



SMMGP Policy update – July 2009

Our attention was drawn this month to the paper by *Glenn Greenwald* for the *Cato Institute*:

Drug decriminalisation in Portugal: lessons for creating fair and successful drug policies.

http://www.cato.org/pub_display.php?pub_id=10080

A new decriminalisation regime was introduced in Portugal in 2001 whereby those found guilty of possessing small amounts of drugs, instead of being sent to jail, were referred to a specialist 'dissuasion commission' which included at least one lawyer or judge, and one health care worker or social services worker. There is one in each health area and this panel can advise on appropriate treatment (or give no sanction or a small fine).

The report by Greenwald finds that, five years on, contrary to the fears of the citizens of Portugal that rampant drug use may follow, there was significant reductions in most types of drug use and rates of new HIV infections caused by needle sharing dropped. At the same time, the number of people seeking treatment for drug addiction 'more than doubled' (source - Time Magazine article Apr 09) and instead of being imprisoned, addicts are going to treatment centres and learning how to control their drug use, or getting off drugs altogether.

The review by the Cato Institute demonstrates - from all the aspects examined - that the exercise has been largely beneficial (the cautious response) or, some may say, a resounding success.

SMMGP comment

SMMGP feel that this is convincing evidence that decriminalising drugs helps people who use drugs and society in general. As has been shown with alcohol, the banning of drugs with criminal sanctions against users is counter-productive and should be abandoned in favour of more effective and health-related ways to manage drugs.

With the UK topping most of the statistics for the equivalent period, by 2006 Portugal had some of the lowest drug use, HIV, overdose and other statistics in the entire EU. They reported no 'drug tourism' which some had predicted.

Additionally they moved substantial resources from policing to treatment and now have a well run treatment system. With the recent reclassification of cannabis it feels as if we move backwards and are set to remain at the top of the worst statistics in Europe regarding drug use and related viral infections, unless we address this.

Let us know if you agree with our view after you read this excellent report.

Dedicated drug courts: a progress report (Acknowledgement to www.findings.org.uk)

The UK Ministry of Justice has produced a framework (modelled on similar in Scotland) of a Dedicated Drug Court system for England and Wales. This scheme piloted specialist courts to exclusively handle cases relating to drug misusing offenders. Two magistrates' courts (Leeds and West London) were selected to use magistrates trained to supervise offenders from conviction and sentence to completion (or breach) of a community order. Despite the pilot sites being promising in terms of having a pre-existing system (Leeds), and staff enthusiasm (London), offender throughput was lower than expected, which in turn raised costs per offender. The evaluation was unable to establish whether the costs per offender was money well spent, and gave no reassurance that the additional money it takes to supervise an offender via a specialist drug court yields benefits to society in terms of reduced crime, or by being cost effective.

SMMGP comment

We acknowledge that there are some good CJS projects - such as IDTS - but after the Portugal example cited in this update, the above evaluation and the emphasis placed on cost-effectiveness, shouldn't we look urgently at all the money going into the criminal justice system and consider redirecting some of it towards health?

Statistics on Alcohol: England 2009: see www.ic.nhs.uk

This wide-ranging report by the Health and Social Care Information Centre presents information on alcohol use and misuse drawn from a variety of published

sources and includes additional information from the NHS Information Centre, all in a user friendly format.

It presents a broad picture of health issues regarding drinking behaviour among adults and children; knowledge and attitudes to alcohol; drinking related costs and ill health and mortality.

Home Office consultation on how alcohol is sold and supplied – last chance to have your say:

Opinion is invited from a range of interested parties (including health bodies and others who have to deal with the impact of alcohol related harm) on a proposed new code of practice for alcohol retailers.

Complete the questionnaire online before 5 August 2009 at:

<http://www.homeoffice.gov.uk/documents/cons-2009-alcohol/>

COMING SOON - RCGP certificate in the management of alcohol problems in primary care - launch event Thursday 24 September 2009 in York.

The certificate is aimed at GPs and other healthcare professionals who deal with the serious impact that alcohol misuse has on mental and physical health.

For more information see:

http://www.rcgp.org.uk/practising_as_a_gp/substance_misuse.aspx

SMMGP comment

Alcohol is such an enormous problem SMMGP welcomes the introduction of the RCGP Certificate and encourages all members to go on the course and bring it to your local areas.

Diversity: learning from good practice in the field (NTA report July 2009)

The National Treatment Agency (NTA) has published a report which highlights good practice in diversity, based on interviews with partnerships that performed well in 2007/08 service reviews.

