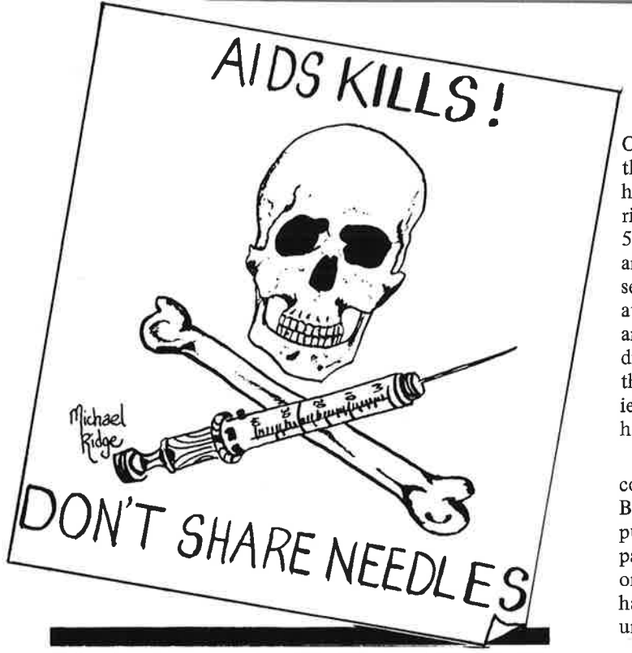

THE NEW PLAGUE

As the number of people contracting AIDS from drug abuse increases, **Tony Maden** looks at the implications for Public health policy. He asks should syringes be made readily available.

Printed over a skull and crossbones, this is the message on a New York subway poster. There is also a version in Spanish. Many of New York's addicts are Puerto Rican. Both versions are part of a campaign to stop the rapid spread of the Aids virus amongst injecting drug abusers. Unfortunately, it's already too late. Blood tests show that 80% of addicts there already carry the Human Immunodeficiency Virus They are not ill, but can pass on the virus and have a 30% chance of developing the disease and dying within the next few years.

In the UK the situation is rather different. Government publicity is more subdued, calmly presenting factual information. It stresses the fact that it is difficult to catch the virus. For most adults, it can only be done by sharing needles or having sex with an infected person. Yet, in some cities, this information comes too late for a large number of young people.

Dr. Roy Robertson is an Edinburgh GP with a particular interest in drug abuse and Aids: "Over a ten year period, the number of known drug users in Edinburgh spiralled from 40 to 2,000. It seemed to come from nowhere". Worse still has been the spread of the virus. "In 1980 it was unknown; by 1983, 80% of Edinburgh's addicts were infected". Heroin was used as a social drug on large housing estates. "Over a three month period, 50 people may use the same syringe".

The implications of these events are enormous. One in four of those infected are women (in England, the virus had previously been more or less confined to homosexual men). Should they become pregnant, the risk of passing on the infection to the child is about 50%. In addition, drug users tend to be mobile, young and sexually active, encouraging the spread of Aids as a sexually transmitted disease. Ominously, a recent survey at St. Mary's in Paddington identified three carriers amongst female prostitutes; all three were heroin addicts. Perhaps the complacent and moralistic attitude that regards HIV as a problem only for deviant minorities will now be discarded. In fact, it is a major public health problem which concerns everyone.

So, what is being done about it? HIV is a central concern of all agencies dealing with drug abuse. As Brian Wells, Senior Registrar on the Maudsley's DDU put it: "I seem to spend most of my time talking to patients about Aids now, instead of being able to work on their drug problem". Counselling for people at risk has now become a major drain on resources in such units.

"Aids Counselling" is a rather grand term for the simple but laborious process of educating drug users about the risks they run and how they can be reduced. In addition, support must be provided to patients, or their relatives, if they are found to be carriers of the virus. This is an enormous task for a service already stretched by the recent increase in heroin addiction. Outside the NHS, many other agencies are putting resources into education. The Terence Higgins Trust was set up in response to Aids in the gay community, but has now turned its attention to drug-users, publishing leaflets aimed at addicts and workers in the field.

The issues raised are complex and emotive. At-risk individuals must decide whether or not to have themselves tested for the virus, knowing that a positive result would mean a high probability of developing a fatal illness in the next few years. Thanks to current attitudes, it would also mean a high probability of losing employment, accommodation, and the services of family doctor and dentist, should the result become widely known; it is not only drug users who need education.

When people are found to carry the virus, they need to take difficult decisions about informing others. Child-bearing becomes a major concern for women. Sexual relationships become a concern for everyone. Counselling aims to provide information and support to allow individuals to take sensible decisions when faced with these problems. In addition, it encourages drug users to take decisions which will change their lifestyles in ways which will benefit themselves, other drug users and the community.

The advice is simple. If you must use drugs, don't inject. If you must inject, don't share needles and syringes. Those at risk of infection are advised to use "safe sex" techniques. All these changes are in the best interests of the drug user; they reduce the risk of getting the virus or the risk of developing Aids if the virus is already present.

