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Primary prevention

Common themes

Poverty
Alienation
Lack of public services
Substance abuse in the family of origin
Abuse or deprivation in the family of origin

It is often said that anyone can develop a drug habit and children from the most "normal" families can be affected. Whilst that is true, it is also very misleading, because there is no doubt that some people are at greater risk than others. Some people do seem to have a genetic predisposition, but leaving that aside, there are common themes in the stories of patients presenting at treatment agencies which make clear what the factors are which make someone more likely to develop drug dependence. These are; substance abuse in the family of origin, abuse or deprivation in childhood, an environment of poor or degraded public services, unemployment, poverty, and the alienation which accompanies them. No government which does not address these social evils can expect to deal with the drug problem successfully.
From this, there is a simple four point plan which the average person can follow to minimise the chance of their children developing a drug problem.

1. Don't smoke
2. Drink only within safe limits
3. Spend the majority of your leisure time with your children
4. At election time, vote for parties with credible policies to lower unemployment and deliver adequate education, healthcare, housing and other public services.

Secondary prevention

Harm minimisation

Subject to evidence
Should not be confused with tertiary treatment
Should not reinforce drug use as a reasonable lifestyle option

Secondary prevention means measures used to avoid the complications of an illness once it has developed. In this case, it refers to measures designed to minimise the harm done once someone has decided to use drugs. It is not enough however that the measures are *designed* to avoid harm, they must be shown *actually* to reduce harm and not to do more harm in the process. Good intentions are not enough, actual evidence of benefit is required. In Australia, the evidence is not conclusive for all the measures that have been used.

The availability of clean needles does seem to have controlled the spread of HIV in drug users, but has had little effect on the spread of Hepatitis C because the epidemiology and biology of the latter virus is different. Widespread use of methadone has not had a noticeable impact on the rate at which drug users are admitted to hospital or take overdoses. We continue to see significant numbers of women in antenatal clinics whose pregnancies are seriously compromised by their drug use in spite of efforts to educate young women about health risks.

A good example of the trend to promote measures on the basis of good intentions alone is the proposal for safe injecting rooms to prevent deaths from overdoses. This relies on the erroneous assumption that all overdoses in addicts are accidental, but in fact, 50%-70% of overdoses in addicts are not accidents but deliberate self harm. Therefore, the best that could be hoped for would be a reduction of 30% in overdoses and to achieve even that we would need all addicts in all parts of the country to use a safe injecting room each and every time they inject. This is clearly not going to happen and even if it were, any advantage would have to be discounted by the increase in drug use produced by this apparent official endorsement of the practice. To deny even the possibility of an increase in use under such circumstances is to be disingenuous. One really must wonder if this proposal is not little more than liberal grandstanding

Harm minimisation measures in Australia often become confused with tertiary treatment measures to the detriment of both. Sometimes, measures such as education programs are funded as treatment programs when they are actually attempts at prevention, and methadone programs are often advocated simultaneously as both harm minimisation and treatment.

Australia has more patients on methadone than most Western Nations and yet its precise role has never been defined. If methadone is intended to be a form of treatment, then its success or failure should be defined as whether or not the patients on the program are still using and participating in the drug using lifestyle or not. If it is a form of harm minimisation, then success or failure should be determined by whether it does or does not, reduce the transmission of blood borne viruses and the incidence of overdoses in the target group regardless of continuing use. If the overall incidence of overdoses rises in the target group, then the program is still a failure as a *harm minimisation* measure even if the patients who are compliant actually have low rates of overdose..

If the aim of methadone treatment is not actually to stop drug use, but to educate people in safe injecting practices and deliver good health advice, then it would seem necessary to have as liberal an approach as possible, to contact as many people as possible. The advantage of that would have to be balanced by the disadvantage of increased diversion and illicit use of methadone. If the aim is to get patients to cease their use, then there is no point in providing methadone to people who are continuing their use and lifestyle. That would mean that only patients compliant with treatment should be included and it would not be reasonable to expect such a program to have a significant impact on parameters such as the incidence of blood borne viruses in the drug using population overall. Failure to resolve this dilemma is the major problem with methadone problems in Australia. It is just not possible to have it both ways.

The most disturbing element of “harm minimisation” policies is the way in which they sometimes seem to endorse drug use as a legitimate lifestyle choice. There is a real reluctance to acknowledge that drug use itself may have some undesirable effects, that intoxication impairs the ability to exercise normal responsibilities such as child care, or that dependence on a substance will destroy someone’s life independently of the medical or other problems it may cause.

The most striking example of this trend is the use of taxpayers’ money to support organisations such as NUAA (NSW Users & AIDS Association), a “support group” for active users. This strategy follows some programs overseas in attempting to use such bodies to communicate with users “in their own language” to persuade them to use safe injecting practices and to give them health information. This is a noble aim, but it clearly runs the risk of strengthening the drug using network and providing official sanction to drug use so that any assessment of benefit would have to look at both sides of the equation to determine the net benefit. The possibility that such activities will actually promote drug use is never acknowledged and at the same time there is remarkably little information on what the benefits have actually been. There have been some spectacularly disastrous incidents with people receiving public funding charged with drug dealing, and it is almost inevitable that there are many other as yet undetected cases. This particular program is the silliest and most naïve of the “trendy” initiatives in “harm minimisation”.

