

# **Substance Misuse – Public Health Interventions**

**A submission to  
The National Institute for  
Clinical Excellence  
on the scope of  
Public Health Interventions**

**by The Maranatha Community and the  
Council for Health and Wholeness**

**March 2006**

# **Preface**

## **THIS DOCUMENT**

This document has been prepared in response to the invitation for written submissions by the National Institute for Health and Clinical Excellence. It is in the required format stipulated by NICE for comments on this subject.

This submission is addressed to the National Institute for Health and Clinical Excellence, MidCity Place, 71 High Holborn, London, WC1V 6NA. Tel: 020 7067 5800; Fax: 020 7067 5801; Email: [substance misuse@nice.org.uk](mailto:substance misuse@nice.org.uk); Web: <http://www.nice.org.uk>

## **THE MARANATHA COMMUNITY**

The Maranatha Community is a Christian movement with many thousands of members throughout the country active in all the main churches. Its membership includes a substantial number of people involved in the health and caring professions and in a wide range of voluntary work. Since its formation 24 years ago, it has been deeply involved in work amongst children and young people, people with drug and alcohol problems, the elderly, the disabled and the disadvantaged. It has taken the initiative in a broad range of projects directly contributing to the health of the nation and it also has extensive international experience.

The Maranatha Community

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The Maranatha Community Trust is a registered charity number 327627.

The Leader and co-founder of the Community is Mr. Dennis Wrigley.

## **THE COUNCIL FOR HEALTH AND WHOLENESS**

The Council is a multi-disciplinary body embracing doctors drawn from a variety of specialist disciplines, nurses and various medical auxiliaries, counsellors, chaplains and others. It has close links with the healing ministry of the Christian church and is involved in a broad range of research projects.

The Council for Health and Wholeness is based in the offices of the Maranatha Community.

Its medical co-ordinators are Dr. Hans-Christian Raabe & Dr. Linda Stalley.

**National Institute for Health and Clinical Excellence**

**PUBLIC HEALTH INTERVENTIONS – SUBSTANCE MISUSE  
 Consultation 13<sup>th</sup> February – 20<sup>th</sup> March 2006  
 Comments on the Scope by 20<sup>th</sup> March 2006**

**Stakeholder Comments**

Please use this form for submitting your comments to the Institute.

1. Please put each new comment in a new row.
2. Please insert the **section number** in the 1<sup>st</sup> column. If your comment relates to the document as a whole, please put '**general**' in this column

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| <b>Name:</b>  |  |
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| <b>Section number</b><br><br>Indicate <b>section number</b> or ' <b>general</b> ' if your comment relates to the whole document | <b>Comments</b><br><br>Please insert each new comment in a new row.  |
| Sections 3;<br>4.1.1 and 4.5.<br><br><b>Comment on nature of vulnerable population</b>  | <p>The guidance will refer to vulnerable populations, as explained in section 4.1.1.</p> <p>It is 'politically not correct' to point out that a significant risk factor in the development of substance misuse is family breakdown and esp. the absence of a father. Children living in single-parent households are twice as likely to live in poverty, they are twice as likely to have a mental health problem, they are twice as likely to have no qualifications when they leave school, they have a 25% increased risk of becoming young offenders and have a 60% increased risk of being a persistent offender, they are 50-80% increased risk of smoking, at least 40% more likely to drink alcohol and 50% more likely to take drugs. (All data from CIVITAS report 'Experiments in living – the fatherless family, Sept. 2002)</p> <p>The cluster of 'symptoms' described here such as young offenders, mental health problems, poverty, being in foster care etc. is strongly associated with family breakdown. The guidance therefore would need to look at the impact of interventions (financial, educational, legal, etc.) to strengthen the two-parent family. To reduce family breakdown is likely to reduce not only the risk of taking drugs, but also the preceding risk factors for drug taking, such as smoking, drinking, poverty, emotional problems, etc.</p> <p>This would therefore be relevant to examine as intervention.</p> |

