STABILISE NOT CRIMINALISE

Twice rebuked by her own profession's disciplinary committee, Dr Dally still forcefully argues the case for 'stabilisation' treatment for long-term opiate addicted patients.

Ann Dally

THE PRESENT DEBATE about prescribing and the increasingly prohibitionist policies of the past decade, can already be seen as an episode in the long history of medical madness. Every now and then the medical profession launches an attack on a section of the community. The causes usually include a desire for power, fear of alternative, rival approaches, and the attempt to forestall inevitable changes. The attacks usually take the form of a bid for ascendancy on the part of a few doctors backed by moral indignation in the general population: the aim is to destroy, control or conceal what is regarded as 'morally unacceptable'.

The victims are usually without power or organisation and often disadvantaged:
— they may be young, as when doctors informed the world, on 'scientific' grounds, that masturbation caused insanity;
— they may be unfortunate, as when psychiatrists shut unmarried mothers into lunatic asylums;
— they may be potential rivals, as in the vicious attacks by doctors on independent midwives during the nineteenth century.

Doctors are in a unique position to make such attacks, for they hold a unique kind of power and knowledge. Recently one of their most blatant attacks has been on drug addicts, particularly long-term addicts. Like all such attacks, it claims to be in the best interests of the patients and to embody 'good clinical practice' formulated in the 'light of experience' — but it is none of these things.

After the drug dependency units were set up in 1968 and GPs were forbidden to prescribe heroin, they came to believe drug dependency was now a matter for 'specialists' and so did not develop skills for dealing with addicts. Later events reinforced this trend. The *Guidelines*[1] of 1984 purported to encourage GPs to look after addicts but in effect carried the opposite message. Now few GPs feel competent in the field and most don't want to be involved.

No one makes trouble for doctors if they ignore or reject addiction treatment, but plenty of trouble awaits those who take an interest and dare to prescribe. Home Office and General Medical Council disciplinary procedures have become more frequent. It has become increasingly clear that doctors who try to help addicts are putting their heads above the parapet, and are likely to have them shot off[2] — a position powerful doctors have worked to achieve.

Meanwhile the 'official' policy, initiated by a small group of London drug dependency unit consultants but adopted over most of Britain, has become increasingly restrictive. The policy is as far as possible to:
— stop prescribing for addicts, or prescribe non-injectable heroin substitutes only for a short period to those who say they wish to give up drugs, regardless of the patients' increased use of the black market;

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— make the prescribing regime the same for everybody, regardless of individual differences;
— make a contract with the patient about what you are going to prescribe and when they will be drug free: s/he will sign anything to get their drugs, it gives you control, and if they can't keep to the 'contract', that's *their* problem;
— if it becomes known that you never prescribe injectables, no one will ask for them: then you can say there is 'no need' for them and the policies are working.

This regime caused severe suffering among long-term addicts, many of whom had been prescribed injectable opiates for 15 years or more. Few could give up just because the policy had changed. Those who could not had to raise perhaps £80 a day or more for black market drugs. Almost invariably this meant theft, prostitution or drug dealing. It became virtually impossible for an addict to lead a normal, honest life — excellent for the traffickers but tragic for addicts and their families. Stable addicts became unstable. They gave up their jobs, sold their houses, lost their interests and became absorbed in obtaining drugs. Many died or became physical wrecks. Many deteriorated as people: marriages broke, children were deprived. The decisions of a few doctors caused havoc in the many addicts' lives.

The community also suffered. Soaring drug-related crime meant prisons became overcrowded, largely with drug-related cases, and in turn became centres for drug trafficking — many new addicts are now created in prison. Meanwhile addiction spread as addicts were forced into 'pyramid-selling' to new users to finance their own black market purchases.

Now there is an even worse threat — AIDS, spreading faster among heterosexuals by intravenous drug users sharing needles than by any other means. AIDS has added urgency, but in spite of the huge shift in public opinion,[3] it has not yet changed policies except in a marginal and cosmetic way. But, as the *Lancet* emphasised recently, even if AIDS did not exist, there would still be a need to review drug policies.[4]

Instead of acting, doctors and administrators are still arguing about how they can change as little as possible and whether 'maintenance' means 'no intention to get the patient off drugs' or whether it is only another word for 'slow detoxification' or 'long-term prescribing'. Talk about 'flexibility' has so far not amounted to very much. Recently the Royal College of Psychiatrists rejected by a large majority the motion that 'maintenance' has *any* place in addiction treatment — and only one third voted for providing clean needles on an exchange basis.[5] The Advisory Council on the Misuse of Drugs is still in the process of appointing a working party to 'look into it'.

Medical madness has often been followed by nemesis. Likewise the attack on long-term addicts has been followed by a vast and continuing increase in addiction and AIDS. You can't hold back the tide of whatever is happening, but you *can* make it worse. You can pretend nothing has changed or that you must appoint a committee or do more research before making up your mind. In an emergency such as this, many people, including perhaps you and me, will be destroyed while 'experts' argue about the morality of 'encouraging something that is inherently wrong' or the precise meaning and implications of 'maintenance'.

YET WE COULD ensure addiction does as little damage as possible. We could separate the clinical problems from the power struggles and accept the realities. Come what may, addicts will continue to get their drugs. If we would only be more logical, they could get these in a way that would protect us all and also eliminate the black market. Understandably doctors are reluctant to be drug suppliers — yet they insist on keeping their monopoly on prescribing. If doctors cannot be more realistic and less power-conscious, then supplying drugs to addicts need not be done through them — other arrangements could be made. If this were to happen, we, as doctors, would have to be prepared to give up some of our power. □

1. Medical Working Group on Drug Dependence. *Guidelines on good clinical practice in the treatment of drug misuse*. DHSS, 1984.
2. Marjot D., in *File on four*, BBC Radio 4, 14 February 1987.
3. Shown for example in the Granada TV *War on drugs* programme, 11 May 1987.
4. "Management of drug addicts: hostility, humanity and pragmatism". *Lancet*: 9 May 1987, p.1068-9.
5. At a meeting of the Royal College of Psychiatrists held in Llandudno, 28 March 1987.

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