Changes to the laws

What problem are changes trying to fix?
What evidence is there that different countries with different approaches have different outcomes?
How do we compare with ourselves over time?
What changes are actually suggested anyway?

Barely a week goes by without yet another “drug expert” or social commentator attracting publicity by a “courageous” call for drug use to be legalised or decriminalised. These people usually argue that the problem is out of hand, costing the Nation huge sums of money and about to destroy the entire fabric of our community. Drastic action is therefore said to be necessary. The problem with such assertions is that they are usually short on the quantifiable problems and benefits of a change in the law. What precisely is the scale of the problem? How much reduction in for example, the incidence of criminal activity could be expected as a result of the proposed change? Is it possible that some problems would actually increase? What would constitute success and what failure? Under what circumstances would the experiment be abandoned?

The lack of answers to these questions reveals that the real motivation for these campaigns is an ideological opposition to constraints on personal behaviour.

Examples are quoted of the success other countries have had with liberal drug policies, with Switzerland and The Netherlands often quoted as examples. However, it is almost impossible to make valid comparisons between countries because every nation collects statistics on things like drug related deaths slightly differently, and societies differ in the way in which they react so that subjective comparisons can be very unreliable. It is

stating the obvious to point out that data which allow a real comparison to be made would be highly politically sensitive. I am not aware of any information which would allow the conclusion that countries which have liberal regimes have consistently better figures for related health and other problems than those which have a conservative approach.

Most of the assertions about overseas experience are misleading. In Switzerland, the program of providing heroin in a controlled manner to addicts is not a generalised legalisation, it is only for patients who have well established dependence and who have proved untreatable by other means. It replaces a disastrous harm minimisation strategy in which drug dealing and use was allowed to occur openly in a park in central Zurich leading to an enormous increase in drug related crime and overdoses. In any case, Switzerland already has an extensive and well resourced treatment network so the heroin program is occurring in greatly different circumstances than we have in this country.

In The Netherlands, the liberal approach to drug laws has not been without serious problems. An article in, of all places, the Australian Financial Review in May 1999 reported that as a result of the more lenient regime, Holland has now become the major source of synthetic amphetamines such as “Ecstasy” for the world, and Europe’s major portal for the importation of heroin. Liberal laws may be well intentioned, but they sometimes merely succeed in creating increased room to move for illegal enterprises. Unless it is seriously intended to allow heroin and other drugs to be sold completely freely, this risk will always be there.

Rather than looking at overseas experiences, perhaps we can gain some insight into this question by comparing ourselves with ourselves over time. Our harm minimisation policies, along with more liberal policing practices have now been in place since the mid to late 1980’s. During that time, the rate of illicit drug use has doubled, the death rate from overdoses has trebled, and the age of first use of heroin has fallen. We may still have restrictive drug laws, but as we have changed our practice to become more liberal, we have experienced a change in problems for the worse. We are far from being the worst country in the world for drug problems, in fact on a world basis we look pretty good, but we are the only Western nation to report an increase of this magnitude.

Finally, in this discussion of legal changes, it is reasonable to ask what changes precisely are the “reformers” advocating? This is another question which rarely produces a coherent answer. Clearly, the sky is unlikely to fall in if people are allowed to have a small amount of marijuana for personal use, but that is hardly relevant to an argument about legal heroin.

If a change in the law is proposed to overcome a problem related to law enforcement then the proposed change must be in the area of law in question. That is, each proposal should be examined on its own merits, not on whether one is a conservative or a liberal. Clearly, it may be possible to be liberal sometimes, and conservative at other times, depending on what the evidence is on each occasion.

The South Australian experience with marijuana law reform provides an interesting case history. Initially, possession of up to six cannabis plants was tolerated, but with

hydroponics it became possible to produce commercial i.e. trafficable quantities of cannabis from six plants, so the number has been cut back to two. An interesting example of the “room to move” principle in action.

Unfortunately, this continues to be a battle of ideologies rather than logic and it is extraordinarily unlikely that we will ever see a masterstroke of legislation which will eliminate the problem. This is not to say that our laws about drugs should not be under continual review and debate. They should, but it is unlikely that the public posturing involved will ever be anything more than a distraction from the task at hand

Tertiary prevention

Tertiary prevention is traditionally defined as the prevention of disability. In the drug and alcohol field it means treatment of the medical complications of drug use and the treatment of dependence itself.

Types of treatment

Traditional abstinence based
Drug assisted e.g. naltrexone
Drug substitution
Need to look objectively at strengths and weaknesses of each

Ironically, this is an area where there is genuine good news. We now have available a number of effective treatments for both alcohol and drug dependence. There are three or four accepted counselling approaches, which are effective in different settings with different patients, three separate drugs are available for alcohol dependence and at least two for opiate dependence. In addition, we have a wide variety of adjuncts such as relaxation training, group programs, and the traditional self help groups such as Alcoholics Anonymous and Narcotics Anonymous.

