Commentary

Heroin maintenance and attraction to treatment

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Professor Fischer and his colleagues offer a useful and thoughtful overview of developments and plans for heroin-assisted treatment studies in a total of NINE countries. The practical problem from which all the trials start is that some part of the population of regular users of illicit heroin and other opiates does not come voluntarily into treatment either with prevailing forms of opiate maintenance or in various ‘drug-free’ treatment regimes, even when the thresholds for entry to these treatment modalities are lowered. As Fischer et al. note, in France the prevailing form of opiate maintenance is with buprenorphine; elsewhere, it is with methadone.

The proposition that heroin users should be in treatment rests on a variety of concerns and assumptions: a socio-
political concern to reduce the criminality often associated with heavy use of illicit opiates; a public health concern to limit the spread of AIDS and other infectious diseases for which heroin use is a potential vector; welfare concerns to offer a better life to the presumptively miserable; and the addiction-as-disease idea that heavy opioid use is a disorder and anyone suffering from it should be in treatment. To offer opiate maintenance therapy in a professionalized and sterile environment potentially answers to the first and second of these concerns, and services to meet the third concern can often be provided more conveniently to a client who is on opiate maintenance. But opiate maintenance operates under a continuing moral-political cloud, smaller in places like the Netherlands and larger in others like Sweden, since it cannot answer to the last of these concerns, at least without contorting the ordinary meaning of ‘addiction’. One way to get heroin users into treatment is to compel them. Compulsion or coercion, or the threat of compulsion, has been a major means of getting detected heroin users into treatment in countries which are notably not on Fischer et al.’s list, e.g. through the criminal justice system in the USA; through the welfare system in Sweden. But while there is a wide assortment of compulsory treatment laws internationally,\(^2\) in many places they are less and less used, perhaps partly because of longstanding ethical questions.\(^3\)

The other way to get heroin users into treatment is to attract them. The search for what will attract those who have not been attracted by the opiate already on offer for maintenance naturally ends up pointing to the substance for which the user has already developed a taste and a habit. Hence the idea of ‘heroin-assisted treatment’. The user’s ‘modest appetite for white powder’, as it was once termed,\(^4\) becomes in itself the means of attracting the user into continuing contact with the treatment system. However, the logic of this approach runs up against the fact that heroin is classed as a Schedule IV drug by the international drug control system. This means that it should not be used in general medical practice, but only for ‘medical and scientific research’. Those who wish to stay in compliance with the control system, but to use heroin as an alternative for opiate maintenance, are thus compelled to frame their programme or service as a research project. And not just any research project. The international arguments over the pioneer Swiss trial of heroin-assisted treatment have raised the stakes so that the projects most acceptable to the control system, and perhaps the only ones acceptable to it, are random controlled trials (RCTs), the ‘gold standard’ in research into the effectiveness of pharmaceutical treatments.\(^5\)

This is the conceptual and policy context which has brought forth the flowering of actual and proposed RCTs of heroin-assisted treatment in so many places. As Fischer et al. state, the trials are expensive, and the replications in so many national contexts seem a potential waste. As Bammer et al.\(^6\) have noted, the normal model of an RCT design comparing heroin-assisted treatment with another modality does not work well, since those assigned to the non-heroin arm differentially drop out. Furthermore, Jepsen\(^5\) has argued that RCT is not the appropriate design for the questions which really need to be answered about heroin-assisted treatment. Judging from the research questions Fischer et al. put forward in their ‘Discussion and Conclusion’, it seems that they agree.

Standing in the way of this sensible conclusion, however, is the international drug control system. And even if the system were to back away from upholding an RCT model for the research, there is the question of what happens next, supposing that the research supports the usefulness of heroin maintenance in addiction treatment (as the Swiss trial did). What will be required to implement heroin maintenance as a regular treatment option, rather than under the rubric of research? Either the international drug control system must change its mind about heroin classified in – or the affected countries must denounce or ignore the drug control treaties. In this matter, the international drug control system presently stands in the way of a public health approach.

**REFERENCES**


