



## Alcohol consumption, mortality and morbidity

Full report available at:

<http://www.alcoholconcern.org.uk/servlets/doc/1519>

Professor Martin Plant (University of the West of England, Alcohol Health and Research Unit) was commissioned by Alcohol Concern to investigate what the future may hold given the nation's drinking habits - and associated harms. Professor Plant's research indicates a definitive link between alcohol consumption and deaths in society: the higher the consumption the more deaths occur.

A forecast of our drinking habits reveals how health harms from alcohol may increase in the next 10 years, if our drinking habits continue as over the past 15 years:

- 2009: Alcohol consumption in the UK has increased in recent years to the point where we are among the heaviest alcohol consuming countries in Europe. There are 1.1 million adults across Britain who are alcohol dependent.
- 2019: If current trends continue, and given the average increase in per capita consumption of just under 0.9 litres over the past 15 years, an extra 810 deaths would occur across the UK over the next 10 years. With current alcohol-related deaths at almost 9000 per year (as calculated by Prof Plant's team) this means that 90,800 people will die over the next ten years from alcohol-related causes.

The current Government policy focuses on encouraging sensible drinking among young people; however, Professor Plant's report suggests that the strategy should be to lower **overall** alcohol consumption levels for the whole population, for all age groups.

The research revealed that the highest death rates and the steepest rise since

1990 occurred in the 55-74 year old age group. It is clear from the evidence base that price is the most effective lever to achieve this (see also next item) and the report calls for Government policies to include the introduction of a minimum price per unit of alcohol, especially in off-licences and supermarkets.

It suggests that:

- the Government should consider revising alcohol duty, and that all alcohol products should show mandatory unit and health information.
- brief interventions and advice should routinely be offered in all primary health and social care settings to those that are drinking at unsafe levels, as international evidence shows a reduction in the health care needs and therefore costs if there is early identification by front line services of this group.

### SMMGP comment

Alcohol consumption has more than doubled since 1950, with the rate of increase particularly noticeable since the early 1990s making the UK amongst the highest consumers of alcohol in Europe. There could be multiple social reasons for this startling picture but what we now need are sound public health policies to address this dramatic problem.

Many august individuals and bodies are calling for minimum pricing including the Chief Medical Officer, the Royal College of Physicians and Alcohol Concern. The old accusations of government becoming 'a nanny state' by introducing minimum pricing suddenly seems rather weak when set against the significant healthcare costs that will accrue - and evidence confirms that increasing the price of alcohol is the best way to reduce consumption.

## Model based appraisal of alcohol minimum pricing and off-licensed trade discount bans in Scotland

Meier P et al Uni of Sheffield 2009

[www.findings.org.uk](http://www.findings.org.uk)

This study uses a model developed for England, to estimate the impact of plans in Scotland to prohibit alcohol sold at discount prices and the introduction of a minimum retail price per unit of alcohol.

The findings detail the probable results should the favoured option of £0.40 per unit of alcohol (according to Press reports) be implemented in Scotland.

These are: a 5.4% cut in consumption concentrated among harmful drinkers; lives saved; enormous savings to the health service (nearly £116 million), including workplace costs due to sick days; and reduced criminal justice costs (nearly 3300 fewer offences per year) with 'added value' of lives saved, harm reduction and improvements to health and well being bringing savings to a total of an estimated near £950 million. The Scottish administration seems determined to proceed with a course of action which will significantly reduce alcohol-related harm, but there are currently no plans to set minimum prices in England.

The Scottish Parliament tabled the Alcohol Bill on 25 November 2009 which suggests measures to impose a minimum price per unit of alcohol.

### SMMGP comment

Sadly, despite the evidence, and calls from eminent experts such as Professor Ian Gilmore (President Royal College of Physicians and Chairman, UK Alcohol Alliance), at the time of writing there is strong opposition to the Alcohol Bill in Scotland, and it is unlikely that there will be sufficient support to have the Bill passed.

