Coming clean: Saying ‘know’ to drugs – Part II

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Drug myths

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Due to the repeated drug narratives based on a moral or political position, people who carry a lot of fear throw common sense out the window. One thing they don’t do is speak to people who actually use drugs, whose opinions are often disregarded, even in research, because the accepted narrative is that you can’t trust someone who uses drugs. And this has led to some big problems in the South African context. The other day, a paper described nyaope as unique to South Africa. It’s just not true. Nyaope is unregulated diamorphine or heroin. Heroin here has the same chemical makeup that you’ll see in Italy.2 It’s the same heroin that unregulated diamorphine or heroin. Heroin here has the same chemical makeup that you’ll see in Italy.2 It’s the same heroin that comes down from the Middle East; it’s not ARVs, like many claim.

There might have been small amounts of ARVs in some of the early samples. But today, most of the people who are subsistence drug sellers do not cut their drugs. Drugs already get cut outside the country where they are certainly not using ARVs. This narrative has been perpetuated, which means we haven’t been able to treat people properly. We haven’t had access to medications, specifically methadone, for nyaope users. And we are underdosing people on HIV medications because the assumption is that pre-exposure to HIV medication through recreational drug use leads to drug resistance.1 It’s a significant problem because we don’t speak to people who use drugs. After all, back in the late 1990s, early 2000s, when we were starting to see nyaope, whoonga, unga – which are all heroin – come into the communities, all you needed to do was ask somebody who used these drugs, and they would tell you that it was heroin. I know several people dependent on heroin who visit South Africa and buy nyaope, and they don’t complain. They don’t say, “this is not heroin”. They say, “this is heroin, and it’s the same quality as I get overseas”. So do you have any of those myths?

Bill Ebiti

Yes! People are chasing a high. For instance, baking soda used in cooking is dissolved in coke (Coca-Cola) and drunk, and then people say that they get high from this mixture. But when we look at it clearly, we do not see any psychotropic element in what they are drinking.

Words and stigma

I reviewed the speech given yesterday by the head of the Nigerian drug law enforcement agency. The use of certain words struck me: ‘Fight the drug scourge’, ‘the menace of drugs’, ‘the epidemic of the drug problem’, and so on and so forth. And this seems to be the trend in government and media. Unfortunately, I also hear it from experts within the field. Now, I don’t know what you think about it. I’m reading a book called “Words, Words, Words” by David Crystal, and there are specific ways words are used to denote a specific meaning, and people respond to that issue because of the choice of words. I think the deliberate use of these dramatic words has also made the addiction problem look evil, like demonic, unrighteous, demoralisation and all that. I think that words profoundly influence the way people who use drugs are viewed. And even how we approach the care of people with substance use problems.

Shaun Shelly

Absolutely, and it’s negatively affected the research in this area. In the UN documentation, one of the only places that the word “evil” is used, is in the single convention of drugs, which describes it as ‘an evil that must be fought against at all costs’.4 And that’s problematic. We know that how people perceive a drug will significantly affect the outcome. In South Africa, a little while ago, we also had this report on the so-called Zombie stimulant drug, alpha-Pyrolidinopentaphenone (PVP), more commonly known as Flakka.4 The zombie story came from a bizarre situation in Miami, where somebody apparently tried to bite somebody else’s face. But they got it wrong because the person on the Flakka wasn’t the person biting the face. The person biting the face was actually floridly psychotic, and no drugs were found in his blood.5,6 So, this narrative is spread worldwide. And suddenly, we were supposed to have Flakka in

South Africa. I spoke to police labs, and I tried to get samples – we found none in the country,1 but people were presenting in emergency rooms with extreme heat and heat exhaustion; they were chaotic in their thinking. And they were saying, "I've had Flakka, what's happening to me?" But all one needed to do was calm them down and have somebody talk to them. And suddenly, those symptoms resolved.