The report describes the following factors which influence good practice in diversity: fulfilling statutory duties; focusing on diversity as a routine part of needs assessment and equality impact assessments; and reliance on good quality local data and consultation. <http://www.nta.nhs.uk/publications/publications.aspx?CategoryID=39>

Investigation into BME communities Equality and diversity NTA July 2009

http://www.nta.nhs.uk/publications/documents/equalitydiversity_intro_2009.pdf

This report is the result of an investigation into knowledge of drugs and drug services among a range of black and minority ethnic groups in England. It consists of an introduction and five reports covering the following communities: South Asian, Black African, Black Caribbean, Kurdish, Turkish Cypriot Turkish and Chinese and Vietnamese.

Some of the key messages are: drug services need to work locally in order that the heterogeneity of what are described as 'the South Asian / African etc communities' are addressed; cultural competence includes recognising the differences between, for example, Bangladeshis, Indians and Pakistanis: ('what works' for one of these groups may be inappropriate for another); and that there is under-representation in all services of all these communities. Meeting the needs of these communities

not only relies on action by drug service planners, commissioners and providers, but also by the communities themselves. The reports also show that ethnic groups require more and better targeted information and that there is a need to build trust in the confidentiality and the cultural competence of drug services. Adaptation and flexibility are clearly required so that the barriers can be overcome.

The most commonly cited sources of support for drug problems were GPs, private doctors and community organisations, followed by friends and family. GPs were a frequently-cited source of professional help that community members reported (particularly women). In the Chinese, African & Asian communities, GPs are seen as good and knowledgeable persons, but in others concerns around confidentiality were mentioned and also a belief that sometimes they weren't helpful.

SMMGP comment

It is important to read these reports to remind ourselves that things are improving but we need to be aware of our local communities, offer accessible and flexible services and ensure our local population is accessing services as required.

Do you know if your local drug partnerships have undertaken a race equality impact assessment (REIA) specifically relating to substance misuse services?

Nationally, just over half (54%) have done so and only a third have (36%) had consulted Black and minority ethnic (BME) communities as part of a REIA - and less than a quarter have published results.

National Drug Treatment Monitoring System (NDTMS) themed report on patterns of mortality amongst individuals in contact with drug treatment services in the north west of England. *Hurst et al, May 2009*

This somewhat distressing report examines five years of data capture to detail the death of those identified (via the NDTMS system) as having died whilst in contact with structured drug treatment services in the NW of England in the period 2003 - 2008. Results show that between 1st April 2003 and 31st March 2008 there were 504 confirmed deaths of those in contact with treatment in the North West of England.

Analysis of the data indicated that the 176 (34.92%) died of a drug related death (DRD) but the majority of individuals (328, or 65%) died from a non drug related death (non-DRD) as classified by the National Drug Strategy definition of a drug related death. The individuals who died from a DRD were significantly younger and more likely to have stated a history of injecting drug use.

However, closer examination of the deaths identified as non-DRD revealed that a number of those deaths were the likely result of long term effects of drug taking behaviour e.g. deaths from hepatitis C; liver disease (17.99%) with a high proportion of these deaths directly as a result of alcohol consumption (79.66%); influenza, pneumonia other bacterial infections and other respiratory diseases many of which may have been as a result of smoking both cigarettes and crack cocaine; accidents and suicide; malignant neoplasm's with high levels of liver and lung cancer.

The report also mentions the incidence of certain neoplasms within the cohort (one from cervical cancer and two from breast

cancer) and suggests that drug users may not be accessing screening programmes. The report also reveals that those dying whilst in contact with treatment during 2007/08, died at a significantly older age when compared to those who died in 2003/04.

The average (mean) age of all those in contact with treatment in 2007/08 was 33.75 years; significantly older than the treatment population in 2006/07. The proportion of those in contact with treatment aged 45 and older rose from 6.42% in 2003/04 to 11.37% in 2007/08. A growing older population in contact with drug treatment could have public health implications. Data has shown that, whilst there were many disparate causes of non DRD, some were more common than others.

The report goes on to question whether drug use played a role in those deaths identified as non DRDs and suggests that a number of these deaths could be attributed, at least in part, to the individual's drug use.

SMMGP comment

We agree with the report's conclusion that the investigation of all causes of death for those in contact with structured drug treatment is important as a means for greater understanding of risk amongst the in-treatment population. It can also act as a measure of the effectiveness of public health interventions for those in treatment. We are all too acutely aware of the rise in deaths as a result of alcohol use and hepatitis C and the report highlights yet again the need to address alcohol problems of those in drug treatment and the importance of hepatitis C screening. Let us never forget to monitor and treat physical and psychological health of those in treatment, in addition to treating their drug use, which we can do so well in primary care.