**The 2009 Drugscope annual Street Drug Trends Survey** indicates that quality in illegal street drugs in most areas in the UK is deteriorating, and suggests

that this may be accelerating a trend toward poly-drug use as drug users consider available alternatives and/or adjust the effects of low quality drugs by 'topping up'.

The survey considered feedback from 70 drug services, police forces, DAT and service user groups in 20 UK towns and cities. The data analysis reveals patterns of use and supply and highlights current trends in the UK's street drug markets. For example, 17 out of the 20 areas reported a drop in the quality of cocaine (powder and crack), with one area reporting a purity level of only 2%.

A drop in quality has also occurred in prescription tranquillisers (particularly diazepam) available on the street, with low quality and fake pills from laboratories in China and South East Asia on the market.

In some areas, the survey indicated that older teens and young adults who use drugs recreationally are combining or interchanging substances including cocaine, ketamine, GBL (gamma-butyrolactone), ecstasy, cannabis and alcohol. For the first time, some concerns regarding so-called 'legal highs' such as GBL (which converts to GHB when ingested) and mephedrone were raised by drug services. GBL is not currently under the Misuse of Drugs Act, but will be Class C by early next year. The survey also records national averages of the prices of street drugs, which were relatively stable as compared to last year.

### SMMGP comment

Drugscope's annual street drug survey provides a useful snapshot of the state of the UK illicit market. Importantly, it also sheds light on emerging patterns (e.g. ketamine and mephedrone use) and some which are likely to provide fresh challenges to treatment providers in the coming year. It's important to monitor levels of purity especially noting increase in purity resulting in overdose risk.

## Shooting Up – Health Protection Agency report *Oct 09*

The Health Protection Agency's essential annual update on infections among injecting drug users in the UK, reports on the figures for 2008.

Key messages are:

- Transmission of HIV and Hepatitis C infection remains higher than in the late 1990s.
- Injecting site infections are common (about one-third of drug users report infections).
- Groin injecting and injecting crack cocaine (associated with higher levels of infection risk) have become more common.
- Needle and syringe sharing have declined in recent years, but sharing of other injecting equipment still occurs.
- There has been a marked increase in Hepatitis B vaccinations – over two thirds of injecting drug users report vaccination.
- Harm reduction services to reduce harm associated with injecting; and support and encouragement for those who want to stop injecting should continue.

Findings in brief are:

**HIV** – Evidence suggests that HIV transmission among IDUs has increased, with 1 in 77 IDUs becoming infected within 3 years of commencing injecting (in 2002 this number was around 1 in 400).

**Hepatitis C** – Current levels of Hep C transmission remain higher than a decade ago, with a fifth of IDUs becoming infected within 3 years of commencing injecting.

**Hepatitis B** – The transmission of Hep B continues and around 1 in 6 IDUs had been infected in 2008. However, vaccinations have increased with over two-thirds now reporting having accepted at least one dose of vaccine.

**Behaviours** – the two practices previously mentioned which are associated with greater risk of infection have become more

common, namely groin injecting and injection of crack cocaine.

Recommendations include that all services (including general practitioners) working with IDUs should provide easy access to a range of information and services such as information and practical advice on safer injecting practices; Hepatitis B vaccination services and diagnostic tests for Hepatitis C and HIV. IDUs should be offered health checks and treatment for injection site infections.

There is a wealth of further information and recommendations in the full report, available [online](#).

### SMMGP comment

Although some good news with regards to HBV vaccinations, most of this report is depressing reading and shows we are not winning against HIV and HCV in IDUs, and there is still much work to be done with regards to sharing.

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## Making it local – strategic drug partnership delivery

From a report by David McKintosh and Sarah McGrail for London Drug Policy Forum, *Oct 2009*.

Against the increased emphasis on localism and personalisation, this interesting report examines current and future roles of local partnerships in delivering the outcomes of the 2008 Drug Strategy. It highlights the challenges partnerships face in embedding drug treatment delivery in communities, and impacting positively on everyone's quality of life in the neighbourhoods where they live and work, whilst also addressing the needs of young people and linking in with other mainstream services (e.g. mental health).

