MORE THAN A QUICK FIX

Despite its long use in the UK, prescribing heroin to misusers remains controversial. **Tony Sheldon** looks at the history and the evidence behind the increased prescribing in Europe

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“The past is a foreign country: they do things differently there.” The famous line from L P Hartley’s *The Go-Between* seems

to sum up the medical prescribing of heroin to addicts. British medicine has a history of prescribing heroin, and the practice is now also largely accepted in Switzerland and the Netherlands. But use of the British system, as it was known abroad, in the United Kingdom has declined in favour of methadone maintenance—although not vanished completely.

It was 1926 when a government committee chaired by Humphry Rolleston, president of the Royal College of Physicians, advised it was legitimate medical practice to supply heroin to addicts for their maintenance. Only later was the practice restricted to doctors licensed by the Home Office. Past UK examples include the drug dependency clinic of London’s University College Hospital, which prescribed injectable heroin during the 1970s.¹ Later, a team led by psychiatrist John Marks offered heroin on prescription in Widnes, Merseyside, in an attempt to restrict the spread of HIV.

However, by 1992 researchers estimated there were little more than 100 addicts prescribed heroin in the UK, while 17 000 were prescribed oral methadone.² Today the number of addicts in the UK regularly prescribed heroin is around 300, although the practice is enjoying a revival.³ A trial of supervised injecting, the randomised injecting opioid treatment trial (RIOTT), among 150 addicts at clinics in Brighton, London, and Darlington is set to run until 2008.

Similar relatively small scale trials of heroin assisted treatment have taken place in Canada, Spain, and Germany, where a multicentre trial with over 1000 participants took place between 2003 and 2005. However, only Switzerland and the Netherlands have had the political will to build a long term policy.

Wider acceptance

Switzerland was the first country to launch a large scale evaluation of heroin prescribing with a national cohort study running from 1994-6. It included more than 1000 people who were in poor health and who had repeatedly failed to benefit from conventional drug treatments during years of heroin addiction. They were offered controlled medical prescribing of heroin as part of a comprehensive programme of social and medical care.

By 1997, the Swiss federal authorities claimed a “substantial improvement” in addicts’ physical and mental health and

Will prescribing injectable heroin help reduce the problems the drug causes?

social situation as well as a 60% reduction in criminal behaviour. Clients’ reported use of non-prescribed heroin fell significantly, and there were no deaths from overdose or complaints from local neighbourhoods. The study concluded that it is possible and clinically effective to provide injectable heroin at a clinic three times a day, seven days a week.⁴ Meanwhile public opinion swung behind the project. A referendum in September 1997 returned 71% in favour of heroin maintenance.

A later cohort study in 21 community outpatient treatment centres assessing more than 1600 heroin users between 1994 and 2000 concluded: “Heroin-assisted substitution treatment might be an effective option for chronically addicted patients for whom other treatments have failed.” It showed 70% of users remained in treatment for more than a year with positive health and social outcomes.⁵

Currently there are about 1300 addicts enrolled in 23 clinics across 16 Swiss cities. Criteria for inclusion include age 18 or older, being dependent on heroin for at least two years, having had two unsuccessful attempts at other treatment, and existence of severe medical, psychological, or social problems associated with heroin use.

Typically, people prescribed heroin are in their late 30s and have been addicted to heroin for 10 years; a quarter are women and more than half will stay in treatment for two years or more. Of the up to 200 addicts who stop heroin prescribing each year, about 40% will transfer to methadone maintenance and a quarter will move to treatment based on abstinence.

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Sandra Wuethrich, head of the heroin assisted treatment programme, said: "In many cases patients' physical and mental health has improved, their housing situation has become considerably more stable, and they have gradually managed to find employment." In addition, there is a substantial decline in consumption of non-prescribed substances and earnings from illegal activities. Heroin assisted treatment, she argues, is nationally and internationally acknowledged as an "established treatment for severely dependent heroin users."

However, she adds, the programme only represents 8% of heroin replacement treatment. It was never intended to replace methadone maintenance, prescribed for 15 000 Swiss heroin users. It is not seen as a first line treatment but an option for a small minority.

But the scheme has critics too. A review of the trials published in 1999 by Swiss and US researchers claimed they "did not withstand scientific scrutiny," in particular because they did not "randomly assign patients to comparison groups."⁶ Eric Voth, chair of the US Institute on Global Drug Policy, and Ernst Aeschbach, a Swiss doctor argued: "As seen in Switzerland, heroin handouts simply further the addiction and enslavement of suffering addicts."⁷ However, the Swiss trials encouraged the Dutch to act. The Netherlands Health Council, a government scientific advisory body, was charged in spring 1994 to report on prescribing heroin.

Just as in Switzerland, the context was concern for a section of heroin users that current treatment failed to reach. The council estimated that methadone maintenance programmes had proved inadequate for 8000 out of 25 000 Dutch addicts. It believed

heroin prescribing could establish contact with difficult to reach addicts, leading to benefits such as limiting the spread of infectious diseases.

In 1995 it advised conducting a randomised clinical trial into the "benefits or harmful consequences of prescribing heroin to severely addicted heroin users who fail to respond to current treatment."

The council stressed that it was "good clinical practice" for a doctor to prescribe medicines to an addict that will bring about "an improvement of the patient's medical situation and will not in principle harm the patient." However, it distanced itself from any concept of "free supply," saying it did not take a position on any form of legalisation of heroin.

Wim van den Brink, scientific director of the Central Committee on the Treatment of Heroin Addicts, said in 1997 that prescribing heroin would be one small piece of the puzzle of treatment—a "pharmacological intervention to stop a destructive pattern of behaviour."

A three month pilot project was launched in 1998 and, after parliamentary approval, a larger experiment with 300 heroin users in six cities, followed. Addicts had to attend clinics three times a day and use heroin under medical supervision, thus encouraging a daily routine that enabled close contact with medical services. Also the relatively safer method of inhaling rather than injecting heroin was encouraged.

Between 1998 and 2001, 549 patients participated in two randomised controlled trials comparing heroin and methadone with methadone alone over 6-12 months. The researchers claimed that the proportion of patients with a favourable response—defined as clinically relevant improvements in physical and psychological health as well as improvements in social functioning and criminality—was 20-25% higher among the group receiving heroin.⁸ In addition, despite their long term addiction 13% of addicts stopped using heroin in the second year, choosing either to return to methadone or total abstinence.

As a result the Dutch cabinet extended the scheme in 2004. Criteria for inclusion are being addicted for five years, unsuccessfully treated in methadone programmes, in poor physical and mental health, and aged over 35.

Today up to 450 patients are prescribed heroin in six cities. This is set to grow to 850 patients in 15 cities during the next year. Last year the Medicines Evaluation Board registered diacetylmorphine (heroin) as an effective treatment for a specific group of addicts, accepting it offers a positive balance between effectiveness and risk.

Ten years on, Professor Van den Brink believes prescribing heroin has gained scientific and ideological acceptance as a normal treatment, albeit with a specific indication. He hopes, although he accepts this is harder to judge, that it also "shows that we can deal in another way with addicts by not regarding them as criminals but as patients who are treatable."

He believes that in the future, as can be expected in any chronic disease, treatment will diversify. Heroin may not be a first line treatment but can play a small part in the range of care offered.

The latest figures from the UK's National Treatment Agency said 58% of addicts who attended drug clinics up to March 2007 failed to complete treatment. In the light of such data the successes claimed by the Dutch and Swiss with addicts who were all but beyond help, will continue to demand attention.

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