

Alcohol and drugs

DESPITE A SCIENTIFIC history spanning barely five decades, the field of alcohol and drugs is now a legitimate medical subspecialty. The conceptual base is developing, evidence-based approaches are being used, and more effective interventions are now available.¹ With the first adoption of a scientific perspective came the development of more rigorous diagnosis and several robust screening questionnaires, which have proved valuable in research but are not yet widely used in clinical practice. Progress has been made in improving detection rates and in providing interventions for at-risk patients. Now, the Royal Australasian College of Physicians is establishing a Chapter of Addiction Medicine, reflecting the growing scientific base of the alcohol and drug field and paving the way for future expansion.

Interventions. In the past decade or two, new and more effective drug treatments have been developed, and the pharmaceutical industry now sees alcohol and drug dependence as a new area for research and development.

For alcohol dependence, acamprosate has been shown to promote abstinence or assist in reducing alcohol consumption in a substantial proportion of alcohol-dependent patients.² Naltrexone, an opioid antagonist, may achieve similar results, but the evidence is less impressive than for acamprosate, and naltrexone's action of blocking opioid analgesics precludes pain management with morphine or other opioids. Brief cognitive-behavioural interventions have been used to help "problem drinkers" reduce their drinking to safer levels before their drinking has health, social or financial complications.

For smokers, improved forms of nicotine replacement, nicotine replacement without prescription, and the combination of nicotine replacement with bupropion,³ have made smoking cessation more effective. As reduced smoking prevalence owes more to improved smoking cessation rates than to reduced smoking initiation, these are important developments. Smoking prevalence remains unacceptably high in some vulnerable populations, including Indigenous Australians, prison inmates, and people with alcohol and drug or mental health problems.

For heroin dependence, buprenorphine, a partial opioid agonist released in Australia in 2001, is the second effective pharmacological treatment, methadone being the first.⁴ Naltrexone was introduced in 1997 amid extravagant claims for its effectiveness, but these have not been confirmed, strengthening the arguments for a more evidence-based approach. Perhaps the most important recent advance for people with illicit drug dependence has been the belated recognition that health and social interventions are less costly, more effective and less inclined to result in collateral damage than criminal justice interventions. Increasingly, drug treatment is being combined with criminal justice interventions, although methadone treatment, which was introduced officially in Australia in 1970, was not used in prisons in Australia until 1986. Buprenorphine is also very effective for ambulatory heroin detoxification, although obstacles must first be overcome before it can be made readily available from general practices.

Management of selected amphetamine-dependent patients with prescribed dexamphetamine has shown encouraging results overseas, and there has been a successful Australian feasibility trial.⁵

Prevention. Following the decline in per-capita alcohol consumption over the past 20 years, alcohol-related mortality fell substantially during the 1990s. Alcohol-related brain damage declined after the introduction of thiamine-fortified flour in 1991.

Tobacco-related deaths have fallen considerably among men and levelled off in women, reflecting the steady decline in smoking prevalence and per-capita tobacco consumption in recent decades. Antismoking campaigns have played a small part in this decline, with other factors including increased prices, reduced advertising, and restrictions on smoking in public places.

Outcomes for prevention of illicit drug use have been extremely disappointing. Drug overdose deaths increased from six in 1964 to 958 in 1999, before dropping sharply in 2001 as a result of a "heroin drought". The control of HIV infection among and from injecting drug users in Australia is a major public health achievement, with successful early and comprehensive programs encompassing explicit and peer-based education, needle syringe programs, methadone treatment and community development. Rapid implementation of these programs was facilitated by the adoption of harm minimisation as Australia's official national drug policy in 1985.

Remaining challenges. The alcohol and drug field still struggles to be emancipated from moral and politically inspired constraints. Although there are now better outcomes from the intake of legal drugs, they are still responsible for 97% of drug-related mortality. Moreover, alcohol and tobacco account for half of the 20 years' lower life expectancy of Indigenous Australians. Primary and secondary prevention for alcohol and tobacco needs to be more widely available from general practices. General practice is also an appropriate setting for shared-care management of heroin-dependent patients with methadone or buprenorphine. Improved outcomes for illicit drugs await a political decision to accept that health and social interventions are more effective than law enforcement.

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