The project's principal findings were that partnerships faced a range of challenges to working together, including:

1. Structure and positioning – the major emphasis placed on treatment where

the primary focus of Joint Commissioning Groups is on the crime elements of the strategy, squeezes out housing and social support.

2. Local influence and links to Local Strategic Partnerships – these were found to be few and far between.
3. Relationships with stakeholders and key partners – the report lists many examples of key partners whose contributions are needed to deliver the drug strategy effectively – but who never (or rarely) make it to the drug strategy discussion table.
4. Relationship with communities and residents – community perceptions as a measure of progress in addressing drug issues is a frequent yardstick. Working with communities can save both time and money, yet there is often a lack of dedicated resources for community development work.
5. Relationship with elected members – many community elected leaders/members were uncertain of their remit in the light of local funds being directed toward drug treatment and the lack of an integrated policy which includes the serious issue of alcohol.
6. Relationship with central/regional government – it was suggested by partnerships that support from central government focussed too narrowly on treatment and the Drug Interventions Programme.
7. Local strategy – most partnerships confined themselves to the needs assessment requirements for the Crime and Disorder Partnerships and the National Treatment Agency at the cost of developing clear local strategies with e.g. housing and social inclusion agencies.
8. Resources – delivering those parts of the strategy not funded by either DIP or PTB was problematic as it was harder to establish shared objectives locally where routes to mainstream funding is via Local Area Agreements.
9. Performance management and the National Indicator Set -(including Comprehensive Area Assessments) these do not reflect the objectives of the national drug strategy, making it difficult

for local partnerships to generate local performance management frameworks

10. Scrutiny – Locally elected non-executive panels and scrutiny committees are useful to support activities related to addressing problems with substance use, however, this is patchy.

### **SMMGP comment**

Whilst the large central investment in drug treatment in recent years is welcomed, the difficult task of negotiating a way through current funding constructs to achieve a local partnership which best serves **everyone** who lives and works in a community where drugs and alcohol are used, including the users, is the conundrum facing local partnerships.

The report makes recommendations at both local and central levels.

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### **Guidance for the pharmacological management of substance misuse among young people** (available on the NTA website)

The Department of Health/NTA best practice guidance document published last month advocates an organised and systematic approach across children's services.

The document sets out the need for a clear patient pathway (care plan) and rapid information sharing across agencies. It is crucial too to link pharmacological and psychosocial interventions with all other services in the community, particularly mental health agencies. Where assessment indicates a need for pharmacological intervention, it should be based on individually assessed need.

There is a 'roles and responsibilities' section for medical and non-medical practitioners in relation to prescribing of medication to children. Practical application of the guidance is described in detail in the chapters on pharmacological approaches including treatment regimes and prescribing protocols for opioid, alcohol and

non-opioid drugs, benzodiazepine detoxification and management of co-morbidity.

There is a similar guidance document on the treatment of young people in secure environments.

### **SMMGP comment**

This is overdue and tells us to have a systematic approach to working with young people and the only way to work is together in a multidisciplinary way. This is great, but, which is great, but often not what is happening on the ground.

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Transform Drug Policy Foundation (TDPF) have launched a noteworthy new book entitled:

### **After the war on drugs: blueprint for regulation**

This book describes what a post-prohibition regime might look like, including details which propose specific models for legally regulating each type of currently prohibited drug, and includes doctors' prescriptions, pharmacy sales, licensed premises – according to the nature of the drug.

[http://www.tdpf.org.uk/downloads/blueprint/Transform\\_Drugs\\_Blueprint.pdf](http://www.tdpf.org.uk/downloads/blueprint/Transform_Drugs_Blueprint.pdf)

### **SMMGP comment**

As Craig McClure, Former Executive director of International AIDS Society eloquently puts in the foreword of this book, *'the vast majority of the horrific harms associated with drug use – crime, HIV and other blood-borne infections, violence, incarceration, death – are clearly fuelled by the prohibitionist drug policies our government pursues'*.