Some of these, such as AA, are traditional abstinence based approaches, and those are the only acceptable forms of management for some people, others, such as naltrexone for alcoholism and opiate addiction or acamprosate for alcoholism, are “drug assisted” in which a drug is used to assist the patient to avoid temptation, others such as methadone are best described as “drug substitution”. None of these is the whole answer for all patients but all are the right treatment for some people. For example, methadone helps about one third of patients to remain drug free or at least largely so, and naltrexone is helpful in about the same number. These are not the same patients however, and so the treatments are complementary, not alternatives for one another, or in competition.

Effective delivery of these treatments requires the existence of a fully professional service located in the mainstream public system meeting the same scientific and clinical standards as other healthcare activities and subject to the same degree of peer review.

It is particularly unfortunate therefore, that the addiction field has become so divided and ideological with various groups vigorously defending "their" treatment and disparaging others. I am sorry to say that this reflects the way in which the field has been allowed to degenerate by its practitioners so that the normal standards of clinical and scientific performance are not met.

The other significant point to make about the treatment of addiction is that no treatment has more than a 30% - 40% success rate in spite of the claims of some enthusiasts. Not all patients receiving methadone are actually doing any better than before, and not all patients referred to a residential treatment program will emerge drug free. This causes problems for politicians and bureaucrats who always want good news stories to report. A 30% success rate is a good news story in fact, but it doesn't seem like that to people outside the field.

Political commitment

Benefits will be patchy and slow in coming

Local scene is typical of problems that arise when an important area is politicised

Substantial sums are needed
This is either a major problem or it is not

To take the last point a little further. If Addiction Medicine became an accepted part of mainstream health care, with adequately resourced units in public hospitals in most parts of the country our capacity to care for patients with dependence would be greatly enhanced. However, the benefits would always be patchy and slow in coming because that is the nature of work in such a difficult area.

Given that, for the process to work in the same way as the management of other health problems does it would be essential to remove politics of all sorts from it, and that includes the politics that clinicians play also.

An example of the difficulties that can arise has occurred in this Health Area. For ten years we have been pleading for the establishment of a "Co – morbidity" unit at the Mater to deal with the patients who present either in need of medical detoxification , or following overdoses, or with other medical problems but whose drug dependence or psychiatric condition makes their behaviour difficult to manage in a traditional acute ward setting. The Area Health Service however, takes the view that such a unit is unnecessary. In saying this they rely on advice given to them by people within the field who do not themselves have responsibility for patient care. These people in turn are expressing the prevailing ideology that drug and alcohol problems are best dealt with either in "the community" or by the private non profit sector. The non profit private sector does excellent work utilising a variety of volunteers but they are complementary to, not an alternative for, trained health care professionals.

The moves to shift responsibility to the community and the voluntary sector ignores the large number of addicted patients who present every day to general hospitals because they need the medical nursing and allied health expertise that can only be found within them. Trendy proposals to launch "innovative" community based approaches and

donations of public money to worthy, but basically non professional treatment agencies should be seen for what they are, substitutes for real commitment of real resources.

We have estimated the cost of a unit such as the one mentioned above to be approximately one million dollars per year. Assuming that this would be the biggest single ticket item for the Area Health Service, we can estimate that we would need overall about $1.5m. Assuming that the need is evenly spread across NSW, that gives us a sum of $15m for the State, or about $70m. for the whole country. Compared to the sums being talked about in the current row over the PBAC, that really is a very modest sum to give us a fully professional public sector treatment network.

In the end the issue is one of political will. A few years ago, a great deal of attention was given to the problem of breast cancer which was correctly seen as a major health issue deserving of national attention. As a result, substantial sums were devoted to research, treatment and prevention and that has continued. We are continually told that drug dependence is the most serious problem facing the Nation but the resources, clinical and scientific expertise brought to bear do not compare with those used for more respectable problems. The community would never tolerate the amateurism and politicisation prevalent in Drug and Alcohol problems in any other area of health care.

This is either a major problem or it is not. If it is then major resources should be devoted to it. If not, we should say so, and take it off the National agenda leaving those who wish to work in the field to get on with it as best they can with whatever resources are left after other health care priorities have been met.

Conclusion

In the end a complex series of issues comes down to some simple propositions.

1. The causes of drug dependence are largely social and relate to the environment in which people develop both within their own families and the wider community.
2. There is an urgent need for a reality check for many of the current approaches to the reduction of harm from drug dependence and abuse.
3. Changes to the Law may occasionally be necessary but they are highly unlikely to provide the “masterstroke” some people are looking for.
4. Substantial but not astronomical sums will need to be devoted to providing professional treatment within the public health care sector for patients with drug dependence.
5. If governments wish to be taken seriously about this, they will need policies to reduce the causes of drug use and to provide realistic resources to address the results.

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