, that is where we thought the field was going. However, the answer is that, for every single drinking measure, the change occurs at the time they see the ad and before they receive the intervention materials, irrespective of what they are. What we think happens is that these folk saw this ad, they were ready to change, and what the ad did was to catalyse the change process. And remember, it did one other thing: it says 'Do you know that 75% of people can change on their own?' What we are going to do is tease out the effects of some of those statements, look at effective assessment and do some other fancy things.

The implication here is that we just plaster the world with ads. If it actually has some effect for some people who are thinking of changing, who don't know that it is possible, it is very interesting. When we started to think about it, it really is similar to trigger events from the tipping points of natural recovery stages. But I did not understand it initially; it took us a while to see it.

We went back and found something that we didn't realise that we had, and we asked people why they responded to the ad: 29% said the ad title and 27% of the people said the statement – when you add that up, it's almost 60%. So, something was going on, and this was before the intervention occurred, when they called in and we asked them what stood out. Statistical work shows that at the time the ad comes in, that is where the change point occurs for every single drinking measure, every single health measure.

Future directions: what do we need to do in our clinical trials? We have to examine and control for mechanisms and change beyond treatment effects; we need to look at ads, assessment, talking with the screener, online materials; we need to time course this, and look at what may be going on at certain points; and, eventually, we are going to translate some of that into treatment.

So if you had to ask yourself: Where does a mail intervention fit in a system of health care when there is a finite number of resources? We don't have all the money in the world to do addiction treatments. What I am going to give you is our recommendation, that it is a sensible first step in a stepped care model of treatment. What do we mean by a stepped care model of treatment? It is a treatment that is least restrictive, least intrusive into a person's life, least costly (obviously, an ad or a brief intervention or SMART Recovery are not costly), likely to have good outcomes and, very importantly, has consumer appeal. We want to start with a treatment that basically is very similar to the health care field. The health care field has used a stepped care model to provide treatment services, because of health care resources being very costly. If you take hypertension, if you take cholesterol levels or eye surgeries, what we do is we try treatment A – it is least restrictive, least intrusive, all of those things; there are good outcomes – and we are doing a lot of surgeries on an out-patient basis that we never did before. But take hypertension. Most people don't like to take medication – medication compliance is a problem – so we start with exercise and diet; for those people for whom it works, all we are going to do is monitor their outcomes; but there are going to be some people for whom diet and exercise don't make any difference, so we step up the medication; and, for some people, some medications don't work, and you step up another medication – depression is a good one because you can use two types of medication. The point here is that you can get a lot of folk with brief interventions, least intrusive treatments, positive outcomes, and you save the more intensive treatments, more costly treatments for those people where things aren't going to work, so your treatment intensity increases. This is a model that health care physicians are using in most Western societies simply because of health care costs containment.

What are the public health and policy implications of mail interventions? In the context of a stepped care model, what we are saying is that you can promote self-change through a mail intervention, and it is consistent with an efficient approach to health care. As a first step, they are least restrictive, least intrusive and, to date, they have had good outcomes and consumer appeal, by virtue of the fact that we had 2,500 people call in. From a harm reduction perspective, stepped care looks at incremental improvements – it is all consistent – and when the intervention does not work, you step up the care.

To summarise: the ad was the change mechanism that appeared to motivate many people to change their drinking; it is a low-cost, population approach that can get to large numbers of people who are unwilling to access traditional treatments. And that is where we started off: the vast majority of people will not cross the clinical threshold because of the stigma. Such interventions can be coupled with messages to seek treatment, if self-change is not successful. This is the surprising thing: during the 12 months that we followed up these 825 people, some participants – and these were participants who had never been in treatment – some of them reported stepping up

their own care. And this is the exciting part: 28% of the people followed up and stepped up their own care; they went and sought treatment or they went to self-help, something else. We would suspect – we don't know – that this happened sooner rather than later because of them responding to that. These folk who did seek more treatment were significantly more impaired – not surprising – and so the added benefit of the mail intervention is that some problem drinkers who were never in treatment sought additional help.

Providing intervention outside the clinical arena: basically, the addictions field needs to respond to the full range of addictive behaviours by offering multiple and varied pathways to change; however, such efforts are going to require that the field shifts. The field needs to shift from its long-standing clinical focus in the clinical arena to a broader public health perspective.

## Scotland's Futures Forum
## Alcohol Forum February 2008

## Gavin Hewitt
## Chief Executive of the Scotch Whisky Association (SWA)

My name is Gavin Hewitt, Chief Executive of the Scotch Whisky Association, and our chairperson for this afternoon is Gillian Bowditch, the *Sunday Times* columnist and features writer. She has followed the issue of alcohol's place in society and how we tackle misuse assiduously over many years and she writes very interestingly.

This afternoon's seminar is an important part in the year-long Scotland's Futures Forum, looking at how we can reduce the harm caused by drugs and misuse of alcohol by 50% so that the damage of these scourges – for individuals and society alike – will be radically diminished by 2025. That is indeed a tall challenge. Today we are looking specifically at alcohol misuse. We will explore what the alcohol industry has done and can do to tackle misuse and contribute to reducing harm; and in the panel session at the end we can debate these activities and discuss what other action the industry might contribute, in collaboration with government, NGOs (non-governmental organisations) and other stakeholders.

The industry does not shy away from the fact that the health statistics for Scotland arising from the misuse of alcohol are not good. Perhaps they are not quite as bad as the government and media make out, but we accept that there is room for improvement. Since I returned to Scotland in 2003 to take up my job at the Scotch Whisky Association, I have been struck by the commitment of the alcohol industry to address the issue of alcohol abuse. The Scotch Whisky Association has been at the forefront of this activity; indeed, I am often ribbed by some of my fiends, who wonder why I and others in the industry are such advocates of action. They think – cynically – that the industry's only interest is to make money and protect its profits and that our heart is not in work to tackle alcohol abuse, as it would only lead to less consumption. Can I immediately disabuse you of that idea: our heart *is* in it.

In Scotland's Futures Forum, partnership-working is very much part of the philosophy. It is about bringing disparate views together, to learn what each is doing, to learn what works elsewhere and what lessons and experiences can help shape our approach in Scotland. That is why I am delighted that Robert Madelin, Director General of the Health Directorate at the European Commission and the architect of the European Union (EU) Alcohol and Health Forum, has joined us this afternoon.

Today has been billed, in shorthand, as industry's day to showcase its activity and to suggest what difference it can make through its own activity: that really belittles what today is about. Today, certainly, is designed to show a little of what industry is doing and can do, but it is also about understanding the benefits of partnership and of working together. I am a very firm believer in partnership – that is why I was insistent that the SWA should be an active and enthusiastic founding participant in the Scottish Government and Alcohol Industry Partnership. It is an initiative that is already delivering tangible results.

This collaboration between industry and government reached out last year to embrace other stakeholders. Among other things, we delivered Scotland's highly successful first Alcohol Awareness Week last October, an event originally conceived by the SWA. Its purpose was to raise unit awareness and responsible drinking choices direct to consumers. The SWA was also the first national trade association to sign up to the EU Alcohol and Health Forum, reflecting our international standing; and we are the only UK association, I think, which has a mandatory code on responsible marketing and promotion – of Scotch whisky, of course, in our case – with both an independent complaints panel and a set of teeth through clear sanctions that underpin the code.

Later this year, we intend to extend the mandatory reach of the code to cover Scotch whisky sold anywhere in the EU, not just sales in the UK; and our code will continue to serve as best practice guidance to our member companies worldwide and as a minimum standard of practice overseas where a tougher code does not exist.

Success in reaching our target of reducing misuse by 50% by 2025 will require a significant change in our culture and attitudes to alcohol in Scotland. But what is that culture? Sometimes, we are in danger of self-perpetuating – and indeed normalising – the acceptability in Scotland, rather than challenging those who stray beyond what is appropriate. For example, headlines that state that 29% of Scotsmen are drinking over the Government's sensible drinking guidelines reinforce the acceptance of heavy drinking. Perhaps we might start to make some progress if, instead, we and the press were to stress that over 70% of Scotsmen have got the sensible drinking message, and challenge the behaviour of the 29% who have not.

Last month, the Office of National Statistics (ONS) reported that Scots drink less than drinkers in England and Wales. More importantly, average consumption was within government guidelines. It is good news that our message is beginning to get through, and the statistics show that the picture is not all doom and gloom. The ONS figures suggest that the heavy consumption is being pursued by a minority, but we need to understand why liver disease and other alcohol-related health statistics are worse in Scotland than in England. We need to challenge acceptance of the stereotype of the hard-drinking Scotsman. Reaching out to them to understand their motivation is crucial; applying some of the social norms work which was highlighted in an earlier seminar in this series may be one route to success.

Each of us has a role to play, both as individual organisations and together in partnership; and individuals, too, must accept responsibility for their drinking and for their behaviour, but they need help to do it if we are to change cultural attitudes.

Price, promotions and availability are often cited as the key components to tackling alcohol misuse in Scotland, but raising the price of alcohol will not directly target those who abuse alcohol. Social and economic deprivation may not be the only drivers of alcohol misuse, but they play a very big part in Scotland's problems with alcohol. We need more joined-up activity from government, health practitioners, the social enterprise sector and industry to target those who need our help most.

Before I pass over to Gillian to chair this afternoon's event, I wish to set out the SWA stall very clearly. The Scotch Whisky Association and its members are committed to

fostering a step change in cultural attitudes to the consumption of alcohol in Scotland, which recognise that responsible, moderate consumption is part of a modern healthy society and that misuse of alcohol is as unacceptable as drink-driving. Cultural change in attitudes to alcohol misuse will require a long-term commitment, close collaboration and a concerted effort by a wide range of public and private stakeholders.

The SWA and its members are committed to, and support, the following actions:

- Partnership: We embrace the partnership approach of government and all stakeholders, focusing action on evidence-based measures.
- Enforcement: There must be strict and consistent enforcement of the law on the sale of alcohol to those under the legal purchase age and to those who are intoxicated. Measures such as 'no proof – no sale', 'challenge 21' and 'test purchasing' when combined are powerful drivers of cultural change. Test purchasing should be carried out regularly and consistently across the country to catch those selling in breach of the law, and retailers who fail to respect the obligations of their licence should lose their right to sell alcohol. Equally, I would call on the police to step up action against anyone under-age who tries to buy alcohol illegally. Tighter enforcement must also be accompanied by a better and faster response from the enforcement authorities to help protect from intimidation or the threat of violence staff who are manning shops or bars on their own.
- Training: We fully support the Scottish approach of training in the law all servers of alcohol, including casual bar and retail staff. It must be compulsory before they can serve or sell alcohol.
- Education: This is fundamental to a better appreciation, particularly among the young, of the risks associated with the misuse of alcohol; and alcohol education should be introduced in schools at an early and formative age and be a compulsory part of the curriculum. Alcohol education should also be reinforced in adult life through effective government multi-media campaigns, supported by the industry and other stakeholders, and better communication of responsible drinking messages through measures such as 'on-label messaging' – and advertising can contribute to this. The industry is committed to help roll out best practice on alcohol in the workplace, in association with employers and the trade unions.

  The delivery of brief interventions in health care or criminal justice settings must be a routine part of the lifelong educational approach. I tried that concept out on a doctor friend of mine only last night, and he confirmed the efficacy of brief interventions with most of his 'at risk' patients who have called in the last six months, finding the success rate in those last six months has been extraordinarily good. I was much encouraged by that.
- Marketing and promotion: We are committed to upholding the mandatory SWA code in the responsible marketing and promotion of Scotch whisky that was drawn up by the industry in 2005 and regularly reviewed and updated; and this year, part of that update will require members to include a responsibility element in their sponsorship activities. Advertising, promotions and sponsorship are a legitimate part of commercial activity in every industry. They play an important part in competition between brands and, particularly, in the launch of new brands. The alcohol industry has already successfully

introduced self-regulation to address their responsible promotions, but we have to recognise that voluntary measures must operate within the constraints of competition law and may not cover every situation.

I am delighted to be part of a sustained piece of work that looks to change the culture and attitudes to alcohol in Scotland. Ultimately, I hope we can encourage all Scots who choose to drink to take pleasure in their national drink – of course, I would say that – but in other alcohol drinks as well, and to do so appropriately and responsibly.

## Gillian Bowditch, *Sunday Times Scotland*

As fate would have it, I found myself this week interviewing Kenny MacAskill, the Justice Secretary, for *The Sunday Times* newspaper; and round about one third of my interview ended up being about alcohol and alcohol misuse. This is largely because Kenny MacAskill has made it clear that tackling alcohol misuse is one of his three priorities in government, the other two being tackling organised crime and reforming the penal system.

We spoke at some length about alcohol misuse – including his own, it has to be said – and Mr MacAskill is quite clear that he sees alcohol misuse as the root cause of everything from the rise in the homicide rate to low-level antisocial behaviour in our society; and he made it quite clear that his preferred method of dealing with it is to levy the industry, so there is no doubt in my mind that this debate today is a very timely one.

But Kenny MacAskill also said that he was very proud of Scotland's breweries and Scotland's distilleries. According to the Scotch Whisky Association, whisky exports now account for 67% of all Scottish non-oil and gas exports. Our drinks industry plays a vital role in the economy, particularly in the Highlands and Islands, where it is often the key employer; and I think, in government and elsewhere, balancing the needs of the industry and of employment and the economy with the problems brought about by problem drinking is clearly one of the most difficult things that they have to do.

As anyone in the media knows, it is very easy to blame the ills of society on a nebulous, homogenised group, but the alcohol industry is made up of many different companies with many different approaches. Does the island distillery producing fine malts share the same level of responsibility as the corner shop whose best seller is Buckfast? Is the common denominator of alcohol enough to bracket them together?

There was one remark that Kenny MacAskill made which I think is of particular interest. He said that he sensed a mood swing in Scotland with regard to alcohol and alcohol misuse – and I think the very fact that this Forum is happening suggests that is true. Four years ago, I wrote a series for *The Scotsman* newspaper on Scotland and its relationship with alcohol, and we devoted quite a lot of newspaper space and quite a lot of time to looking at lots of different areas within those parameters. What I think was very interesting was that, although I had a great number of personal letters – some of them very tragic, some of them from people with alcohol problems – there was very little in the letters pages of the newspaper. In fact, I don't think there was a

single letter on the letters page and, given that part of the reason for doing the series was to try and kick-start some sort of debate, it was quite disheartening. But I think that is no longer the case. There is certainly now a much greater interest in discussing these problems openly. There may not be a consensus on how we achieve the results that everybody wants to achieve, but I think the fact that there is a willingness to engage is the first step in any solution.

Today, we will hear what role the industry is playing in combating alcohol misuse and we will raise the question of what more can be done. It is very much a day for the industry, so we are going to concentrate on alcohol. There will be opportunities to discuss drug misuse at other sessions. There will be time at the end for a two-way debate with the panel and with contributions from the floor, and I will say a little bit more about that at the time of the debate.

**Mark Baird, Programme Director, Scottish Government and Alcohol Industry Partnership**

I am going to be talking this afternoon about the Government and Alcohol Industry Partnership, but it is fair to say that not everyone was enthusiastic when the Scottish Government announced that it was going to be forming an alliance with the alcohol industry. Professor Gerard Hastings said: 'It is like putting foxes into the chicken coop and asking them to be nice'. What I am going to talk about this afternoon is what the foxes have been up to over the last 12 months, and I will leave you to decide whether you think the chickens have any reason to be nervous.

Today, I am going to ask and answer a series of questions:

- What is the Partnership?
- Who is involved?
- Why was it formed?
- How do we work together?
- What have we achieved so far?
- What do we intend to achieve over the next 12, 18, 24 months?

The Partnership itself was launched almost a year ago, on 22 February 2007, alongside Scotland's updated plan in tackling alcohol problems, and it was in recognition of a shared aim of the industry and the Government in tackling alcohol misuse. It provides a basis for voluntary activity: the agreement itself is not binding on the industry, but I would suggest that up until now it hasn't had to be.

The two main aims are tackling alcohol misuse and promoting responsible drinking.

I hope it will be a long-term collaboration. We started off with 14 initial initiatives, which are designed not only to tackle alcohol misuse, but to use the expertise of the industry – and it is not just the capital resources of the industry that we have been employing. We also have a huge reach into the resources, be it marketing or whatever resources, within lots of the companies that are involved to be able to help us with this.

The emphasis is very much in delivering tangible outcomes. It is not about mere rhetoric or talking about things that we should be doing. I hope you will see this afternoon that we have actually achieved a fair bit so far and hope to do so in the future. It has been very clear that the Government has said: 'We are not anti-alcohol, but we are anti-alcohol misuse'. We talked there about Kenny MacAskill who, at the Scotch Whisky Heritage Centre on Burns Day, said: 'We are not prohibitionists' – and that is obviously very important to the industry.

In terms of membership, we have got companies and organisations involved from producers, the off-trade and the on-trade. From the producer side, we have Diageo, Tennents, Scottish & Newcastle and a number of the key organisations. From the off-trade, we have the Scottish Retail Consortium (SRC) and Scottish Grocers Federation (SGF); and from the on-trade, the SLTA (Scottish Licensed Trade Association), SBPA (Scottish Beer and Pub Association) and the British Institute of Innkeeping (BII).

What's important, as well as the organisations involved, is the level of the individuals who are involved in representing their organisations. For instance, in Diageo, we have Rachel Robertson, who is Government Affairs Manager; for SWA, we have got Campbell Evans, who is Government Affairs Director; for the WSTA (Wine and Spirit Trade Association), Jeremy Beadles, who is Chief Executive; John Drummond, Chief Executive of the SGF; and Fiona Moriarty, Director of the Scottish Retail Consortium. I think that is important because the individuals who are involved in the Partnership and the steering group can actually make decisions on behalf of their organisations, and we can get things done rather than having to constantly take things back to an organisation for decision-making.

As Gillian said, I am seconded from Diageo for a couple of years or so. To show commitment, my salary is funded by the industry partners, and I am actually working within the Government. I work alongside the Alcohol Policy Team in St Andrew's House, although it goes without saying that I have absolutely no influence or input into alcohol policy.

My role essentially is overall programme management: making sure that the work streams that we have agreed to actually happen; liaison between the industry and the Government, where applicable; and also seeking further opportunities outwith what we have agreed to do jointly in ways that we can promote responsible drinking and tackle misuse.

Let's look at the reach that the Partnership gives all those organisations involved: we have over one quarter of a million direct employees; we can reach over 3,000 bars, restaurants and hotels through our own trade partners; we have over 1,000 shops and supermarkets; and, through our association with the Scottish Retail Consortium and WSTA, we have probably covered about 80% of the alcohol volume in the UK.

We started off with 14 original initiatives. For each of these, we have objectives, timelines, and timescales; and also each objective has a Government lead and an industry lead to make sure it happens. I am not going to go through every one of these initiatives today. I am going to concentrate on seven and talk through what we have done in these particular areas. However, I am more than happy, either later on or at

the panel debate, to talk about any of the others. We have actually completed six of these already, so there are eight we are still working on. You will see later on that we are currently talking with the Scottish Government on how we can move forward with some more initiatives over the next 18 months or so.

The initiative I want to talk about first of all is Scotland's Alcohol Awareness Week. It really was a unique partnership and quite groundbreaking, in the fact that it brought together the public, private and voluntary sector, probably for the first time, with the aim of getting the Scottish adult drinking public to think about how much alcohol they consume, thinking about units and, then, once they understand the units, to relate that to their own drinking behaviour and to the sensible drinking guidelines. We did that via a very simple message, which was: 'Does your drinking add up?' We wanted the Scottish public to start to talk about this.

There were two key posters or vehicles we used throughout the campaign and, as you can imagine, a lot of discussion took place on what kind of message we were going to use: is the unit message strong enough? Is it enough to get the public talking? In one of the ads, there is a question mark at the end of 'two pints = four units'. That came about because a number of people in the group said it was very, very difficult nowadays to find a pint that is only two units. In the other key poster (which has 'two glasses of wine = six units?'), we said: 'Well, most glasses of wine are less than three units'. The main idea of these two posters, which we used throughout the campaign, was to get the Scottish public talking. We wanted to get people talking in the pub, at home, at work. Actually, these did start to engender debate because, if people started to say in the pub, 'I would have thought two pints of beer was more than four units, I would have thought it was five or six', then that is exactly what we were after. I met a husband and wife just at the start of the campaign, and when I said what I was doing, they said: 'We have seen one of these posters recently and, actually, the first time we drove past it, we thought it was a beer advert; then, the second time we drove past it, we started to read it and then thought "Surely two pints is more than four units?"' – which was exactly what we were looking for. We wanted people to start to discuss alcohol at any level, to start to talk about units, to start to talk about daily guidelines – just get the conversation going.

We launched the Awareness Week on 22 October; and there was a speech by Tom Wood, the Chair of SAADAT (Scottish Association of Alcohol and Drug Action Teams), Bryan Donaghey, Managing Director of Diageo, and Shona Robison MSP, who said: 'I am proud to be able to showcase an initiative that I see as truly groundbreaking. The spectrum of activity being carried out across the week demonstrates just how much we can achieve when we set a common goal and work together in partnership.' It is very important for us that Shona Robison actually talked about the partnership approach and what we could achieve through this week.

As well as the communication vehicles that we had via posters, etc, another very important aspect was a toolkit, which we made available because, in addition to communicating directly with the public, we wanted companies and organisations throughout Scotland to get involved themselves. We contacted many, many organisations and literally hundreds got on board by taking the toolkit, and they decided how they got the message across to their own workforce. Some did presentations; some had workshops; some put all the materials into their own

restaurants or whatever. The important thing was that it wasn't just the Partnership that was communicating with the Scottish public: organisations took the toolkit and found ways that *they* could communicate.

Alcohol Focus Scotland (AFS) also ran road shows in key cities throughout the country, for example, at Braehead Shopping Centre in Glasgow. Again, these gave an opportunity to have that dialogue with the public: having people there who could speak knowledgeably about alcohol and the public coming up and having a discussion. One of the anecdotes from that particular road show in Braehead was a little woman who came up and said: 'My husband drinks, but I don't drink at all – apart from the wine of course'.

We also had terrific coverage throughout the week from the *Herald*, the *Paisley Express* and the *Daily Mail*, while the *Record* ran a full double-page spread – we had much better coverage than we hoped we would get. And it wasn't all just about what the Partnership was trying to communicate. Lots of different media actually ran different campaigns to get the awareness up. For example, the Scottish Rugby Union (SRU) offered to help us launch, and there was an international match just a couple of weeks before where they started to talk about Alcohol Awareness Week.

All 32,000 copies of *The Big Issue* that week carried a free unit calculator; ASDA's in-house magazine talked to their employees about unit awareness and responsibility; and Marks & Spencer took the main poster campaign but also personalised it for their staff and their customers – which is exactly what we wanted people to do. We didn't just want to have one message out, but for people to take it and do with it what they could.

The achievements:

- Most of the major high street retailers had in-store promotions or events distributing materials.
- Over 400,000 beer mats and posters were sent out to over 3,000 pubs, clubs and hotels.
- We distributed around one quarter of a million drink aware unit calculators through pubs, clubs, shops, off-licences, chemists, GP surgeries, police stations and *The Big Issue*.
- We ran responsible drinking promotions in every single army mess in Scotland, which was identified as a particular target audience.
- We had poster materials on literally hundreds of buses throughout Scotland, and most of the companies agreed to do that for us at nil cost.
- We had stalls in shopping centres.
- There were 209 broadcast and print articles, generating a PR value of over half a million pounds.
- There were 16.4 million opportunities to see or here the message, which is basically if you add up all the circulation of all the different media that people could have seen.

What was particularly pleasing to us was that, at the end of that week, there was a Scottish Omnibus Survey, and we arranged to have a couple of questions in there just to test the public's awareness at the end of the week to find out if they had actually seen anything at all about Alcohol Awareness Week. We were really pleased that 56%

of those surveyed had heard of Awareness Week one way or another – and that was unprompted, just 'Have you heard of Alcohol Awareness Week?' About 73% of people had seen the beer and the wine poster one way or another. We believe it had the highest penetration and impact of any alcohol-related public communication exercise with a similar spend level.

Here were some of the comments towards the end of the week:

- Fiona Moriarty, of the SRC, said: 'Through the SRC, media retailers were very positive about working in partnership with the Scottish Government, health professionals and the voluntary sector to deliver a common message to hundreds of thousands of customers.'
- Tom Wood, Chair of SAADAT Scotland, said that Alcohol Awareness Week was the first of what he hopes will be an important annual event.
- Jack Law, Chief Executive of Alcohol Focus Scotland, said: 'Influencing Scotland's drinking culture requires action from many different people and agencies and we look forward to building on the success of this initiative.'
- Theresa Martinus, National Alcohol Liaison Officer at SAADAT, said: 'Alcohol Awareness Week brought together for the first time the alcohol industry and those managing the problems and, in that respect, it was a resounding success.'

I want to go on to one of the other initiatives that we are working on, which is a multicomponent geographical pilot. One of the first initiatives that we wanted to get involved with, and which has just come to fruition over the past month or so, was taking one area of Scotland and working with a series of interventions and evaluating whether a multicomponent approach would have more effect than just a series of individual target interventions. (The Joseph Rowntree Foundation very much thought that a multicomponent approach would achieve more.[67])

We chose Fife as the area we wanted to work with because the key agencies have coterminous boundaries. There is a mix of urban and rural areas, so we can try things in a city and we can try things in a small village or a small town. They have recent experience in Fife of hosting the test pilot activity. They have got experience of working with industry: Diageo in Fife has been involved with many, many projects with the local agencies up there. Also, we wanted particularly to talk to students, and we can do that through St Andrews University.

Some of the objectives we are aiming to achieve through this partnership with Fife are:

- reducing alcohol harm
- promoting responsible drinking
- increasing awareness
- reducing under-age drinking and related youth disorder and proxy purchase
- reducing antisocial open air drinking
- reducing alcohol-related crime.

[67] Thom, B. & Bayley, M. 2007, *Multi-component programmes: an approach to prevent and reduce alcohol-related harm*, Joseph Rowntree Foundation, York.

These are some of the areas that we have talked about potentially getting involved in, though none of these has yet taken place. We have just had our first meeting with Fife over the course of the last couple of weeks, and that was with police authorities, NHS and the local ADAT (Alcohol and Drug Action Team), who are coming together for the steering group.

Some of the things we could do in the on- and off-trade are:

- greater availability of low alcohol and alcohol-free products, both in the on- and off-trade
- removing alcohol potentially from supermarket till points
- having challenge 21 in as many establishments as possible
- increasing the Best Bar None and Pubwatch schemes that already exist in Fife
- conflict training for staff
- experimenting with soft drinks pricing perhaps in bars for drivers
- bottle marking schemes
- challenging more proxy purchase.

