# Substance abuse: tempering the debate

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A physician might define problem drinking objectively, in terms of the number of alcoholic drinks consumed per week. A person with a drinking problem, on the other hand, might offer a subjective definition, such as the anxiety of not knowing whether the next drink can or will be the last. Given the range of perspectives and participants, there seem to be as many definitions of substance abuse as there are theories about its causes, prescriptions for its management or choices of substances to abuse. This diversity is reflected in the eclectic range of articles presented in this special issue on substance abuse in Canada.

Some of the papers, such as Alan Ogborne's study (page 1705),[1] speak to the reader as clinician and aim to assist with the identification and management of patients who are abusing substances. Others range from a glimpse into the circumstances and conditions from which drug abuse problems can arise (page 1720)[2] to a review of the lessons learned, or not, from the evidence and experience of other countries with respect to injection drug use and harm reduction (page 1709).[3]

All of the articles point to the same fact: the health care burden of substance abuse in Canada is enormous. According to Eric Single and colleagues (page 1669), it accounts for 20% of deaths, 22% of years of potential life lost and 10% of hospital admissions in Canada.[4] Yet ours is the only country in the developed world without a clear, coordinated approach to substance abuse problems. In 1997 the federal government chose not to reinvest dollars in Canada's Drug Strategy, despite the fact that it receives more than $3.3 billion yearly in tobacco and alcohol taxes alone.[5] One result of this inattention is that the United States government spends 6 times as much as the Canadian government does on addiction research conducted in Canada.[5]

To some extent the dearth of evidence on substance abuse in Canada derives from our drug policy and contributes to that policy. As Wayne Hall explains in his commentary on policies toward cannabis (page 1690),[6] there has been little evaluation of the costs and benefits of different cannabis policies due, in part, to an international consensus on the prohibition of cannabis use. Governments are reluctant to direct research funds toward a problem or substance that has no legitimate status. Yet cannabis is the illicit drug most frequently used by Canadians and the drug about which opinion polls show Canadians have the most ambivalence.[7] And, as the survey by Ogborne and associates reveals (page 1685), cannabis is used by a small proportion of Canadians for medicinal benefit.[8] In the absence of research, drug policy is formulated principally by prevailing opinions and shifting values rather than by reason and evidence.

But ignorance is only one of the harms fostered by policies that favour criminalization and prohibition. As Catherine Hankins points out (page 1693),[9] criminalization has fostered violent crime, sex work to finance drug consumption, deaths by overdose from drugs of unknown purity, HIV transmission through shared needles and a culture of marginalization that excludes drug users from systems and spaces of safety and support. She argues that current Canadian drug policy frames the health consequences of drug use as a moral issue requiring a moral and punitive response rather than as a health issue requiring comprehensive public health policies.

Yuet Cheung informs us (page 1697) that "harm reduction" is a model that emerged in the 1980s to shift the debate about substance abuse from legal sanctions to public health principles.[10] It offers a practical and pragmatic approach that aims to decrease the adverse consequences of drug use without necessarily requiring a decrease in drug use. It tempers the prohibition–legalization debate with the argument that the extent of regulation of a drug should reflect the relative risk of harm posed by that substance and that the examination of harms should include those caused by the policies of control.

The findings presented in this issue suggest that Canada could benefit from a coordinated harm reduction approach to drug use. This implies bridging the polarities of prohibition and legalization, abstinence and pharmacomaintenance, intuition and information. It implies that the medical profession has a responsibility to demonstrate temperance, to bridge internal polarities between treatment modalities and to moderate the extremes of the debate with evidence, advocacy and compassion.

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