Canada's drug problem: time to get serious

It is time for Canadian physicians and policy-makers to get serious about the country's drug problem. Edward M. Adlaf and Frank J. Ivis[1] report that marijuana use increased by 112% between 1991 and 1997. It is no wonder that cocaine and heroin use is increasing as well, given the virtual anarchy surrounding drug use in places like Vancouver. A 1997 study[2] reported that since the inception of Vancouver's needle hand-out program in 1988, HIV prevalence among addicts who use drugs intravenously has risen from 2% to the current level of 23%. Vancouver now has the largest needle exchange program in North America — it provides 2 million needles per year — but the rate of needle-sharing is still high. The study found that 40% of HIV-positive addicts had lent a used syringe in the previous 6 months and 39% of HIV-negative addicts had borrowed a used syringe during the same period.

Another study of misguided public policy[3] demonstrated that the Montreal needle hand-out program was associated with HIV seroconversion rates of 7.9 per 100 person-years among those who participated in the program and 3.1 per 100 person-years among those who did not. Even the authors were surprised by the findings and tried to discount them.

In an editorial accompanying Adlaf and Ivis's report, John S. Millar[4] calls for greater harm-reduction efforts by equating addiction with other diseases such as diabetes and hypertension and citing the poor compliance common in the management of chronic disease. What he fails to realize is that for any disease, an element of coercion is often necessary to effect changes that will improve health.

We at the International Drug Strategy Insitute believe that harm-reduction policies are doomed to failure and doomed to result in increased drug use. We instead call for harm prevention and harm elimination through a tough international policy that tries to prevent drug use in the first place and, just as important, places pressure on the user to eliminate drug use.

Eric A. Voth, MD
Chairman
International Drug Strategy Institute
Topeka, Kans.

References

1. Adlaf EM, Ivis FJ. Recent findings from the Ontario Student Drug Use Survey. *CMAJ* 1998;159(5):451-4.
2. Strathdee SA, Patrick DM, Currie SL, Cornelisse PG, Rekart ML, Montaner JS, et al. Needle exchange is not enough: lessons from the Vancouver Injecting Drug Use Study. *AIDS* 1997;11(8):F59-F65.
3. Bruneau J, Lamothe F, Franco E, Lachance N, Desy M, Soto J, et al. High rates of HIV infection among injection drug users participating in needle exchange programs in Montreal: results of a cohort study. *Am J Epidemiol* 1997;146 (12):994-1002.
4. Millar JS. A time for everything: changing attitudes and approaches to reducing substance abuse. *CMAJ* 1998;159(5):485-7.

[Dr. Millar replies:]

I agree with Eric Voth's sentiments about trying to prevent drug use. However, I fear that his opposition to harm-reduction efforts arises from a serious misunderstanding of the approach.

Voth calls for a "tough international policy that tries to prevent drug use in the first place." If by this he means efforts to reduce illicit drug supplies by targeting criminal syndicates that produce, traffic in and promote the use of drugs, his suggestion is compatible with a harm-reduction approach. However, if he means that individual drug users should be treated as criminals, then we disagree.

The addicted drug abuser no more makes a personal choice to be an addict than an obese inactive person chooses to have atherosclerosis or diabetes. Addicts deserve to be treated the same as people with any other disease and to be given the best available care. However, this does not mean that some form of coercion is never appropriate.

There is growing evidence that many drug users who are convicted of nonviolent drug-related crime and who are offered an alternative to jail — such as enrolment in a drug rehabilitation program — can be successfully and cost-effectively rehabilitated. This is analagous to the "coercion" now applied to doctors, airline pilots and others with substance abuse problems: "Get rehabilitated or lose your job."

A harm-reduction approach aims to achieve a drug-free lifestyle when-

ever possible through primary prevention and access to effective rehabilitation services. But it also recognizes that this goal will not always be realized. A supportive approach often reduces the occurrence of the negative aspects of addiction — criminal activity, social disorganization, needle sharing and sexual transmission of diseases.

It is time to implement this harm-reduction approach for the drug abuse problem and to develop policies on the basis of evidence, not the stale rhetoric and worn-out battle cries of the failed "war on drugs."

John S. Millar, MD
Vice President
Canadian Institute for Health Information
Ottawa, Ont.

Watch out for drug–drug interactions, too!

Evelinda Trindade and colleagues report on the important issue of adverse effects related to the use of antidepressant medications.[1] Although their meta-analysis yielded helpful information that might be used by the clinician in making choices about antidepressant medications, it did not address the important issue of drug–drug interactions.

In choosing the "right" antidepressant for an individual it is imperative to consider carefully any concurrently prescribed medications. The selective serotonin reuptake inhibitors (SSRIs) are known to interact with many medications, including benzodiazepines, some antipsychotics, tricyclic antidepressants and antihistamines.

When the potential for drug–drug interactions exists, the decision as to which antidepressant will be most appropriate acquires another level of complexity. Physicians who prescribe SSRIs must be well acquainted not only with the adverse effects commonly experienced when the drugs are given in isolation, but also with their particular drug–drug interaction profiles.

George Dresser, MD
Fellow
Clinical Pharmacology and Therapeutics
University of Western Ontario
London, Ont.

Competing interests: None declared.

Reference

1. Trindade E, Menon D, Topfer LA, Coloma C. Adverse effects associated with selective serotonin reuptake inhibitors and tricyclic antidepressants: a meta-analysis. *CMAJ* 1998;159(10):1245-52.

Improving communication skills

We would like to add to Victor Neufeld's list of actions under way in Canada to improve physicians' communication skills.[1] Medical schools are continuing to develop and improve their communication programs for medical students. Residency programs are following suit with an eye toward reinforcing the foundations laid in the earlier years. Canadian resources provide research and conceptual foundations that influence program development in Canada and elsewhere.[2–4]

Activity has been burgeoning at medical schools across the country. On Oct. 16 and 17, 1998, 50 people from across Canada and from Norway, Britain and South Africa participated in the first Canadian Patient-Centred Faculty Development Conference on the theme of "Communication Skills Education — How to Prepare Faculty." The purpose of the conference, sponsored by the Centre for Studies in Family Medicine and the Faculty of Medicine and Dentistry at the University of Western Ontario and the Faculty of Medicine at the University of Calgary, was to enhance the ability of faculty to teach communication skills to undergraduate and postgraduate medical students. The Division of Medical Education at Dalhousie University trains faculty in communication skills and maintains the Dalhousie Medcom Collection, a database of research and resources in communication skills relating to medical education and practice. The University of Manitoba medical school has been conducting in-house workshops for faculty development. During the Conjoint Medical Education Conference of the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada (CFPC), held in Toronto in September 1998, several sessions were devoted to communication skills, an indication that medical educators across the country want to teach these skills.

Several other programs have been developed to improve the skills of physicians already in practice. The Collège des médecins du Québec and the Quebec chapter of the CFPC provide workshops (by request) on topics related to physician–patient relationships. In a similar effort, 2 representatives from each of Cancer Care Ontario's 8 clinics attended several days of training with the Bayer Institute for Health Care Communication in the US, returning home to begin a variety of communication programs for staff at their institutions.

The federally funded Canadian Breast Cancer Initiative, in collaboration with the Royal College and the CFPC, has been developing tools and strategies to enhance the communication skills of practising physicians in response to the expressed need of women with breast cancer. Health Canada has produced *Talking Tools I*, a 1-hour presentation kit to remind physicians that communication skills can be taught and learned, and *Talking Tools II*, which contains material for a 3-hour training session. Finally,