Drug users need more choices

The brothers **Arash and Kamiar Alaei**—internationally celebrated doctors who advanced treatment for drug users in Iran but were imprisoned, to the vociferous protest of the international medical community—set out their experiences and hopes for harm reduction

The patient first arrived at our clinic in 2001, complaining of a persistent cough and feverish chills. His cheeks were sunken, and his weathered clothes hung loosely from his frail body. He nervously wiped away beads of sweat that formed on his pale forehead, and his yellowed eyes looked warily past us while we spoke.

The patient did not admit it then—and we, as a policy, did not ask—but he was one of the one or two million drug addicts in Iran at that time,[1] out of a population of about 67 million in the late 1990s.[2] We had opened our first clinic of this kind in the Iranian city of Kermanshah. It served the needs of three overlapping target groups: those infected with HIV; individuals with other sexually transmitted infections; and injecting drug users.

We invited the patient to come into the office. He had learnt about our clinic from other drug users through our peer to peer advocacy programme, which brought more clients into our programmes and expanded our reach for harm reducing education and supplies. These peer advocates had informed him that we offered no-cost medical services in a safe environment where drug users would not face punishment for their habits.

At that time the response by law enforcement was to deter drug use harshly through imprisonment.[3] This approach was both callous and ineffective: the rate of drug addiction increased; the spread of HIV infection increased; drug related deaths increased; and drug users were further marginalised, heightening barriers to their access to care, and diminishing their hopes for meaningful engagement in society.

We refer to our programmes as the "restaurant approach." If you want more people to come to your restaurant, you need to meet the diverse culinary tastes of your clientele

We treated the patient for a severe infection at his chosen injection site; this infection would have soon landed him in the hospital with septicaemia if left untreated. Finally, we asked him whether he would like clean syringes and alcohol swabs. He was hesitant at first, but finally accepted the offer.

His test results came back positive for HIV, tuberculosis, and hepatitis C. The cough, chills, and sweating were caused by tuberculosis, and his yellowed eyes were likely a sign of the liver malfunction that had resulted from the hepatitis. Fortunately, the patient returned soon; his visit may have been merely to pick up more clean needles, but it meant we were able to start him on medical treatment and psychosocial support programmes. This approach was beneficial both for the early patient management and to prevent the spread of infection to society.

The patient joined our peer support group, a community resource that improved adherence to medical and addiction treatments and promoted a culture of respect and encouragement, which was largely unfamiliar to injecting drug users, who were typically shunned and stigmatised. Through other members, the patient became aware of other clients' success with opioid substitution therapies. Clients receiving long term maintenance therapies were not susceptible to the risks of related infections, and they were better able to engage productively in society. Furthermore, it gave us ongoing access to these clients to follow up not only their medical needs but also their psychological and social needs and, in some cases, to work with them to become completely drug-free.

Soon after beginning therapy, the patient's weight went up, and his mood brightened. He became more active in the community and soon after began working. In the time we knew him he never stopped the maintenance therapy, but he successfully avoided heroin use and lived a vibrant and engaged lifestyle.

The results of these comprehensive programmes were a marked decrease in drug use, the spread of disease, crime, drug dealing, inpatient medical visits, and addicts sentenced to prison. They improved the number of patients treated, and promoted better understanding and a positive relationship with target groups, resulting in better access, more trust, and a better ability to meet their needs.

We cannot control people's behaviour; we can only help them to make choices that are best for them and for society. To optimise outcomes we must be flexible in our approach and strive to meet the needs of our target population. We refer to our programmes as the "restaurant approach." If you want more people to come to your restaurant, you need to meet the diverse culinary tastes of your clientele. If you want to attract more people who are addicted to drugs, they need to feel that they have choices. With this approach, clients could choose from a range of programmes, from needle exchange to opioid substitution therapy.

Many addiction centres throughout the world provide only one path to treatment or rehabilitation and pay no attention to harm reduction. Similarly, in some harm reduction programmes they either offer needle exchange or methadone therapy, but not both.

Any one programme may work for a subset of the drug addicted population or at a certain point in a person's recovery, but to reach more people and to achieve the desired results we must have a more comprehensive programme, offering a wide range of options for treatment, harm reduction, and recovery.

Kamiar (left) and Arash Alaei were imprisoned for championing treatment of Iran's injecting drug users

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Patient consent not required (patients anonymised, dead or hypothetical).

References are in the version on bmj.com.