Some of the things we could do more generally are:

- perhaps working with the BII Schools Project in some of the schools in Fife
- working with the social norms programme that Gavin touched on earlier, and it would be great if we could actually put that programme into St Andrews University
- take CragRats and Boozebusters, which are two theatre productions, into as many schools as possible
- working on diversionary activities for youth, with age-targeted awareness programmes
- working with student unions and workplace alcohol policy and workplace awareness workshops. We are very, very keen to work within workplaces and use that as a new target audience that we can work with.

The first work stream that we completed was the Scottish Social Responsibility Standards. These took the UK standards which were already in place and adapted them for Scotland, giving lots of guides and hints and tips on how they could be used in both the on- and the off-trade; and what this document has allowed us to do is to talk to many people in the licensed trade and use this document as a standard.

One of the other initiatives that we have been working with is event messaging. The on-trade tends to be very heavily regulated and mostly responsible, but we realise that there are literally thousands of events in Scotland every year such as Highland games, church fêtes, gala days, etc, where there are probably not trained staff, and the risks of selling to under-age youths or to drunken individuals is probably higher at these events than in bars. So, what we have started to do is work with the EventScotland organisation to say: 'We would like you to insist that if EventScotland is involved in an event, and if you are funding it, then you write into the contract that the event organisers agree to take on board all the principles of the Social Responsibility Retailing Guidelines and also adopt challenge 21 as a standard.' They have actually agreed to do that as of the first quarter of this year, and they are now looking at how they can write that into their contracts so that each organisation that gets involved with EventScotland will actually have to take this on board.

Another area we are working with is alcohol policies. From the perspective that only around 50% of Scotland's companies actually have a formal alcohol policy, what we have done is work in conjunction with the Centre for Healthy Working Lives to produce a policy that any company can take: they don't need to go to an employment lawyer and draft one up. Basically, what we have done is devise and develop a policy that any organisation can take and badge under their own name.

Many companies that do have a policy only tend to take on the most serious issues of what happens if you get drunk: the disciplinary issues and what is going to happen. What we have done in developing this particular policy is to take it much further and look into areas like business entertaining and office parties. There is an option in there for zero alcohol, which more and more companies are going towards; and there is alcohol awareness information that organisations can share with their employees. It is supported by the Centre for Healthy Working Lives and, with other organisation like AFS and SBC (Scottish Business in the Community), we hope to have it on a number of websites that can be promoted by these organisations, and companies will be able just to go in, take the policy, adopt it as their own and change the title pages.

Another initiative we have agreed to get involved with is server training. For a variety of reasons, the Licensing (Scotland) Act 2005 doesn't cover staff training for occasional licences; and, similar to what I talked about with events such as Highland games, church fêtes, etc, there is a fair risk that many of these events will be served by untrained staff. What we have agreed with ServeWise, AFS and BII Scotland is that we look for opportunities to make that training available free. The other aspect of volunteer training is that they wouldn't be able to afford to have the training. What we are exploring right now with AFS and the SCVO (Scottish Council for Voluntary Organisations) is how we can make that training available. If there is a training programme for a personal licence holder, for instance with 12 people, and one drops out, what we would like to do is make that place available to a volunteer, someone in the voluntary sector. What we also want to do is to have those who are trained and then take it back into the communities and train staff who are actually just serving at the events. So, we will have personal licence holders trained, but also serving staff. We believe in maximising the relationship between the licensed trade and the local community because, as well as offering training places, we also hope at some stage in the future to start to work with the local licensed trade, for licensees who are trained – maybe the local landlord – might agree to train some of the local volunteers. Again, it keeps that relationship between the local licensed trade. We also believe that, through time, it makes the volunteers more marketable from the perspective that having formalised server training makes it easier for them to apply for a job in the local hotel, the local pub, or the local retail outlet, because they will already have received the two hours' mandatory training.

We have also been working with Road Safety Scotland quite extensively in promoting responsible drivers and, basically, anti-drink-driving. We have used the network of organisations SLT, BII and SBPA to get the materials into pubs as quickly as possible. The summer campaign, with a poster and a beer mat, was brought into 3,000 pubs very, very quickly; and it ran again in the autumn and, again, we got it back into the bars and clubs.

With the Christmas and New Year campaign, Road Safety Scotland approached us and asked if we could help them get their poster out to as many offices as possible; and we saw an opportunity, not only to go into offices, but also to get it into licensed premises. So, again, through the organisations, we got it into literally thousands of pubs. This is an example of how we can use our network to get responsible drinking messages – be they Government messages or whatever – into as many establishments as possible and get them seen by the public.

I have talked a little bit about the 14 agreed initiatives and concentrated on seven of those. What I would like to do now is talk about some other things we have done, because I mentioned right at the start that another key plank is that we are constantly looking for opportunities where we can either tackle alcohol misuse or promote responsible drinking, and I would like to give you some examples of those.

Back in September 2007, when it was decided that Murrayfield would get their alcohol licence back after 20 years, it was very clear that the SRU, the police, the local council and the Government were keen that this went as smoothly as possible, given that we were giving the licence back and it was going to be for senior international matches. We worked with Murrayfield and their bar provider to get challenge 21, first of all, as a standard, but also to make sure that it was very prominently displayed and to have some hints and tips that people could use and see when they came to the ground. All 19 of the bars around Murrayfield displayed very, very prominently challenge 21 and that was to avoid anybody under-age approaching the bar and taking a chance. We also had marshals managing the queues to make sure there were no youths at all who looked under 18 who would approach, but the idea was in having challenge 21 prominently displayed to give the message very, very clearly.

The one thing we didn't get quite right was selling Heineken at £3 a pint and alcohol-free lager also at £3 a pint. One of the future things we want to do is to try and make alcohol-free lager a little bit cheaper than normal lager.

Now that we have formed a relationship with the SRU, they are very, very keen to keep that relationship going, and it is great that they want to promote responsibility at every opportunity. Just a couple of weeks ago, they approached us to say that they had the Six Nations internationals coming up, and that they would like to give us an opportunity again to get the responsible drinking message across. They offered us a full-page colour advert in the programmes for both the French match and the English match. They also offered that Jason White, the Scotland captain, would record a responsible drinking message that would be shown pre-match and at half-time to the 67,000 capacity crowd.

We have also been working with the Scottish Football League (SFL) and Road Safety Scotland to get the message across to football grounds. We put the SFL and Road Safety Scotland together. Road Safety Scotland sponsored the Challenge Cup Final and had anti-drink-driving branding all around the ground and in the programme. It also presented to the 30 Scottish Football League Clubs and persuaded them to take these adverts, which are very much aimed at football crowds, and put them into their washrooms and all around the stadium. Many of them have done that since and, again, that has been free of charge, so it has allowed us to get that vehicle out there.

Coming up to Hogmanay last year, we recognised it was a very important time to talk about responsible drinking and get some really important messages across, so I worked with Edinburgh, Glasgow, Stirling and Aberdeen Councils and basically asked them to get a responsible drinking message across to as many people as possible at that time of the year, in whatever way they could. Stirling, for instance, had a big event at Stirling Castle, but they didn't have any screens there and they didn't have any bars. What they did was put the responsible drinking materials on to their website on the Hogmanay page. Edinburgh Council agreed to run a Portman Group ad. For a very nominal fee, they agreed to show two Portman Group cinema ads on responsible drinking to the crowd 10 times during Hogmanay, which was a great thing for them to do in terms of getting that message across to the public. In Aberdeen, the council had a huge screen right beside where the bands were playing, and they played two responsible drinking ads immediately before the show started.

We have also been working with nightclubs. Again, Road Safety Scotland approached us with an idea that they would like to get the message of anti-drink-driving across to the night-time economy. Working with BEDA (the Bar, Entertainment and Dance Association), they suggested 20 of Scotland's busiest nightclubs where, if people go out to smoke, they stamp their hand and, usually, it would be with the name of the nightclub. We gave them stamps which said 'Drink-drive – lose your licence. Don't risk it' and these clubs are actually using this now as people go out for a cigarette. One of the ideas was to get across a subliminal message, if people wake up in the morning and they have still got the hand stamp.

We are working with licensees to advise organisations like the National Trust for Scotland and student unions on the Licensing (Scotland) Act. Over the past few months, we have also started working with Eileen McArthur, who has a terrific project up in Angus working on a whole series of avenues to tackle alcohol misuse with broadly similar objectives to what we are going to do in Fife. The difference is that, up until now, they haven't had much support or input from the licensed trade. So, that is what we want to do, and we are also exploring how we can help with some of the other areas such as schools, event management and workplace policies.

We have recently opened up dialogue with the Government officials and ministers in the areas that we can get involved in next. In fact, over the last three days, I have been up in Shetland, where the local ADAT are working with the police and health professionals to adopt a programme that has been very successful in Quebec, which was called the Educ'alcool Programme. They are adopting it for Shetland and calling it Drink Better. We want to take more alcohol awareness programmes into schools and a number of organisations have the capability to do that. We are developing a workplace alcohol education programme right now, which will be available on a CD-ROM in a couple of weeks.

I have talked about the social norms programme. The strengthening families pilot is a very successful programme that is aimed at 10 to 14 year olds, but works with the whole family. There is also tackling alcohol-related antisocial behaviour through diversionary activities, mostly through football – and you will be reading more and hearing more about that over the next couple of weeks.

I think we have been successful. I think the partnership has achieved a lot, and I think that is mainly because we have one common purpose. Both the Scottish Government and the alcohol industry agree that Scotland has a problem with alcohol misuse. The Government is committed to tackling that misuse, and we have evidence of that through the £85 million that have been announced recently to go into tackling Scotland's problem. The alcohol industry is determined to be part of the solution, not just part of the problem. We are delivering tangible outcomes; the activities we are involved in complement what is happening in government; the industry is absolutely resolute in their commitment to stay on board. A number of the things that have been announced over the past six months or so with display regulations and promotions have been pretty tough on the industry, but the industry is determined to stay on board. There is also a belief that we can achieve more by working together, and I would like to finish with a positive note, going back to what Shona Robison said about Alcohol Awareness Week: "The spectrum of activity being carried out demonstrates just how much we can achieve when we set a common goal and work together in partnership."

## Robert Madelin, Director General of Health and Consumer Protection, the European Commission

Working in the European Commission on Health, it is very important to engage in this sort of process about the delivery of health outcomes in specific places, because you can't improve health just in Brussels. Also, I think this exercise around Scotland's future is exactly the same sort of exercise, at the Scottish level, that we in Brussels on the health side are trying to conduct for the 27 member states of the Union.

One of the fruits I hope will come out of today's seminar is to talk not just about the alcohol dimension, but also about the Futures Forum as a process, and to try to understand how what happens at the European level can be helpful to what is going on in Scotland. Furthermore, I believe, over the four years I have been Director General of Health and Consumer Protection, that the health promotion activities in Scotland are among the best examples of grass-roots activism for health promotion in the European Union. As we expand from 15 to 27 member states, there are a lot of regions and big cities – and even small countries – out there which I think could learn a lot from engaging with the Scottish example.

What I want to do is talk about the European background, so here are some facts. I think the basic message is that the problems you face here are being faced by many different countries in slightly different ways. I also to talk a little bit about the Health and Alcohol Forum which we have set up at the EU level as another example of partnership. I think that what you will see as I describe it is that, compared to the partnership approach being developed here, the partnership is broader, some of the processes are looser because we are trying to bring together a much more disparate set of partners who are operating across many different communities, but the basic challenges and tools are the same.

I will start by looking at the size of the problem. The population-wide average consumption levels are going down, but the EU is still the part of the world which

drinks the most[68]. (Many of the figures I will give will be for the EU average; within that, the UK figure, and within that, the Scottish figure – you will know those.) Broadly, from a Brussels perspective, we are still big drinkers everywhere in Europe. Within that, the decrease is not continuing, so we are levelling out at a relatively high level, and we have what we call a 'conversion of harm'. If you look across Europe, we would say there is not a northern, southern, eastern and western pattern: the patterns are converging. For example, you find youth binge drinking in Scotland, London, Barcelona, Madrid and Milan – and that was not the case 10 or 15 years ago.

If you look at the self-reported figures, clearly the UK comes up high in terms of under-age binge drinking[69]. If you look at even younger boys and girls, the UK is still rather high. (I asked my colleagues what the figures for Scotland are, but we didn't gather them at that level.) If you look at the EU problem, getting on for 10% of ill health and early death in the EU are linked to abuse of alcohol. Up to 25% of male premature deaths and up to 10% of female premature deaths are caused by excessive alcohol consumption: that comes to a staggeringly high number of avoidable premature deaths in the EU (195,000 a year). With regard to diseases, if you look at the overall figures, alcohol is way up there. If you take tobacco out, it is the biggest single issue driver of the disease burden in developed countries. These figures, which are World Health Organisation (WHO) figures[70] hold pretty well true for Europe as well. So, if we could tackle alcohol as a problem, we would be tackling one of the big parts of our disease burden. Equally, I think it is true to say that the things we need to do to tackle the alcohol problem relate to other social problems. You can build social capital that is going to help with a lot of problems in society if you can find the right solutions to the alcohol problem.

There are tangible health and social costs to alcohol[71]. I think this is important if we are thinking about competitiveness in an aging society across Europe. The sheer number of days lost to absenteeism and mental health in business as a whole due to alcohol abuse comes to 20% of overall costs. Clearly, it is not just good for the individuals, it is not just good for their families and for victims of crime and road accidents, it is also good for society – in the economic sense – if we can do better.

The ministers of Europe therefore asked the European Commission to come up with some ideas for a co-operative approach across Europe to deal with alcohol, and we developed five goals:

- tackling the youth problem, by protecting young people, children and the unborn child
- tackling the road traffic problem, by reducing injuries and deaths from alcohol-related road traffic accidents
- reducing the negative impact on the workplace setting
- education in the broad sense

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[68] Anderson, P. Baumberg, B. 2006, *Alcohol in Europe: A public health perspective*, Institute of Alcohol Studies, London.
[69] Hibell, B. Et al. 2004, *The ESPAD Report 2003, Alcohol and Other Drug Use Among Students in 35 European Countries*, The Swedish Council for Information on Alcohol and Other Drugs (CAN) and the Pompidou Group at the Council of Europe, Stockholm.
[70] Lopez, A.D. et al, 2006, *Global burden of disease and risk factors,* World Bank, Washington (D.C.).
[71] Anderson, P. Baumberg, B. 2006, *Alcohol in Europe: A public health perspective*, Institute of Alcohol Studies, London.

- continuing to work on the evidence of what the problem is, but also evidence of what works.

The Eurobarometer[72] is a sort of EU-wide public opinion survey. We don't have the Scottish figures, but the UK figures show that the vast majority of people want a more interventionist approach, for example, that alcohol advertising targeting young people should be banned. In certain media, such as television, that is already the case, but the debate about whether alcohol should be made less present in the environment is clearly a continuing debate. On other issues which are less controversial, like a ban on selling and serving alcohol to people under the age of 18, we have a strong consensus with the industry, because this idea of responsible serving and server training is pretty consensual; the difficulty there is delivery rather than whether we want to do it. Warning labels on alcohol bottles is something I see coming. We have seen it in France; we have it in Finland and Poland at the moment, so there is a debate there.

It is clear that there is popular support – as well as health minister support – to do something. We want to improve the environment and, at the EU level, we want to do two things. Firstly, to bring together the health ministers of the member states and the regional health authorities; and, secondly, to try a stakeholder partnership approach, which brings me to the launch of the European Alcohol and Health Forum last year.

Perhaps, before I go into the detail of what the Forum does, I can introduce you to a Greek temple that is my vision of what it means. Here, we have a stakeholder approach that brings together government and industry in a sort of co-regulatory approach, where you agree an objective and a government person and an industry person co-ordinate the pursuit of the objective. It also brings together academics, scientists, NGOs and self-help groups, so the number of actors you have is very much broader and makes perhaps the design of a real partnership slightly more challenging. My own belief is that it also adds to the legitimacy of the partnership because I think, over time, if the sorts of initiative that are being described here in Scotland go forward, the important next challenge is how to convince the rest of the community that the outputs are indeed tangible. How do you convince the community that the objectives are the right ones? At the European level, where the legitimacy of government is lower, we are not paid to do the same things that the Executive in Scotland is paid to do. The European Commission needs to bring more of society into the room to begin with, in order to make sure that we have got the right goals and the right processes. We start from the foundation, the vision – and it has to be the same vision that is being described here: everybody sees the problem of alcohol abuse and everybody agrees to be part of the solution to the problem.

I think what I have learned during these partnership processes – and this is truer in some societies than others – is that you have to have people in the room together working for a common goal, without their necessarily believing exactly the same things as all the other people round the table. For example, some of the self-help groups do not believe fundamentally that it will be a good thing if twice as much Scotch whisky is sold next year as last year; clearly, the Scotch Whisky Association believes that would be a good thing. What they both agree is that alcohol abuse should

[72] European Commission. 2007, 'Special Eurobarometer, Attitudes towards Alcohol', Available at: http://ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/ebs272_en.pdf.

be reduced. Trying to keep that tension requires a certain degree of human honesty and, sometimes, patience.

What pillars hold up the Greek temple I referred to earlier? Actors have to come from a broad range of society. Relevance is important: you can't just say 'Look what I am doing', unless you can prove that what you are doing is useful. I think one of the challenges that we will face as the Alcohol Forum goes forward at European level is to show that tangible inputs campaigns lead to tangible outcomes: reduction of harm, reduction of road traffic accidents, reduction of crime – and that is the bit that is difficult to measure. It is easy to measure how much effort people are putting into responsible drinking messages, but it is much harder to measure the impact that this seems to have, even the associated trends in responsible drinking in the area or in the population targeted by the messages.

Coherence means you can't have responsible drinking messages and offers of the 'Pay a tenner, drink all you want during the match' type – and I think that is an issue which is harder to tackle in some countries than others. It is a journey. If you want to get an alcohol company to promote responsible drinking, my perception is that, at the beginning that needs to be bought into at a very high level. However, to achieve coherence across the whole of the strategy of a company, which is a complex organisation, takes leadership and time within the company, just as you need leadership and time to change culture within a society.

There are some very complex dynamic processes here, which means that during the time between starting and achieving your objectives, you are vulnerable to criticism. For example, for me, there is the question: 'Why are you, as a health official, in bed with the brewers and distillers and they haven't delivered? There is still alcohol abuse and there are still road traffic accidents' – and that is a story which is hard to sustain. You sustain it best if you have roots. That is why I think it is great to come from somewhere distant from the real world, like Brussels, to here, which is closer to the real world, because what we have also learned is that you can reach the parts that national measures cannot reach if you have a Brussels initiative. Here in Scotland, you are lucky: you are focused on the alcohol problem. When you look across the map of 27 member states, there are places where the health minister is weak; there are places where the drinks industry is not yet actively engaged in responsible campaigning. There are therefore places where European citizens are facing a passport lottery whereby, depending on where they live; they get more or less help to deal with this common problem.

We can only achieve something at an EU level of 27 member states – half a billion citizens – if the companies and the civil society organisations, as well as the governments, take the objectives back to the local level. The overall objective of the European Alcohol and Health Forum[73] is to look at five areas: under-age drinking, data collection, promotion of behavioural and cultural change, consumer information and dealing with the controversy around what sort of commercial communication is right and what is wrong.

[73] Charter available at: http://ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/Alcohol_charter2007.pdf.

As I have said already, we don't just have government and industry, we have a much broader set of players; and I think that is a complexity, but it is also a strength. We have to have a slightly different approach to who can come in. We have European-level organisations: so it is not the Scotch Whisky Association, it is the European Confederation of Spirit Producers, and then the SWA and then Diageo as well. It is companies and national players and European players. This means that, although we have half a hundred founding members, they are umbrella organisations with counterpart players in most of the countries of Europe; and the commitment process, as I have said, is less directed than what is being done in Scotland. We didn't start by saying: 'Let's agree 14 action areas and let's agree a common objective'. We said: 'Depending on where you are coming from, the members should bring their own commitments', so it is a much softer process. That may mean, when we have our first public Alcohol Forum meeting in April – to which any of you, any journalist in Europe or in the world can come – it may mean that people say that these commitments don't add up to a coherent policy. On the other hand, it gives the opportunity for each player, in the different countries, to start from where they are, because not everyone is yet at the Scottish level – some are above, some are below. It also gives the opportunity for innovative approaches. For example, the youth organisations that are coming into this discussion for the first time are, I think, really thinking outside the box, trying to find ways of engaging with their youth networks in different countries and trying to package the alcohol issue with the drugs issue, but also with tobacco, with sexual health, with all sorts of issues that matter to youth. The way that they approach this is completely different from the way the companies approach it or the way the academics will approach it. This more open approach is, I think, going to give some good ideas; and we will know whether they work, because we make it a condition that they are not only monitored, but monitored with some third-party credibility. You can't say in 2007, 'I am going to do this', and come back and say, 'Trust me, I did it'. You need to come with some facts and figures and, ideally, you need to bring outsiders into the game. If there is one message I think I would say I have learned, not just in the last four years, but also in previous self-regulatory or co-operative approaches in Brussels, it is that if you do not have an open door, if you do not bring non-business players into the game from the beginning, at some stage, somebody will criticise your motives. Maybe having other people in the room complicates the process; maybe, in the end, you do the same things, but you do them with greater creditability, and whatever you achieve gets more recognition.

So far, we have had our first round of commitments: 50 organisations, 75 commitments, roughly a third covering all member states, though there are no representatives at country level from the new member states. The new member states are covered by some of these big umbrella commitments, but this tells you something about the challenge of building a strong civil society, a strong community, in some of these other countries. This is a challenge that will take decades, but it is one of the advantages that I think Scotland is certainly using in its endeavours.

What are we actually doing in these commitments? As well as the development of information and education programmes, I am very pleased that there is a lot around responsible commercial communication and sales, because that is extremely important, and around cultural change. With regard to information and education: one is short-term and one is long-term, and one of the challenges is how to fit them

together. You can have challenge 21, and you can have adverts and posters – they are very nice; but how do you build them together so that the social norms change?

In the interests of time, I am going to skip a long exposé of the bureaucratic aspects of the Forum. There are a lot of meetings, but what I would underline is that we have some specific focus groups on youth and on marketing because those are the two most promising issues: marketing, because it is very controversial – nobody agrees; and youth because, as I said already, if you bring the youth voice into this process, you get some good new ideas. The other thing I would emphasise is that we have a science group. We don't have it yet – we are currently sifting the applications to join – but, over time, if we want to demonstrate that there really is a best way of tackling alcohol abuse in a co-operative way, we need to be able to have a science-based, evidence-based demonstration that these different commitments add up to the beginnings of a solution. In other words, I think we do have tangible inputs at the moment, but we don't yet have tangible results.

The final thing I would say on the bureaucracy is that it is not all going to happen through this alcohol platform, any more than co-operation in any setting would solve all the problems. There will still be national policies, and they could include issues which we are not discussing, like tax and pricing and changing the licensing laws. That, in a way, is the ultimate challenge for a process that I personally believe in: if the co-operative approach delivers a solution, the need for big government solutions goes away; but if the co-operative approach fails to deliver what society judges to be adequate progress towards the reduction of harm, we will end up with more interventionist solutions.

The long-term objective of the Forum is to change the culture: being drunk should no longer be socially acceptable. I think that is a simple vision; it is one which I hear is shared. There is a lot of commonality between the sorts of intervention that seem to be developing at the Scottish level and those that are coming up to us from the different member states, which means there is a lot of scope to share data. However, I see two challenges going forward: one is to link the effort to outcomes, and the second is to ensure that all parts of society know that they are part of the process so that they own the results.

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**Text from Advert**

Hi, I'm Jason White, the Scotland captain. I'm delighted to welcome you all to Murrayfield today. As you are now aware, you can have a pint of two within Murrayfield. There are, however, quite serious consequences that come with drinking. You need to be responsible for your own health, for your relationships and also for your local communities. Myself, the Scotland players and the Scotland management hope you all drink responsibly. You need to learn how to drink responsibly, without damaging your health or experiencing other alcohol-related problems, like antisocial behaviour or violence. To find out some top tips, log on to www.infoscotland.com/alcohol or read the advice in the programme for today's match to get to know your units.

## Benet Slay
## Managing Director, Diageo GB

I am the Managing Director of Diageo GB so I run the commercial organisation for Diageo in Britain but I am also a Trustee on the Drink Aware Trust which is a relatively new independent charity which brings together both alcohol producers, retailers, health professionals and academics to work on reducing alcohol harm. I am going to come back and explore that a little bit more later on but what I do want to do today primarily is to bring to you and to Scotland's Future Forum the lens from one individual producer operating within the total alcohol space. It really is about our approach and creating an industry approach to change with the view in marketing speak of trying to get across the message that it is totally uncool to get drunk. That is the idea that we are trying to work against.

It is probably worth saying a little about Diageo for those of you who don't know us well. We are the world's largest premium drinks company. We have got many long established brands including obviously Guinness, Smirnoff which is a substantial brand here in Scotland, Bells, Gordon's, Johnny Walker, Baileys and a number of other spirit and beer brands.

In Scotland we produce over 50million cases of Scotch whisky and white spirits every year. We produce 6million cases of ready-to-drink per year. We employ over 4,000 people and operate 27 malt distilleries and two grain distilleries. This sounds like a large organisation but actually in Scotland it is also very much a small series of communities that are joined together into one company called Diageo.

To put responsible drinking in context, our business mission, and our purpose as Diageo is celebrating life every day, everywhere and I think when we talk about a purpose in our business this is what we do. This is the enduring notion of what we are about. Celebration tends to leap out of that and celebration and alcohol obviously fit together very well and quite naturally in peoples' minds. Perhaps 10 years ago when Diageo was formed that was really what we were thinking about primarily. But over time we have really moved on to thinking about celebrating life and really understanding what celebrating life means in the way that we bring products to market and in the way that we take our corporate social responsibility and in a way that we interact with communities as well.

So today that shapes what we try to do both individually and collectively and it really simulates us to think and act on our role in society and in our local communities in a different way. In the alcohol area we have an agreed set of ambitions and that is that we really want to make a significant and sustainable impact on how alcohol is valued in society. To do that we believe that we have to engage a broad range of stakeholders in the debate. We do need to develop some remarkable alliances to promote responsible drinking and I think the Drive Aware Trust is a very good

example of that. We want to be widely admired for our industry leadership in responsible drinking; ultimately to make it totally uncool to get drunk.

