LOOK BEFORE YOU LEAP

Half the drug injectors at Roy Robertson's practice in the early '80s were HIV positive, showing Edinburgh to be one of Europe's AIDS/drugs blackspots. But he believes a panic policy shift back to prescribing is no way to counter the threat.

Roy Robertson

WHERE THERE are many conflicting theories and treatment options for a particular disorder, then none is likely to be either wholly effective or completely useless for every patient. It follows that the most important part of treatment becomes matching the patient to the most appropriate therapy at the appropriate time. In a disorder which persists over many years, selection of therapy becomes further complicated by the need to match the patient to different therapies at different stages in their illness.

In the field of drug abuse therapy, the passage of several decades has failed to resolve some of these basic problems. Rather than a progressive evolution and application of therapies found useful in particular circumstances, generalised major policy shifts have characterised national and international responses. These have been accompanied by intermittent funding followed by withdrawal of support for associated agencies and specialties.

The provision of well supported medical treatment for drug misusers in the late 1960s was followed by a gradual deterioration in support and a switch of emphasis in the 1980s to non-statutory and hence non-prescribing agencies. The initial response to the problems of overprescribing in London in the late 1960s was largely a political reaction, hoping for a medical answer to emerge out of nowhere. But lack of funds prevented the new drug dependency clinics in most centres from evolving to provide the support services needed to respond to what was, by then, being increasingly recognised as a psychosocial rather than a medical disorder. The wave of heroin use in the early 1980s therefore came at a bad time. Existing statutory services were offered little substantial resources and the voluntary sector — correctly seen as having most contact with the clients — were expected to deal with the emerging problems, often funded on an insecure year-by-year basis.

This was the situation in which advent of the AIDS virus raised some of the most pressing social, medical and political questions for a century. If medical agonising has been substantial in coping with the epidemic in the gay population, this will seem straightforward compared to the upheaval in society that HIV infected drug users will cause. The prospect of political pressure, public anxiety and medical lack of know-how, bodes ill for drug users and those attempting to manage the problem.

Moreover, the 'establishment' are likely to view the problem of AIDS in heterosexual drug users as too threatening to allow it to be handled by non-statutory agencies, however well they could be supported. Allocation of new funds to inexperienced professionals in the statutory sector or policy shifts by government advisers — most likely back to the medical model of management — might easily prevent the agencies which have evolved over the last five years from further maturing, taking us back to where we were in 1968.

Failures of drug abuse therapies over the last 20 years have arisen, not so much from lack of the right ideas or building bricks, as from the failure to allow experience to evolve effective agencies. Political and social anxieties in the 1960s in the UK, the 1970s in North America, and the 1980s world-wide, have led to the prevailing structures being replaced by alternative initiatives thought at the time to promise a short-term solution to the current crisis.

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Here we are therefore, on the brink of ignoring the lessons of a decade of substitute prescribing and another of the more logical multi-disciplinary approach to a psychosocial problem. It seems that increasing political and social pressure to control drugtaking may shift policy back again to widespread substitute prescribing.

There are several reasons why this might prove to be a mistake. The sheer size of the problem in the late 1980s is the first and perhaps the most immediate consideration. A national increase of nearly 400 per cent in addiction, according to Home Office figures, and frequently local expansions of several times that magnitude, mean that unprecedented funds would be required to adequately supervise a widespread return to substitute prescribing. Experience of economies elsewhere in the health service suggest it is more likely that minimal supervision would create problems from the start.

A second problem area would therefore be the selection of patients suitable for treatment. Changes of policy are rapidly recognised by drug users and exploitation is an inevitable consequence. In areas which have 'managed' the increasing prevalence of drug use by taking a minimal prescribing approach, an avalanche of interest from drug users may follow a change in policy and the increased prescribing may prove difficult to control.

Finally, widespread prescribing of substitute drugs will certainly lead to the concentration of drug users in medical establishments. Institutions offering prescriptions will require increasing support. The corollary is that resources and personnel will be allocated preferentially to these areas. In the finite world of the health budget, money would undoubtedly come from other initiatives in the same field, to the detriment of non-prescribing and community agencies.

It seems, therefore, that the future of drug abuse treatment is once again in some disarray. If it was possible to compare the various features of drug misuse which might indicate progress, or lack of progress, then a clearer view of the relative virtues of different policies might be available. However, there is little information about drug users' mortality, morbidity, socialisation, psychiatric problems, prison sentences, etc, in areas of differing treatment availabilities. But there are indications that regional variations in provision of services and in their prescribing philosophies make little difference to the final outcome.

It seems inadequate to make a major policy shift back to substitute prescribing without finding out more about the present wave of heroin abuse. Although Home Office figures for 1985 show a further increase in numbers of heroin addicts, it seems likely that the rapid increase has peaked. Changing policy now, or glibly attributing a fall in 1986 to government AIDS campaigns or other factors, may further confuse the issue, and find us proceeding into the 1990s still not knowing what to do in the best interests of the individual and of society.

So the suggestion that the 1984 *Guidelines of good clinical practice in the treatment of drug misuse* should be reviewed is very welcome — they were never much use anyway. Most importantly it is being recognised that the treatment of drug misuse needs to be much more prolonged and that 'cure' is no longer the immediate goal. Early access to problem drug users is vital, prescribing is necessary, sometimes long-term, and attention to wider risk-reduction measures vital. The responsibility of a worker or doctor is not just to prevent drug misuse or to minimise it, but to prevent the transmission of infections and the aggravation of social and environmental problems.

IT IS TIME that a lasting structure emerged outside London to cope with drug misuse. Prescribing policy is a major issue, but without better local research, deciding policy is difficult; without increased, long-term funding and resources, implementing it is impossible. □

The author is an Edinburgh GP and head of the Edinburgh Drug Addiction Study funded by the Scottish Home and Health Department. His recent publications on AIDS and drug use include Heroin, AIDS and society *(Hodder & Stoughton, 1987).*