STATE-RATIONED DRUGS

John Marks's acceptance of a role as purveyor of state-rationed opiates on a 'maintenance' basis to addicts determined to continue their addiction, contrasts sharply with anti-maintenance treatment trends elsewhere. But, he contends, better a live maintained addict than a dead treatment reject.

John Marks

WE DO NOT say to a chronic arthritic: 'you will be cured in six months and, even if you aren't, your supply of analgesics will then be withdrawn'. Yet we say precisely this to drug addicts. Stimson and Oppenheimer[1] have shown a typical ten year duration for the addictive tendency and Vaillant[2] and Griffith Edward[3] have shown how impervious this is to 'cure'. But this does not rule out all therapeutic interventions: symptomatic treatment of addiction can be life-saving and, just like similar management of many other conditions, is a laudable and achievable aim. If addicts pay for the modest cost of the drugs, it is also extremely economical.

Prescribing heroin to a derelict, addicted drug user is a cautious course. Telling him to come back in a fortnight 'for further assessment' and urine tests, though seemingly cautious, increases the likelihood that he will use poisonous black market drugs, that he will turn to crime or 'push' to newcomers to finance his use and, most importantly, it increases the likelihood he will not return for treatment. Instead he becomes yet another member of the vast, hidden reservoir of drugtakers.

There are three arguments that yield important insights on drug policy. Firstly, the Treasury is concerned with the spiralling cost of enforcing the drug laws and 'curing' drugtakers. Secondly, the Home Office is concerned with the criminal exploitation of black markets, the crime waves associated with black market drug use and the criminalisation of thousands by illicit drugtaking. Thirdly, the DHSS is concerned with the health hazards of insanitary, impure drugtaking. A final irony, of interest to parliamentary lawyers, is the inconsistency of our laws on private vices. Arthur Koestler could kill himself quite legally, but if he did so with heroin, he was breaking the law. The only arguments I have space to examine here are those of concern to the DHSS that arise from the prejudices of the public and those working with drug users against prescribing.

The most pressing problem for doctors dealing with drugtakers, is that the vast majority of the drugtaking population refuse to attend them.[4] Only a tiny minority want 'treatment' and they get orthodox psychiatric help. The majority just want drugs and do not see themselves as 'ill'. Indeed, the doctors can find no psychopathology: subjectively there are no symptoms, objectively there are no signs. The police have a saying: 'If you do not have a drug squad, you do not have a drug problem'. A similar adage applies to medicine: if you do not prescribe drugs, you will only see a tiny fraction of the drug problem. The provision of drugs is thus essential, for no matter how effective your 'treatment' nor how eloquent your counselling, if patients are not there to receive it, it is wasted on thin air.

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I can understand the hostility of non-medical staff to prescribing. It appears to concentrate power with the doctors: drugtakers will only listen to the doctor and other therapeutic endeavours will be undermined. Yet many of today's drugtakers have no more psychopathology[5] than coffee drinkers and their determination to continue with an illegal habit is as much a social phenomenon as a medical one. So the clinics in the Mersey region are run by multi-disciplinary teams, including nurses, social workers and probation officers, who decide doses of prescriptions or whether a patient gets a prescription at all.

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The doctor is there only because he is legally required to be to sign the prescription. He otherwise functions as an intelligent layman, for operating a state rationing system is not a medical activity. Providing drugs doesn't cure drug use, rather it continues it. But this is exactly what so many drug users will do — illicitly and dangerously — anyway.

Medical hostility to prescribing is also well attested.[6] At worse it is seen as doing legally what is otherwise prohibited — 'legal drug pushing'. At best it is seen as being an innkeeper akin to the managers of the Scandinavian state alcohol monopolies. 'This is not what doctors were trained to do' is the reaction. But the spirit of Lloyd George's war-time legislation controlling alcohol and opium, was just such rational control. Strange to say, it was supremely successful, in contrast to the prohibition in America and here, now.

Doctors were happy to ration opium when, in the days of private practice, it was a source of income and their patients were more genteel and fewer in number. However, because doctors were the agent, it introduced the notion that all drug users needed 'treatment'. Venal considerations contributed to medical adoption of the monopoly initially and these now no longer apply.[7] Until they can persuade parliament to take the monopoly away from them and give it to some other agency such as pharmacists, doctors have a duty to responsibly operate the monopoly.

The lay public are also hostile. But prescribing to addicts is walking the same moral tightrope as prescribing contraceptives to girls. To parents and public alike, the doctor may appear to condone promiscuity in the same way as others appear to condone drugtaking. But a girl who ignores her parents and her family's doctor is likely to be immature or incompetent, and her lover is likely to be unscrupulous or irresponsible, so the prospect of an unwanted pregnancy in the least suitable social circumstances looms. The question then is: do we bury our ethical heads in the virgin sands and accept this prospect, or indulge in some social damage-limitation by prescribing contraceptives, at the risk of appearing to condone promiscuity?

DRUG CLINICS are faced with youths who, despite the advice of parents, the help of friends, the warnings of doctors, the attentions of the police, imprisonment by the courts, exploitation by gangsters, dangers from adulterated drugs and horrific diseases, will yet take drugs. Confronted with this degree of determination the choice is: would you rather your son obtained pure pharmaceutical drugs at a clinic, subject to dissuasion and advice from staff, or from the Mafia, in dangerous, criminal circumstances where the drugs are often adulterated with substances more noxious than the drugs themselves? For a majority of drug users, that is the dichotomy. Not between using drugs and getting off them, but between clean drugs from a clinic and dirty drugs from the gangsters.

The treatment regime of the Mersey clinics is described elsewhere,[8] as are the arguments for and against prescribing[9] and the arguments that would interest government and parliament.[10] □

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