So if that is what we want to achieve, what are we doing about that? I would say in the four years that I have worked in Diageo, we have really moved on very significantly in the way that we are approaching this agenda. A few years ago, it was very much resident in the senior leadership in the business and in the corporate relations department in the business, moving to a place today where it is resident throughout the business. That has come about because of the leadership and the programmes that we have got involved in during the last four years. Our goal has been to impact under age drinking, binge drinking and drink driving, and to deliver that through an industry that is united and mobilised against this and through our employees so that they also can act as ambassadors for Diageo and for responsible drinking. We have always sought to do it in a way that is measured and evaluated. It is a very complex area but we sought to narrow down to input and output measures that we can talk about and I want to illustrate one programme in particular where we can talk about some of the measurement and the impact of that programme because otherwise as you heard earlier, I think we can try to do many good things but not know whether we are really having any success or not.

So what does that mean in practice? For us there are three legs, three primary areas that we are trying to work against and I want to illustrate these three areas to you. We set world class standards in marketing promotion and innovation; we promote a shared understanding of what responsible drinking means; and we seek to work in partnership with others to combat alcohol misuse.

So let me take each of those legs in turn. The first one in terms of setting world class standards; we have what we call the Diageo Marketing Code. That is our primary bedrock which determines all the marketing and promotional activity that we do in our business. Four years ago the marketers generally saw that as the line they could not cross, the barrier that prevented them doing what they really wanted to do. It is quite different today; our people understand exactly the role of Diageo Marketing Code and seek to embrace it and find ways of bringing creative expression to what we are trying to do from a marketing perspective and at the same time meet the marketing code.

We have a responsible research policy that defines how we research, what we research and how we go after it. We have governance over everything that we do in the digital space as well. It is industry leading, it is owned by marketing, not owned by a third party police force within the business and it has a very robust sign-off process. So although it is owned by marketing it is signed off by our Corporate Relations Department, they sign off at the brief stage, they sign off at the development stage and they sign off at the final execution as well. So we are really trying to put a safety net in place that ensures that we really do deliver world class standards in responsible marketing.

In addition to that, obviously we work with and are governed by other world class standards; the Portman Group Code in particular which I think is now very well established and understood and I am glad to say has had very few breaches in the last 12 or 24 months. I also sit on the Council of the Portman Group, the SWA code, the

Europe Forum for Responsible Drinking Common Standards and other standards as well.

What we seek to do as an individual company operating within this space is ensure that we are consistently challenging the standards that we are setting ourselves and try to challenge the industry to move those standards on.

So that is the first area, the first leg if you like of the area of working against responsible drinking.

The second area, is working in promoting a shared understanding of responsible drinking. We are seeking to explore how we can leverage the skills and the expertise that we have to create meaningful impact in the space of responsible drinking. Clearly we are a very successful marketing organisation and I think that we can bring many marketing insights and skills to the area of responsible drinking. That is one of the things that we have really sought to do over the last two or three years in our responsible drinking communication and advertising.

Understanding that the alcohol agenda has deep rooted problems; it is very societal; and it is product specific but also has a very broad agenda, has really made us think quite hard about what role we can play as an individual company in terms of bringing consumer communication around responsible drinking and how we find the right voice, so that the messages land effectively. It is very easy as a marketer to get messages out into the world and every marketer loves doing it. Give me a budget and I will hire an agency, I will get a great campaign and away we go. And you all know that because you are all on the other side of that. Every day when you listen to the radio, when you watch TV and when you drive down the street, you get bombarded by messages and I bet you that the vast majority of those messages just pass you by. So finding a message that really resonates with people is really key, but the message will resonate with people only if two things are true about it. One, it is a message that is relevant to them; and the other is it is delivered by a voice that is relevant to the message. And when we talk about an individual company having a voice and speaking to consumers I believe that is very important. It is not credible for us to say some things but it is very credible for us to say other things, and if we get our message right people listen to it and they say, "I understand that, and that makes sense and I understand why they are telling me that." If we get the message wrong which might be the message itself or it might be the voice, then people just go, "Why are they saying that, I don't understand, why would somebody tell me that, why would that particular person tell me that."

I lived and worked in the US for a while. In the UK as British Citizens we are very happy for the government to tell us, "You should do this." We think the government's job is to tell us things that we can't do. If you go to the US, that is not what people think. People don't accept the government telling them they can't do things. They have a sort of rejection to it because that is not the government's job, so the same voice, a government voice can only deliver a message that is relevant to the people it is aimed at.

So about a year ago, having initially embarked on a primary responsible drinking campaign we entered into a very large research programme around Europe to explore

how we could find the appropriate voice and the appropriate message to hit home. Speaking from Diageo as an alcohol producer into a very complex space and the result of that work was a couple of insights. Robert mentioned earlier that we are seeing this conversion of harm around Europe. Today we definitely see how it is manifesting itself in different ways. Alcohol issues are different in different parts of Europe and from our perspective the primary issue that we are trying to address in the UK is around binge drinking. and the primary issue that we are trying to address across southern Europe is drink driving. So the relative white of those issues is still very different around Europe. We are trying to find the right voice to get into that.

'The Choice is Yours' campaign was developed from some European research. We researched 3,500 people across the whole of Europe to ensure that we could find the right entry point to speak to people and the result of that was a campaign which is really our first integrated campaign for responsible drinking. Integrated in the sense it was on broadcast TV, it was in the press, it was on outdoor and it is in digital because we have created a web space with the same message. There were two adverts. They showed the difference between a good night and a bad night out and they zero in on this notion of, what we would call social erosion. In other words it looks bad on you if you do the wrong thing. Your peers will think less of you if you do that. The reason we picked that is because that is the space that the research told us consumers are open to messaging and are willing to listen. That is not all consumers, not all age groups, not even the same age group sometimes and there will always be some consumers who are not prepared to listen at all and there are some consumers who are prepared to listen but actually not prepared to adopt the message. At one extreme I would say we have irresponsible and indifferent consumers, and it is very difficult to get a message across to those people. At the other extreme we have people who are very responsible and perhaps very listening – great, but this message isn't for them either because they are already responsible drinkers. What the message that we are trying to deliver is- is to hit people who behave in an irresponsible way with alcohol but who are not indifferent to the impact that is having on them. We are trying to play into that space.

So let me show the two ads[74] so you can see how that notion of social erosion is brought to life in 'The Choice is Yours', and then I want to talk a little bit about what the impact is, and how is that helping to change people's attitudes.

So we run that campaign over eight weeks in November and December in conjunction with the Department of Health who run some advertising as well, clearly with a more direct "Don't drink" kind of message but trying to get into that space with different voices to create a broader impact message. The latest evaluation[75] on this campaign is very good and we have a lot of marketing measures for all of our advertising campaigns. We have Diageo norms, you will be delighted to hear, and this campaign has exceeded all of those key measures that we are looking for. So it is highly visible; 63% of people recognise it in research, 80% of people understood the main message. You do wonder what the other 20% were thinking but trust me with advertising lots of people don't get the message. So 80% understood the main message to be about responsible drinking – another great result. It is real; it really helped people bring

[74] Two adverts commissioned by Diageo and aired on UK national terrestrial and satellite television in May 2007.
[75] Millward Brown, 2007.

home a sense of personal awareness. 92% saw it as realistic which means they can relate to it, which means it is relevant for them, which makes them open to the message that is in it. 92% of people said that it made them think, 89% of them said that it made them aware of the choices they have when drinking. 95% of people also said it is good to see alcohol companies advertising a responsible drinking message .That to me says that we have found a voice that we can reach through to those people. 62% of people said that they are more likely to consider drinking responsibly as a result of it.

This hasn't changed anything about alcohol misuse, but it is not designed to do that. It is designed to do something at the other end of the scale, at the awareness and the attitude end because if we can really start to shift attitudes then we start to shift behaviour, them we start to shift outcomes and a lot of effort if it is misdirected at behaviour and doesn't shift attitude isn't going to unlock that kind of space. 'The Choice is Yours' campaign we believe has been a very effective campaign in terms of reaching consumers with a relevant message with a relevant voice.

That is one of a number of things that we are involved in – promoting responsible drinking and promoting a shared understanding of responsible drinking. Similar to what you saw from Mark earlier through the Alcohol Industry Partnership in Scotland, we have run a number of campaigns over a number of years. The 'Know what is in it' campaign is really trying to communicate the idea of units and get some key sensible drinking messages across. Simple messages like – have a soft drink spacer, drink water, eat food before you drink – simple, clear messages that people can understand and act on in a very effective way. We have run that campaign with the NUS over a number of years and we are now starting to take that campaign outside of the NUS bars and into the feeder bars around them, for example, bars in Glasgow where we have found that the core message that has been delivered through the NUS over a number of years hasn't yet reached. So we are starting to find a new population that we can talk to about unit awareness and about responsible drinking.

Through the Portman Group we created the Drink Aware Trust[76], and we have committed £12million over three years as an industry into the Drink Aware Trust. Jean Collingwood, the Chief Executive of the Drink Aware Trust is here today. It is a national programme covering all of Scotland, England, Wales and Ulster. We are in the process of finalising strategy and measures. It has been a journey for all of us to bring together such a collective group and to find the common purpose despite the differences that can drive to really making a difference is society. I do think that the Drink Aware Trust as a model of partnership going forward is very ground breaking and will be truly effective and impactful for us.

We have our own Diageo alcohol beverage information policy which is very clear around labelling on our products and also making information available to the consumer through the website. Also I should mention the Drink Aware Trust has both now what you might call an adult site in a sense that it is something that is targeted at adult drinkers and a site that is targeted at underage drinkers which is called 'truthaboutbooze.com'.

[76] http://www.drinkaware.co.uk/.

Since the Drink Aware Trust was created about a year ago we have reached three and a half million people, a very broad reach of people with some very, very good quality messaging. For example, through the website you know activity and substantial dwell time of web users. We can see that several minutes is the average dwell time on the website so somebody has come and interacted with alcohol messaging over a prolonged period of time and also we have the drink aware unit calculator in the market place for some time. So all of that space has been about working in partnership with other people to create real impact. At Christmas 2007 for the first time in the UK, we created a campaign with Tesco that put responsible drinking messaging into the 'off' trade. This campaign which is still in 1500 Tesco stores is reaching up to 17million shoppers a week. It has responsible drinking messages as unit messaging in it.

Again, reaching people at the point of purchase. We know the shopper isn't always the consumer but linking the messaging in a space and in an area that has been very critically approached over the last year I think is creating the opportunity to bring the responsibility message right across the business.

'Best Bar None' we talked briefly about earlier and 'ServeWise' are other examples of campaigns that we are involved in. I talked earlier about our employees being ambassadors. We have an Employee Alcohol Awareness Workshop which we have rolled out across our 4,000 employees in Scotland. We are now piloting it with external partners so we have taken the Diageo-ness out of it so it can become a more generic programme. We are working with our suppliers right now; we are even working with people like Chivas Brothers who are piloting this programme in their own businesses and will continue to extend that programme and offer that our as we go forward. As you heard from Mark earlier we have obviously put a very strong commitment behind the National Alcohol Awareness Week in Scotland.

In terms of under-18s I just wanted to touch very briefly on that we don't work directly with under-18s. We only work in partnership with other people to approach under-18s. Clearly as an alcohol producer we do not engage directly in any way with under-18s. However, we have sponsored the CragRats Theatre Group for a number of years now and that has reached 224 secondary schools in Scotland since 2005.It is a theatre production and a workshop and it is a very, very compelling programme. If you haven't had a chance to see it and you hear it is in a school near you, I highly commend it to you. It is very, very impactful programme from which we get fantastic response from 13-14 year olds around dealing with alcohol in the context particularly of peer pressure.

We sponsored Mentor UK Awards. We had a winner in Glasgow last year. We have worked with Fife Constabulary with Michelle McNally around Booze Busters which I think reached 15,000 people and we have continued to support Strengthening Families which Mark mentioned earlier as a programme really embedded in families, addressing 14 -16 year olds but in a long term programme.

Likewise on anti-drink driving, we are a corporate partner of Brake. We worked with Central Scotland Police and Central FM with a programme over November and December of this year. We had an anti-drink driving campaign, Central FM reach about 56,000 people every day. They had key messaging going out during drive time

around the drink driving messages and we work with the Scottish Government in the Alcohol Industry partner in that area as well.

So what is next for us? I think we have to continue to lead world-class standards; that means that we are pushing at the margins to understand how we take that further. We want to add value where we know we can. We want to drive strong and consistent industry engagement. Yesterday we had a meeting in London with a number of industry people to discuss how we can work collectively to show further commitment in this area. We want to deliver through exceptional partnerships because we do believe that the creation of working partnerships that bring all the stakeholders together into the room is the route through which we will get to a breakthrough. We want to bring balance to the debate, particularly through the media because that often is unbalanced and I think that that voice needs to be represented well. I think a classic example is what Gillian was saying earlier, you were saying, "Let's not say 29% of people are drinking above the government's guidelines, let's say 71% of people are drinking within the guidelines." That kind of messaging I think is part of the route that we can begin to create cultural shift in this area. We want to be an honest partner in tackling harm, we do more specifically want to influence consumer attitudes to alcohol and play into this space that drunkenness can be uncool and through that encourage people to celebrate life every day everywhere but to do in a responsible way.

So that is a broad description of where Diageo sits in terms of the set of three legs. World class marketing standards; engaging directly with consumers; and then working with other people to address a broad range of issues across the alcohol agenda.

We are one player in a very large jigsaw puzzle but I hope I have demonstrated to you that we play a role both uniquely as ourselves and collectively with a number of other people within the industry and outside the industry to create the kind of shift in attitudes first, behaviour second, and society third that we are all seeking to deliver.

## Jeremy Beadles, Chief Executive, Wine and Spirit Trade Association

We are a producer and a retail organisation but today we are going to concentrate on the retail side of our work. One element of the work that we do is that we have all the major national multiple alcohol retailers on our membership up and down the country and we have a serious challenge ahead of us in terms of tackling underage sales and that is quite a big cultural challenge.

The legislation which has prohibited children seeking to buy alcohol and retailers from selling it to them has been around for quite a long time but in realistic terms actually it was only about three years ago that a proper enforcement and statistics started coming through in terms of how we tackle this.

I remember my days growing up in a small Somerset town and at the age of 16 I would go up the pub, my parents knew I was going up the pub, the landlord knew I was 16 and the local copper used to come in and he knew I was 16 and it was better

for him to see me sitting in there having a quiet drink not causing any trouble than me being out on the street having a drink and probably causing some trouble.

But the attitude has changed – how did that come about? Well I think for the first time we began to understand the scale of the issue and that is pretty important in terms of understanding the problem. In late 2005, the then Home Secretary Charles Clarke called the industry in both 'on' trade and 'off' trade into the Home Office and revealed some fairly startling statistics. They had done campaigns looking at test purchasing in the United Kingdom and they had found that actually the failure rates were somewhere near 50% that is 1 in 2 kids going in able to buy alcohol. I think from an industry perspective that was a serious eye opener. I don't think they had any idea of the extent of the issue and from a government perspective that was a challenge to the industry to sort it out quickly or face the consequences.

The industry reacted very well and today I am going to talk to you about what the 'off' trade did. The 'on' traders had done very similar things. They were lagging just slightly behind us. We were very quick off the mark but you know they are there now, they have got the same kind of programmes underway. What we did was we went straight from that meeting with all the major retailers that were there and set up something called The Retail of Alcohol Standards Group straight after that meeting. The major members were all the supermarkets and the major convenience store chains and that got working very, very fast. The first set of actions was to get some signage together. I have been working in retail for eight years now, in one form or another. These are very, very competitive businesses; they like taking chunks out of each other; they are not particularly good at working together and there are still projects that I started at the BRC which have probably got no forward in the eight years since I started them. This was not one of those projects.

No matter how much the marketing people at Waitrose got upset about the idea of red signs on their stores that is what we did. The 'Challenge 21' sign that you see was produced and out in stores within three weeks. That is a record for the retail industry. It is a record that we managed to agree it. That signage is now in 75,000-plus stores up and down the country and in an equal number of pubs there is a slightly different sign but the same message. We started sharing best practice, we all got our training manuals out and put them on the table and started looking at how and where we did our training and that began to change radically as we started changing best practice ideas.

A whole range of other things came into play – prompts at tills for instance, so every time an alcohol purchase went through a prompt comes up so that the person behind the till makes the challenge. We have a difficulty in this country as we don't have government ID cards and we are not used to carrying ID cards. We are not like America where everyone has an ID card – to be honest even when you lose as much hair as me they still want to see an ID card in America – that is not the attitude in this country. We have something called the pass scheme and Young Scot is the major card up here and so the mood was 'Challenge 21' means if you look anywhere near the age of 21 we are going to ask you for ID and if you haven't got ID and you can't prove that you are 18 you are not going to get served.

That had quite a marked success and the UK government has run five different campaigns up and down the country. The last one saw the failure rate on first instance sales fall down from 50 to 14%. Actually of stores that sold on three occasions which would require a licence review, there was only 1% – that was actually 26 stores in the whole UK from a starting point of 7,408 operations in the 'off' trade.

The problem was when we had been working together for two years; some of the impetus always run out when you are doing that kind of project and it becomes less high on people's agendas. There are other things that come up that people start worrying about and also from our perspective we began to wonder how we were going to get the rates lower than the 10% mark. Some companies did it. ASDA in the second round of test purchasing got their failure rate down to 6%.Therefore we took everyone from the Retail of Alcohol Standards Group up to their stores in Leeds and they did the extraordinary thing of showing all of their competitors around their stores, showed us how they did it, how they did the training, allowed them to crawl over it and understand what they were doing differently and what they could learn from.

The reality is there is no silver bullet in this stuff and kids will go from one store to the next, one pub to the next until they get served. We know that the 'on' trade refuses, at least one million underage people, a month. That is not one million different people because the same kids will be going into one pub after the other trying to get served. We don't have collated figures for the whole of the 'off' trade but we know that a business such as Threshers is refusing at least 25,000 young people a month. So that is quite a challenge on the business day-to-day and we put that into perspective when you might have through a superstore 150,000 people and a week, 3 or 4 million a year whatever it is, and you get your licence reviewed if you fail three times. Well numbers wise that is a very tiny proportion but it is not an excuse; it is how you manage this process.

We did some research with Leicester University and trying to work out why shop assistants, in particular, having been trained would then make a sale 20 minutes later that they shouldn't have made, or not made a challenge they should have made. We came up with some very interesting results and as a result we changed a lot of our training materials. We moved away from the simply legal view that this is the law and it says you can't sell to under-18s, much more to looking at the psychology of how people assess age and it is not anywhere near as easy as you think it is. Last year we ran roadshows up and down the country – England, Wales, Scotland, and Northern Ireland. We had groups of kids or photos of kids with us and the road shows were to the police and local trading standards officers and delegates were asked to vote on how old they thought these people in the photos were. It wasn't a good rate of success I have to say. It is very difficult to make these judgements. Men and women make judgements in different ways and men and women make challenges in different ways and we had to learn from that. Women tend to use more of a complimentary challenge, "You look so young dear, can I just ask you how old you are, have you got any ID?" With men it tends to be more about company policy, 'Can I see some ID please?' Much more blunt messaging but there are difficult circumstances if you are a convenience store operator working late night by yourself and a gang of 16-17 year olds come in. It is a fairly threatening scenario and you know there is a judgement there about whether you sell them alcohol or not and what happens if you don't sell

them alcohol. Alcohol has now become the most shoplifted product in the UK market place – it has just overtaken DVDs. One of the reasons for that is actually success of the industry in refusing sales – what we then find is quite a lot of the products nicked.

The next stage in order to work out how we go forward and make things work was that we wanted to try a local pilot project. Everything up until that day had been done on a national basis. This is an English pilot but we very, very much hope that it is going to be taken forward and rolled out as part of the Fife project. We went to a number of different local areas and actually a lot of them were quite resistant to working with us in a partnership approach which we found odd. We eventually got the lovely place of St. Neots in Cambridgeshire to agree to work with us and the key element was to get all of the partners working together. So local retailers, 'on' and 'off' trade, police, local residents, local young people, local education, local health etc. and we put everything we could possibly think of into this pilot project to see what worked and what we know at the end of it. We are just finishing the bench marking processes, some of them worked really well, some didn't work at all. That is kind of the retail way to find out, take forward the stuff that works, ignore the stuff that doesn't and move forward.

We did survey work right at the beginning. We agreed with the police different tracking measures because what we wanted to do was to prove whether things did or didn't work. One of the ways we are measuring progress on this is there are hotspots areas where young people are known to gather and so we go out on a regular basis to see how many beer cans, vodka bottles etc are sitting in that place and we count them. We go back the next week and see if they are still there and the next week after that and see .We pick the litter up every time we do it so we are being socially responsible in that way, but it is one of the ways of tracking whether we are actually moving people on and changing the way that they are thinking about it.

From a police and trading standards point of view from a retail prospective we see ourselves as the first line of enforcement, we are the people who are asked to enforce this legislation. Sometimes the relationship with police and local retailers breaks down because we sometimes feel that we don't get the support we need and a lot of the time when we are seeing people it is a position where the police or local trading standards are doing test purchases. Therefore our people, if they are failing and getting prosecuted fines they can get criminal records and licence reviews. So what we were concentrating on is not just test purchasing in the retailers themselves but looking at focusing on underage people. It is against the law for under-18s to try and buy alcohol. In the whole of England, Wales and Scotland last year only 13 children were actually done for it, which relates to about 7,000 retailers and licensees who were done for it. So we focussed in on that, focusing in on proxy purchasing, which is the name for getting an older person to buy alcohol for you and then confiscation from under-18s.That is a key part of it because yes it is illegal for them to try and buy but it is also actually illegal for them to drink in public places as well so there is power there to allow the police to take the alcohol off young people and that was a key part of this.

There was then an intelligence sharing thing, so walkie-talkies, contacts for the local police, dedicated phone numbers. People could phone the local police and say, "We have got a problem down at our store, and there is a group of kids trying to buy

alcohol. Can you come down and help us?" or they could communicate with the other retailers in the area saying, "We just had this guy in he tried to buy booze from us, we ID'd him and he didn't have any ID and we have sent him on his way." Also that relates to people telling, "Well we know every Friday night there is a group of kids and they go and sit in this particular part of the park." and then the police get an opportunity they have got the information and they can go and have a chat with them and move them on.

And then instead of it being an 'us' and 'them' retailers and local police, local trading standards thing we started doing joint communication and messaging. We started working with schools and sixth form colleges doing visits and part of that was, if you are a retailer and you get caught selling alcohol there are actually some fairly serious consequences. If you are just a shop assistant doing your job, you get a £80 fine and that could be more than your week's wages working part-time, you get a criminal record which can affect you for the rest of your life. For the licensee there is a fine up to £5,000 and then there is a review of the licence which could be either the end of the licence, which is the end of your business, or a three-month suspension which could well be the end of your business if actually all you do is sell booze, that could be the end of it. And so it was going into schools with local retailers and explaining, "You may think it is just a laugh coming in and it is a rite of passage and everyone does it, come and try and buy booze off us but actually the implications for us as individuals and businesses are fairly serious and this is the kind of effect it can have on us."

We developed handout material which was used in all of the local schools in the sixth form visit and actually the police started sending letters home to young offenders through the schools network and direct to make the parents aware and make the parents realise that there was a responsibility for them as well.

We also got local councillors, school governors involved, the safe neighbourhood teams involved, the local MPs and we got media partners involved and some good headlines and it has been a very successful project. We haven't finished the benchmarking quite yet but we will be finishing it in the next couple of weeks and we do believe that there are some serious pluses that can be rolled out around different parts of the country. We think it is very important that this is local and it is only going to work on a localised basis. It won a government award for better regulation, which is a wonderful thing for us to manage to achieve. Things like the litter indicators count actually proved that we weren't having the same number of kids drinking alcohol in the same areas over and over again; that certainly was falling. And we are now moving it out; we are extending the area that we are operating in. We want to take it and roll it out further. We have got three English pilots that we would like to take forward in slightly different environments. We don't think we are ready for a city centre yet but we would quite like to move on to a bigger town centre and within Fife we certainly want to bring the project up here and work out which would be the best localised areas to run it in and see what we learn.

From an industry perspective what we are concentrating on less is the national campaigns and what we are looking at more now is increased local campaigning that is where we are really putting our resources. That is not to say we are not running Challenge 21 we are but we are concentrating on how we go local.

I think the key thing is that what we have learned is that this project Challenge 21 isn't just about retailers on the front line; it is a problem for all of us. The problem is not just about stopping kids buying alcohol because they are still drinking it so they are getting it from somewhere else. The latest government stats suggest that at least 50% of the alcohol is coming from the parents. So that is parents giving their kids booze and sending them out or them nicking it from their parents. There is an element of proxy purchasing whereby they are persuading older people to buy alcohol for them. There is definitely more shoplifting. What we recognise is there is still a problem with some retailers. The last set of results show that the major multiple retailers in both the 'on' and the 'off' trade have made great steps forward but there are a lot of smaller and independent retailers out there who are not part of this network. All of the information that we have got, all the best practices are available to them, but getting that information to them is much more difficult and probably involves working with the local police and local authorities to get it out there. But kids are not stopping drinking and therefore we need to move beyond looking at just the sales element and actually looking at beyond why they are drinking, why they want to drink, what makes it attractive and what else is in their life that means that this becomes the most important thing to them.

We also think that there are opportunities for better enforcement of regulation. The Licensing Act in both England and Wales and in Scotland provides serious powers to the police and local authorities to take action. There is a kind of 'three strikes and you are out' principle, or 'three strikes and you are reviewed' principle. That gives the power to the police and local authority and our very firm view is that the majority of sales to underages are mistaken, they are not intentional but where they are intentional those businesses should just be shut down. They shouldn't have licences; they should just be closed down. They bring the rest of the sector into disrepute.

It is not quite as easy as it all sounds but over the course of the last two and a half years we have made an extraordinary step forward in terms of how we tackle as issue that wasn't really there as a headline thing three years ago in realistic terms. And I will just leave by saying that this presentation sounds as if it is a bit English but actually it affects Scotland in every single which way. Just because a pilot was run in Cambridgeshire doesn't mean that it shouldn't be as applicable in Fife and shouldn't be rolled out and the learning that comes from it. I used to be an Environmental Lawyer and Consultant and I used to get really worried by the fact that every area, every part of the country when they were doing an environmental initiative wanted to do it slightly differently and re-badge it and do it their own way and slightly change everything. I think it is important in this kind of thing to learn from where the successes have been and take that forward and not worry too much about it being re-badged or re-branded or done slightly differently. Learn from the successes, take those and see if they work in your area.

## Scotland's Futures Forum
## Drugs Prohibition and Policy – 12 March 2008

## Danny Kushlick
## Setting the scene in the UK context

My name is Danny Kushlick. I am the Founder and Director of Transform Drug Policy Foundation. We are a Bristol-based campaigning charity for reform of drug policy. We would like to see an end to prohibition and its replacement with an effective system of regulation and control for the non-medical use of drugs.

