Substance misuse often experience stigma. Would changing the laws on illegal drugs change nurses’ attitudes and result in the delivery of effective care?

Would decriminalising drugs improve care?

In this article...
- The debate on decriminalising drugs
- How nurses’ attitudes can affect the care they give
- Why decriminalising drugs could improve service provision

Introduction
In recent years, the use and misuse of both illegal and legal drugs has increased. The UK, in particular, continues to have one of the highest rates of recorded illegal drug use in the western world, double that of most other European countries (Department of Health et al, 2007). This is despite a rapid expansion of treatment programmes for drug misusers in the past 10 years.

The misuse of drugs remains a crime in the UK and this has been the subject of heated debate for some time. Over 20 years ago, the Royal College of Psychiatrists (1987) said: “Drug problems will not be beaten out of society by yet harsher laws, lectured out of society by yet more hours of health education or treated out of society by yet more drug experts.”

Would a change in the law to decriminalise drug use be beneficial for both patients receiving care and nurses providing it? This question comes at a time when interested eyes – government, health specialist, medical and journalistic – are looking at Portugal, where drug use has been decriminalised for the past decade with dramatic results.

Decriminalisation is not the same as legalisation. The production and distribution of drugs in Portugal is still illegal; decriminalisation simply means that possession is considered a health and social problem rather than a criminal one. It is accepted that it is unrealistic to expect people to give up addiction as a result of legal sanction or coercion, and resources are put instead towards mitigating risk for the individual and the population by harm reduction, treatment and reintegration.

Contrary to some conservative expectations, decriminalisation has not resulted in higher rates of drug use or turned Portugal into a magnet for drug tourists. Instead, there have been recorded reductions in HIV diagnoses, overdose deaths, petty crime and drug experimentation among young people (Hughes and Stevens, 2010). The strategy appears to be working and to have benefited the criminal justice system and wider society.

In the light of this evidence, it would seem a reasonable proposition that reclassifying drug use to encourage it to be viewed as a health problem rather than a crime could also benefit the nursing profession and its patients.

The current UK position
Recently opponents of the status quo have been voicing concerns. The UK government’s position that decriminalisation...
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treatment, and premature discharge
rates for those in treatment
The UK Drug Policy Commis-
sion (2010) revealed that wide-
spread stigma still exists in society and is a
barrier to substance user recovery. In this
report, Professor Colin Blakemore said:
"If the government’s drug strategy is to
succeed, it must first address this very real
barrier of stigma. Our research shows that
the public agree that recovering drug users
need help and support to help rebuild their
lives. But they are also seen as 
blameworthy and to be feared. These
public attitudes spill over into public
services, so we see time and again former
drug users stigmatised and discriminated
against when they try to access services”
(UKDPC, 2010).

However, the culture of care for addic-
tion is changing, with many nurses per-
ceiving substance misuse as more of an ill-
ness than a moral weakness (Grafham et al,
2004). Improvements in attitude have also
been reported in those of younger age or
most senior in grade, as well as among
undergraduates (Rassool, 2006).
New titles such as “substance misuse
nurse” or “addiction nurse” have entered
both the lexicon and job market, which is
surely a sign of acceptance and recognition
that addiction is not just a crime and that
treating it requires a particular skill set.
Nevertheless, many nurses still dislike
and fear substance misusers, describing
giving care to them as the most negative,
unrewarding and unpleasant experiences
of their careers (Peckover and Chidlaw, 2007).

Suboptimal care
Despite an improving picture, continuing
personal discrimination and societal crim-
minalisation means that substance users
receive care that is inappropriate, stand-
ardised, judgmental and ineffective.
Opportunities for change are hampered
by negative attitudes that compromise
learning opportunities and result in nurses
lacking the will to improve their under-
standing of drug use and their skills to care

Nurses’ attitudes to drug users
In cultural terms, many would agree that
the notion of freedom of choice is one of
the defining characteristics of UK society.
We prize individual autonomy, have a
strong sense of democratic rights and no
great love for paternalism.

Philosophically speaking, such a
society would not be expected to seek to
restrict the individual’s freedom to experi-
ment with drugs. Yet, paradoxically, we
accept restrictions on liberty as a method of
ensuring “the greater good” and pro-
tecting the interests of society. Choice over
drug experimentation, therefore, with its
moral and legal facets, produces philo-
sophical conflict, which, of course, has
implications for the nursing profession
(Giddens, 2008).

Nurses, as people raised with the same
values and biases as the rest of society,
undoubtedly have a range of personal
views on the reform of drug legislation.
For some, there is a conflict between their
personal views on drug use and their pro-
fessional responsibilities towards drug
users.