Similarly, with methamphetamine, many people develop psychotic symptoms because of lack of sleep. When I was working in Lavender Hill, in the Western Cape, most people were taking vast quantities of methamphetamine. But as soon as we explained to people that you can take methamphetamine to a certain point, and then you're not going to get any higher, we were able to cut the rates of psychosis. But what didn't help the situation was that many of these people were living in extreme poverty, and so the 72 hours of observation in the psychiatric ward was a relief for some. It was a place where they could get a meal and fall asleep at night. And so they learnt more and more how to become psychotic, so to speak. We see psychosis almost as a learned behaviour in many populations, which is problematic because we know that it can lead to it becoming a reality. And let's look at the work of Howard Becker,8 the sociologist on deviance and labelling. We know that as soon as you tell somebody that they're going to become addicted to something, rates of addiction increase. So when we keep telling kids and people 'just one try, and you will be addicted'; we increase the problem.

**Pain medication**

In America, we know that at one stage, the rates of opioid dependence for people with long-term cancer pain were well below 1%.9 Now, they are much higher because even when granny goes to the hospital, she gets told, “Don't take this, because you'll become addicted”. And when she does take it, she believes she’s dependent on it. Whereas before, people would just think they had a bit of flu when they stopped. And now we’ve seen a lot of people develop an addiction. So to answer your question directly, yes, words are critical. And they affect the pharmacology of drugs.

The most effective drug in the world is a placebo. It's effective in almost as a learned behaviour in many populations, which is problematic because we know that it can lead to it becoming a reality. And let’s look at the work of Howard Becker,8 the sociologist on deviance and labelling. We know that as soon as you tell somebody that they’re going to become addicted to something, rates of addiction increase. So when we keep telling kids and people ‘just one try, and you will be addicted’; we increase the problem.

The most effective drug in the world is a placebo. It's effective in about 40–60% of most cases, especially in people with diseases or issues that are not clearly biological, which may not be an exaggeration.10 So, we know that what people believe makes a huge difference. And the more we put out negative messages and say there's no hope for people, the less hope there will be. And we know from large studies that most people who develop a substance use disorder will resolve it before 30, given the right circumstances, and 70% without any treatment.11,12 Those figures never get told to people. The first thing that happens when somebody is in rehab is they get told: “90% of you are going to relapse in the first week afterwards”. That's not exactly encouraging.

**Bill Ebiti**

I saw a 76-year-old woman with spinal stenosis in severe excruciating pain last week. Her doctors had done everything to help her before surgery, but her pain was intractable to the point where she had not been able to sleep for the past three weeks. I prescribed morphine for her. Within 24 hours, the pain was alleviated sufficiently for her to sleep. However, her doctors were worried that this elderly woman may develop an addiction to morphine. What’s the quality of life of a 76-year-old in severe pain? This illustrates that people's fear of addiction may get in the way of caring for their patients properly.

**Changing minds**

That leads me to think and ask the question, could it be that we as experts are not communicating sufficiently to help people open their minds to have a better understanding and grasp of the addiction issue? I’m saying that because often, when experts who are a lot more liberal and open-minded speak on these issues, and are ready to explore all the options in addressing addiction issues, they may be seen to encourage drug use and may be seen as weak. They are seen as part of the problem even by other experts who are involved in treatment. And that really bothers me. For example, some people may think that we prefer people to use drugs, and that we’re encouraging people to do so. So my question is, are we communicating enough? I don’t know what we can do better in communicating these issues to people.

**Shaun Shelly**

People may become dogmatic in their position. I believe the key is to introduce clinicians to people who use drugs. And indeed, most researchers have not sat down and listened to people's narratives. People who use drugs are not in some unique type of denial. They’re in as much denial as anybody else who is protecting something meaningful to them. I don't know why we expect people who use drugs to walk into a room with a stranger and be 100% honest. It's unnatural to give away your deepest, darkest secrets to a total stranger. So I don’t know why we expect immediate disclosure from them. It's about building a relationship, a meaningful relationship. We know a significant indicator of the efficacy of any treatment system is the quality of the relationship with the service provider and the institution.13-16
they will open up. People know if you have their best interests at heart. You know whether or not the doctor is interested in your case. Their attitude towards you, their behaviour, the way they ask a question, their choice of words and all that kind of thing. Clients pick up on these cues. And when they feel that their healthcare providers don’t care enough, they’re not going to open up to discuss their issues.

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References