One of the things I would like to do, and I am going to use this as a thread throughout my talk, is the idea of stories and competing narratives because I think that drug policy is well known as an almost caricature of the polarised views that exist within the sphere and I want to make it absolutely clear that I don't believe that my story is true with a capital 'T' but I would like to make the claim that it bears a strong resemblance to reality and that it is potentially transformational. But do go and hear other stories, go and visit other websites and read other literature. I think that a big part of what is needed in drug policy development is imagination and I would also like to suggest that ours is an imaginative view of the way forward.

Just a bit of history first. Ten years ago I was a drugs worker working with problematic crack and heroin users in the criminal justice system and it was as a result of that work; working in prisons, working with people on probation. That it became absolutely clear to me that one of the significant, and ultimately the significant problem, that my clients were facing was the fact that their drugs were illegal. A lot of their problems were compounded and a lot of them were actually created by that and as a result of that I founded the organisation that I now run.

In terms of where we are at now, my colleague Steve is currently at the Commission of Narcotic Drugs in Vienna because Transform, my organisation, has now UN accreditation as an NGO so we are truly international.

Just to be clear about what we want. We think that it is possible that we could see the end of global prohibition within 10 years, which it is why it is so good to be in an environment where people are actually thinking beyond the kind of limits that most politicians and policy makers usually think about. So thinking about 2025 I could potentially be redundant by then as a result of achieving our mission. That is my wish. I have got two kids who are 2 and 5 and my hope is that by the time the older one reaches the age of majority the prohibition will be gone.

Why? Because all the evidence shows that problem prohibition is directly responsible for bringing misery, degradation and death to millions in Colombia, Afghanistan, the Caribbean and almost every major industrialised country on earth, including Scotland. And amongst other things has created a trade worth two trillion pounds over the last 10 years and provided significant momentum behind the transmission of HIV/AIDS and brought horror to some of the most disadvantaged and marginalised people on earth. Which is quite something for a policy that claims to

achieve precisely the opposite. As I say there is another story, do go and find out about it, it is called prohibition. Its aim is to reduce the use, supply and production of currently illicit drugs. But do go and check it out my story might not be true.

It is a policy that is held in place at the international level through the UN, through conventions that were signed in 1961, 1971 and 1988 and is backed to a great extent by the US and that makes it very difficult to break that consensus because of the political power that they have obviously. We believe that it is time to break that consensus.

By 2020 what could we achieve? We believe that the war on drugs could be over. Just to say before I go into how things can change, one of the beauties of the narrative that lies behind prohibition is that it has some key elements to it that are very attractive for people, it is very simple – drugs are bad so let's ban them. There are goodies and baddies so the police are the goodies and communities who fight the scourge of drugs they are the goodies and the dealers are the baddies. The traffickers are the baddies and it is important that the goodies beat the baddies. It has got real drama. There is the whole issue of getting clean, cleaning up our communities, getting clean of drugs. There is a redemptive narrative to the prohibitionist's position, which is very, very compelling and appealing. The problem is – it is not true and it doesn't work.

So what is the view that actually engages more with reality and actually deals with a slightly less dramatic and perhaps even less compelling position, at least initially, this is counter-intuitive. What we could see by 2020 is the nightmare of the last hundred years ended so that we have a system in place to manage rather than attempt to eradicate something that we can't, to manage the production, the supply and the use of currently prohibited drugs. Where coca, cocaine, opium, LSD, mescaline, ecstasy are available from legal outlets and it might be interesting to take a look in the workshop later about how that might actually work in practice. Where Melanie Phillips no longer has a platform to stand on and rant about the evils of drugs and how they cause moral laxity, where the US can't wander around in other people's countries under the auspices of the drugs war.

But this has been the place for a long time. What are the signs that prohibition might be vulnerable? One of the serious problems about prohibition is that it contains within itself the seeds of its own destruction. It creates a system whereby drugs become far more expensive, far more available, far more de-regulated, far more dangerous, creating huge problems for producer countries, supply and transit countries and indeed predominantly consumer countries.

So there is an attritional process whereby the reality of its failure comes up against the rhetoric of its success. It is a high price to pay. If things continue the way they are – the value of the market is currently valued at is 320 billion dollars a year. If that carries on at that level and there is a sign that we can significantly undermine that market. It is one of the largest commodity trades on earth and if that continues for another 10 years that is another 3 trillion pounds gifted to that market.

In the UK, the estimate of the crime costs associated with the current policy is £16billion a year. So for each £1 that we spend on our Drugs Strategy we have to

spend another £8 or so just clearing up the criminal justice mess at £16billion a year – another £160billion over the next 10 if we commit to it and the chances are we will – we just have actually – our new drugs strategy is written.

But let's look at where the vulnerability comes from. This has been going on for a long time but back in 2002 the UK Parliament Home Affairs Select Committee recommended that the government initiate a discussion with the commission on narcotic drugs of alternative ways, including the possibility of legalisation and regulation to tackle the global drugs dilemma, that was 2002. One of the gentlemen that sat on that committee was a man called David Cameron; he hasn't been saying much about that recently which shows the way that the shifts in the political rhetoric take place as people move towards power. So it is fine for him to say it as a backbencher but not as leader.

The UK Prime Minister's Strategy Unit's Report of 2003 is well worth taking a look at. It is a beautiful exposition, walks you through how prohibition, what is calls supply site enforcement creates harm globally. A brilliant document. It starts of with pictures of drugs and every time I see this document I imagine Geoff Mulgan who was Director of the Unit at the time with his little pointy stick speaking to the Cabinet saying, "This is what they look like, this is where they come from, this is why they are worth more than their weight in gold at the point of use, where they were vegetables at the point of production, this is why it caused £16billion worth of harm each year" and I can just imagine Tony Blair's head in hands going, "Just please God don't let this ever reach the public domain". It took two years to get that document out into the public domain. It was eventually released partially under the Freedom of Information Act and eventually the rest was leaked to the press but they hung onto that because it was ever so important that that evidence didn't get out. But it has, it is out there and the Cabinet knows about it.

Just to give you another quote and this is recently from Antonio Costa, who is the head of the UN Office on Drugs and Crime, this was in the press release that he issued a couple of days ago from Vienna so this is just straight from the press release,

> "Mr. Costa admitted that drug control has an image problem, too much drug related crime, too many people in prisons and too few in health services, too few resources for prevention, treatment and rehabilitation, too much eradication of drug crop and not enough eradication of poverty".

An image problem or a reality problem? I would suggest a reality problem. But the fact that he is willing to admit that the fact that he puts it under the headline of being an image problem is interesting but he is now articulating this stuff.

Anatole Kaletsky, the Economics Editor at The Times, under the title of an article remarkably headlined 'Give peace a chance'. I just think it is brilliant when the Economics Editor at The Times uses a Beatles song as the headline of his opinion editorial. Give peace a chance, forget the war on drugs – this is Anatole Kaletsky in The Times. All of these observations point to a simple conclusion, simply though not easy – the global war against drugs is in contradiction to the war against violent crime at home and the war against terror, against terrorism internationally. Legalising or at least decriminalising drugs would not, on its own, end terrorism or gang violence and

it is no substitute for long-term measures to promote development abroad or improve education at home but a ceasefire in the war against drugs would at least give peace a chance not only in Afghanistan but also in the streets of Britain.

In The Sun in 2003 I think it was, I have got the article with me somewhere if people want to look at it, an editorial was written under the headline 'Why not legalise drugs – it worked fine the last time' that is The Sun. Now when you begin to see these kinds of articulations of the argument coming from those kinds of quarters you know that something is going on. But I have also seen things in supported pieces in the Scottish Daily Mail when Strathclyde Police Federation called for legalisation, from Adair Turner, UK Government Adviser on Work and Pensions, from the Socialists Workers Party, from Alan Duncan frontbench Tory spokesperson – if you go to his website there is a beautiful chapter from a book that was actually excised by the Tory Party calling for legalisation. From David Ringston, from Lord McCluskey and Mo Mowlem that is a wide range of views and the Economist amongst others.

Just to give you another idea – the moral agenda. Now a weakness that we find from our position is that we are often talked about as being very cold. We offer an economic argument for why things should change but the moral position is ours too. This is the Church of England Board for Social Responsibility in their submission to the Home Affairs Select Committee in 2002, "Alcohol inebriation has long been associated with violence in some cases and it is possible that cannabis abuse could sometimes have harmful effects". However, that is a matter for personal responsibility guided by moral imperatives abuse, which is a sin, it is not necessarily a crime, adultery is wrong but it is not a crime. This is Father John Clifton a Catholic Priest from the US, "Drug laws are a moral issue. 50 years of drugs legislation would produce the exact opposite of what those laws intended, the laws have created a tantalisingly profitable economic structure for marketing drugs." When law does not promote the common good but, in fact, causes it to deteriorate the law itself becomes bad and must be changed. Legalising all drugs in the US would have one immediate and dramatic effect, it would render them cheap and I think Alex is going to talk about how making them cheap makes such a big difference.

How can we speed up the process? We believe that this could happen within 10 years but how can we speed it up? This is a quote from Thomas Paine when he called for civil disobedience against the monarchy, the flawed national policy of his day, "A long habit of not thinking a thing wrong gives it a superficial appearance of being right". It speaks to a syndrome that we call 'green room syndrome' whereby certainly senior policy makers but many others in the green room, before they go on to perform on TV or radio will take one view, but when the record button is pressed they say another. I think it is really important that people look to their hearts and their principles so there are a lot of people who might be nodding and thinking, 'this makes sense' in private but wouldn't dream of saying it on television. They really need to think about coherence.

It is really important that people get educated on this issue. My colleague Sanho Tree from the Institute for Policy Studies in Washington says that broadly, politicians, apart from a minority of very clearly ethically and principle-minded people, certain senior policy makers are prone to three major issues that make life difficult: ignorance, cowardice and opportunism. The important way of dealing with ignorance

is to get educated and I would strongly recommend people go and visit our website, take a look at our materials but also go and visit people who are telling a different story, find out what the counter-arguments are too. Argue with your friends, try out different stories. Try and work out for yourself how to regulate crack in a post-prohibition world. It is important because you might have to vote on this either as a member of a parliament or as a citizen one day. Our view is that you probably will but you need to sort out your views now and there are people who have done work on this including ourselves. You need to be able to answer the question, "What if use increases?" What does happen if use increases in a post-prohibition world, what if it increases a lot? Again, there are many answers from various places and again we have produced two important documents, one called 'After the War on Drugs – Options for Control' and one called, 'Tools for Debate', some of which I have here so do come and see me afterwards if you want to take a look but there are many other things around. We are also working on a publication due to be published at the end of this year called, 'Blueprint for Regulated Drug Markets', which will show what a post-prohibition world would look like.

But in order to move forward in the longer term to achieve the kind of change that we want to by 2018 we are going to have to start working towards it now. An international coalition of countries is going to need to be built in order to achieve that so that the Dutch don't have to front this up the whole time and the Swiss aren't isolated. There are many people who now recognise the limitations that exist within the international conventions that make it impossible at the moment for domestic policy makers to move towards regulated markets for non medical drug use. In order to change that, some international activity will need to take place but it has to start first at the domestic level, both within civil society and within government. We need to move the debate from the personal to the institutional where organisations are actually taking positions on this. We need to make prohibition regulation central to wider social policy issues from international development, international security, criminal justice, health and well-being, sound finance and human rights. It is a part of those issues and it needs to be mainstreamed rather than being left out in the cold as it is at the moment.

In the absence of a political discourse, given that most political parties still treat this as a taboo issue, it is going to be really important to work with the press. One of the most significant places where discourse has taken place, as I mentioned earlier, is both within the broadsheets but also within the tabloids. They are very hungry for this debate and because politicians won't engage, the press is doing it anyway.

We held an event in January at Chatham House providing representatives of some real interesting institutions the opportunity to engage and debate and it was fascinating to see the consensus around the positions that we were taking. But also it was really interesting to enable people to have that opportunity to have a discourse that was cross-fertilised cross-Atlantic and around Europe. It is going to be really important to provide people with safe opportunities to discuss this outside the public glare.

One of the things that is really going to help move things along is the increased call for an evidence-base for drug policy generally but specifically for prohibition. We need to do a cross-benefit analysis; an impact assessment on prohibition as it currently stands of enforcing the drug laws on the supply side. Now whether or not you support

reform we should all support evidence-based policy. We need to know what the costs and benefits are, not just in terms of finance but in terms of sustainable health and wellbeing and human rights.

In another 10 years another £3trillion will have been contributed to the throughput, the turnover of the illegal drugs market. There will be millions more deaths and a lot more misery globally. It is not going to happen overnight. A lot of the bad things will happen but we can change it, but we need to get active now. You need to be active in your personal life, in your professional life and in your political life. But that is just my story but it is a story that I think is potentially transformational. One that will change the face of the world for the better within 10 years, and remember the future is just our collective story that is all it is. We line up behind stories that have imagination; that have a transformational quality to them and bear a very strong resemblance to reality and that then becomes our future.

Thank you.

## Dr Alex Wodak
## Edinburgh Drug Law Reform 2008

Thank you very much for the invitation to come here to discuss not just the illicit drugs problem but also the problems that you face here in Scotland. I am aware that in Scotland you have amongst the worse outcomes in Europe in both alcohol and illicit drugs and problems that are rapidly getting worse so I am going to try and answer the question I was asked, 'Will drug law reform reduce drug-related harm?', but before I do that I am going to try and answer the question about whether this is the question we should be asking. I am also going to ask the question whether tough drug law policies actually do reduce harm; I think that is the question we should be asking. Then I will say a few words about what I mean when I use the phrase 'drug law reform'. Then I will answer the question that was put to me, then I will run over what are some of the obstacles for us trying to move forward on this question and then make some concluding remarks.

So is this the right question, 'Will drug law reform reduce drug related harm?' It is not a neutral question. I think it favours the status quo and there is a very elegant discussion about whether this the right question by a philosopher called Douglas Husak, who has written a book with this terrible title called 'Legalise This – The Case for Decriminalising Drugs',[77] but it is a very interesting examination of this question. When you think about it that formulation of the question, 'Will drug law reform reduce drug-related harm' is a little bit like the question people sometimes get asked, 'When did you stop beating your wife?' There is no really satisfactory way of answering that question that doesn't make the person responding to the question look worse. But nevertheless this is the question that is usually asked and I won't dodge

[77] Husak, D.N. 2002, *Legalize This!*: *The Case for Decriminalizing Drugs*, Verso, New York.

the question. But before answering that question I am going to answer the question I think should have been asked and that is, 'Do tough drug policies reduce harm?"

We have to know a little bit about the history of this subject. Global drug prohibition began 99 years ago in the first opium commission that was convened by the United States in the City of Shanghai in 1909. It gradually developed with further meetings in the Hague in 1912 and Geneva in 1925 and then the formulation of three international drug treaties in 1961, 1971 and 1988 and then the development of an alphabet soup of United Nations organisations that were charged with developing policy, carrying out policy and then monitoring policy and as well as all of that we had a major intensification of this approach. In 1971, when Richard Nixon was facing re-election in the '72 presidential campaign one of his most notorious aids, John Ehrlichman recommended in the Committee for the Re-election of the President (affectionately known as CREEP, it is true that is what it was called), that President Nixon wage a war against drugs as a political strategy, not as a policy but as a political strategy to gain re-election. There is no doubt that that worked and helped to get Richard Nixon elected and that was noted by politicians all over the world who then followed in the same footsteps. And we have been following in those footsteps for the last 36 years and developing countries have unfortunately followed the lead of developed countries and expanded their drug squads, made the penalties for infringing these crimes even more severe, spending more and more money on efforts to cut the supply of drugs. And during this 99-year period and during this 36-year period of further intensification what have we seen? We have seen an ever increasing cultivation of drugs, and production of drugs. The range of different types of drugs is now far greater than it was 10 years ago or 20 years ago or 30 years ago. More and more people around the world are using drugs and more and more people around the world are being harmed by drugs. More countries are reporting drug use, more countries are reporting serious problems related to drug use, and the health, social and economic problems of drugs that were declared illicit 99 years ago have been increasing steadily. They haven't been increasing in a linear fashion it goes in zig zags and so every time there is a slight drop in one parameter this is trumpeted as a great success for the war against drugs.

This slide shows global opium production and the dark brown bars at the bottom of those graphs show the production in Afghanistan. We can see that when the graph starts in 1990, global production of opium was around about 4000 metric tons and by the time we get to 2005 it has reached almost 5000 metric tons[78]. We can see that Afghanistan which was a minor player in 1990 is a major player by the time we get to 2005. In fact, that graphs ends in 2005 production increased by 49% in Afghanistan in 2006 and 34% in 2007 so Afghanistan in 2007 produced 8300 metric tons of opium which constituted 93% of global production and constituted around about half of the Afghan economy. So much for the success of curtailing opium production. Incidentally the predictions for 2008 are that the production of opium in Afghanistan will top production of 2007.

In the next slide, we see global cocaine production and at the left of your screen in 1990 it is around about 800 metric tons and by the time that we get to the right of the screen it is about 900 metric tons. It is not linear but you can see that the increase is

[78] UNODC World Drug Reports 2005 and 2006, available at www.unodc.org.

steadily upwards. Not only has there been an increase in production of opium and cocaine but there has also been an increase around the world in the amount of money that governments are spending on illicit drugs. There has also been an increase in official corruption in police, in magistrates, in judges and sometimes amongst politicians. We have also had the development of half a dozen narco countries, countries where the illicit drug trafficking industry and governments are indistinguishable – they are one and the same. And here I am talking about countries like Afghanistan, Burma, Colombia, Peru, Bolivia, Pakistan and Mexico. Those countries aren't always narco countries but increasingly that is what they are. It is what many of them are today. And allied to that is the problem of narco terrorism. Almost every major terrorist group around the world is now funded to a large part by its proceeds from trafficking in narcotics.

Another problem that we have in the war on drugs is what was called in 1976 by an American researcher, 'The pro heroin effects of anti-opium policies', and what he was referring to, after studying three Asian countries, Hong Kong, Thailand and Laos, was that when the smoking of opium was banned in those countries within 10 years it was replaced by heroin injecting. In the beginning the people who were smoking opium were elderly men, by the time we had shifted in 10 years to injecting of heroin, the population that was now involved was young and sexually-active men. This paper was written by Joe Westermeyer in the Archives of General Psychiatry in 1976[79] and appeared just a few years before the AIDS epidemic was first recognised in 1981. He said the seeds had been sown for public health disasters. There were going to be epidemics of viral infections and hepatitis and abscesses and public health problems and he was absolutely right. The only thing he didn't predict was the epidemic of AIDs because at that stage it wasn't known. And what Westermeyer was talking about what was sometimes called the Iron Law of Prohibition. The more vigorously we persecute illicit drugs, the more we change from having dangerous drugs to having even more dangerous drugs. So when alcohol prohibition was introduced in the United States in 1920 the first thing that happened was that beer disappeared and was replaced by wine and spirits and then when prohibition was repealed in 1933 beer came back.

As Danny has already said there are numerous reports around the world from parliaments and from other distinguished bodies about the failure and futility of the war against drugs. He has mentioned the Select Committee of Home Affairs in the House of Commons in 2002. There is another report that came out in 2003, well actually it didn't come out in 2003 but it was commissioned by the Blair Cabinet from the Strategy Unit and was leaked after some patriotic civil servants got sick of the failed attempts of the Freedom of Information Laws to deliver this document and leaked it to the Guardian[80]. This is what the Select Committee on Home Affairs in the House of Commons said in 2002:

> "If there is any single lesson from the experience of the last 30 years it is that policies, based wholly or mainly on law enforcement are destined to fail. The best efforts of police and customs have had little, if any, impact on the

[79] Westermeyer, J. 1976, 'The pro-heroin effects of anti-opium laws in Asia', *Archives of General Psychiatry* , vol. 33, pp.1135-1139
[80] Travis, A. 'MPs move away from retribution', *Guardian*, 22 May 2002.

> availability of illegal drugs and this is reflected in the price on the street which are as low as they have every been".

So I think you would agree that that is a fairly hearty condemnation. And the Strategy Unit Drugs Project, this is also available on Danny's organisation's website said,

> "A sustained seizure rate of over 60% is required to put a successful trafficker out of business. Anecdotal evidence suggests that seizure rates as high as 80% maybe needed in some cases. Sustained successful intervention on this scale has never been achieved".[81]

So I put it to you that these are not unusual these reports. We see these reports produced from the parliaments of many countries around the world, including my own.

Let's look at the question of 'What is drug law reform?' What are the sorts of things that people like Danny, Larry Campbell and I and others – what are the sorts of things we are saying? I think the first step – the threshold step – is redefining what we are doing. We have to redefine drugs as primarily a health and social problem and when I say primary I mean that is where the emphasis has to be and that means that not only do we put the emphasis in words but we also follow that with funding. So funding for health and social interventions should rise to around about the generous levels that drug law enforcement has enjoyed for decades.

The other thing we have to change is we have to change the objective. Instead of the paramount objectives being the reduction of drug use, or as some would say the production of a drug-free world, we have to change the objective to reducing death, disease, crime and corruption. It would be nice to also have a reduction in prison inmates, it would be nice to have a reduction in government spending, but I think the core objectives have to be a reduction in death, disease, crime and corruption. If we can reduce drug use so much the better but reducing drug use should be a means to these ends.

How do we get there? Well I think there are three specific steps that need to be involved. The first is to expand the capacity of the drug treatment system to deal with people with drug problems and that requires improving the quality so that drug treatment is much more attractive. It also means expanding the range of options for drug treatment - if we do that we will attract and retain most problematic drug users and that is important because we know that treatment works, especially substitution treatment - treatments like methadone and buprenorphine. Nicotine replacement for cigarette smokers is just another example of the substitution treatment and we know that programmes like methadone and buprenorphine don't just benefit the drug users but they benefit the drug user's families and indeed they benefit the whole community. Methadone is one of the major ways we have of controlling HIV infection among drug users. If we don't control HIV among the injecting drug users their sexual partners and their children get infected with HIV and then the sexual partners of the sexual partners get infected and before we know it we have a

[81] Cabinet Office. 2003, *Strategy Unit Drugs Report. Phase one – Understanding the issues*, Available at: http://www.cabinetoffice.gov.uk/upload/assets/www.cabinetoffice.gov.uk/strategy/drugs_report.pdf.

generalised HIV epidemic, so substitution treatment is very important in benefiting drug users, their families and the community.

The second thing I think we need to think about is taxing and regulating cannabis. Now we are not going to get there in one step. We will have to go from having criminal penalties for cannabis to having civil penalties for cannabis but one day I think we will have to, for reasons that I will outline in a minute 'bite the bullet' and start taxing and regulating cannabis.

The third step, which we may not have to do unless these two earlier steps fail to achieve satisfactory progress, is consider having commercial retail sale of small quantities of low concentration drugs. What I am talking about here is going back to the situation which prevailed in the United Kingdom and many other countries a century ago where our great, great grandparents walked up to grocery stores and bought edible opium – which they did 100 years ago. Up until 1913 Coca Cola contained low quantities, low concentrations of cocaine and if you go to Colombia, Peru, Bolivia today and go to a supermarket you can buy cocaine teabags, add hot water, jiggle the teabag around and hey presto, you have a weak infusion of cocaine and I think we might have to consider these kinds of steps as a third possible step. Note here that none of us who support Drug Law Reform want to see one kilogram bags of 100% pure heroin and cocaine at supermarket checkout counters. We are against that, drug users are against that, everyone is against that. Our opponents label us as being supporters of this but what we favour is as a possible third step – the commercial retail sale of small quantities of low concentration drugs.

Now I am going to answer the question that was put to me but before that I am just going to make the point that the common assertion that is made is that any liberalisation in tough drug policies is going to lead to an automatic reduction in prices with an equally automatic increase in consumption and therefore an increase in harm. Needless to say the evidence for this assertion is less than minimum, nevertheless the assertion is repeated again and again as though it was an established fact. It is a fundamental law of micro economics that for general commodities, as prices rise consumption falls, and as prices fall consumption rises, but trying to prove that that happens with illicit drugs has defeated an army of economists. We don't understand that but what is clear is that the relationship between price and consumption for illicit drugs is murky and the relationship between increased drug law enforcement and drug prices is also murky.

But let's look at this question, 'Why would drug law reform produce harm?' Well one of the first things to say is that HIV prevention among injecting drug users requires drug law reform. We couldn't have the needle syringe programmes around the world without some legislative changes and let's not under estimate the seriousness of the HIV problem around the world. This is the most serious threat to global public health since the black death of the 1340s. We have only had the first quarter century of the AIDS epidemic and already we have got over 60million people infected with HIV and there are over 20million deaths around the world so it is a serious problem alright. And when you have infection among injecting drug users there is a reasonable chance that you then go on to have substantial infection in the general population, a so-called generalised epidemic. So one of the reasons we should favour drug law reform is because it has been so effective in helping us to control this

very serious problem of HIV infection. The second reason is that the drug law reform is likely to reverse what I was referring to before as the Iron Law of Prohibition. It will mean that dangerous drugs will be replaced by less dangerous drugs.

I have mentioned already that when drug users are in treatment it reduces the health, social and economic cost to the community and those health, social and economic costs are considerable. A small minority of drug users commit an awful lot of crime. If we can get those drug users to reduce their crime rates it is of benefit to all of us.

Another factor to consider is the drugs that would now be consumed – drugs like methadone buprenorphine, perhaps also supervised dexamphetamine in dexamphetamine substitution treatment for amphetamine users, possibly for cocaine users. What we would be doing is we would be getting people to start taking drugs of known concentration that were unadulterated with contaminants and that were not being injected and these are all important steps to lead people to leading healthier lives with greater well being.

We may also decrease the incidence of drug use. The paper that came out of the City of Zurich study published in the Lancet in 2006 by two researchers, Nordt and Stohler, showed what happened when saturation methadone was provided in the City of Zurich[82]. To start off in the year 1990 there were 850 new heroin injectors; by the year 2002 this had come down to 150 and not only was there a reduction in the number of new heroin users in the City of Zurich and Switzerland but there was also a reduction in HIV infection, reduction in drug overdose deaths, a reduction in crime and also a reduction in the quantities of heroin that was seized. So what was happening was that instead of people going out to buy street heroin, increasingly they were going to methadone clinics and in some cases they were also getting prescription heroin. So the provision of Drug Law Enforcement in the form of expanded treatment will shift people from the street drug market into the regulated drug treatment market.

We should also be mindful of the fact that there are considerable harms associated with drug law enforcement. Sam Friedman and his colleagues looked at 89 major cities in the United States and published this article in the journal, AIDs, in 2006.[83] They looked at three parameters of drug law enforcement. They looked at drug law enforcement expenditure, they looked at crime rate arrest rates and also incarceration rates and then they looked at estimates of the numbers of drug users and they also looked at the prevalence of HIV among the injecting drug users. What they found was that as drug law enforcement was increased there was no decrease in the numbers of drug users in those cities but there was, perversely, an increase in the prevalence of HIV infection among injecting drug users. So don't think for a minute that drug law enforcement is risk-free.

