

parisons with the rest of Europe are often based on data from a few cancer registries which do not completely cover the countries concerned and cannot validly be extrapolated to whole countries.<sup>4 12</sup> This crucial underpinning of policy needs to be given priority. Health care has taken the lead in calling for evidence based decisions; government policy likewise needs to be determined by a firm knowledge base.

Heather O Dickinson *senior research associate*

North of England Children's Cancer Unit, Department of Child Health, University of Newcastle, Newcastle upon Tyne NE1 4LP (heather.dickinson@ncl.ac.uk)

- 1 Office for National Statistics. *Mortality statistics: cause. England and Wales Series DH2*. London: Stationery Office.
- 2 Coleman MP, Babb P, Damiecki P, Grosclaude P, Honjo S, Jones J, et al. *Cancer survival trends in England and Wales 1971-1995: deprivation and NHS region*. London: Stationery Office, 1999.

- 3 Department of Health. *Saving lives: our healthier nation*. London: Department of Health, 1999. www.ohn.gov.uk/ohn/ohn.htm
- 4 Coleman MP, Esteve J, Damiecki P, Arslan A, Renard H. *Trends in cancer incidence and mortality*. Lyon: International Agency for Research on Cancer, 1993.
- 5 Office for National Statistics. *Cancer Statistics: Registrations. England and Wales Series MBI*. London: Stationery Office.
- 6 Quinn M, Allen E. Changes in incidence of and mortality from breast cancer in England and Wales since the introduction of screening. *BMJ* 1995;311:1391-5.
- 7 Gotsche PC, Olsen O. Is screening for breast cancer with mammography justifiable? *Lancet* 2000;355:129-33.
- 8 Richards MA, Stockton D, Babb P, Coleman MP. How many deaths have been avoided through improvements in cancer survival? *BMJ* 2000;895-8
- 9 Peto R, Lopez AD, Boreham J, Thun M, Heath C. *Mortality from smoking in developed countries 1950-2000: indirect estimates from national vital statistics*. Oxford: Oxford University Press, 1994.
- 10 Stiller CA. Aetiology and epidemiology. In: Pinkerton CR, Plowman PN, eds. *Paediatric oncology: clinical practice and current controversies*. 2nd ed. London: Chapman and Hall, 1997.
- 11 Expert Advisory Group on Cancer. *A policy framework for commissioning cancer services*. London: Department of Health, 1995.
- 12 Berrino F, Gatta G, Chessa E, Valente F, Capocaccia R, and the EUROCARE Working Group. Introduction. The EUROCARE II Study. *Eur J Cancer* 1998;34:2139-53.

## Dilemmas and choices in facing the drugs problem

*"Being truthful about drugs ... must remain the foundation of drug policy"*

This week the Royal Colleges of Psychiatrists and Physicians, with help from the Joseph Rowntree Foundation, have published a most important book on national and international problems caused by the use of illegal drugs.<sup>1</sup> Targeted at general readers, *Drugs: Dilemmas and Choices* aims to stimulate a long overdue rational debate on illegal drugs rather than come up with any solutions. But its authors have not shied away from making firm recommendations on law enforcement policies, treatment, and education.

The working party that wrote the book included doctors from several specialties along with a lawyer, a sociologist, a teacher, and the chief executive of the Standing Conference on Drug Abuse. They consulted a wide range of experts and met members of the independent inquiry into the Misuse of Drugs Act, which was set up by the Police Foundation and also reported this week (recommending more emphasis on the health aspects of drugs.<sup>2</sup> It is perhaps this multidisciplinary approach that has led to such a comprehensive and academically rigorous text.

The authors are clearly concerned that they will be misrepresented as being "soft on drugs." Is it, for example, sending a wrong message to juxtapose the annual numbers of deaths in the United Kingdom attributable to various illegal and legal substances: none due to cannabis, about 20 to ecstasy, many hundreds to methadone and heroin, and about 30 000 to alcohol? The book provides extensive evidence that alien drugs or new formulations of older drugs have tended "to excite attention disproportionate to the harm they cause." This assertion will not reassure parents who go on to read its detailed discussion of the apparently inexorable rise in use of these substances.

In 1997 three quarters of the United Kingdom's estimated £1.4bn expenditure on tackling drug misuse was spent on national law enforcement and efforts to lessen international supply.<sup>3</sup> Yet the price of street heroin is falling and its purity rising.<sup>4</sup> The book gloomily predicts that attempts to curb the trade in cannabis,

amphetamines, cocaine, and heroin will be as unsuccessful in the future as in the past 30 years. It also raises the possibility that failure to combat the criminal consequences of drug misuse will eventually force a radical review of international legislation.

The working party calls for a shift of some of the money spent on restricting the supply of drugs (which is failing to achieve its aims) to treatment, which accounts for about 13% of the expenditure on drug misuse. There is now good research evidence for the efficacy of treatment programmes for those addicted to heroin.<sup>5 6</sup> However, "the biggest failing in Britain's drug services is the persistent failure to evaluate ... treatment approaches adequately or to develop practice in response to evidence of efficacy, with training lagging far behind research findings." This situation should be improved by the recent guidelines from the United Kingdom departments of health.<sup>7</sup> Interestingly, those who produced the guidelines considered it necessary to spell out the instructions of the General Medical Council that it is "unethical for a doctor to withhold treatment from any patient on the basis of a moral judgement that the patient's activities or lifestyle might have contributed to the condition."

Britain spends almost as much on drugs education as on treatment. Once again, the working party complains about the dearth of scientific evaluation: indeed, the best available evidence suggests that the methods used in Britain do not prevent drug misuse.<sup>8</sup> In the United States more elaborate educational programmes, with multiple components including involvement of families, can claim success in reducing drug use,<sup>9</sup> but any adaptation of these methods for use in other countries will require its own evaluation.