We cannot improve on his further comment which says *'this is not a radical book, nor does it posit radical approaches to global drug policy. In fact, it point outs, the prohibitionist model is the radical approach, in that it is based exclusively on a moral judgement against drug use and drug users and not on an evidence based approach to reducing drug-related harms'*.

## **Towards effective drug policy: time for an impact assessment of the Misuse of Drugs Act 1971**

Transform Drug Policy Foundation (TDPF) is also making a lobbying call to stakeholders to join them in encouraging the UK Government to develop evidence-based drug policy that is cost-effective and humane – because despite spending billions each year enforcing drug prohibition, the current approach is consistently delivering the opposite of stated goals e.g. heroin use has increase twenty-fold.

Their call is for the UK to take the lead globally by carrying out an objective and independent national assessment which compares the costs and benefits of all policy alternatives. The first step would be an Impact Assessment of the Misuse of Drugs Act 1971 and related legislation.

### **SMMGP comment**

Will you join the call for an Impact Assessment of drugs policy – with the aim of developing the best policy possible?

For more information see [TDPF website](#)

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## **Adult family members and carers of dependent drug users: prevalence, social cost, resource savings and treatment responses**

[Full report here](#) UK Drug Policy Commission (UKDPC) Nov 2009

The timing of this UKDPC report is welcomed as the approach to treating drug and alcohol users broadens to acknowledge the impact on families. It is the result of a 12 month study and findings include:

- Families play a vital role in the resolution of addiction problems
- More focus is needed in the implementation of family interventions and services
- Staff training in mainstream services must include understanding of how

drug problems impact on families and basic information or signposting must be made available.

Key messages from the report include recognition of the considerable, often hidden, burden of supporting relatives with drug problems, both emotionally and financially (affecting nearly 1.5 million adults). It recognises the important role that families can play in reducing harms associated with drug misuse, and the positive contribution they can make when problematic use is addressed and the user wishes to make changes to their behaviour and lifestyle.

### **SMMGP comment**

It only takes a quick look at some of the many blogs on the internet to find out how the families of people who use drugs and alcohol are affected by problematic use. The suggestion that we recognise that they need help and support in their own right is welcome. With greater understanding of treatment, family members can contribute to positive outcomes for the person seeking help and advice.

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## **NHS as preferred provider and implications for commissioning**

An important letter from the NHS Chief Executive went out to all SHA and PCT Chief Executives during October. It sets out, from a speech made by the Secretary of State, and a subsequent letter sent to the general secretary of the TUC, the core principles that commissioners are expected to follow when engaging with NHS providers. You can read the letter [here](#) or read more about commissioning on the SMMGP [forum thread](#)

### **SMMGP comment**

The trend in recent years to retender services, which often resulted in uncertainty, destruction of good as well as poor services and more importantly upheaval to patients and staff, has been a cause of concern and much discussion. This directive can only benefit the situation

by redressing the balance towards preserving NHS services, sadly too late for many. We hope that the contents of this letter will be taken notice of and areas will consider what they have and perhaps slightly alter or offer help to improve before destroying existing services that work well.

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## **International Doctors for Healthy Drug Policy (IDHDP) news!!**

The idea to establish an international doctors' group - now called the International Doctors for Healthy Drug Policy (IDHDP) and which started as a result of a meeting in Bangkok at the 2009 IHRA conference and reported in an earlier Policy update, is becoming a reality - more news in due course! In the meanwhile, we are receiving interesting bits of news from doctors in other countries such as:

### **Methadone program opens in Vietnam**

Methadone maintenance treatment started in Ha Noi on World Aids Day with the first cohort of seven young men being treated in a clinic in a Community Health Centre. The next methadone maintenance clinic is due to open next month in Ha Noi and others in 6 identified provinces in February/March next year. There are now more than 1620 patients on methadone in the six clinics in Hai Phong and HCMC.

### **SMMGP comment**

While methadone is getting some bad press (wrongly we feel) in UK, in other countries - such as Vietnam - it is being celebrated because used well, it saves lives.

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[www.smmgp.org.uk](http://www.smmgp.org.uk)