Let's turn our attention to taxing and regulating cannabis. Cannabis prohibition has got a lot of high social costs. When you pass severe laws against cannabis users this is not without it costs. What it does is – some of them lose their accommodation, some of them lose employment, some of them lose their relationships, but one thing

[82] Nordt C Stohler R. 2006, 'Incidence of heroin use in Zurich, Switzerland: a treatment case register analysis', *Lancet*, no. 367, pp. 1830-34

[83] Friedman, S.R. et al. 2006, 'Relationships of deterrence and law enforcement to drug-related harms among drug injectors in US metropolitan areas', *AIDS*, vol.20, pp. 93-99.

that doesn't happen is that it doesn't reduce their consumption of cannabis. So what we need to think about is taxing and regulating cannabis – this would have a lot of advantages. We could have warning labels on the packages that said, 'Cannabis might cause mental health problems', we could have help-seeking messages, 'If you are trying to cut down and stop, ring this number'. It would help us to keep the concentration of THC, the active ingredient in cannabis, within a narrow concentration band and people complain about the fact that cannabis allegedly is much stronger than it was when Robert Zimmerman was a boy in short pants in Minnesota. It would also reduce police corruption. Cannabis accounts for the majority of the illicit drug trade so if we reduce the size of the cannabis black market we are doing a lot to reduce police corruption. We could introduce 'proof-of-age when purchasing' restrictions, so that people purchasing cannabis could not do so unless they could prove that they were over a certain age, as we can do in some parts of the world with alcohol. We could also separate the market for cannabis from the markets for heroin and cocaine amphetamine. In the only study in the world where we have compared two cities with restrictive policy on cannabis, San Francisco, compared with the more liberal policy on cannabis in Amsterdam[84], data which will soon become published shows that the chances of buying heroin, or being offered heroin, cocaine amphetamine in San Francisco (51%) was three times higher than when the cannabis was being purchased legally in The Netherlands (15%). And as I have mentioned we could also reduce police corruption. So there are a lot of advantages in considering taxation and regulation of cannabis.

We have to think about what the basic problem we are dealing with here is, and I think what it boils downs to, is that the irresistible force of economics is running head to head into the immovable mountain of politics. The economics of this is that we have very powerful market forces and we all know from the failure of communism in 1989 that there is a high price to be paid for ignoring powerful market forces and these are powerful market forces as Danny has mentioned. Three hundred and twenty-two billion US dollars a year, according to the estimate of the UNODC is the financial turnover of the global illicit drugs industry. This means that it is not as big as the armaments industry but it is bigger than the gas and oil industry which comes third. So it is a huge industry and it is a very lucrative industry, a very profitable industry. The Strategy Unit that I referred to before in that document commissioned by the Blair Cabinet estimated that 26 to 58% of turnover in drug traffickers in Afghanistan was accounted for by profits, profits of most companies usually in the range of 7 to 8%.

The other problem we run into in the economics of this area is we run into the inexorable laws of supply and demand. We all know that if there is powerful demand for a commodity or a service that commodity will be supplied by someone or another and if there is no legal source of that commodity or service then illegal sources will emerge.

But what is the politics of this problem that the economics is running headlong into. Well the problem is that supply control sounds intuitively like it ought to work, if somebody stands up and says, "Drugs are bad and I am going to smash them and get

[84] Reinarman C. & Cohen P. 2004, 'The limited relevance of drug policy: cannabis in Amsterdam and in San Francisco', *American Journal of Public Health*, vol. 94, no. 5, pp. 836-842.

rid of them and vote for me and there will be no illicit drugs in Scotland after midnight tonight", there will be a lot of people who will want to follow that advice. The problem is that it is so empirically weak.

The war on drugs has been a political Viagra since President Nixon first cottoned onto what a potent force this can be. Fear campaigns really work. We have just had several of these in Australia. The problem with drug law reform is that it is a much harder sell. It sounds counter-intuitive even though it is empirically strong. So the problem we are dealing with here is that what works isn't popular and what's popular doesn't work. We are familiar with the problem of when economics and politics run in opposition to each other. In the short run politics wins, but in the long run economics wins.

Now I want to make a few comments about alcohol as it is such a problem in this country. Again with alcohol, it is like with illicit drugs. We know what works and we know what doesn't work. There is an extraordinary strong consensus if you go around the world and talk to research and clinicians who look at the prevention of alcohol-related problems about what works and what doesn't work. A book was produced in 2003 called, 'Alcohol, No Ordinary Commodity', by a group which was commissioned by the World Health Organisation. Some outstanding people from around the world put this volume together and they talked about seven steps that really need to be implemented if you want to reduce alcohol related problems.

The first is pricing and taxing increases and there is very strong support for this.[85] This is the single intervention best supported by evidence for reducing alcohol-related problems and I am talking here about small increases in tax on alcohol do reduce harm. Even better, hypothecate these taxes; that is reserve a small proportion for alcohol and drug prevention and treatment and that turns 80% community opposition to tax increases to 80% support. Unfortunately it also brings you 100% opposition from the treasury.

Another important step is to change from ad valorem taxes to volumetric taxes and this means instead of taxing alcohol according to its price, tax it according to its actual content of alcohol. It is an important step.

Next thing we need to do is increase the restrictions or decrease the availability of alcohol. In general when alcohol is less available there is less harm; that means reducing the number of outlets, reducing the hours of opening, considering raising the minimum legal drinking age. These are difficult things politically and we might only be able to do some of these but not all of them. Enforcing restrictions on sale to underage people, increasing the availability of low alcohol content beverages, thinking about having off-premise monopoly sales of alcohol (which works very well in Canada), but again as with taxation we have to avoid the very harmful excessive restrictions. Excessive increases in taxes, big increases in taxes or big restrictions in availability cause more harm than they do good.

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[85] Babor, T. et al. (2003), *Alcohol: No Ordinary Commodity. Research and public policy*. Oxford, Oxford University Press.

Next we have to modify the drinking context. Responsible beverage service is a good way of reducing harm although they are a bit more difficult even than taxing and availability changes. They do reduce aggression and violence in liqueur outlets. Mobilising the community is certainly a help but there is a question about how sustainable that may be. Safety measures for intoxication are also a useful step and these are things like having plastic shatterproof drinking containers rather than glasses so that alcohol intoxicated men can't smash the glasses which they then stab people with, or having heavy furniture that is too big and heavy to be thrown around at people.

Drink driving measures really are effective, and it is important that the punishment follows swiftly on from detection and that punishment has a high degree of certainty and is also severe. But swiftness and certainty are even more important than severity.

Licence suspension has also been shown to work. Random breath testing was introduced in my state in December 1983 and we knew within a week – we could see in the emergency department in my hospital – we could already see the reduction. Random breath testing reduced deaths and severe injuries in my state by a third and that has been sustained since 1983.

We need to reduce the level of blood alcohol concentration. In this book[86] they recommended reducing it to .08 but in Australia we have now reduced this to .05. Ignition interlocks are helpful, graduated licensing is helpful. We can also regulate alcohol promotion and it is also important although the book mentions education and persuasion strategies, these have small benefits and the benefits are short lasting. So although this is a favourite strategy of politicians and the community and the alcohol beverage industry, it is unfortunately not one that is all that effective.

And likewise we ought to think about the importance of treatment for people with severe alcohol dependence. We have a number of treatments that have been shown to work in randomised control trials but these are inadequately funded. We have some pharmacological treatments that work and brief interventions work as well.

Another group of people in Australia looked at best-supported interventions across the board and they looked rigorously at all the evidence; all the different interventions for alcohol, tobacco, prescription illicit drugs.[87] The top eight included tobacco taxation price disincentives. This is particularly important because the people who start smoking are young people; young people have small discretionary incomes so small increases in tobacco prices really do hit young smokers and that is what we ought to be doing and these are strongly supported by evidence. Other successful interventions included enforcing environmental tobacco smoke regulations, volumetric alcohol taxation as I have mentioned before, random breath testing, briefing interventions for alcohol and tobacco, treatment of alcohol and drug problems, needle syringe programmes, and hepatitis B vaccinations.

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[86] Babor, T. et al. (2003), *Alcohol: No Ordinary Commodity. Research and public policy*. Oxford, Oxford University Press.

[87] Loxley, W et.al. 2005, 'A new integrated vision of how to prevent harmful drug use', *The Medical Journal of Australia*, vol. 182, no.2, pp. 54-55.

Well, what are the conclusions from all of this? First is that, 'Will drug law reform reduce drug related harm?' is the wrong question but the answer to it is 'yes it will', and I have shown you the mechanisms for that and will come back to that in a moment. Even more importantly though tough drug policies are ineffective, expensive, cause of lot of nasty collateral damage, don't reduce the harms from drugs – if anything they exacerbate it and the only sense in which the can be said to work is politically.

I have defined drug law reform as redefining drugs as primarily a health and social problem and the way that these work in reducing harm is by keeping HIV under control, by getting most drug users into treatment with a reduced health, social and economic cost of the practice to the community by shifting the drug market from more dangerous drugs to less dangerous drugs and reducing the problems that are inherent when we rely so heavily on drug law enforcement. The basic problem as I put it to you is that the economics of the drug trade ensures that drugs will always be available while they are illegal. However, the other part of this puzzle is that the politics of the war against drugs slows the inevitability of drug law reform.

Finally, I want to leave you with a thought that is really a very strong consensus around the world about what works and what doesn't work.

Thank you very much for your attention.

## The Honorable Larry Campbell, Senate of Canada

In the beginning, we have what is known as the Downtown Eastside, and this was the original spot where Vancouver started. It was the site of what was called the skid road, which we now assume is something to do with poverty and a bad place to be, but in fact it was the road that was used to skid the logs from around Vancouver down onto the water to be taken to the mill. It was a vibrant community. There is a large number of retired people there; it has always been an area where there was a lot of single room occupancy, single hotel rooms. There were loggers and miners and fisherman and all kinds of people who retired there, but there were also families and businesses. The major one was referred to as Woodward's, which was a huge department store that occupied one complete city block. In the 1970s Woodward's shut down and there was a steady decline, boarded up shops. There were nightclubs down there, butcher shops, all the rest; gradually, because there was not the feed from the people coming to Woodward's, they started slowing down.

By way of background, I should have explained that I started out as a steelworker, then I became a member of the Royal Mounted Police. I spent eight years on the drug squad from street crew, which was street-level enforcement, to undercover, to running major projects. I left there after 12 years and became the Coroner for Vancouver. In 1996, I became the Chief Coroner for British Columbia. In 2002 I was elected mayor, and in 2005 I became a senator. I am telling you this to show that I have a tough time keeping a job.

During the 1980s, as a coroner, I remember one day being down there and looking up an allay and all these people were down, sort of digging in the dirt. I didn't know

what it was and I said to one of the cops who was with me, because we were with a dead body, 'What are they doing?' and he said, 'They are tweaking. They are cocaine addicts and one of the things they do is continually think that they see cocaine, and they tweak: they go down and they look and they are picking up stones.' We hadn't seen cocaine: it had come as far north as Seattle, but suddenly it flooded into Vancouver.

In the 1990s, we started to see crack and we started to see methadone amphetamines, and the area went into continual decline. As a result of that, my predecessor as mayor, who actually lost the nomination for his party because of his politics with regard to drugs, started a discussion and realised that we had let the Downtown Eastside get away. We had let things happen down there that we would not let happen anywhere in our city, and so we started a wide-ranging discussion. Different groups would meet, but it was always open – anybody who wanted to come could come, anybody who had something to say could say it. For instance, we had the Vancouver Area Network of Drug Users, we had churches, we had police, and sometimes we had politicians, but very rarely because this is not a subject that politicians really want to get into. We sort of came through this process of 'what are we going to do about this?' and we came up with a drugs policy. It was passed by my regime in 2005, but in 2002 we clearly had what is now known as the Four Pillars. There are 27 recommendations in that, and if you would like to see it there is the website www.vch.ca/sis that you can go to and get the complete package. I would urge you to do that because it is quite an amazing document put together by a government. While we were having this discussion, we had to decide what the motivators behind drug use and some of the solutions are. In 1996 in the province of British Columbia we had over 400 deaths, and there are a number of reasons for this. There was a huge glut in the market – the Golden Triangle, also Afghanistan and Turkey were involved. When I worked street crew, for instance, in the 1970s, we would see percentages of heroin of maybe 5 to 7%. I was analysing street drugs at 99% pure, so they were taking it straight from the country into here and selling it on the street.

When we talked about why people become addicted to drugs, how this happens, some would have you believe that this is a character flaw: you have a character flaw and that is why you are a bad person and you use drugs. In fact, what we found were poverty, substandard housing and availability of this heroin – it was just flooded. People who would be able to spread it out and take it over a long period of time suddenly had access to it and they were feeding their addiction and, as a result, many people were dying. There was also the flight of the legitimate businesses from the Downtown Eastside.

Perhaps the most important circumstance was the deinstitutionalisation of mentally ill people. In the 1970s, in most countries, we went through this period of time where we deinstitutionalised our mental health patients, which was the right things to do. Unfortunately, we lied to them because what we said to them was: 'You know what? We are going to let you out, and we are going to put you into the communities, and we are going to supply you with support, and we are going to help you get better or, at the very least, we are going support you' – and we didn't. We gave them a ticket and some medications, and they got on a bus and they came to Vancouver. One third to one half of the people who live on the street in Vancouver, and one third to one half of the people who are addicts, are mentally ill. In fact, if you are mentally ill in

Vancouver, it is automatically assumed that you will be dual diagnosed. So, you are mentally ill and then you can add addictions on to that.

We found that displacement of enforcement procedures helped this. We found that we displaced the addiction from what was the west end to the Downtown Eastside, and we did that because we passed a law that said prostitutes were not allowed on this side of Granville Street. The majority of the prostitutes who were working the scroll were also addicted, so they all came over to the other side of Granville Street, which puts them in the Downtown Eastside. Today's drive-by journalists always go on the idea that 'if it bleeds, it leads', and nothing bleeds more than gun-related drug deaths, nothing relates more than 400 people dead. But what we are finding from journalists – or, not so much the journalists, but the columnists – those who have time to look at this issue and think about it are coming along and understanding what we are doing, understanding that things have to be done differently.

The goals of our whole process are very simple: to reduce individual, family, neighbourhood and community harm from substance abuse; delay the onset of anybody using substances; reduce the incidents (that is, the rate of new cases over a period of time) and the prevalence (the number of cases of a problematic substance use and substance dependence at one time in the population); and improve public health, safety and order.

In 2002, I ran for mayor. I had never been a politician – I would like to say I am in remission now – and I ran on harm reduction, I ran on the Four Pillars. The Four Pillars are:

- prevention
- harm reduction
- enforcement
- treatment.

People want to lump me into that group that doesn't believe in enforcement, but I do believe in enforcement. I believe that enforcement is a crucial part of that and, as the Chief Constable said, if you reach 20% of interdiction, you would be doing really well. My position is that, if we took our resources – our police resources – and targeted them towards the upper level, the high end, then we would be doing something with our police resources.

Overdose deaths increased in British Columbia from 39 in 1988 to 201 in 1993, to over 400 in 1996. It was the leading cause of deaths for adult males aged 30 to 49 in British Columbia. It wasn't always the heavy users who were overdosing: when you get a shot at 99% pure, you are in deep trouble. I would go, for instance, to death scenes and I would find in one case three people all dead who never even got the needle out of their arms. What was happening was that even those people who were – I can't say marginally addicted – but even those people who had some control over their addiction in that they would only use, say, twice a day, once they got into this heroin, it was just a clock ticking, it was just a matter of time before they would get into trouble. Probably more importantly, when we analyse the drug overdose deaths, they were all multi-drug. It was rare to see heroin, it was rare to see cocaine; it was much more common to see heroin, cocaine, what was referred to as a 'speed ball' and

alcohol – almost always there was alcohol in there some place; or we would see heroin meth, we would see all of the various combinations. So, to call these strictly illicit drug deaths is not exactly true: they were multi-drug deaths, usually with alcohol involved.

In 2002, I was elected mayor. In 2003, we got permission from the Federal Government to open Insite. People think for some reason that supervision injection sites are illegal – they are not illegal. In fact, under the drug conventions, there is a section that says if the site is used for research or health, it can be opened. Usually there a sunset clause built in and, in our case, it was a three-year sunset clause, which can be extended. In 2003, in the fall, we opened Insite to much fanfare. I mean that we had all of the US channels up there; I had a threat from the drug tsar that he would close down the border and I told him that LA would be in the dark and very thirsty if he did that since we supply all their electricity and oil.

One of the interesting facts concerning Insite is that you would not know where it was. If you walked downtown Vancouver, you wouldn't know where it was. There was this argument that we would have what is called the 'honey pot' effect – in other words, all of the addicts would come here. Think of this: 'I live in New Westminster and I am going to score. So, I am going to climb on the sky train and I am going to ride all the way to Vancouver, and I am going to go to Insite because they give me a clean needle' – it doesn't happen. The people who use Insite are within a ten block radius of that site, it does not draw them.

Enforcement: you do not want to be dealing drugs at Insite, you don't want to be standing outside dealing drugs because the police will get you. It doesn't mean that we have taken out drug trafficking – we certainly haven't. In fact, I point out that when I was in the drug squad I had to hunt addicts. We'd go set up and look and watch for them. Today, I could take a van to the Downtown Eastside, open the door and just pick any 15 that are standing there and they are 'dirty'. That is how bad it was at that point. Before we opened up Insite, it was nothing to walk the streets of Vancouver and see people cranking up in doorways, in allays, sucking up puddle water, using that, just smoking crack. Is that all gone in Vancouver? No, but I can tell you this. We have 7,000 registered users at Insite: 25% are women, 18% are aboriginal, 41% of the injections are heroin, 27% are cocaine, 12% are morphine. We have had 453 overdoses in that site in the four-year period (and these range from 'gee, I am a little woozy' to boom – on the deck), but we haven't had one single person die.

We have had over 4,000 referrals to counselling, and that can range from detox to treatment, but we have had 4,000 referrals. Of those, 40% are for addiction counselling, two individuals per week are referred to methadone maintenance. Again, is methadone the be all and end all? Absolutely not. It is hugely used in British Columbia: there are probably 9,000 addicts on it. But I like to look at it this way: this is the continuum of care – just say no, okay, heroin maintenance. I don't care if it is the most whacked-out idea in the world, if it works for somebody, I am all over it. Believe me, there are some whacked-out ideas there, but when I have spoken to people who have been involved in it, they are clean. I don't know how – and I don't care – but it works.

We have to look at this as a continuum of care. If I had cancer, I wouldn't be going in and saying this is the only treatment you have. No, there is a continuum of care that you can move back and forth along, depending on severity and where you are in this. We have an average of 607 visits a day – 607 people injecting in an 18-hour period; the most we have ever had is over 800. We have had 4,000 interventions for medical treatment, 2,000 of which are abscesses; these would be going to our hospitals.

Maybe I should describe what happens. When you walk in the door, you have an identification, a way of identifying you: we don't know who you are, but we know you are 60 years old, we know that you are white, we know that you live within this area. You go into a room with mirrors on two of the walls, and there are eight stations. You come in and we give you a kidney bowl. In that kidney bowl there is a clean needle, a spoon, clean water, in little packs a swab, a tie off and a lighter. You sit down, you tie yourself off, you put the drugs that you bring off the street into a spoon, you heat it up, suck it into the syringe and you crank it.

Seated on one wall is a registered nurse who can see all the mirrors and can see all the people. She is there to make sure that nobody gets himself into difficulty. After you have finished injecting, everything goes back into the bowl; swab; you then move into the next area where there is a nurse who asks, 'How are you feeling? Any abscesses, any problems, any cuts, scrapes, bruises?' Also, there are peer counsellors who are ex-addicts who are there to talk to you, basically to chill you out, and you can have a coffee. We can deal with the problem you have about not getting any housing, about no clothes, employment – you name it, we have it all there in that area so you can actually gain something from that – and then out the door you go. So, that is a description of the site.

We have already talked about drug use as a health issue. Drug addiction is recognised by medical practitioners as a disease, and it is no different from any other disease. It could be alcohol, it could be my tobacco use, it could be any kind of addiction. What we do know is that incarceration, increased sentences, criminalisation and prohibition have failed to get the desired results of reducing use, association with crime and, as importantly, deaths among the addicts. If the war on drugs worked, there wouldn't be one in one hundred people in the United States in jail. Prisons would not be a growth industry. This is all privatised now. I don't know why people build holiday inns – get into the prison business. If I build a prison, I never have to worry about vacancies – it is a growth industry. That is exactly what happens: I build a prison, they fill it; I build another prison, they keep filling it, successively, year after year. And what does that do? It destroys our communities, it destroys our families, it ensures that if you are a minority you have got a much higher percentage going to jail than I do. You are not going to get any treatment while you are in prison. In Canada, if you aren't in there over four years, forget it – they are not going to get around to you, they are not going to treat your mental illness. And if you go in for the first time, when you get out, you are a much better criminal because you have now learned how to plan armed robberies, how to do BNEs, how to break into cars, where you can take all of your ill-gotten goods. You come out a much, much smarter criminal and the chances of recidivism are much greater.

What did we do for the research portion of Insite? We set up a process where people came and conducted research on all kinds of different issues. This research had to be

scientifically-based, had to be peer-reviewed and had to be published in a recognised medical journal. There are some 23 papers now and every single one has been positive. The research has dealt with the social aspects. Has the number of needles that are left lying around dropped? Yes, it has. Has the rate of social harm from people causing us difficulties dropped? Yes, it has. There is a website you can go to which will give you all of those papers: http://www.communityinsite.ca/science.html.

But I have to stress to you that this is not a silver bullet. This, in itself, is not going to change the majority. If you went down there tomorrow you would be horrified, you would be absolutely horrified. I go down there and I see changes, but then I spent my life down there. It is a work in progress and we are seeing more and more people coming on board. We should have many more of these supervised injection sites. They don't need to be big. They should be out in the communities: they should be in New Westminster so that those addicts don't find themselves in this position; they should be in the nice communities that I live in, where we have a huge addiction problem, where we have homeless and mentally ill people. So, it is very much a work in progress.

Some of the papers showed there is a 30% increase in detoxification: 30% of the people who have gone in there have at some point gone into a detoxifying process. Anybody who is familiar with addictions knows how many times you have to go through this process before you finally can come out the other end. In fact, some scientific studies say that if you reach 50, you will kick it because you are just too tired, just too beat up, you just can't continue with this existence. We have a reduction in syringe sharing. There is improved public order. We have reduced public injection drug use and public syringe disposal. There is no increase in drug trafficking or assaults and robberies. There is a decline in vehicle break-ins and vehicle theft. There is a large number of overdoses with no deaths. There is disease intervention for HIV and hepatitis. Vancouver had the distinction of having the largest per capita HIV population in North America and it was going through the roof. We have seen that decline, we have seen it stop, we have seen it slow down.

Some people ask me how I ended up going from a narcotics officer to this position here because, while I was not Attila the Hun, I certainly was a law and order person – and I still am. I went from enforcing a law to trying to find ways to prevent people from dying because that is the job of the coroner. Whether it was an industrial accident, a car crash or an overdose death, I was continually searching for ways of keeping people alive. Over a period of time, it became clear to me that what we were doing – namely straight enforcement – was not working, so I got involved in this process of harm reduction. But I am also involved in the process of enforcement, I am also in the process of prevention, I am also in the process of treatment. People would like these four pillars to be equal, but they can't be equal. When we started Insite, the first thing I needed was enforcement. I needed somebody to go down there and break up that drug mart that we had. So we did that. We put a police car every half block, we had policemen on horses, we had policemen walking the streets, and we broke it up. Where did it break up to? It broke up away from Insite, but it broke it up to the point where we could start Insite, where we didn't have to worry about the traffickers sitting outside our door. We knew that the people still had to score. Because we weren't supplying drugs, we knew that but they weren't doing it right outside there

and so that allowed the street scene to calm down. It is still bad: to anybody here who went there, it would still be seen as bad, but we started to see the deaths drop.

The time for change is upon us, and I believe that change has to come from the municipal level – that is where the rubber hits the road, that is where people are tired of seeing this behaviour or that behaviour, and it is through those people and their politicians that we will start to see the change move up. It is very difficult to start this change at the top. It is very difficult to start it with your Parliament. For starters, as mayor, every day I was in the grocery store, every day I was walking down the street and every day they came and talked to me and they came and told me things. If I was a Member of Parliament, when I do get home a couple of times a month, I am not going to the grocery store, I going to a fund raiser. I don't get to talk to the people, I don't get that same sense of urgency so it is at that level that you deal with it. It is at that level, where you get to talk to the cop who is on the street, who is giving you information of what is working, what isn't working, how they feel about this and how we can go forward on this.

In Vancouver, this was embraced by our police department – not by everyone, but embraced. Certainly, the Chief was all over it, and so were the vast majority of the police officers. Some weren't. That is the way it goes, but you need to bring all of these people into the tent and you need to address their worries – their worries about it being a 'honey pot', their worries about where the drugs come from. (They come from the same place they have always come from.)

The supervised injection site was supposed to end in the fall of 2006. We had a change of government: we went from the Liberal Party to the Conservative Party, and the Conservative Party made noises that they were going to shut down the supervised injection site. It has since been extended six months, and now it is another six months – it is extended until June 2008. I will stand at the door if they try to shut it down. What are they going to charge me with? Obstruction of a police officer would be the first one that I would see coming down the pipe – I would never get physical. Would they charge me on the grounds that people were shooting up inside there? I could take them by the arm and walk around the corner in the allay and say, 'They are shooting up there and you are not doing anything there. Inside, I am providing health care and making sure people don't die; I am trying to get them into treatment.' The uproar would be great; it would be wonderful – I don't think they will do that.

The difficulty is how we move to the next step, how we allow this to happen in other cities. In Vancouver we have what is known as the Naomi Project. Basically, that is a study of what happens if we give somebody heroin and we give the control group methadone. Do we see a change in behaviour? What is the pattern? This is going on in three cities in Canada. It is very controlled; it is hugely expensive – way more than I would ever have imagined – but from that, they are going to come to some decisions on drug policy: what do we do? Do we continue with methadone? Is there a place for heroin as treatment? Does it stabilise you? I don't care if you sit at home all afternoon stoned on heroin, watching Oprah. I don't care. You are not breaking into my car, you are not using dirty needles and you are not going to die from it because we have got the dose down. You know you are not continually avoiding the police, avoiding other dealers, avoiding other users who are going to rip you off and, if you actually start eating properly and your life starts getting into some semblance of normality, we have

a chance of your getting off that. The other way we have no chance. The morality of it is that I don't care, I really don't care. Or people say, 'Oh, users will be on welfare'. Guess what? They are on welfare and chances are they are on it about five times, with different names, so that argument doesn't match. That is sort of the way that we are going.