Nevertheless, there is one simple educational intervention that could be tried without evaluation. On the assumption that knowledge about a problem is desirable, educational authorities should flood secondary schools with this book. Parents would need no encouragement to read such a well written book and to

discuss it with their children. There is, in fact, some evidence that children (albeit from a different culture) can influence their family's knowledge of mental health issues.<sup>10</sup> The parents who are challenged by this book will include heavily drinking dads who condemn all illegal drugs; general psychiatrists who are at times driven to distraction by drug addicted patients but are not providing the best available treatment; and some journalists whose simple approaches to complex problems stifle rational discussion by policymakers.

Nobody is going to disagree that being "truthful about drugs and their effects must remain the foundation of drug policy." But there may then be no option but to face up to the end of the quotation: "even if it sometimes results in greater acceptance of drugs and more widespread drug use." The authors of *Drugs: Dilemmas and Choices* seem to have done their best to give readers the whole truth and nothing but the truth, but they are hampered by inadequacies in the scientific research on treatment, education, and international and national drug control. Even if all the very obvious research questions were answered there would still be disagreement about every aspect of the drugs problem. Nevertheless, every responsible (and irresponsible) adult and teenager in Britain could do worse than to

take this book as their starting point from now on as they debate some of these major problems of our time.

Anthony Pelosi *consultant psychiatrist*

Hairmyres Hospital, East Kilbride G75 5RG

- 1 Working Party of the Royal College of Psychiatrists and the Royal College of Physicians. *Drugs: dilemmas and choices*. London: Gaskell Publications, 2000.
- 2 Police Foundation. *Drugs and law*. London: Home Office, 2000.
- 3 HM Government. *Tackling drugs to build a better Britain: the government's ten-year strategy for tackling drug misuse*. London: Stationery Office, 1998.
- 4 Strang J, Gossop M. Heroin in the United Kingdom: different forms, different origins, and the relationship to different routes of administration. *Drug Alcohol Rev* 1997;16:329-37.
- 5 Strang J, Marks I, Dawe S, Powell J, Gossop M, Richards G, et al. Type of hospital setting and treatment outcome with heroin addicts. Results from a randomised trial. *Br J Psych* 1997;171:335-9.
- 6 Gossop M, Marsden J, Stewart D, Lehmann P, Strang J. Methadone treatment practices and outcome for opiate addicts treated in drug clinics and general practice: results from the National Treatment Outcome Research Study. *Br J Gen Pract* 1999;49:31-4.
- 7 United Kingdom Health Departments. *Drug misuse and dependence: guidelines on clinical management*. London: Stationery Office, 1999.
- 8 White D, Pitts M. *Health promotion with young people for the prevention of substance misuse*. London: Health Education Authority, 1997.
- 9 Botvin G, Baker E, Dusenbury L, Botvin EM, Diaz T. Long-term follow-up results of a randomized drug abuse prevention trial in a white middle-class population. *JAMA* 1995;273:1106-12.
- 10 Rahman A, Mubbashar MH, Gater R, Goldberg D. Randomised trial of impact of school mental-health programme in rural Rawalpindi, Pakistan. *Lancet* 1998;352:1022-5.

## The new primary care organisations: one year on

*Some successes—but many issues remain to be resolved*

Primary care groups have been with us in England for a year. In that time we have also had a winter bed crisis; a general practitioner serial killer; a new secretary of state; the introduction of NHS Direct and walk in centres; and, only last month, the promise of much greater resources for the health service provided that it can "modernise." How have these events affected the development of primary care, and what are their implications for the future?

Primary care groups attained several successes in their first year.<sup>1</sup> They have become much more corporate: interprofessional working has broken out in an encouraging way at board level, though its progress beyond board level is less clear. They have generally done well in managing their prescribing budgets. And their emphasis on defining and refining primary and community care has made much progress, with the boundaries between general practice and community services now being blurred to the extent that the transition to primary care trusts is unlikely to cause much conceptual difficulty.

Nevertheless, not every aspect has seen such progress. Most primary care groups have not been greatly involved in commissioning, partly because they have been concentrating on getting their own houses in order but also perhaps because purchasing-commissioning does not seem to have had much impact in general. Relationships between primary care groups and their health authorities are mixed, with wide variations in groups' management allowances and in the way responsibilities are apportioned.

These operational issues apply mainly to the English primary care groups, but the conceptual ones

also hold true for Welsh local health groups and Scottish local healthcare cooperatives. Each overseen by their own form of devolved government, these have been slower to rouse and are generally less "driven" than the primary care groups. A real opportunity has been missed in formally comparing the three models.

So what about the future? Firstly, the messages about primary care trusts are now largely consistent, and it is no longer a question of whether to become a trust but when, although the issues of size and configuration remain to be resolved. Most primary care groups seem to be aiming to become level 4 trusts, responsible for providing community services, which suggests that deficiencies in these services are the drivers of change rather than the desire to commission services (as would be the case in a level 3 trust). Nevertheless, many groups feel that more time is needed to consolidate as primary care groups before they are ready to convert to trusts. Secondly, trusts will succeed only if enough clinicians—medical and non-medical—feel sufficiently involved to make a personal commitment to the concept. This will require a degree of organisational development and long term investment outside "core" patient services that has never before been acknowledged or encouraged.

Thirdly, primary care trusts are not the only community based NHS development: NHS Direct and the walk in centres have as yet had little linkage to the rest of primary care, and one of this year's key tasks must be to ensure that these disparate systems come together in a way that meets the need for better accessibility and convenience without destroying the NHS cornerstones of coordination and continuity.