Historically, negative and ill-informed
beliefs about drugs produce negative
and ill-judged reactions to those who use them –
that is, people will subscribe to common
stereotypes (Eliason and Gerken, 1999).
In the past, some nurses have regarded
drug users as weak rather than ill, and cul-
pable rather than victims (Rasool, 1993).
Even more judgemental terms have been
documented, including “immature”, “neu-
rotically impulsive”, “crime prone”, “psy-
chopathic” and “inadequate” (McLaughlin
Judgemental and punitive attitudes to
drug users from nurses have included
notions that: drugs corrupt the young;
drug users represent a threat to society and
should be treated in specialised units; and
drug users should be compulsorily tested for
HIV infection (Carroll, 1995).

More recent research indicates these
attitudes are still prevalent in both nursing
(Bate, 2005) and medicine (Landy et al,
2005), and that stigmatisation of
this group is hampering effective
care and rehabilitation (Lloyd,
2010).

Links have also been found
between these attitudes and drug
users’ reluctance to enter treat-
ment, and premature discharge
for those in treatment
(Rassool, 2006).

The law on drug misuse is a confusing
and divisive issue. There is an inherent
illogicality at the heart of drug legislation
whereby the drugs that have the greatest
potential to harm are not necessarily the
ones controlled by law (Nutt, 2009).

Use of alcohol, tobacco and tranquil-
isers (if prescribed) are not prohibited,
although tens of thousands die prema-
turely each year from their adverse effects
(Working Party of the Royal College of Psy-
chiatrists and the Royal College of Physi-
cians, 2000).

Use of these drugs carry no stigma or
threat of criminalisation, unlike the pro-
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Drugs Act (Room, 2005; Misuse of Drugs
Act 1971). This seems confusing when – as
Dr Nutt did – we look at the proportion-
ality of harm. Famously, Dr Nutt pointed
out that ecstasy use can be compared with
horse-riding in terms of risk; deaths from
smoking and alcohol abuse eclipse both.

Nurses have described caring for
users as their most unpleasant
and unrewarding experience
Conflicts in the legislation
These questioning voices show debate
opening at all levels within government
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(Bate, 2005) and medicine (Landy et al,
for users (McClelland, 2006). Poor training via nursing education programmes and in-service training compounds the problem – and not only in general hospitals. Criticisms have been noted in primary health care, mental healthcare and, particularly, with adolescents (Green, 2000).

Judgmental approaches have been shown to severely hamper health professionals’ ability to deliver primary healthcare and health promotion messages with the sincerity they deserve and require for success (McLaughlin et al., 2000).

The Nursing and Midwifery Council’s (2008) code of conduct states that nurses must not discriminate in any way against those in their care, and must act as an advocate for them. Attitudinal difficulties related to drug use, personal or peer influenced, will lead to nurses being unable to follow their own code of professional conduct (McClelland, 2006).

Service provision
What kind of care do drug users need? The range is vast and the role diverse.

Some care relates to the effects of the drug itself, such as overdoses, obstetric problems, unsupervised withdrawal and psychiatric complications including psychosis and suicide.

However, more often, care needs relate to self-neglect or risk-taking as a result of the drug’s effect on behaviour. Common problems include life-threatening infections, physical injury and accidental injuries such as burns, head injuries and road traffic accidents. Infections and ulceration associated with long-term needle use are also common.

Many practical problems associated with nursing substance misusers are exacerbated by the client group being classed as criminals.

Lack of training may mean health professionals could confuse symptoms of drug-taking with other conditions. For example, cannabis may make someone appear confused, disoriented or frightened, all of which may cause ill-informed practitioners to suspect some form of head injury (Jones and Owens, 1996).

Another area where problems can occur is in nursing patients with coexisting pain and substance misuse, where pain control can be inadequate because health professionals fear patients are faking pain to obtain drugs (Finney, 2010).

Care can also be compromised if nurses fear criminal charges for not giving police the names of drug users, or if families are fearful of disclosing important information about patients’ drug habits (Duffin and McMillan, 2000).

Some of the most demanding nursing work in this field takes place in the community; specialist nurses working in primary healthcare teams are at the forefront of service provision for this client group (Matheson et al., 2004).

Positive attitudes based on cooperation and acceptance, where nursing care is non-judgemental, non-confrontational and accepting of drug users’ autonomy, would enable nurses to fulfil a crucial role in preventing, recognising, screening and managing substance misuse (Gold, 2009).

Conclusion
Nurses could – and indeed should – be care providers, educators, counsellors, therapists, health promoters, researchers, supervisors and consultants for those in their care who misuse substances of any kind (Rassool and Marshall, 2001).

If this laudable aim is to be achieved, a reform of drugs legislation would remove some of the barriers to change. Criminalisation is a powerful stigma and cannot fail to result in discrimination; the current system has an enormous financial and human cost and simply does not work.

Far more productive would be to view drug addiction as a public health issue rather than a criminal justice issue. A good relationship between nurse and client is a high indicator of a positive outcome for clients (McClelland, 2006).

Until legislation changes, nurses will struggle to provide truly appropriate and compassionate care to those whom society considers to be criminals. NT

References
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