I would say about 30% of the Canadian public are tight and think that this whole thing is just nonsense. But there are two thirds who say they are not sure – they are starting to move. Most of it is coming from big cities, most of it coming from Vancouver, Calgary, Toronto and Montreal where we have these problems; and more and more we are starting to see it from middling cities; and soon we will start to see it from smaller cities because that is the way that it grows.

This should be treated as a medical problem. We should have people involved in it from all of the specialties – medical, scientific, the social communities, the addicts themselves and enforcement. All these people need to be involved, but make no mistake, it is a medical problem. Who should be in charge? Again, it should be the medical people.

What are the benefits of moving drugs into the health field? First of all, you save money. Okay, every time you convert to HIV, it costs the government one quarter of a million dollars a year to treat you; and you are not going to die – you are going to live long because we have found ways, thank God, to keep you alive. So, let's figure it out: 600 injections a day, times 365, times four years. To break even, I had to prevent 40 cases of HIV – figure it out, 40 cases over that period of time. I am saving them money, I am saving the health care money. Wouldn't it be much better if my enforcement dollars went towards money laundering, went towards gangs who run the whole nine yards I might add. Wouldn't I much rather have my money going into that upper level, because these people are not only involved in drugs, they are involved in prostitution, car theft, identify theft, you name it? I don't know of one gang that exclusively does drugs, not one. They are into everything – they are corporations. The days when the Hells Angels wouldn't talk to the Big O Gang in Vancouver are long gone. Some guys are involved in the transportation; some guys are involved in the production (meth labs); some guys are involved in the enforcement – they are all working together, and it is multi-national. We would eliminate that stranglehold they have on this addiction, on this medical problem. We would empty the jails. Somebody was asking earlier on about the costs of jailing. It is probably around $80,000 on average to keep somebody in jail; for $60,000, I can send them to the Betty Ford Clinic. Now, Betty Ford is not going to allow the people that I know in. Certain celebrities may get in there but Joe Blow scabby is not getting in there. So, we could start lowering our population in jails. What else would that add? It means that it wouldn't be breaking up families for what are basically minor offences. There are people in jail for growing pot. In British Columbia, it is a $9 billion a year industry – it is just behind forestry. Imagine if we regulated that and I taxed the living hell out of it, like I do for my cigarettes and alcohol, and I put that straight into health care, and a chunk of that is legislated to go to nothing but addictions – and addictions can range from drugs to eating disorders, you name it.

One of the amazing things you will see all the time in the Western world is that we decry that they are denying children in Africa sex education, they are refusing to

distribute condoms. It creates a huge outcry, all of those barbarians! But then we deny adults access to clean needles, as they do in the United States (you can't get money from the government to run a needle exchange) or we refuse to give our children the proper information. In Canada, we have what is know as the Deer Programme, run by the Mounties. Basically, it is: 'Don't do it, it will be really bad for you, you will grow horns or something'. And the children look over and they realise that within this class are all these people who have tried it at least once and they haven't grown horns, and so the whole thing goes out the window. We need to have people there – not necessarily police officers – we need to have pharmacologists, we need to have people who can say, 'These are drugs. You should not use them – and that includes tobacco and alcohol – but you should also know what they are, you should know the properties, you should know how they will affect you, the dangers and where they can lead you.' That is what they need to know.

People can get all of the right information from the internet and they can get all of the wrong information, because both sides are represented there, as they should be. But how do they make a decision based on proper education? They need to get that from the experts who know it. Not from a police officer, although there is nothing wrong with a police officer describing what life is like on the streets of Vancouver, with all of this addiction going on, there is nothing wrong with that; there is nothing wrong with describing what happens when you are addicted to heroin; there is nothing wrong with describing young girls and boys who are selling themselves for this drug. In fact, some of the most persuasive speeches and talks I have ever been to have been by police officers not saying 'No' but saying 'This is what could happen to you, not 100%, but this could happen to you' – and we have to be doing that.

In summary, the recommendations we came up with are:

- Public education
- Employment training and jobs. For many of these people, their thinking is: I got into a programme and I kick the habit, but I can't get a job. So what do I do? I can't get employed, I can't get trained, nobody wants to touch me with a bargepole. What do I do? I go back to the people who know me, the street people, and get back into the habit.
- Supported and transitional housing. People think: I can't get a job if I don't have an address. If I give my address as under the Granville Street Bridge, they are not going to hire me. So, somehow we have to find a way to educate, train and house our people.
- Easily accessible healthcare. We need treatment on demand because, when I am ready, as an addict, you give me half an hour. I am on the streets trying to score. You have a very, very narrow window.
- We need legislative and regulatory changes to create a regulatory system for all currently illegal drugs. This is what Danny was talking about, but I am not as hopeful that it will be within 10 years. We are going to have to shift the United States and, believe me, we live next door to the elephant. As a former Prime Minister said, 'There is nothing wrong with sleeping beside an elephant until it decides to roll over'. It is a difficulty that they see themselves as the arbiter of good taste and morals in society. They are going to be tough to move.

- We should control all potentially harmful substances, which will limit the control that organised criminals have over the drugs. Will there still be some drug dealing going on? Yes, I think there will be. Will I take the time to grow my own marijuana? I have never smoked, but I would suspect that, yes, I would if I was that way inclined. Would I grow enough to sell it? Why? At the end of the day, it is just too much work when I can have it controlled and I can go and buy it anyway.

Why does there continue to be a drug problem in Vancouver? There is inadequate treatment: compared to other treatments, it is virtually non existent. There is a focus on criminalisation and incarceration. There is inadequate housing, specifically affordable and subsidised housing. Criminal records would prevent users from reintegrating into society, which is really quite interesting. If you are convicted in Canada for possession of marijuana, you are never going to see Disneyland in the United States and you may not see a lot of other countries either, which is quite a limiting thing when you live next door to the United States and you are in Canada.

A whole community of people are excluded from society. One of the groups that we dealt with when we were doing this large community involvement was called From Grief to Action. These were parents whose kids were addicts and, unlike the portrayal of this poor down-trodden person, we found that the vast majority of these parents were just like you in that there was Crown Council, professors, firemen, police officers – basically, it was society as we know it. Being an addict had a profound effect because, no matter what they did, they were continually marginalised; no matter how much they tried to get treatment, they were marginalised. If it had been any other disease, they would have had treatment right now, on-demand treatment. If I went in and they said, 'Larry, you have got cancer', they would be dealing with it. These people, who come from good families, end up in poverty, they have no hope, no employment, they have nothing except the addiction that keeps driving them, which keeps them in poverty, which keeps them in a state of no hope and no employment.

AIDS and hep C is a disincentive to addicts. If we had not had the needle exchange, if we had not had the supervised injection site, and if we had not had the public awareness that came into being in Vancouver, there would be hopelessness. As an aside, I should say that Vancouver has a large gay population, so in the 1980s, when I was a coroner, these people were dying and nobody knew what it was. When we figured out what it was, there was a huge outpouring from the community to do something about it. So we got into it, and we realised that some of it was as a result of unprotected sex, some of it was as a result of sharing needles, and there was a huge community push to end it. In 1977, before this even came out, the mayor, who is now the Premier of the province, started a needle exchange.

I am not going into why the criminal justice system is unsustainable. Here are the costs of it: $80,000 per year; for a federal female prisoner, it is $150,000 per year; for somebody who is in heavy security, it goes through the roof. (I have never been able to figure that out. You get fed once a day by somebody sliding a plate to you, you get out for half an hour – and it is more expensive to keep you than the normal prisoner.)

Whether we like it or not, whether we agree or we disagree in this room, we need to move these issues into the public health field. Society cannot realistically continue to

lock up every drug dealer and every drug user. It simply is not viable, it can't work – and we know that by looking at the United States. The increased health costs can be offset by legalisation of sales. No one grows their own tobacco, it is no different from legal pot, and it would probably get rid of all the grow ops that we have in British Columbia. There is just no incentive: if I can grow three plants and not get into any trouble, what is the incentive to go out there and grow 1,000 plants? Who is going to buy this product?

Criminals will have to get real jobs – and I know that is a laugh. I would be happy if the gang members just got a real good jail sentence: get them out of my community, get them out of my life, these are the people who should be doing long terms. We are probably not going to save them, so let's get rid of them.

By not educating our children in all areas of drugs, legal and illegal, we are doing them a great disservice. We have to have more and more education. I realise that Alex says it is short-term, but in that short term, they learn a lesson, in that short term, we can help them. As importantly, what we should be focusing on is recognising those children now who are having problems, who are having difficulties within the system, and we can then focus our efforts on those who are most at risk of moving into this kind of dangerous behaviour. Where is the logic of locking up some guy with a bag of grass? I can never get that through my mind, it makes no sense to me.

Finally, the longer we wait, the more entrenched these problems will become. I firmly believe that we are at a point now where we have to start making decisions, where we have to start moving forward, where we will get politicians with some jam, where we will get politicians who will lead and not follow, who will actually answer questions that the people on the ground are asking about how we can move forward, where they can reverse their stereotypes and look for rational solutions.

# Scotland's Future Forum
# Inequalities
# 3 April 2008

**Mike McCarron**
**Scottish Association of Alcohol and Drug Actions Teams**

I am very pleased to present some thoughts about the mainstream challenges of developing healthier alcohol and drug policies and practice, but first of all just to say I think the Forum is really a unique opportunity for critical but also ground breaking ideas and thinking. I hope this morning that we have some ideas to challenge us in what we might do in the future.

We are ready to think outside current policy parameters and we can look at the long term. I think we can share in that. A very important aspect of this Parliament is that it is built for the people to be able to come in and share in the power of the Parliament through discussion and I think that is a very important spirit which we would want to engage in.

So I am going to start looking at the global view. We are looking at issues of alcohol, drugs, deprivation, poverty, multiple-deprivation, social exclusion. Using the global village perspective we see there that poverty is really a challenge, not just in Scotland but around the world, and I think if we are looking forward to 2025, we in Scotland, need increasingly also to be in touch with global thinking issues and patterns. The stock market has been booming for the last decades and that might now be coming to an end. Things are going to be tighter but the people who have benefited from that boom have been the capitalists holding money, not working people necessarily. It is George Soros himself who said he is one of the people who have been really getting the benefit of that boom.

Modernity across the world is causing additional stress. So if we are looking for more balanced controls and, contented lifestyles, the trends across the world are actually provoking more choices, information, difference and forms of stress. We find in terms of our own subject matter that it is the poorest communities in some of the countries around the world – Afghanistan, Columbia, Peru, Bolivia – who are producing the drugs which are doing such terrible harm being most felt in the poorest communities in the western sphere – in Europe and in Scotland.

If we look just briefly at the issues of substance use by adults we see that across the world 50% of the adult population use alcohol, 30% tobacco, 5% prohibited drugs – 4% of that is cannabis and .6% is really considered to be problem drug use. It is quite interesting that the small percentage of prohibited drugs produces $400billion worth of business a year around the world, the second biggest business after armaments. That is another issue. Increasingly, there are discussions about whether prohibition itself adds to some of the harms, and increasingly this is coming out in public discourse. The Chief Executive of the United Nations Office on Drugs and Crime was recently at a Drug Law Reform Conference in New Orleans not arguing for drug law reform but justifying why that wasn't the case. I see in London there is to be an event looking at the new 10 Year Drug Strategy for England which will involve Danny

Kushlick from Transform Drugs Policy which is a drug law reform organisation. Again I think it is just an element of widening the areas of debate and looking at what are the critical factors – it is not clear yet who are winning those arguments.

I want to come now to inter-country comparisons and as an example last weekend in the press there was a short report that Graeme Pearson, the last Director General of the Scottish Crime and Drugs Enforcement Agency was talking to the Labour Party Conference saying that 20,000 people on methadone in Scotland is ridiculous and pointing to Sweden as a place where there was half the amount of people with serious drug problems. We know also places like Holland or Switzerland do very well in reducing drug problems, or have lower amounts of drug problems. If we had Holland's degree of serious heroin use we would have 8,000 not 52,000 for our population.

So it is not necessarily particular policies which you can say are causing that. I wondered whether Mr. Pearson was actually arguing something else which was namely this: that what we ought to do in Scotland and the UK is increase the tax rates overall by 42% because you will probably be aware that in the UK we have about a 36% tax rate – in Sweden it is 51% of GDP and that interests me because I think my hypothesis would be that with that degree of investment over decades there is likely to be a whole range of better opportunities, more equality, better services when people need them and all that would add up to very powerful reasons why you might have lower numbers of social problems such as alcohol and drug problems. So we have a lot to learn from different countries, including Sweden, Holland and Switzerland but I don't think there are any quick fixes, we need to look and understand all the different issues.

I now want to just briefly look at community contrasts. In this graph all the bars to the left hand side are actually indicators of health and the vertical bar in the centre is the Scottish average and you see that in one community, Broom in Newton Mearns, all the indicators are positive in that community. The same indicators in another community in Glasgow, in Bridgeton, are in the other direction, with only one or two positive – one is positive is because they are located near the Glasgow Royal Infirmary. I think this issue about the difference between communities will be very familiar to you and I am just using that as a very good example which makes the point very well.[88]

We have been moving from global to inter-country to local communities and now I want to touch on the individual situation. The Service User Group in the Scottish Drugs Forum did a photo gallery on the issue of poverty last year with a whole range of different photos and statements and so I have selected this one which is very much about low income and poverty and struggling to live –but there is also a lot more than just income there, there is that issue about, "death is no great deal", there is a lack of hope and aspiration, a lack of self belief", a whole range of different issues being experienced by that person.

And here we have another photo from that same gallery. Here I suppose we have somebody living in what seems to be a little roofless enclave; there is a bottle in there

[88] Based on data from the Glasgow Centre for Population Health, http://www.gcph.co.uk/.

somewhere, there are clothes being dried or maybe it is the curtain; they are homeless, there is a degree of humour around there – can you see Travel Lodge painted on the wall – but that is really somebody at rock bottom. Such a person was at a recent conference in Glasgow and he was talking about when he was using alcohol, on the streets, completely on his uppers. A Simon Community Worker came along to him and said to him, "May I book an appointment with you next week sometime?" and the guy said, Well you can do whatever you want, you can have an appointment with anyone", but he said, "No I want you to give me a time when I can see you." And that switch of making him the person who is making decisions, having power, led that guy to gradually start using that opportunity, start forming a a plan for himself and then taking various opportunities which actually allowed him to get out of homelessness, probably get out of poverty and start overcoming the exclusion which he had been experiencing. So undoubtedly I think that illustrates that there are pathways out of poverty for individuals which we can facilitate.

However, my next point is that it is not just individual solutions to poverty. There are structural issues about inequality and deprivation which Richard Wilkinson, an epidemiologist, writes a lot about. His main point is that it is not to do with the fact that actually everybody in Scotland is better off than so many people across the world in different countries where they are much poorer. It is that within any one country, if there is a range of inequalities, then that country starts experiencing a range of problems, and that is why in the richest country in the world, the USA, people in Harlem have a lower life expectancy than people in Bangladesh which is one of the poorest countries in the world.

On this slide, I don't know if you can read it, but the child on the left hand side is saying, "How come you are rich and I am poor?" and the one across the structural canyon division says "Mum and Dad have highly paid jobs working on that very problem." You have probably seen that cartoon before. I think it is a good indication of structural differences and gaps and I think there is a message in there for people like ourselves working in services. We need to be extremely careful that we are not widening that gap; there needs to be much more engagement between the expertise and the knowledge that people with alcohol and drug problems have about how they got there, how they feel about it, what they would want to do to get out of it, where they want to get to, how their world works – all that knowledge about what the problems and the solutions are, have to be engaged with and exchanged and learned from by the professionals who have a different range of expertise to share with them.

I am going to use a slide provided by Alan Sinclair which I think starkly says, "Where do we start from?" We are looking at children in this one – basically it shows a graph that if you spend an equal amount of money from nought years, right through school years and through post-school years on an individual, the curve graph shows where you get the most value from – you get it from the early years.[89] I think that whole area which we discussed in June in the Forum is going to be a big one in terms of, if we seriously wish to reduce the inequalities in Scotland, which are undoubtedly there, and invest in young people for them to grow up into adults who have significantly

[89] Cunha, F. Et al. 2005, *Interpreting the Evidence on Life Cycle Skill Formation*, National Bureau of Economic Research, Cambridge MA.

less problems with alcohol, drugs, offending, violence etc., then early years is going to be an important theme to get our heads around.

Scotland's challenge in terms of alcohol and drugs. Here we have another graph – we can see that while other European countries' alcohol-related deaths are going down, Scotland's are sharply going up and way above England and Wales. In fact, for male liver cirrhosis mortality rates, the Scottish rate is two and a half times that of England and Wales.

The same is true for drugs. I think we are running about twice the prevalence rate of the drug problem of England and Wales and we know the UK is amongst the highest in Europe so if we are above England then we must be up there at the top .

Looking at deprivation and alcohol – this slide shows that in Scotland in 2005 men in the most deprived areas were 6 or 7 times more likely to die of an alcohol-related death[90]. Again, in terms of legal drugs, a recent report came out saying that Scotland was the highest in the Europe for drug-related deaths. There is an issue regarding alcohol which we need to explore. I don't think anybody understands why, but people are dying in the poorer areas not necessarily because they are drinking more alcohol. It is just that the amount of alcohol they are drinking is producing more health damage and people are dying. Maybe that is to do with poorer nutrition etc.

I now want to move on to what I think might be some promising policies in Scotland to address some of the problems which this presentation is posing.

First of all before I talk about the policies, I should talk about some programmes which have been evaluated that we can learn from. We know already that 85% of drug users are unemployed and that relatively speaking they are still of young working age, so there is a big issue about if people are overcoming drug problems then what about the rest of their lives? Employment must be one of those issues. We also know that from the point of view of employers probably this group is the most stigmatised, that is the one group that employers don't want to employ so there is an issue there.

There are also other issues about the effects of a range of health problems. I am thinking in particular of hepatitis C; there is a very high level of hepatitis C in the previously injecting drug using population of Scotland. I have never yet seen a very good account of what the health implications are for employment of that particular condition. And we also have coming from the English strategy an approach, would you call it a threat? – linking a person's benefits to engagement in treatment. I think that is quite worrying for people who are in our services in terms of what it might mean and we need to see how it unfolds.

I am going to show you now some evaluation of the New Futures Fund which I think most of you will know well. This has been one programme uniquely Scottish which was run over 5 years. It was well evaluated and reported on and basically it showed that homeless people, offenders and people with drug and alcohol problems, when offered the opportunity to engage with services, not with high expectations, actually

[90] ISD Scotland figures based on GROS data.

ended up taking a lot of opportunities – 75% reported an increase of self confidence. Now when we had Linda Sobell from America over here in December, she said, "increased self confidence – that is a wow factor – that is pure gold – that is what is the beginning of change". So I think that a programme like that to get that kind of return has been a marvellous example about the sorts of things which actually we need to be investing in.

So, of course, it was a great pity that it was a time-limited, 5-year programme. That will not be an issue new to you. But there is no way round it, apart from saying that the funding ended and that many people achieving those kinds of results were not mainstreamed. I think we need to learn from that. If we are expecting our clients to change and to take hard decisions and be self critical then I think we have to expect that government and we ourselves have to be able to look at what we have done and say, "that was wrong we need not do it that way in the future".

Another few programmes – I think Progress2Work is a very important one. It is meant to be aiming at people nearer the job market. In fact, there have been high numbers of people referred but relatively few people actually getting into jobs. Now that seems to indicate that the people going in aren't at that stage of getting into jobs, therefore something else is needed. And also we haven't had any kind of public information back evaluating the whole programme but it has been, and continues to be, an extremely important service. There will shortly be published an evaluation of another uniquely Scottish programme, the Better Off Programme, funded by the Lottery. That will give us a lot of information about how to make things work: partnering between organisations, offering opportunities close to where clients are and giving them opportunities to move on.

Promising policies – I think the Scottish Housing Act of 2001 is brilliant legislation offering everybody the right to a house by 2012. There is a a big risk that we won't make it by then. Also we also need to find the right sorts of support that people need to maximise holding down those tenancies. But it is a very, very important policy.

Work Force Plus did very good analyses of unemployment in Scotland, including those on job seekers allowance and those on incapacity benefit. It has a very good understanding of all the different issues involved. I don't think we have followed through well on it. There are a number of interesting relevant developments. For example, we have with us today Pamela Brown from the Raploch Regeneration Unit which is developing the concept of community benefit in contracts and there are also the growth of apprenticeships in Glasgow.

In the world of mental health and wellbeing in Scotland there is a huge amount of good policy development taking place where we need to locate a lot of the drug and alcohol issues..

Progressing "recovery" is becoming talked about more within the Scottish Advisory Committee on Drug Misuse. Particularly in its recent report on essential services; otherwise called wrap around services.

The Anti-Poverty Strategy of the government today includes the intention to increase the proportion of income of the lower deciles of people - an important aspiration.

And lastly, the issue of Early Years prioritisation. Again it is in government policy and we have recently had the Kinship Care Allowance announcement.

All of that is beginning to shape a world where we may look at having productive outcomes.

I will just finish up by asking what might the next step be? So I looked back to 1998 where we had a very important document by the Advisory Committee on the Misuse of Drugs in the UK, 'Drug Misuse and the Environment',[91] which looked at all of the issues that we are talking about today in relation to drugs and to deprivation and it came up with a statement that "we want now and in the future to see deprivation given its full and proper place in all considerations of drug prevention policy at both the local and strategic levels and not let slip from sight".

I think we have let it slip from sight quite often. It has been there but I don't think we have progressed it so much, so I would propose that the next step be that from now on, alcohol and drug policy and practice should be fully integrated within strategies and practice seeking to reduce poverty, multiple deprivation and social exclusion - and vice versa, because I don't think that those working in the anti-poverty world necessarily understand or even have an inclination to engage with people who have drug and alcohol problems. But we need to bring that integration together.

I had a look at the English 10 Year Drugs Strategy. Our Scottish drug and alcohol separate strategies will be due out in the summer. But looking at the 10 keys planks of the English 10 year drugs strategy: one of them at the end was on linking people to employment, which I see as being very much that personal way out of poverty with support: one was about supporting young people, protecting them because they are affected by drugs or are in drug using families; and one might have been about treatment. 7 out of the 10 were about criminal justice measures and I think that that isn't the right balance and needs to be thought about a lot. There was nothing in the English Strategy about really strong integration between the anti-poverty, anti-social exclusion, and combating deprivation and drugs. It just wasn't knitted in, so I would like more thought about that. The reason being that a big reduction, and I put the emphasis on BIG, reduction of equality in Scotland would make a major contribution to what the Forum's overarching question is about, "How we could reduce the damage to its population caused by alcohol and drugs by half by 2025".

## Dr. Ailsa McKay, Reader in Gender and Economics, Glasgow Caledonian University

For me this is a really exciting and interesting opportunity to be here today. Interesting and exciting because I don't do drugs. Maybe that is not the right way of putting it but it is not specifically my area of research and I am talking to a group of experts that I have no expertise on so I am feeling slightly vulnerable today.

[91] Advisory Council on Drugs Misuse (ACDM). 1998, *Drug Misuse and the Environment*, HMSO, London.

But for me really exciting because this Forum presents a real invaluable opportunity to think about policy outwith the confining parameters of existing policy strategies, and that is the focus of my research. I like to think about it as 'thinking out of the box'. I hope that what I have to offer maybe does apply to your own particular area of research and so let's try and apply that thinking out of the box approach to some policy responses that you might not have thought about.

The focus of my research is very much about challenging the norm which you could say you might expect from a feminist economist. I am a woman doing economics and doing it from a gender perspective so by definition on a daily basis I challenge the norm. Sometimes that works, sometimes it doesn't, but essentially it is what defines us – a group of feminist economists who work really hard at promoting a more gender sensitive analysis across all policy areas. So challenging the norm is not new to me; I do it on a daily basis so again hopefully I am bringing this perspective to your expertise.

With regard to my particular research interests I have lurked around debates on social security reform for quite a number of years now and as a consequence I was drawn to the citizen's basic income proposal. In the context of challenging the norm I think the Citizens Basic Income Proposal provides a framework for a new and fresh way of thinking about how we delivery social security policy or how we deliver state supported income maintenance measures. So I applauded the proposal when I first came across it about 10 or 12 years ago. However, upon further investigation I got really depressed about the proposal and I want to say a little bit to you about why, and hopefully your work in this Forum can maybe turn that around and change my depression into something a bit more gleeful.

What do we mean when we talk about Citizens Basic Income? I think it is the first thing you need to try and understand so that we can understand why we are depressed thinking about it, and that turns me to the definition. Now this definition is provided by Philippe Van Parijs[92] who is one of the most well-known, eminent supporters of a Citizens Basic Income. It's an income unconditionally paid to all on an individual basis without means test or work requirement. In other words it is a form of minimum income guarantee that differs from any of those that now exist in various European countries, by virtue of the fact that it is paid to individuals rather than households – now that's key; that it is paid irrespective of income from any other sources – so it is not means tested; it is unconditional and it doesn't refer to any present work or future work patterns in terms of conditionality. So unconditional, universal and paid on an individual basis, the three main aspects of a Citizens Basic Income that set it apart from any other form of existing social security policy.

It would in essence replace all income tax release to all release set against personal income tax liability. It would replace all existing social security benefits and if paid, key is the word basic, if paid at a level sufficient to meet economically defined absolute essential expenditure patterns then would remove the economic necessity for many to enter into paid work. However, once you did enter into paid work the

[92] Van Parijs, P. 1992, *Arguing for a Basic Income: Ethical Foundations for a Radical Reform*, Verso, London, pp. 3-4.

financial gains from paid work would always be positive, so very simply, very compelling, very easy to understand policy proposal for social security reform.

Those who argue in favour of a Citizens Basic Income have put forward some really powerful convincing, compelling arguments to support the integration of the tax and benefit system which would promote real ease of administration – really strong economic arguments in favour of a Citizens Basic Income aside from the social justice arguments.

Those who have argued in favour of it have come from an economics perspective, a political science perspective, sociologists, philosophers, very eminent academics arguing over the last two or three decades for it. The policy would effectively, because the financial gains from paid work, would always be positive, would effectively end the poverty and unemployment traps which, as we know, are significant problems associated with an increased reliance of means testing – a characteristic of our current benefit system. So for many individuals it would remove those disincentives to work, or disincentives to engage in different kinds of work.

