MAINTENANCE OR ABSTINENCE?

Countering AIDS and curing addiction are different aims requiring radically different strategies. Half-hearted merger could doom both to failure, argues Jackie Chang.

Jackie Chang

REPEATED, frequent contacts with my drugtaking patients over the past ten years have led me to the startling conclusion that they are actually *people* and, moreover, likeable, resourceful, worthwhile people. They have gained from being treated with respect and where they have been successful in staying off drugs for any length of time, have invariably made dramatic leaps in personal growth.

I have come to believe addiction is an illness which, with correct treatment, can be brought under control and cured. The cure, however, cannot be written on a prescription pad. Although there is no 'medical' cure, the advantage of seeing addiction as an illness is that it takes away that most counter-productive emotion — guilt. How much less judgmental and more encouraging it is to talk of sick people becoming well rather than bad people becoming good!

My use of the word 'addict' is deliberate. To call a truly addicted person by any other name serves only to reinforce the denial on the part of the addict and indeed the professional. Use of the word detracts neither from my sense of respect for the person nor from my sense of responsibility *to* him.

Not only is addiction an illness, it is a family illness and families frequently suffer more serious and longer lasting harm than their addict members. Help to my patients is often 'traded' for their permission to liaise with the relatives or friends whose support they need if they are to make significant and successful changes in their lifestyles. My current initial approach to the management of an opioid addict involves possibly a short 'detox' with counselling and family involvement where possible. I like to point my patients and their relatives in the direction of Narcotics Anonymous and Families Anonymous respectively. Where relapse occurs, a re-run of the above may be appropriate after further assessment and counselling, or referral to another agency may be indicated. I see myself as a *signpost* rather than as a prescriber or a counsellor.

There is a world of difference between 'maintenance' and a short or even a long 'detox' where abstinence is the ultimate goal. Controlled drugtaking without abstinence as a goal is not a treatment objective, and maintenance is not a treatment for addiction. It is a method by which people are enabled to continue taking drugs. Moreover, it is a method which can rob the drugtaker of any reason to change.

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People do not stop taking drugs until they make a personal decision to do so.Such decisions are often prompted by the medical, legal and social consequences which normally ensue as a result of the drugtaking. If doctors enable addicts to rid themselves of their medical problems by prescribing, this almost automatically rids them of their legal problems. Families may well then contribute to this enabling process by removing their social problems and making them comfortable. The scene is then set for the drugtaker to carry on taking drugs indefinitely, without having to face the inevitable natural consequences.

HOWEVER, a new issue has entered the arena. It is the increasing prevalence of AIDS. The figures are spine-chilling and they suggest heterosexual AIDS is very closely linked with intravenous drugtaking. With the other routes for HIV transmission relatively under control, it is thought this country can be spared an AIDS epidemic if only intravenous drugtaking can be contained. If the facts and predictions are correct, then something must be done on a national scale to protect society from the havoc which will otherwise ensue.

Maintenance is not a treatment, it merely enables people to continue taking drugs.

There seem two possible ways to curb the spread of drug-related AIDS. The first, and the one we seem to be adopting, is to attempt to tinker with and adapt addiction treatment. It involves more education, easier access to needles and syringes and more readily available methadone. Superficially, it may seem an acceptable way of dealing with the problem. It is cheap: indeed, it costs almost nothing to shift the onus for more prescribing on to the GP — seen here as elsewhere as a limitless resource. But that is its only advantage. It is otherwise a grossly inadequate, haphazard response and one doomed to failure.

Not only are such tactics inadequate as a means of controlling AIDS and counter-productive with respect to the separate issue of addiction treatment: they are even more grossly counter-productive in the messages they convey. It must not be implied that the solution to the problem of addiction to illicit drugs is simply to chuck licit prescribed drugs at it. It would follow that the solution to the horrendous tranquilliser addiction epidemic is simply a matter of prescribing more tranquillisers!

The alternative — an effective national harm-minimisation strategy to counter AIDS — will inevitably involve a much more painful and costly response. It could only be justified if the threat of AIDS dissemination is as grave as the scientists predict. Instead of attempting to subvert addiction treatment, a massive network of maintenance centres could be established, with no pretence at aiming for abstinence but solely intended to prevent the spread of AIDS.

Which drug is provided and how much will have to be left to the addict — there would be no point offering oral methadone where injected heroin or, indeed, amphetamine is the preferred drug. Points such as provision of 'fixing' rooms, 'help' with 'safe' injection techniques, biochemical marking of the drugs for ease of identification in compulsory urine tests, and indeed many other issues, will have to be carefully considered.

Such a drastic attempt to solve the demand side of the drug problem would have to be backed up by massive law enforcement on the supply side to effectively force addicts into the maintenance centres. Severe sentences would need to be given to anybody caught for offences such as importation or dealing and even possession of drugs for personal use.

The financial cost of such a strategy would be very high. It would not solve the problem of illicit drugs, but should reduce the demand for illegal injectables and, as a consequence, minimise the potential for the spread of AIDS and hepatitis B. It would also reduce the numbers of young people getting sucked into the drugtaking network due to existing addicts' need to sell drugs to finance further drug use. Set against the financial and social costs to society of an AIDS epidemic, it could be argued that the money would be wisely spent.

Within this group of 'forcibly' maintained addicts, there would be some who wanted to change — most notably those who would feel they were being controlled not only by the drugs, but also by the system. The jobs and interests of professionals working to an abstinence goal would therefore not necessarily be threatened.

Many doctors, including myself, would find it distasteful to work in such a setting — but since the maintenance centres would dispense rather than prescribe drugs, there may be no need for doctors to be involved at all.

It is ridiculous to equate maintenance with treatment. However, the kind of 'enforced' maintenance which I have described backed by a massive increase in policing may be a suitable strategy for the quite separate issue of AIDS prevention.

AT THE MOMENT I see my role as helping to provide a service for people who want to stop taking drugs, and I shall continue doing exactly that. □