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FROM THE FRONTLINE **Des Spence**

Bad medicine: co-codamol

The UK Home Office has recently highlighted the sharp rise in prescribing, misuse, and deaths linked to tramadol.[1] We've known tramadol as a problem in general practice for years. And death from prescription drugs is but the merest tip of an addiction iceberg, with at least 800 other misusers for every death, according to US data.[2] The UK has been slow to acknowledge misuse of prescription drugs, a problem described as an epidemic in the US, where prescribed opioids kill 15 000 people a year.[2]

We have another, far bigger potential problem than tramadol: codeine combined with paracetamol (co-codamol). A 2009 parliamentary report highlighted addiction to low strength co-codamol sold over the counter.[3] It called for more awareness, control, and education. Yet since this report, use has increased further, with a doubling of co-codamol prescriptions in a decade.[4] Prescribed co-codamol is stronger and is dispensed in much larger pack sizes than that sold over the counter. Indeed, doctors prescribe five times more total codeine than is bought over the counter.[4 5]

Co-codamol addiction is grossly under-reported because official statistics relate to referrals to addiction services

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I witness addictive behaviours, especially with co-codamol 30/500 (30 mg codeine phosphate and 500 mg paracetamol per tablet), with patients massively exceeding the recommended dose, taking many tablets as a single dose, and sourcing prescriptions from relatives. Patients can be aggressive and defensive if questioned and experience classic physical and psychological opioid withdrawal. Patients risk fulminant liver failure from unintentional paracetamol poisoning. The medical indication for co-codamol was a long forgotten, vague, musculoskeletal pain.

Yet repeat prescriptions of co-codamol are churned out monthly on repeat prescribing systems, out of the sight and consciousness of doctors. Co-codamol—a legal, seemingly safe, and legitimate addiction—has an atypical dependent population: young women. This may be simple anecdote lacking evidence, but the internet rattles with accounts of co-codamol addiction. There are also huge anomalies in prescribing, with a fivefold difference in prescribing rates by region, unexplainable by disease rates.[6]

Doctors have been encouraged to use opioids in non-malignant pain syndromes, told that, if used therapeutically, opioids do not cause addiction. This is not true. Co-codamol addiction is grossly under-reported because official statistics relate to referrals to addiction services. GPs do not refer patients with co-codamol dependency to addiction teams. The true scale of the problem is reflected in a UK website for codeine dependence, which has counted more than three million visitors since 2007.[7] We need some urgent research, action, and honesty. Doctors and patients are in denial about the scale of unaddressed addiction to co-codamol. This is very bad medicine.

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DRUG TALES AND OTHER STORIES **Robin Ferner**

Divination

While every pea sea has a spell checker, it can't tell the Thai pose from the typos; nor can it separate Miss Prince from misprints. In analyses of drug errors, lookalike names and soundalike names cause confusion.[1] Prescriptions for rabeprazole, a proton pump inhibitor, are confused with those for the antipsychotic aripiprazole. The dopamine agonist ropinirole, used in Parkinson's disease, can be confused with the antipsychotic risperidone, which can cause parkinsonism. More confusing still, they have similar trade names and are used at similar doses.[2] Computer systems are prone to lookalike errors because, when a prescriber or dispenser chooses drugs from a menu, it is easy, for example, to choose penicillamine, which comes first in an alphabetic list, rather than penicillin.[3]

A suggested solution is "tall man" lettering to emphasise the distinctive features of a drug name. So the antidiabetes drug chlorproPAMIDE is less likely to be confused with the antipsychotic chlorproMAZINE.[4] A review advised that this system be adopted for names that may be confused, but not generally.[5] But which words will be confused?

One measure of how similar two words are is the Levenshtein distance, the number of changes you need to make to one word to arrive at a second word.[6] More sophisticated measures look at how similar words sound when spoken.[7] Our hospital switchboard has recently installed a system that tries to connect you with mythical colleagues unless you speak to it in a Yorkshire accent, something of a problem in Birmingham.

I recently saw a letter referring a patient with "pain on deification." Perhaps this referred to the existential angst some might feel when placed in charge of their own healthcare; the meekness of many patients inhibits them from taking over the divine role traditionally assumed by consultants. But I guess the referring doctor meant pain on defecation. An important diagnosis to consider is anal fissure. Some drugs can cause it,[8] but drugs don't effectively cure it. A recent Cochrane review showed that, although surgery is effective, medical treatments give little benefit.[9] Glyceryl trinitrate ointment induces headache, and botulinum toxin should probably be reserved for wrinkles elsewhere.

Our new hospital switchboard system tries to connect you with mythical colleagues unless you speak to it in a Yorkshire accent, something of a problem in Birmingham

Still, I was wondering whether the cure for pain on deification might be the Lord's anal dilator.[10]

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