I have put a question mark next to the next "fors" an effective anti poverty strategy and maybe we can open that up to debate. I think it does present a solution in terms of anti- poverty strategies but not as a standalone measure and I would like that to be clear. Often those who advocate a Citizens Basic Income view it as a kind of sole policy response which will answer all kinds of current problems and it is this kind of panacea for welfare reform. It needs to be considered particularly in a Scottish context, alongside some of the policy responses that Mike mentioned with regard to housing, education etc. but however despite all of the arguments in favour of a Citizens' Basic Income that promotes greater flexibility; it promotes greater choices for individuals in terms of the work they do, the work that they don't do, ease of administration. Those who are entitled, are easily identified by the system in the same way that child benefit is universally paid and it is easy to identify those who should receive it, those who should pay into the system are easily identified through the tax system. Despite all of those powerful convincing arguments coming from practical and theoretical perspectives, arguments that the proposal remains a text book phenomenon if you like, it remains a radical proposal and that is where it stays. A radical proposal, not yet endorsed fully, nor implemented and that led me to question 'why?' Well I think it is pretty obvious in today's culture of caution and restraint with regard to public expenditure the immediate question is, "How much is this going to cost?" OK now we can talk about that again in panel discussion but I don't want to engage in cost consideration so you may say well what is the point of talking about this proposal if we don't have any real costings we are not going to get it passed, if we don't consider the financial considerations then the policy will remain a radical proposal.

I think we have a step to take before we get to talking about implementation and costs and that step is to further strengthen the justifying arguments for a Citizens' Basic Income and this is where I think that thinking out of the box is important.

The second big argument put against a Citizens' Basic Income relates to the work incentives/disincentives debate. Now we know that that basically dominated social security policy at least over the last 15 years – that the focus was on creating

incentives to work and save, and removing the disincentives to work and save from the system. So with that in mind I looked to see what was it that was informing those particular 'against-arguments' and what made those 'against- arguments' so powerful compared to the very convincing 'for-arguments' and it led me to the conclusion that paying people an exchange for what is perceived to be doing nothing is highly unlikely given the value modern society attaches to work. Therefore, the political will – imagine the headlines – 'Politician/MSP argues for basic income to be granted to all in exchange for nothing' – you can just imagine the kind of response you are going to get and the debate in Chamber on that kind of statement.

So that then takes me on to the next stage of exploring Citizens' Basic Income and that is why I have got 'perceived'. What it is we mean by 'nothing'? And what is it that people do and what kind of activities is it that we value in terms of our policy responses? This kind of statement rang alarm bells for me in terms of my own academic perspective, as an economist and as a feminist economist I regularly criticise my own discipline for being too narrowly confined with regard to what we value as economic activity. So that is where feminist economists try to think out of the box. Now we all know how economists respond to, 'What do you define as economic activity?', it is that kind of activity that takes place within a regular production/consumption exchange pattern so we can attach a price to it because we have some kind of tangible output.

Now upon further investigation of the Citizens' Basic Income literature I found that particular way of thinking dominating the debates. The dominant focus within the literature was on analysing the impact the Citizens' Basic Income would have on labour market participation rates. For me that stems from an unyielding attachment to mainstream economic analysis within debates focused on social security reform. Now go back to what Mike says earlier for me that represents the challenge in terms of thinking out of the box and challenging the norm, to try and move beyond those confining parameters of mainstream economic analysis.

I got a bit suspicious on looking at the Basic Income literature at this stage, thinking that what we value is a particular set of socially constructed norms about how we should behave rather than how we could behave or how we could respond to policy. I therefore came to the conclusion that the Basic Income literature was biased – biased in the sense it privileged a socially constructed analytical framework and that socially constructed analytical framework was dominated by mainstream economic analysis about how a capitalist economy should operate and that is where I think the big challenge is for you in terms of trying to apply the kind of policy needs of a whole range of disadvantaged groups to this kind of thinking.

I will say a little bit more about how we identify bias. If you think about a Citizens' Basic Income and paid work – now for me the assumptions around this are associated with a particular perspective on how the economy should operate so for me a whole range of benefits associated with a Citizens' Basic Income are sadly being overlooked within the literature and this is where I might grab your attention in terms of thinking about the benefits of the proposal. The benefits of the proposal, outwith the world of paid work, if we can start thinking like that we have got to start from where everybody else is and then challenge that, so if we are arguing for a Citizens' Basic Income within the context of paid work, the assumptions are that the labour market is

the primary source of economic and social well-being for all men and for all women. OK now that is the assumption that we have got that informs current thinking around social security policy, that is the assumption that therefore informs current thinking around a Citizens' Basic Income.

Secondly, all policy should not damage the traditional 'work and pay' relationship but rather should preserve that traditional 'work and pay' relationship. So policy should not act as a disincentive for us to work and save but rather act as an incentive.

And finally, the assumption is that individual welfare is best promoted via the structures and processes directly associated with the world of paid work.

Now like them or not, those three assumptions are implicit within the debate around social security policy in particular but any kind of policy response is focused on targeting economic inequalities. So what I tried to do in my research on the Citizens' Basic Income was to contribute to the debate in the 'for' camp; to look at how I could strengthen some of the 'for' arguments to make the 'against' perhaps a bit weaker. I am a supporter of a basic income but questions of implementation I leave to others so again maybe something that comes up in the debate, I am not concerned about cost considerations at the moment because I have put them to the side, I think there is still work to be done on arguing the 'for' side; much work to be done in terms of the kind of theoretical justification for a Citizens' Basic Income. I think existing debates remain extremely confined within these assumptions and we need to unpick these assumptions that make many people very uncomfortable and that is the challenge that is the thinking out of the box. If you think about these assumptions they inform much of what we do in our daily lives so to start unpicking them leaves you quite vulnerable unless you have got a response that you can lead yourself to and I think Citizens' Basic Income provides you with that tool.

I started to think about how these assumptions ignored the life experiences of many women and that then allowed me unpick those assumptions. So I adopted the gender perspective and I look at how Citizens' Basic Income was argued for and decided that there were two main routes. Those two routes I refer to as the co-modification route or the non co-modification route and it won't be a surprise to any of you that the existing debate is focused around the co-modification route. So I thought I would take the debate down the non co-modification route. Now what does that mean? Right in terms of thinking out of the box, I thought maybe we should start from: 'What is it a Citizens' Basic Income can do for us rather than what it should do?' So I thought I need to discover where this proposal came from; if we are thinking about what it can do just now rather than what it should do for us – what it should do is support the labour market, support incentives to engage in paid work, let's think about what it can do, when we are thinking about what it can do – where did it come from, where was this proposal or where did it emanate from, why did we start thinking about it, why did academics start writing about it?

So I thought initially about locating the Citizens' Basic Income proposal. I looked at it from a historical perspective and there was a real established and heterogeneous tradition of attempts at justifying some form of a basic income. You can trace it right back to Thomas Paine looking at the rights of man, which brings me to another point. Women were completely missing from the debate, even the historical material.

Anyway, most of what was put forward in terms of some form of minimum income guarantee proposal was put forward as a policy response to deal with poverty amidst plenty, some of the issues that Mike was referring to about growing inequalities and capitalist society. So at the onset of capitalist development, minimum income guarantees were put forward as a way to shore up the structures associated with capitalist development to ensure that poverty is addressed through policy responses.

In a contemporary sense the model is presented as an alternative to the kind of Beveridge social insurance model. It meets the needs of a Keynesian demand management welfare policy response but as we all know Beveridge won through for a number of reasons. In terms of contemporary measures it is presented as an alternative to existing policy responses because of a crisis in welfare but throughout that whole period it is viewed within the confines of capitalist production and consumption and you could say that is what we live in, so why wouldn't it be, but again this is where I wanted to question it.

I then get to the point that in terms of what a CBI can do for me it presents real freedom for all, the name of one of Parijs' seminal texts on a basic income is that it provides real freedom for all; it really is an emancipatory measure. So it has a potential then for me to promote both economic efficiency and social justice. Now we can discuss that in the panel discussion about how, but I can think in terms of the 'for-arguments' there is real economic justice/economic efficiency arguments and you can also think of the Anti-Poverty Strategy in terms of social justice arguments. However, if you locate CBI, it is often presented as an alternative to existing social security measures as opposed to a right of citizenship. It is presented within the text as social security reform. You see it in welfare reforms texts in academic papers focused on social policy; it is not viewed as a right of citizenship, it is not talked about in those terms but talked about in terms of an either/or scenario and the 'or' scenario is the CBI with regard to social security policy.

It is thus considered exclusively with regard to the aims and purpose and outcomes associated with current income maintenance measures. So what is it we want current maintenance measures to do? Encourage paid work, right? The whole Welfare to Work Reform Agenda has been around encouraging incentives to work. If we consider a CBI within that remit then we consider it within the goals and outcomes associated with current measures.

I spent a long time thinking about this. We need to think about it in terms of outcomes and aims and perhaps purpose – that is outwith that parameter of current social security thinking.

For me then it becomes truly a radical idea as opposed to a policy reform option and that is what you have to start thinking about. This is a radical idea not a policy reform option, and as a radical idea it allows us to think differently about what a basic income could do for a whole range of individuals, not what it should do for everyone.

Now this then leads me to, 'Where is the bias, and how can I uncover that bias?' If we agree that costs and labour market impact dominate current debates, and I am sure you would all agree with that, then priority will be given within reform debates to measures designed to cut expenditure. If priority is given to measures designed to

reduce expenditure then we are going to be looking at ways of containing the growth of spending and limiting deficit financing. Costs then become a big issue. Now in considering at CBI proposal Thatcher's Government was advised by Christopher Monkton who was at the Policy Unit at Number 10 that it was a worthwhile proposal in terms of costs, and it could be implemented in a cost neutral way. Thatcher said, 'Go away and do the sums and come back to me.' He went back to her and said 'There you go' and she said, 'Great policy proposal, let's go with it.' She went to the Treasury and the Treasury said, 'No, no, no we can't do this because of the way we keep our accounts in the UK, now a CBI proposal would entail the abolition of all relief set against tax as I said, integration of the tax and benefit system. The way we keep our accounts is that relief set against tax don't go down as expenditure but go down as negative revenue. It is money that we don't get in, so it is on the revenue side but it is a minus. If we transferred that all to expenditure, put CBI income its place and all benefit expenditure became expenditure, it would look as though we were spending more money. We wouldn't be spending any more money but it would look as though we were spending more money so the Treasury stalled it and said, 'No you can't do this. It would make us look uncompetitive on a world stage', so Thatcher ditched it.

So costs are important but we have got to think about structures and institutions in terms of thinking out of the box; you have got to bypass the Treasury. Now that is not possible at a UK level clearly and social security policy remains a reserved matter as you all know but I think in terms of this Forum it provides a really exciting challenge to think about how we keep our national accounts in Scotland and is it a policy that perhaps has some future in Scotland or is it a radical idea that has some future in terms of costs?

So costs and labour market issues dominate. So let's put costs aside and think about labour market issues. The focus thus far has been on eliminating adverse incentives; incentives to work and save as we know, so no more acutely than in the UK since 1997 at least with the Welfare to Work reform agenda and Mike mentioned some of the stuff that is going on. I don't know if it is pilot work that is going on in terms of benefit sanctions for not accessing rehabilitation, I don't know how we can put that in place in one area and not in another but that is another debate.

So the Welfare to Work agenda dominates, I think everybody agrees it is about encouraging incentives; encouraging us all to engage in paid work, both with regard to now and in the future in terms of saving for our pension. So policy proposals are evaluated almost exclusively, so if we view a CBI as a policy proposal as opposed to a radical idea, it will be view exclusively with reference to the world of paid work.

Right, now we all know there are powerful arguments to say it promotes a greater flexibility; it gives individuals greater choice as to whether they want to go into education, training, take a lower paid job. The economic issues are removed, if you like, with a guaranteed minimum income. However, the powerful argument about what is to prevent people just staying at home and doing nothing; the arguments we have heard about social security policy for years, leads a lot of those who support a basic income to consider the free rider problem. How do we deal with the free rider, how do we deal with that person who stays home and does nothing? Right? For me that was more evidence of bias because it ignored the life experiences of many

women who stay home and do nothing within that context. Right? So I was led to looking at where the gender in this is and who is being ignored. Women are not a minority and women who do stay home and do nothing are not a minority so I thought about this in terms of within that confining parameter I can identify bias. You have got bias here in that you are ignoring the life experiences of 52% of the population perhaps, so maybe we need to think about where women are in the debate. So I did more searching and yes over the last 15 in the CBI debate more reference to women, with respect to the world of paid work. Now for me as a feminist economist I call that the add women in stud approach so we don't change the tools of analysis we just throw women in. So we have done some women and we think that the policy response and the way that we analyse the policy response applies to the population as a whole. So yes a CBI would help support more women into paid work by providing a safety net but is that the desirable option, is that what we want to do? Again we can talk about that in the panel debate.

That led me to the conclusion which I am sure you have all come across in your area that providing equal rights for groups of individuals does not necessarily lead to equal outcomes. So providing a CBI for women would not necessarily shift the balance of unpaid/paid work, if we are thinking about it purely in terms of supporting women into the labour market. Now we all know that gender inequality in the world of paid work is a big issue at the moment for a range of efficiency and social justice arguments, so ignoring women is not on in my book, you know in terms of our policy responses. So the next thing you want to do is move beyond the bias. And how do we move beyond the bias, yes the CBI could affectively displace the necessity to enter into paid work for many individuals but that is not all it could do. Many who support it said, 'Well it may remove the economics necessity and some people may stay at home and do what we think is nothing but let's think about that nothing and that is let's think about what it means to society and what is means to further economic development. Let's start thinking about value.'

And that is why I called the presentation, 'A question of value'. What is it that we value? So let's move beyond this bias and start valuing a whole range of activities that traditionally we don't. So you look at the basic income literature, I am not the first who has said this, so of course there are attempts to value a whole range of activities and I thought this quote might be useful in terms of highlighting the bias. Dore talks in his article 'A Feasible Jerusalem'[93] about justifying a CBI within the free rider context, the people that stay and home and do nothing, 'A society in which those living quietly on their CBI included not only those who would find it difficult to get a paid job but also a lot of people who have the ability to get a job but choose not to.' His examples, I think, are crucial, 'a budding poet, the passionate bonsai grower and the hyper-political activist'. Nothing there about staying at home and caring for children or establishing relationships, building communities but basically anything that has a productive output. Now yes growing bonsai trees you do for no pecuniary gain I assume, maybe you can get lots of money for bonsai trees if you are good at it, but I am assuming these people do these kind of things because they enjoy them and there is a measurable productive output which does enhance individual and social welfare, if you are a happy bonsai tree grower then I am assuming your family is going to be quite happy because you are happy at your bonsai tree growing and the

[93] Dore, R. 1996, 'A feasible Jerusalem', *The Political Quarterly*, vol. 67, no. 1, pp. 58-63.

same if you are happy at your political activism. The point is the notion of leisure, or the notion what people do for leisure, is being categorised to fit with the modern notion of work – there is a productive output, that can be measured, that can be exchanged in the market place. Now that leaves me to say, 'What do we then undervalue, or what do we not value?' – and the conclusion is that idleness per se is condemned. So there is a difference between idleness and leisure and those who engage in idleness are labelled non-workers with all the negative connotations that that implies. So arguing for a CBI within this framework leads me to think we would end up with the deserving versus the undeserving poor type arguments. So that is where it becomes a policy response and not a radical idea and I don't think we will get anywhere as long as we think about it in those terms.

So moving on to the non co-modification route then. If we move beyond the arguments that focus on costs and adverse incentives, because they are not yet tested, we don't know how much it is going to cost and we know from Monkton's work that it could be cost neutral. We don't know what the adverse affects are. It is hypothetical to assume all of these people once they get their basic income are going to stay at home; it has not been tested so we don't know. There was one particular experiment in North America in the '70s, the New Jersey Income Experiments where they did give everyone a basic income and monitored it over a period of five years to see how people would behave and the only people who decided to stay at home with their basic income were women looking after children, so there is literature there to say that adverse incentive effects were perhaps not as great as the economists would have us believe.

I think we need to start asking the questions about value we attribute to productive versus non- productive activities. The whole range of unpaid activity associated with caring for families is viewed as non work and we subsequently don't value it. Now feminist economists have been working for years to get national accounts to consider unpaid work. It is not happening, but we are still plugging away at it.

If we consider the redistribution of work from the domestic realm to the market place, if we continue to re-categorise all the kinds of things we do so that they fit with the modern notion of work, then society continues to value work. Therefore, those of us who engage in non work prefer to do work because it is what policy is targeted at helping us to do. If we continue to do work, who then does the non-work that used to be done by those individuals who are moving into the market place? Now in mainstream economic analysis any leakage from the economy requires an injection to balance that out. I would argue strongly that what is leaving the domestic economy isn't coming back in anywhere. Men aren't suddenly changing their preferences for paid work and staying at home; maybe some are you can argue with me on that one if you want, but I don't think the evidence indicates that it is happening. A CBI maybe a way of redressing that balance of putting something back into the domestic economy, putting something back into the leakage that is coming out because of this move to the market economy.

Those activities that don't fit neatly into the model have been undervalued by society in general. Now for me, I consider the activities in the domestic economy that are undertaken by women but I think in terms of your interests, your client group, there is a broader perspective here; the whole concept of building and sustaining relationships,

building and sustaining communities requires a significant degree of unpaid work with intangible, immeasurable, unquantifiable outputs – is a CBI a way of rewarding that kind of activity, is it a way of recognising that kind of activity, is it a way of recognising individuals who would normally be identified as non-workers or idlers and more accurately recognising their rights of citizenship?

I came to it because of the work women do. You may come to it from a different angle but I think the provisioning affiliation needs and caring needs of disadvantaged groups would be met by a CBI and we could continue to support that kind of activity to go on in local economies and local communities and that is where I think the challenge lies in terms of Scotland's future and the kind of witty retort I always give when people say, 'But what do you mean paying people in exchange for nothing?' Now relationships are hard work and people need to work at them and we should recognise perhaps that relationships are work but do we want to categorise them as such.

And finally, finally just some ideas for thought.

- Do we want to think about CBI as a reform proposal or as a radical idea? I think we think about it as a radical idea in terms of Scotland's future.
- Do we want to think about it in terms of encouraging active labour market participation? Yes it does, but is this how it should be considered, should we consider it differently? Should we think out of the box that work and income should be divorced, that income should derive from other sources not just work? Right now that is a big challenge; work and income are temporarily separated through the social security system. People are compensated for their lack of access to paid work; should we think about divorcing them rather than just separating them?
- Do we really want to think about offering real freedom for all to choose between work and non- work however we define it, or is it just not a route we want to do down?
- Do we want to recognise that the experience of work for many individuals is not necessarily liberating nor is it welfare enhancing; work can be bad for you and do we want to think about that in terms of inequalities?

So what is it a CBI can achieve? It would allow for greater autonomy in the pursuit of individual life choices but the question remains – is that what public policy wants to do, are we really in the business of producing greater autonomy for many individuals or it is about supporting capitalised economic development within the confines of mainstream economic analysis?

That for me is the big challenge so hopefully I have interested you sufficiently in the proposal for you to ask more questions rather than dismiss it out of court or view it simply as a policy response.

So thank you for your time.

## Max Cruikshank
## Youth worker and health issues trainer

I was very keen to do this session today because one of the aims of the Forum was, in fact, to look at the whole issue of children and young people and drug use and we have hardly touched on that topic and I felt before this finishes it is really important that we do, in fact, address the issue of children and young people as far as drugs are concerned.

The only slide I have got with me is a poem I wrote a long while ago.

Once we learn to listen to young people we will realise they are like mirrors reflecting back to us what it is we have done to them.

Now I wrote that at a time when I was absolutely furious trying yet again to get the voice of young people heard in the Forums that make decisions about their lives and being knocked back again and again so I thought it was quite helpful to reflect on that. We have talked a lot this morning about how if we concentrate on the younger end of the market in terms of children and so on then we might find some of the solutions. But we mustn't abandon young people because young people have reached the point where they have been children, they have been through all that stuff and they have now reached the point where they have got a viewpoint to make. I think it is really important that we listen to it.

Today we are addressing the whole issue of drugs and alcohol and young people. When I talk about drugs, I am talking about all drugs – tobacco, alcohol, prescribed drugs, over the counter drugs, and of course all the illegal stuff and in my experience over 40 odd years working in this field these are all interlinked. People don't just drink alcohol, they don't just smoke, the whole thing is interlinked and when you start working with people who have got drug problems they almost always use all of these drugs and they just interlace them. So I am talking about all drugs.

It seems to me that adults exploit the innocence of young people and children by selling them a whole variety of substances. But there are also lots of other things nowadays that we are selling to young people that badly affect our lives and I think we need to take that into the equation because it is not just about substance misuse; it is about the whole culture that we live in and all the things that are happening around them.

What seems like apparently a quite innocent thing, in fact, impacts on people's lives. It is things like the poor diet, the fast food, the mobile phones, the ipods and the MP3 players, computers, audio equipment and systems and DVDs in young people's bedrooms because we are ending up trapping children and young people at home because we have told them that the world is a very dangerous place, so we have put them in cotton wool and we hide them in their bedrooms with all this fancy gear but that fancy gear can actually access them to a whole lot of really bad influences whether it is pornography or violence or myths about sex and drugs and alcohol and everything else that is not helpful to them. So these things are not all necessarily positive and I think all this is happening at a time when kids should be out there enjoying themselves and having fun and instead we have got the commercial enterprise homing in on that and it seems to me that we have allowed big business almost to take over the upbringing of our children and they are making a fortune out of them and they are not doing a lot of good.

Think a bit about how life progresses, we start off as children and children are innocent. They don't come into the world with any badness in them, they haven't got any prejudices, they aren't sexist, they haven't got any of that kind of stuff. I mean the worse the kids are going to do to you is fill their nappy or piss on you, that is about as bad as it is going to get. And then they grow up through their family and they become children and then young people and by the time they get to be young people they have picked up all the inferences that are around them from their family, their friends, their church or what have you and they have learned an awful lot, particularly about drugs, in their life by that point and then once they grow into adults they then get out there and they try and do their best with what they have learned so far. And they look back at the careers of people who have got addiction problems. They have picked up an awful lot of baggage on the way that they then talk forward with them including all the myths about drugs and so on that then just gets spun on into the future.

So concentrating on drugs alone, I think we have to ask ourselves, 'Who is it who provides young people with tobacco, with alcohol, with all the other drugs?' It is adults, it is adults, we do it, who makes the profit from it? Well the first profiteer, in fact, is the government from the legal drugs, something like about £25billion a year in taxes come from tobacco and alcohol and yet the government is saying they want to do something about this, but they are the first in the line of the big profiteers. They are followed of course internationally by the Mafia or whatever you want to call them a completely unregulated business, 24/7 everywhere, no controls on them and then there are the multi-nationals, the nice guys who sell all the pharmaceutical stuff and so on and again it is all owned and run by adults. And who is it that makes the laws that affect young people, again it is the adults, the laws about what you can and you can't do. They have got complete control on that and who is it that makes the laws which affect young people, again it is the adults. And who is it that denies young people access to really access food, really healthy food and the opportunities for a good education and to accessing really good fun and leisure and healthy things to be doing, again it is controlled by adults.

I ran the biggest youth centre in Scotland 40 years ago. It was an experimental centre to be run by young people, they were to be in charge of it, they appointed me as the manager and that was an amazing thing. The minute I left, five years later, the council decided they didn't want all that nonsense you know and it is now run by the council and young people turn up and do what they are told. And who is it that provides the services that young people need when they do get into trouble – the rehabilitation services; they have troubles with addictions, trouble if they get violent and end up in jail, when they have got problem with mental health, again it is all controlled by adults doing what they think is good for young people.

Virtually everything in the world of young people is controlled by adults. I think that our understanding of drugs, all of us, starts from our childhood, what has been happening to us as we grew up, and the problem with drug use, is that basically it becomes an adult problem. It starts off with kids just dabbling and then they start getting more into it and then it goes on from there and before you know where you are we have got an adult problem. So if we want to find a solution to the adult problem with drugs we need to go back a few stages and work out what is it we are doing with our young people and kids and then we start to get nearer to it I think.

We really need to start to think quite out of the box as was suggested we should do this morning. It seems to me that what we are providing at the moment are adult approaches, because adults are completely in charge of it, we have got adults approaches to smoking cessation classes, but they don't work for young people, so why do them? You need to find a different approach.

We have got adult approaches to alcohol misuse, things like AA and that kind of approach – it doesn't work but we keep repeating it. We have got adult approaches to drugs education and you have got a paper in your hand about drugs education because one of the themes that has come up constantly is that it doesn't work. I don't believe that for a minute. What doesn't work is duff drugs education and we have been delivering that for years by adults thinking they knew what young people needed.

The same on drugs rehabilitation – it is an adult approach – we are delivering services that suit adults but don't suit young people.

And lastly, on the issue of laws. I have appealed all through the debates we have had here that we have to look at the laws that exist to try and deal with the drugs issues, because the laws are not child friendly, they are not young people friendly, they are aimed at controlling adult use and they don't work.

It is very interesting that one of the debates we had was on the drinks industry and I blew my top at the end of it. I was raging at them because what happened was that we had four imminent people from the drinks industry telling us how clever they were. Between them they had managed to find a way in collaboration with the police and the licensing authorities and politicians to stop anybody under 21 getting a drink. That was going to be how to solve it.

And last week in West Lothian they actually launched this – the 21 rule in Blackburn. I was a detached worker in Blackburn 42 years ago. My job was to go out on the streets and meet with young people wandering about, misbehaving, drinking, fighting, this that and the other and my job was to find out what is it that you need and we will find it and we will solve it. Forty-two years on, I drive through Blackburn and it is exactly the same as it was then, because we didn't listen to the young people. We certainly didn't deliver what they needed and what we do instead is that we come along with this crazy idea, if you are under 21 you can't get a drink between 5 and 10 on a Friday or a Saturday. There is a lovely quote in the papers because a reporter went out and met a 20-year old and he said to this guy, 'What do you think about this?' and he said, 'Oh it is not very fair that' he says, 'you know I leave my work on a Friday and I go for a couple of pints and then on the way home I get a couple of cans and go home, but never mind, I will just have to go and buy my drink earlier.' So young people solved it within seconds, they didn't have to think about it twice but the adults are all wandering about and thinking, 'We have knocked it off here guys we have got a 21 age rule and that will solve it' and they have got it wrong again. It is a complete con. It will not work; it is a quick fix and young people have got round it within days. We will all be scratching our heads thinking, what do we do next, well the answer is quite simple – we will listen to young people and we are going to finish at that.

The only other thing I want to say, I did ask Kathleen Marshall, the Children's Commissioner if she was doing this speech what would she want to say, and she said more or less the same as me: that for children on drugs and alcohol, we have to give them things to do, things they can hope for, things they can aspire to, to satisfy their needs for activity and meaning and achieving in life without having to resort to drugs and alcohol.