Nevertheless, it has been argued that addicts will be unable to make these changes as they are irresponsible, self-destructive and anti-social. SHADA, an Edinburgh based self-help group, takes a more optimistic view. According to Neil Stewart, a counsellor, "Drug users are now very conscious of Aids as an issue. Needle sharing is still going on, but people are making a great effort, phoning around chemists to try and buy needles or thinking about how to clean the ones they have. There are exceptions, but most people are being responsible. We get a lot of people asking questions if they're thinking of starting a family, wanting to know more about the risks. We concentrate on education and have produced a couple of leaflets. Unfortunately, there is still ignorance amongst some professionals, including doctors, social workers and police. Everyone dealing with addicts should know the basic information on what is safe and what isn't. The police will still take syringes and needles off people, even if they're new and wrapped in packets, without any drugs".

The availability of needles and syringes is a major issue at present. There is no doubt that a shortage of equipment contributed to the epidemic spread of the virus in Edinburgh. Few shops sold them and police clamped down on their possession, seeking to discourage drug abuse. Many would now argue that clean equipment should be made freely available, to prevent further spread. Others feel that this would be counter-productive, in encouraging the spread of drug abuse.

The exchange of new needles and syringes for old is a possible compromise and has been adopted by the Dutch Government in Amsterdam. It is currently under consideration by the UK Government and both SHADA and THT would like to see it happen. Roy Robertson thinks it may be helpful, but only as part of an overall programme of education about safer drug use and sex: "Needle exchange is important, but we shouldn't pretend that it will solve the whole problem". He also appreciates the difficulties in implementing any programme encouraging safer drug use. "You are up against lots of resistance from the establishment, opposition to the idea that drug use can or should be made safe". Recent tactless remarks by certain politicians certainly support this view.

Still, it is not only extreme conservatives who find the idea of safe drug use difficult to accept. Many addiction treatment agencies have come to regard abstinence as their goal. It requires a major change in attitude to accept that this may not be possible and that a move to a safer pattern of drug use would be an acceptable target. Also, there is the question of where it will all end; Amsterdam's needle exchange programme is based on buses which also function as mobile clinics dispensing methadone and it has been suggested that similar prescribing in this country may be helpful. Bill Nilles of THT is one advocate: "The priority is to stop people injecting and I'd like to see everything done to achieve this. In some cases, that will mean giving out methadone". SHADA disagrees: "There are lots of difficulties with dosage and supply. Probably some people would sell it and buy heroin with the money. It wouldn't be helpful". Roy Robertson was also firm in his opposition: "It isn't the answer, certainly not in our situation. Many of our drug users only take heroin sporadically or when they can afford it. They have long periods of abstinence. To start giving out liberal supplies of methadone would be disastrous".

Since the experience of the 1960s current policy has moved firmly away from prescribing. The reminiscences of one long-term addict are illuminating: "There was lots of methadone then, but it didn't stop anyone injecting. We'd go straight from the clinic down to Piccadilly, selling it so we could buy some Chinese heroin".

Prescribing may not be helpful, but other ways of risk reduction are being actively investigated. Part of the response to Aids within the gay community, here and in the USA, has been a major change in behaviour. Promiscuity has declined and sexual practices have changed; this would have been considered impossible a decade ago. In the field of drug abuse, this is a crucial time. John Strang, consultant in Drug Dependency at the Maudsley describes the situation: "We are in a pre-epidemic phase whereas much of the USA is in a post-epidemic phase. That means that we do have the opportunity to do something about Aids, if addicts can modify their behaviour". This raises some very basic issues about addiction. Is it an all-or-none phenomenon, in which the addict has little or no control and is bound on a self-destructive course? Or is drug taking behaviour open to modification in order to make it less dangerous, even in those who are unwilling or unable to abstain?

Some recent studies suggest that most addicts can and do alter the pattern of their drug use over a period of time, often in the direction of risk reduction. Major changes are seen in the amount of drug used and in the route by which it is taken. In Edinburgh it appears that the natural history of drug abuse often involves passing through long periods of abstinence; many users abandon heroin spontaneously, as they reach their late teens and settle down. Surveys in other areas also suggest that the true picture of an addict is much more complicated than a single minded pursuit of self-destruction over which the individual has no control. This is important because it means that drug taking behaviour can be modified in order to reduce the transmission of Aids.

At present Britain is experiencing an increase in two major health problems ; heroin abuse and Aids. We may not have a cure for either, but we do have the means to break the link between them. Britain has the advantage of being able to learn from the experiences of the USA; communities **can** make great changes in their lifestyle. In Edinburgh, Britain can also see the potential fate of drug using communities that fail to make such changes. Public health concerns demand that resources now be channelled into persuading drug-users to adopt safer habits and practices. Safer drug use becomes a possible goal of treatment, even if this means providing clean equipment for addicts. Compared to the cost of treating the disease once acquired, these measures also represent an efficient use of resources.

Finally, it is worth considering the possible consequences of failure. In the early part of this century, when syphillis was an untreatable disease, a state was reached when 10% of the population was infected. At that point a Royal Commission was set up to look at the problem. Aids may be less infectious, but it is just as un-treatable; preventive action now seems like a better option than waiting for a Royal Commission.