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| <p>Section 4.2.1.</p> <p><b>Comment on drug prevention models</b></p> | <p>It would be relevant to examine the ‘Swedish model’ for drug prevention. Sweden has probably the lowest rates of drug misuse among all European nations, as indicated by the prevalence of the abuse of cannabis, amphetamines, ecstasy, and cocaine. – see graph in Appendix. (Sources, various annual reports by the EMCDDA, European Monitoring centre for Drug misuse and Drug dependency.</p> <p>While we accept that these are essentially population-based interventions, the resulting impact on the drug problem has been impressive. We would therefore urge NICE to consider the lessons learnt from Sweden regarding drug prevention as summarised below:</p> <ol style="list-style-type: none"> <li>1. A consequent approach aiming at prevention of drug misuse (demand reduction) aiming for a drug-free society as adopted in Sweden can lead to a significant reduction in the prevalence of drug misuse. Sweden has by far the lowest rates of drug abuse of any major European country (see graphs in Appendix)</li> <li>2. Sweden’s drug policy is based on the goal to create a drug free society. Drug prevention, education and the criminal justice system are aimed towards limiting any use of illicit drugs. Public opinion strongly supports this approach.</li> <li>3. A strong consensus in politics, education and public opinion to aim at a drug-free society leads to significantly lower drug abuse than the harm-reduction approach used in the UK.</li> <li>4. Sweden’s drug policy used to be liberal in the 1960s, basically reflecting a harm reduction approach. Following this, drug misuse escalated significantly. However, in the late 1960s, Swedish drug legislation became restrictive until the goal of a drug free society was officially adopted in 1978.</li> <li>5. The Swedish drug policy is formulated around the gateway hypothesis, i.e. cannabis use is associated with “harder” drug use. Efforts are therefore focussed on preventing cannabis use since this is frequently the first illicit drug experimented with. The dangers of cannabis are strongly emphasised in education.</li> <li>6. Low use of cannabis (like in Sweden) is associated with a low use of other illicit drugs whereas high use of cannabis (like in the UK) is associated with a high use of other illicit drugs including cocaine, amphetamines and ecstasy.</li> <li>7. Taking a soft stance towards cannabis is likely to lead not only to an increased abuse of cannabis, but also to a steep rise in abuse of other illicit drugs such as cocaine, amphetamines and ecstasy. We maintain that the recent downgrading of Cannabis was a grave error.</li> </ol> |
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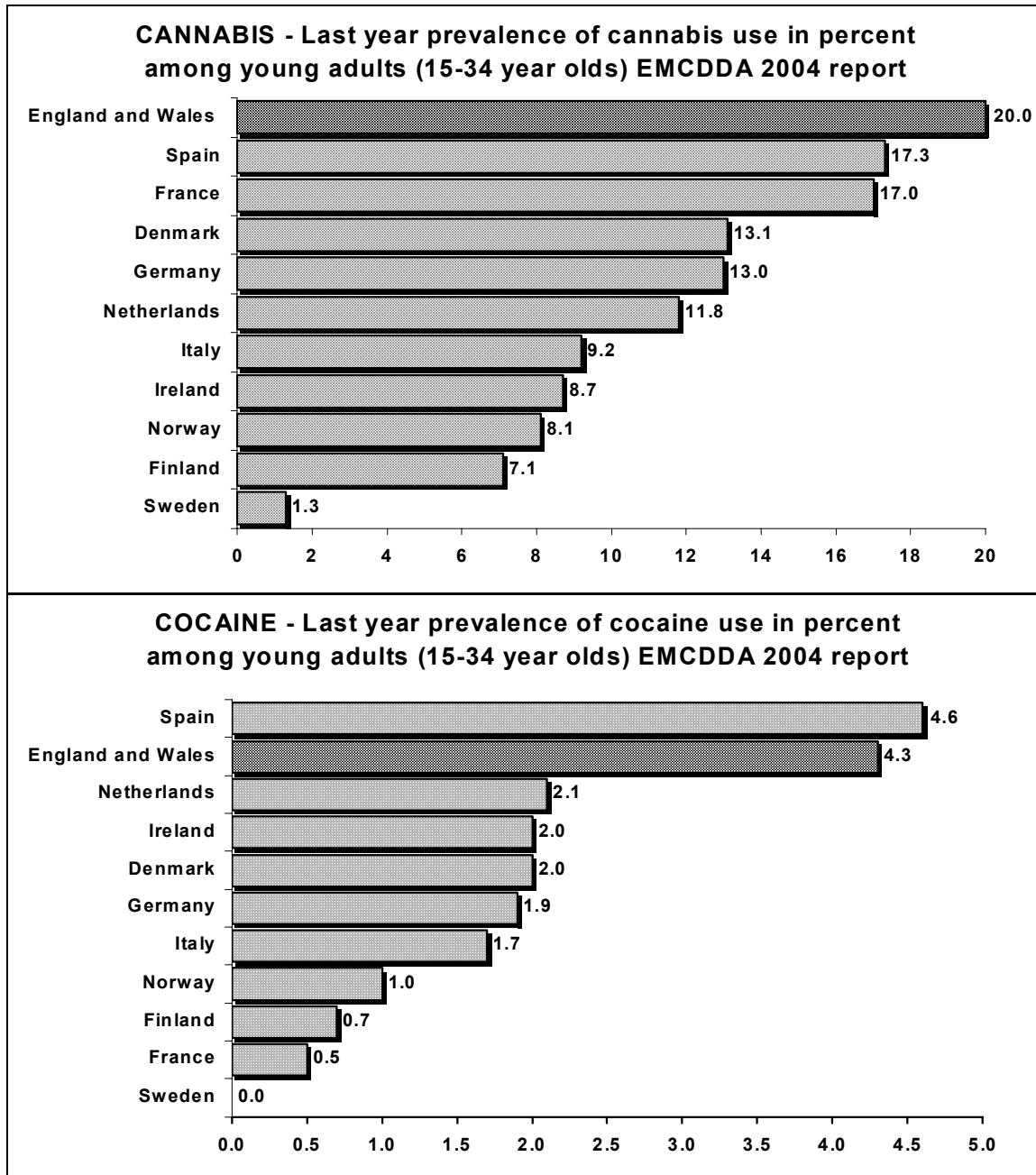
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| <p>Section 4.5</p> <p><b>Comment on drug education interventions; drug prevention vs. 'harm-reduction'</b></p> | <p>Regarding the interventions it would be helpful to examine different approaches to drug education, keeping in mind that there is a difference between harm reduction and primary prevention. A lot of drug education material is based on harm-reduction, starting essentially from the assumption that young people are going to take drugs anyway, we might as well teach them how to do it safely. However, this is essentially encouraging – rather than preventing – drug misuse. One of the phrases that is used in the harm-reduction approach is the statement, that children should be given 'informed choices' regarding their behaviour, including drug taking. However, drug education material needs to discourage young people from taking drugs, not offering them a 'choice' whether or not to take drugs!