So that is all I want to say at this point because the whole purpose of this session here was not to listen to Max Cruickshank but to get a dialogue going in this room between the young people that have turned up today and the adults that have come in for the session. So I would like to just open that up now. I have left one paper with you which is about drugs education. My argument is that if people are well informed they can start to make decisions for themselves. We have missed out very, very badly in not reaching parents about alcohol and drugs and all the drug scene so parents are actually perpetuating the problem by perpetuating the myths so that maybe something that you want to take up.

**Scotland's Future Forum**
**New Abstentionists**
**3 April 2008**

## Mike Ashton
## Editor, *Drug and Alcohol Findings*

On the issue of the debate between abstentionists and harm reductionists, there are three points to be made.

The first point is that abstinence is not the same as recovery, and recovery is not the same as abstinence. Beware when you read things. You will find people eliding from one to the other: in one paragraph, they speak about recovery – and that is fine – nobody could be against recovery; in the next paragraph, they are talking about abstinence and drug-free as if the two things were the same. They are not. Those who were at the National Drug Treatment Conference in Glasgow will have heard the person from the mental health field say that in the mental health field recovery is conceptualised, not as a total cure from an illness, but as managing to deal with that illness: yes, you might still feel a bit panicked when you go out of the house, but you have learned how to cope with that and how to deal with it. He offered to the audience there the analogy with the drugs field saying that you could still be using drugs, perhaps you don't have to be abstinent to be recovered. I think that is absolutely right. These two things are not the same, and that is why, when you look at the literature, and you look at the relationship between people's quality of life in or after drug addiction treatment and whether they are abstinent or not, the relationship between those two things is either non-existent or it is loose. In other words, you can have people who are abstinent but miserable and having a terrible life, or you can have people who are occasionally still using drugs and having a good life.

Penny McVey has talked about her experience of 'the vulnerable abstinent', people who had stopped using drugs but whose lives were still constrained by continuing vulnerability, a continuing dependence. They are abstinent, but they are not really recovered; they are not living fulfilled lives, they are not fulfilling their potential. That is why, for example, a major questionnaire called the LEAS Drug Dependence Questionnaire is designed to measure dependence, even when people aren't using drugs. So, these things are not the same – be aware of that. That is message number one.

Message number two is to think about the implications. Addiction is a relationship: it is a relationship between the addict and the rest of the world around them. In particular, their social world is not something inside the addict's head, it is not a dysfunction in there somewhere that can be fixed by putting some chemicals in or by doing a bit of cognitive behavioural training: it is a relationship. If you grasp that concept, you will realise that that person's addiction is as much in our heads and hearts as it is in the addict's head and heart. What are the implications of that? The implications are that people can recover from addiction by changing themselves, of course, but they can also recover when the world around changes because it is a relationship.

For example, when people who have been multiply excluded and widely despised, with everybody looking down on them, nobody wanting to know them, being treated as if they don't matter, suddenly come across someone who treats them as an individual, treats them with respect, treats them as if they matter, treats them as if they can do something with their lives, that is a radical change in the way the world is relating to that person. Time after time in the literature, when people in treatment are allowed to speak for themselves, they talk about these moments when they met that worker who treated them that way. It might not even have been a worker – it could have been somebody else in their lives. This is a radical change in the way the world around them relates to them.

Addiction is a relationship and, by changing the world around the addict, you can cure their addiction, you can lead them to recovery. You can also do the opposite, of course, and this is perhaps the worst bit: you can push them further down, and we do this very effectively across the world. When people start getting into that hole of addiction, we push them further down, and then we haul up the ladder so they can't get out; we take away from them, we systematically dismantle all the things they can haul onto. Imagine that picture: all the things they could haul onto to pull themselves out of this hole they have started to drift into, their homes are gone, they are criminalised, they are stigmatised, they lose touch with their families and no one wants to know them, no one wants to house them, they will never get a job. That is something society does to them, which makes it impossible for them to recover; and then society says, 'You have got a chronic relapsing condition, haven't you?' Of course they have. It is impossible for them to get back on their feet. Burton Exology, an Italian psychiatrist, put this very nicely when he said that we 'close the doors on people': once they become addicted, stigmatised, criminalised, lose touch with all of the things that we all hold onto to keep ourselves normal and sane, we prevent them going back to those things and, of course, you get a chronic, relapsing condition that we call addiction. It doesn't have to be like that, but that is another aspect of the relationship I am talking about. Addiction is a relationship between the addict and the rest of the world around them.

The third point is that detoxification kills – and the better the detoxification, the better it kills. Having done all these things to these people – robbed them of the support that we all rely on to bring ourselves back to sanity and back to a normal life – we say to them, 'Yes, you want to fly, you want to jump off that cliff and fly – that is a noble ambition.' We encourage them to do that. And detoxification without all the things that should be going with it is a bit like jumping off a cliff – and some people smash at the bottom. In one Australian state, as many as one in ten people died within three months of being detoxified. One in ten within three months – that is a terrible death toll. Some people might fly (recover); others will kind of waver. The report of the Scottish Advisory Committee on Drug Misuse (SACDM) says there is no evidence that recovery orientation can do harm. It's right, if that recovery orientation is not of the kind just described; if, instead of encouraging people to jump off that cliff willy-nilly, we help them build up their wings, we surround them with supports, we have skilled people with strong safety nets underneath to monitor what is happening and to put that safety net in the right place if they are going to fall, we secure them some kind of decent employment, some kind of decent housing, mend the relationships with their families. Most of all, try and destigmatise addiction so that they can rejoin

mainstream society and get all the things out of life that others probably take for granted. Until you have done that – or have gone a long way towards that – you are taking a terrible risk with that person because the chances are that they are going relapse. If they are an opiate user, they have totally lost their tolerance level for the drugs, they are going to take them again because their lives have not reached the point where they are stably recovered and many of them will die.

## Neil McKeganey
## The Centre for Drug Misuse Research, University of Glasgow

Mike has ended his talk in a way that is the core of his advice and the advice of many people for what the £600 million drugs treatment industry should be doing, and it is summed up in two quotes from his paper. The first is that we can at least radically alter one aspect of the drug user's social environment: we can give them the drugs they previously had to source by relating to criminals and offering them a socially acceptable role as a patient rather than a junkie criminal. That is something we can do, and we can do it very frequently. Becoming legally maintained is in itself a massive environmental change, but sometimes an incomplete one because patients remain stigmatised, excluded from the mainstream and hampered by the obligations placed upon them.

People have ideas about what drug treatment should be about, but what do the drug users themselves say? The Centre for Drug Misuse Research carried out a survey of over 1,000 drug users in which they were asked what they wanted to get out of treatment. They could say one thing or a number of things. Overwhelmingly, they said they wanted to become abstinent, they wanted to become drug-free; hardly anybody to any significant degree said they wanted to get other things out of drug treatment. That was true across all the different treatments that we looked at: it was true for those addicts treated in the prison and it was true for those addicts treated in the community; it was true for men and it was true for women.

How have those statistics generally been responded to? Predominantly, they would be responded to by people saying, 'You can forget about that, because I would have guessed addicts would have said that if you asked them, but that is not really what they want. It is all entirely predictable: if you ask any drug users what they want, they will say they want to get drug-free; if you ask any cancer patients what they want from cancer treatment, they will say they want to be cured.' That is a way of saying we should just disregard 1,000-plus drug users. Actually, whether they like it or not, more drugs are what addicts are going to get in Scotland. In 2007, the provision of methadone was up to 22,000 addicts. That is an estimate, because we don't actually even know how many addicts are on methadone; we get to that estimate by dividing the total amount of methadone consumed by an average dose, and that gives us a total number of people we think are on the drug. So, here we are, giving a population with a known propensity to become drug-dependent a highly dependent drug, and we are not even bothering to find out how many people are getting it. More than that, we don't actually bother to count how many people are coming off it because all the emphasis is on getting people on it, not getting them off it. And that is irrespective of the fact that the majority of addicts who were surveyed wanted to become drug-free.

What has drug treatment actually achieved? It has some notable achievements. Over nearly a three-year period, a series of measurements of people's heroin use shows that at the start of the study 87% of people were on heroin; after nearly three years of treatment, that was down to 53%. The big decrease was in the first eight months; after that, there is not much notable reduction in people's heroin use. We measured how dependent these people were: the big reduction comes in the first eight months; thereafter, up to nearly three years, there is very little further decrease in the level of dependence amongst those addicts in treatment.

In terms of recovery, it is absolutely crucial to get drug users – recovered drug users – into employment because employment opens up a whole range of opportunities to build a non-addict identity and form relationships with people who are not involved in drug use. After nearly three years of treatment, however, there are fewer people in work than there were at the start of the study, when they started treatment. So, treatment has actually done less well in getting people into employment.

The Centre for Drug Misuse Research has looked at what the drug users felt about the drug treatment services in Scotland, how they evaluated them. It used a thing called the Treatment Perception Questionnaire, which is a validated instrument for measuring what drug users felt about their drug treatments. The mean total score in Scotland for the drug Treatment Perception Questionnaire was 20.08, which is lower than in England, Italy, Spain and Portugal. So, drug users in Scotland think less highly of the services here than do drug users in these other countries. Looking at the scores across the different types of treatment offered, it can be seen that the highest was one-to-one counselling – that was the form of treatment which the greatest proportion of drug users evaluated highly; next came residential rehab, residential detox, then methadone, groupwork and then other substitute drugs. Drug users were asked, 'Do you feel that you are involved in key decisions relating to your care?' Fifty per cent of people said they are not: 50% don't regard themselves as being involved in key decisions regarding their care. The study looked at the prison service, residential clients and community clients. The proportion differs across those domains, but to find overall that 50% of drug users treated in Scotland do not feel involved in key decisions regarding their care is a pretty shocking indictment. It's not entirely surprising, however, if the majority of drug users say they want to become drug-free but what they are predominantly getting is methadone.

What does the future hold? The Essential Care report has been produced, which says we should increase aspirations and put greater focus on recovery. Nobody should feel anything other than acutely uncomfortable that after nearly 10 years and nearly £100 million spent on drug treatment, it is only now that we are discovering that drug users want to become drug-free, or they should be into recovery.

Anyone working in the world of drug treatment needs to ask themselves what they thought they were doing for the last 10 years if only now are we discovering the idea of actual recovery. Advisors to Scottish drugs policy are still reluctant to talk about abstinence, so we promulgate the idea that actually recovery doesn't mean becoming drug-free – that is the service providers' ideology. When you interview the drug users, they have no ambiguity there: they want to become drug-free. The challenge that we face is do we have services that can help them to do that? We don't, and in all probability we won't have, because the Essential Care report has nothing on how we

are going to get people off methadone. Indeed, there is a real possibility that in the light of the changes set out in the Essential Care report we will have even more drug users on methadone, so the 22,000 figure may actually go up even further.

What is actually needed? We need to ensure that everyone and anybody who is on methadone is deriving some positive benefit from it. We should not have social problems. We should not be prescribing to tens of thousands of people on the basis that it is a good idea, as we don't know whether it is a good idea for that individual who is getting that prescription. Where there is no clear evidence that the individual is deriving benefit from methadone, they shouldn't be on it. That goes for any medication whatsoever, and that isn't the case at the present time. We need to deliver on aspirations for becoming drug-free because that is what drug users say they want when they are surveyed.

We need to recognise, however, that turning addicts or drug users into patients may be good enough for us, but it is not good enough for the drug users and it is not good enough for the drug users' families, because the easiest thing of all is to say to a drug user, 'I will give you the drugs that you are dependent on'. That is no accomplishment whatsoever: that is taking someone who is dependent and saying 'I will give you the drugs upon which you are dependent' – and that is not what the £100 million drug treatment industry in this country should be achieving. It should set its sights a good deal higher than that. We also need to ensure that abstinence-focus services of whatever kind work well with harm reduction services. At the moment, they operate in two entirely separate silos for the most part. We should be moving people who have been on methadone, who have attained the much wanted stability, into a drug-free environment because that gives them the opportunity for full recovery, not just stabilised on-going drug use.

Why is that important? Employment here holds the key. We know that getting recovered drug users into employment is critical in terms of their recovery. Unless we are going to persuade employers that they should give employment to people who are currently on-going in their Class A drug use, we are not going to get them into employment. Most employers are going to say, 'Give me people who are no longer using Class A drugs. I will accommodate a certain other kind of drug use, but I cannot bring into my workforce people who are still using Class A drugs because, if I do that, what message am I sending out to all the other people in my workforce?' If the recovery industry thinks it is going to persuade employers that they should take people who are continuing to use Class A drugs because they are using those drugs less frequently than they were a year ago, that is not good enough. We are not going to succeed in getting recovered addicts into employment unless those addicts have actually ceased their Class A drug use. We can tell ourselves that recovery doesn't mean abstinence, but when we do that, we are distancing ourselves from the stated aspirations of the drug users themselves; and, sooner or later, we are going to have to provide services which are focused on getting addicts off drugs, even if we as a treatment industry do not really rate that as a goal.

**Dr Tom Gilhooly**
**GP, Glasgow NHS**

One of the things that is absolutely true and is fundamental to this argument is that if something is dangerous and is going to kill people, we should not do it. It is unethical and it is immoral to say that if methadone is not working for somebody, take them off it, because you are going to kill lots and lots of people: thousands of people are going to die. That is not moral, it is not ethical, it should not happen and we should not be advocating it. We are wasting an enormous amount of energy having arguments when we should be trying to do what we can. It is a big thing and it is a politicised area, but if you try and condense a very complex and difficult thing down to one soundbite, you might get it wrong; and when senior politicians in this country come out and the first thing they say when they take over a party is that they are going to get rid of the methadone programme, they have got it wrong.

Detox has not been studied to any degree. There was the Australian paper that Mike mentioned, and there are two papers published in 2003 – these are the only ones that follow people up for a year after detox. These showed a huge mortality. One was in the *British Medical Journal* and one was in *The Lancet*. One used buprenorphine as a detox drug and one used methadone. It didn't matter: you took people off the drugs and they relapsed and a lot of them died – between 10 and 20% died. To put that in perspective: in a surgical operation, if the mortality is above 8%, they don't do it except in emergencies as it is considered to be too dangerous. Yet, here we are advocating a policy which has a mortality higher than that.

How does that compare to maintenance? A survey was done in Glasgow, looking at just under 6,000 drug users who were in general practice methadone programmes. It looked at hospital records, police records and GP records, and the mortality in that year was 0.75%. So, as the worst possible scenario, it could be 25 times more dangerous to detox them and take drug users off methadone. If someone is not deriving benefit from a treatment, we need to look at the treatment. Let's not just withdraw the treatment and see what happens, because what happens is that a lot of people are going to suffer, a lot of people are going to die.

One of the things I disagree with Mike on is that we cannot get away from the fact that the brains of people who have used large amounts of opiates for a long period of time are changed, and probably changed forever, unalterably changed: the receptors in the brain do not work the same way and they are never going to. That doesn't mean you have to take opiate substitutes or whatever substitute to survive. Some people can manage to do that with abstinence. It is a false dichotomy, because abstinence is a harm reduction message as well, it is just a different modality. Some people can do that. We have to be more sensitive to the individual, see what is going to happen and take on board that they have a fundamental change in their brain which is not going to go away; and any treatment that we design has got to take that into consideration. We must be very careful how we deal with people because there is no doubt that the research that has been done over 45 years says exactly the same thing – every country, every model: it says drug use reduces when you give somebody a substitute, mortality improves, morbidity improves, people's lives are healthier and they are more likely to engage. That is not qualitative research, but rather looks at hard end points, and they all say exactly the same. Are we to ignore that in Scotland? Are we to say that we are not going to look at the research, we are not going to study detox because we might find something that we don't want to see, we might find an inconvenient truth that says that this is actually going to kill lots of our young people? Don't just look at

Sweden and say it is fantastic. It is not fantastic: they have the highest mortality and drug use; they have fewer drug users, but they have the highest mortality in Europe by a long way. We need to be taking into consideration the research; we need to look at doing more research; we need to get the safety right because we cannot ethically and morally continue down this route if it is going to cause young people to die – that is fundamental.

We haven't got past first base in doing the simple things in this country. There is not a uniform access to treatment for anybody who wants it in this country, and that is a scandal because we know it is going to help. It is very difficult to influence the regions. It is very difficult to get buprenorphine out there, which is a much cleaner drug than methadone. It is a substitute. I have got 100 patients in my practice on methadone; I have got 32 on buprenorphine. I hardly ever see the buprenorphine ones: they go to work, they take a wee tablet in the morning and they go to work. They are a self-selecting group: they have been allowed the choice in our practice to say whether they would like methadone or buprenorphine. The ones who have gone on to buprenorphine, generally speaking, either don't do well on it and come back after a week and say it didn't work, it was horrible, or they just get on with life.

A third, or just under a third, of the population in our practice are doing well and are engaging. Employers don't like methadone, but they never test for buprenorphine, so buprenorphine users are quite happy and they go to work and they get on with it, and nobody knows. Society is not going to change: the man in the street is not going to embrace drug users; we have to try our best to do that, but it is not going to happen. We have got to do what we can, and what we can do is produce good quality services; look at the evidence-based research and evidence-based practice, and at the end of the day we will have improved the lives of a lot of people. We will not have turned it round in an Alice in Wonderland type way so that everybody is happy and holding hands and never has a problem, but we will have made a huge difference to this country.

## Jackie Johnston
## Manager, Forth Valley Tox

The debate should not be 'methadone or recovery', as if the two somehow sit worlds apart. The client group should be provided with treatment which ultimately leads to recovery. There is a place in treatment for methadone; however, methadone is not the only game in town. Tom spoke about buprenorphine, and one of the services we provide is a detoxification service that works with people with buprenorphine. It is a very early stage intervention and works with people at a very early stage in their drug use, probably a service that hasn't been available to many people prior to Forth Valley Tox coming along.

Each and every client approaching drug services in Scotland should be provided with a comprehensive assessment that should identify their needs. That comprehensive assessment should be followed by a care plan, which should have a beginning, a middle nd an end; and people coming into treatment should also be coming out of treatment.

The care plan that is provided to people should identify the necessary lifestyle changes. We should then be able to support them to make these lifestyle changes and also help them develop strategies to maintain these lifestyle changes. The most important thing in anybody's care plan is a therapeutic relationship with a key worker.

Currently in Scotland we are collecting evidence that services like this work. Services like the LEAP project in Edinburgh and the Tox project on a much smaller scale in Forth Valley are gathering evidence to show that when clients are provided with the intense level of support that they need, they can make changes to their lives.

There is not enough measurement of the good practice that has been done in Scotland. The current trend is to look to places like Holland and France and Switzerland for what has been done there – and that is despite the fact that we know that our own drug problem is unique to Scotland. The problem with methadone is that, for far too long, far too much has been expected of it. Methadone is simply a substitute for heroin: it doesn't have side effects that improve somebody's parenting abilities, nor does it stop drug users craving heroin. Methadone, in its own right, is an illicit drug; and as long as we have drug squad officers crashing in doors and finding methadone in places it shouldn't be, we haven't got it quite right.

Clients have to identify what they want to achieve from treatment. What is needed in Scotland is an endemic culture change: we need to meet substance misusers where they are at and provide services for them when they are ready to change. Until they are ready to change, we need to provide them with services which keep them safe and also keep our communities safe. That is the opportunity to engage with service users on their territory, providing services that they need.

We can never entirely remove the risk of substance misuse: substance misuse is a risky business and people will die – people will overdose and die. We can't take that risk away entirely, but we must work hard to make sure that we do everything we can to prevent it wherever possible.

We need to provide substance misusers with clean equipment, access to services that will provide them with the advice and information that they need. We can do this by providing harm reduction, starting to meet clients in harm reduction services and delivering motivational services that will encourage them to seek recovery. Methadone can play a part in that, but we must make treatment available.

**Jason Wallace**
**Volunteer, Scottish Drugs Forum (SDF)**

Along with Gordon Wilson and Catriona Doran, who are also volunteers with the Scottish Drugs Forum, I am going to give you a service user's perspective on the issues raised in Mike Ashton's article on the new abstentionists by highlighting some key themes that have emerged from SDF peer-led research. I and other volunteers with the SDF Glasgow User Involvement Group have selected from our research themes which more accurately reflect our own experience; consequently, these views may not be shared by all drug users. The article we wrote highlights what we all know: that research is shaped by funding methodology and that even the most rigorous research studies are open to question and debate, particularly as so much

research is not able to catch or capture drug users who have never received treatment or who have successfully completed treatment. We hope that the response to the paper will add to the debate today.

Some people may not be familiar with the model of service user involvement within the SDF, so I will go through this to highlight that the views and voices we represent are those of drug users and include those who have never accessed treatment, as well as people currently in treatment and also those who have completed treatment.

All the research that we do, regardless of whether it is qualitative or quantitative, is conducted in a groupwork or a one-to-one setting, all with the same aim of trying to influence service provision in the wider drug agenda.

SDF currently has five User Involvement (UI) Groups throughout Scotland, and all are managed and supported by SDF staff, so they are very experienced in their approach in gathering drug users' views. What we are going to do now is give a response to each of the assumptions identified by Mike Ashton as underpinning the new abstentionist movement. We will do this by highlighting data from two pieces of work that have a national UI focus. The review of the role of methadone and treatment of drug problems and recent aftercare research, and two studies which have a Glasgow focus hepatitis C managed care network patient pathway evaluation and some photographs will be included from the Drugs and Poverty exhibition.

Is abstinence good? From being abstinent, you gain stability, improve relationships, improve finances, move into training, education and employment and gain self-respect. However, all these benefits, which may come from being abstinent, were also identified as positive outcomes of effective substitute prescribing by people whom we interviewed.

What is success? Whose success? It is relatively easy to become drug-free; the difficulty is maintaining it; and the key for all treatment is that it is according to the service user.

**Catriona Doran**
You need to feel like it is you making the choices rather than feeling they have been made for you. You do need to feel part of the choices made throughout your life.

**Jason**
There is a need for services to move away from providing the kind of help which is designed to suit their particular working practices to services which are truly responsive to the individual needs of service users, regardless of the choice of treatment.

Focusing solely on abstinence as a requirement for other services such as housing denies people whose short-term goals will never include abstinence the chance to further move on in their recovery. Moving people away from inadequate housing would help to move drug users on to becoming drug-free in the long term.

For some UI volunteers and people interviewed, being on methadone is a form of abstinence as long as they are no longer using illicit drugs. Arguably, many in this

group may aspire to abstinence from substitute drugs in the long term. However, the most pressing challenge for this group is that, while on methadone or any substitute drug, users described feeling more together in themselves, but they were not perceived this way by most people. Although they themselves had made a big change, the perception of those around them – including peers, family, community, media and some workers – was that they were still junkies and that they had merely changed their addiction from illicit drugs to legally prescribed ones.

The challenge for the new abstentionist is therefore where does this group, who already see themselves in the middle but are making progress in their lives, fit?

Where does the point come that recovery ends and you are now classed as drug-free? Surely the criteria for success with regards to treatment should be measured by how individuals feel they have progressed, and not whether they are still prescribed substitute drugs, are smoking the occasional joint or having an occasional drink.

Misleading figures, or figures which are not viewed as favourable by the media and wider society, perpetuate feelings of prejudice and judgemental approaches in dealing with addiction issues, which has a knock-on effect in terms of people accessing services.

**Gordon Wilson**
The issue is not community versus residential rehab, but there is a need for non-medical supports to go hand-in-hand with any kind of recovery plan, whether it is substitute prescribing or an abstinence plan. The priority areas that service users feel they require help with and that are not currently being provided include help with housing and council tax arrears, money and finance advice and information, access to volunteer work, access to education and training.

Poor maintenance management and social stigma are incompatible with leading a truly productive life while on a substitute prescription. Having some choice over their treatment and a flexible approach to the treatment received are key for service users. For them, choice means options over when, where and for how long they receive their prescription, over dosage level and reduction. With regards to flexibility, this means that services must respond to the change in circumstances of a service user. For example, often a big barrier in moving into education and employment is having to collect a daily prescription and the stigma attached to just being on one, rather than the ability to move on.

Recent national User Involvement-led research in aftercare decided that the majority of service users from across all SDF UI groups felt that their needs were not being met in relation to the move on through services, and a consensus emerged that people are pap on methadone.

It is apparent from the work conducted that people feel that maintenance prescribing does have its place and that a range of treatment options should be available. It may not be a suitable option for everyone; however, there are some service users for whom maintenance is the only way forward.

Maintenance prescribing at least means society benefits from reduced crime. However, society would benefit more from curing social inequality than attempting to cure one symptom, and focusing solely on crime figures is doing just that. Instead of focusing on crime, the money would be better spent in getting to the heart of the drug problem in the communities that are most blighted by drug use. So many areas are no-go areas except for the unfortunate residents who have no choice but to live there.

The paradox with drug policy is that committing crime in some areas actually qualifies you for a drug treatment and testing order, which results in more intensive support from the environment relative to other community drug services.

Some areas are better now: there are more and more accessible needle exchanges, naloxone pilot schemes are available in some areas of the country, there are more easily accessible services available for those who wish to access them. There are also more User Involvement Groups starting up all the time, giving service users the chance to make sure that their voices are heard when it comes to the planning and delivery of services. There is also a much wider range of treatment options available to those seeking help such as subutex as an alternative to methadone. Those who are coming to treatment via the criminal justice route now have the option of completing a drug treatment and testing order, rather than just serving another short sentence and returning to where they were.

However, getting more things better requires services to be more accessible and needs-led. Meaningful service outcomes should be about ensuring that more accessible and realistic pathways exist to employment.

A recent survey that a User Involvement Group completed around hepatitis C showed that over half of those questioned had not told anyone about their hep C status. This would seem to indicate that, while things may be changing overall, the drug user is still fearful of being stigmatised within society.

Additionally, it is estimated that 80% of drug users are not aware that they are hep C positive. There is only so much that the drug using population can do; society as a whole, and the drug field in particular, needs to change to see each service user as an individual and not just another statistic; services need to move to a more person-centred approach and take into account the needs of each individual service user to plan their route to a successful recovery and not just deliver the service package most convenient to them.

**Appendix A: List of contributors**

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- Mike Ashton, Editor, *Drug and Alcohol Findings*
- Mark Baird, Programme Director, Scottish Government and Alcohol Industry Partnership
- Jeremy Beadles, Chief Executive, Wine and Spirit Trade Association
- The Honorable Larry Campbell, Senate of Canada
- Max Cruikshank, Youth Worker and Health Issues Trainer
- Professor John Davies, Director, Centre for Applied Social Psychology, University of Strathclyde
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- Gavin Hewitt CMG, Chief Executive, Scotch Whisky Association
- Dr Thomas Horvath, President, Practical Recovery Services
- Jackie Johnston, Manager, Forth Valley Tox
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