</p> <p>We would like to make the following comments about the difference between these approaches (drug prevention vs. 'harm-reduction') and urge NICE to consider this when assessing the effectiveness of drug education material or recommending drug education material.</p> <ol style="list-style-type: none"> <li>1. Harm-reduction may have its place where a drug addiction is an established pattern. However, Harm-reduction, which essentially normalises drug misuse and has no place in drug education in schools, where the majority of pupils do not use drugs. In this context, 'harm-reduction' actually encourages rather than prevents drug misuse.</li> <li>2. An example for this is the drug education pack 'Taking Drugs Seriously', which is presented as 'A Manual of Harm Minimising Education on Drugs'. It states: <i>'This pack starts from the position that drug use is a part of some young people's lives and will not be prevented by education.'</i> One of the aims is <i>'developing the skills of safer drug use'</i>; It includes lessons which suggest that children role play being a drug dealer. or cover tips on how to react when confronted by the police over drugs possession. (Taking Drugs Seriously - A Manual of Harm Minimising Education on Drugs, Healthwise, 2000)</li> <li>3. Further examples of drug education material based on harm-reduction downplaying the risks of drug taking are the examples of the recent Lifeline publication <i>'Cannabis – frequently asked questions'</i> where it states <i>'Is cannabis completely safe? That the answer to this question is 'yes'</i> The leaflet claims that cannabis <i>'is one of the safest drugs known to man'</i> Among the 'tips for managing cannabis abuse' one finds advice such as: <i>'Avoid regular heavy consumption. Have days when you don't use,....'</i> The message therefore is not that cannabis is illegal and one should not use it at all. Instead we are advised: <i>'Be discreet when buying, carrying or using cannabis'</i> - therefore almost encouraging use and giving advice on how not to get caught.</li> <li>4. The Home Affairs Committee in their inquiry The Government's drugs policy – is it working? were highly critical of some of the drug education material presented to them. Another Lifeline publication <i>'How to survive your parents discovering you are a drug user.'</i> gave the advice: <i>'don't get caught in the first place.'</i> There was 'drug education material' which gave advice on how to roll a joint. A DrugScope leaflet pictured two young men in a cannabis field wearing police helmets with the message <i>'Have fun – take care'</i>. (Home Affairs Committee, The Governments Drugs policy: is it working? 2001-2002 vol III; Ev 149)</li> </ol> |
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| <p>Sections 4.2.1 and 4.5</p> <p><b>Comment on community based interventions – the role of spirituality.</b></p> | <p>As a Christian Community, we need to point out that drug taking has a spiritual dimension. For example, many young people who take drugs start because of (emotional) pain, trauma, problems with poor self-esteem, issues to do with boredom or lack of meaning in life in addition to the above-mentioned risk factors. This is especially relevant for individuals from vulnerable groups. Studies have shown that religious commitment, religious involvement or being part of a religious community significantly reduces the risk of alcohol, nicotine and drug misuse and reduces the risk of depression and suicide. We therefore would encourage NICE to look at studies involving spirituality and drug prevention.</p> <ol style="list-style-type: none"> <li>1. Spirituality and drug prevention. Lack of religious commitment is a risk factor for drug abuse. A review of nearly 40 studies found that people with higher levels of religious commitment were less likely to become involved in substance abuse. Another survey of almost 14,000 U.S. youths found that analysis of six measures of religious commitment and eight measures of substance abuse showed religious/spiritual commitment was linked with less drug abuse. In this study, the measure of "importance of religion" to the person was the best predictor in indicating lack of substance abuse, implying that the controls operating were internalised values and norms rather than fear or peer pressure. (Benson P. Religion and substance use. In: Schumaker JE (ed) Religion and Mental Health. New York: Oxford University Press, 1992: 211-220. Loch BR, Hughes RH. Religion and youth substance use. Journal of Religion and Health 1985; 24(3):197-208.)</li> <li>2. A U.S. national study of 5,000 high school seniors found those who both attend church weekly and report that religion is important to them are much less likely to engage in binge drinking, smoking, or using marijuana, are less likely to carry weapons or get into fights, and more prone to eat in a healthy fashion, to exercise regularly, get adequate sleep, and wear seat belts, researchers found after controlling for sociodemographic factors. Relative to their peers, religious youth are less likely to engage in behaviours that compromise their health, suggesting that religious resources may serve as a potentially important, often overlooked, ally in promoting health. (Wallace, J, and Forman, T. Religion's role in promoting health and reducing risk among American youth. Health Education and Behavior 1998; 25 (6):721-741.)</li> <li>3. Confirming other studies showing reduced depression and substance abuse, a study of 1,900 women twins published in the American Journal of Psychiatry found significantly lower rates of major depression, smoking, and alcohol abuse among those who were more religious. (Kendler KS, et al. Religion, psychopathology, and substance use and abuse: A multimeasure, genetic-epidemiologic study. American Journal of Psychiatry 1997; 154: 322-329.)</li> <li>4. Parallel to reducing use of illicit drugs, spiritual/religious involvement similarly predicts fewer problems with alcohol. A systematic review found 86 studies that examined spiritual/religious commitment and alcohol use. Some 88% found lower alcohol use/abuse among the more religious, including the high-risk group of adolescents and young persons. (Koenig HG, Larson DB. Religion and mental health: evidence for an association. International Review of Psychiatry 2001; 13:67-78. Amoateng AY and Bahr SJ Religion, family, and adolescent drug use. Psychological Perspectives 1986; 29: 53-73.)</li> <li>5. We would encourage NICE to study the initiatives taken by the US Drugs Czar, John Walters, to join with faith-based communities to prevent drug misuse. (Press Release, Office of National Drug Control Policy, 10 July 2003 – link <a href="http://www.whitehousedrugpolicy.gov/NEWS/press03/071003.html">www.whitehousedrugpolicy.gov/NEWS/press03/071003.html</a> )</li> </ol> |
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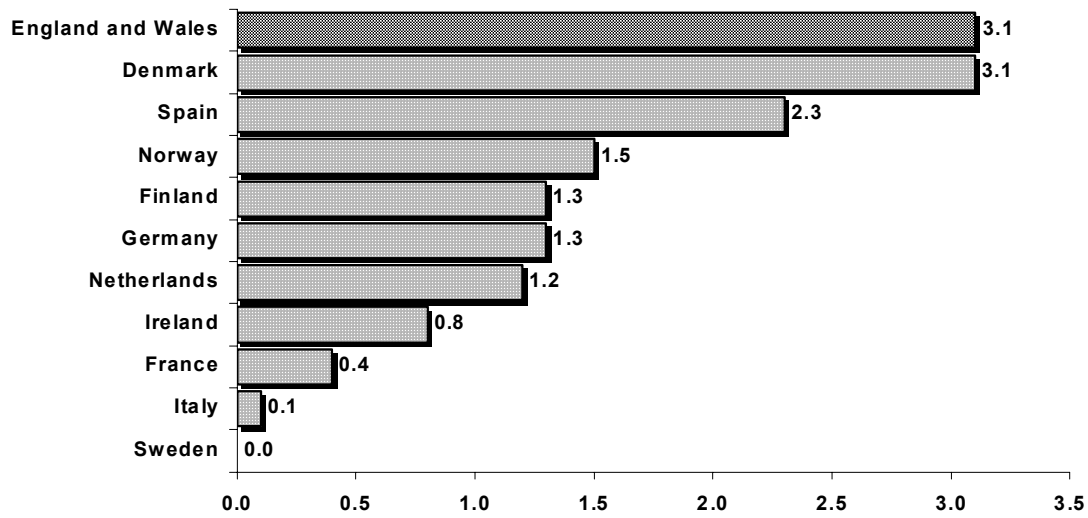
## APPENDIX

### Last 12 month prevalence of illicit drug use among young adults aged 15-34 among European countries.

Data taken from the 2004 Annual Report of the European Monitoring Centre EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) The data from England and Wales are based on the 2002/2003 British Crime Survey.



**AMPHETAMINES - Last year prevalence in percent among young adults (15-34 year olds) EMCDDA 2004 report**



**ECSTASY - Last year prevalence of ecstasy use in percent among young adults (15-34 year olds) EMCDDA 2004 report**

