THE CASE FOR HEROIN-ASSISTED TREATMENT IN CANADA

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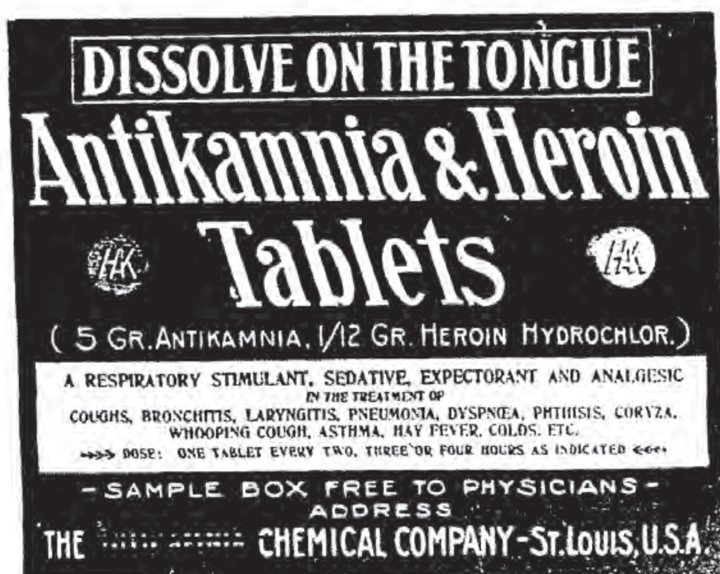
WHAT IS HEROIN?

A chemical compound derived from opium, diacetylmorphine was first synthesized in London in 1874. A few years later, the German pharmaceutical company Bayer trademarked the drug with the name "Heroin" and marketed it as a therapeutic remedy to treat respiratory ailments. Like other drugs derived from opium ("opiates"), heroin was also used as an analgesic to relieve severe, acute pain from injury or surgery.

Initially, heroin was believed to be non-addictive and was considered an effective cure for morphine addiction. It was soon discovered, however, that heroin was itself addictive. Since that time, the human and social costs of heroin dependency have continued to be borne by individuals, their families, and their communities. In Canada, there are currently 60,000-90,000 people who are dependent on opioids, the class of substances that includes both opiates and synthetically produced drugs with similar effects.

Over the past 100 years, the official response to opiate addiction has come in the form of new international conventions and domestic laws aimed at reducing the availability and use of opium, morphine, and heroin by restricting the manufacture, trade, distribution, and use of these drugs to "legitimate" scientific and medical purposes. International policies regulating these substances obtained near-universal adherence by nations in 1919 when countries became party to the Hague Convention. Focusing on this law-enforcement approach to drugs and addiction has resulted in great costs to the public that are just recently being recognized: prisons being filled with people who are addicted to drugs, the spread of deadly diseases such as HIV/AIDS and hepatitis C that threaten public health, loss of life, wide-spread violence related to gang activity, and the increasing difficulty of connecting people who are dependent on drugs with treatment and even basic health care. Each of these results means excessive economic and social costs to all of us.



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Individuals who are dependent on heroin personally experience even greater hardships beyond their addiction to drugs. Because heroin is prohibited for most uses and strictly controlled, using "street" or black market heroin carries its own risks. These risks include accidental overdose, exposure to blood-borne infections, a criminal record and prison time, exploitative relationships with dealers, and the diversion of housing and food money to purchase the drug, leading to further insecurity and vulnerability. Because heroin is illicit, its use is also highly stigmatized in our society. Misperceptions about people using heroin and living with addictions often lead to marginalization and loss of social networks. Stigma and ideology also lead to governmental policies, laws, and regulations that infringe human rights of people who are dependent on drugs, are enacted contrary to accepted scientific evidence, and put lives, well-being, and the public health at risk.

But, there is now a growing movement in support of treating addiction as a disease requiring medical interventions and not a moral failing requiring punishment. Where they are available, harm reduction programs such as syringe distribution and supervised injection services aim to prevent some the worst side effects of opiate use such as HIV / hepatitis C infection and overdose while allowing the continued use of illicit "street" heroin. While these programs provide an important access point for medical and social service professionals and peers to connect with marginalized populations, they cannot take away all of the social and personal harms of using a substance that is criminally prohibited.

Doctors, nurses, and others working with people who are dependent on drugs see first-hand the costs of addiction to patients and clients, and work with these people to minimize the harms of their dependency and ultimately help them end the use of substances that harm them. However, traditional abstinence-based treatment programs do not work for many people with addictions. Many patients for whom abstinence will not work have had success with drug substitution therapies, including Methadone Maintenance Treatment (MMT). Importantly, though, these programs also do not work for everyone. As with any medical intervention, there will always be a group of people who do not respond to the treatment. How can we respond to this challenge? The answer is prescription heroin treatment, the logical next step in the continuum of medical care. This proven treatment will allow us to offer the best medical care for that small population of people living with heroin addiction who have failed at other medical interventions.

WHAT IS HEROIN-ASSISTED TREATMENT?

Prescription heroin treatment, also known as Heroin-Assisted Treatment (HAT), allows a physician to prescribe medical grade heroin to a patient. The drug is produced in a hygienic medical laboratory. It is then provided to the patient under a controlled environment, such as a specialized medical clinic, and is then injected by the patient under medical supervision. Prescribing heroin means that a drug dependent individual is removed from an unsafe environment centred in the use of illegal "street" drugs and the criminal justice system and welcomed into a medical environment where care is provided. Often, in addition to providing the medication, patients are connected with social services that also help to stabilize their lives, including housing support, counseling, and life skills education.

I didn't have to worry about having to get up every morning and run all over [...] just like a chicken with my head cut off wondering where I was going to get the money to get better.

HAT programs are based on the understanding that opiate addiction is a medical condition and not a moral failing. It is often supported by medical professionals, politicians, and law enforcement personnel who see the results for themselves. Mike Barton, Chief Constable of Durham in England, sums up the philosophy behind these programs, noting that:

People who encourage others to take drugs by selling them are the criminals. But addicts need to be treated, cared for and encouraged. They do not need to be criminalized... If you started to give a heroin addict the drug therapeutically, we would not have the scourge of hepatitis C and HIV spreading among needle users. I am calling for a controlled environment, not a free-for-all.

Typically HAT programs recognize the importance of stabilizing the often chaotic lives of people dependent on heroin, so patients also have access to counselors, legal advocates, and other social supports that can assist with housing, employment, or other needs.

As one female participant in Vancouver's NAOMI HAT trial and member of the NAOMI Patients' Association stated:

They helped me get a room at the Empress Hotel and from there everything started to move forward.

I didn't have to worry about having to get up every morning and run all over hell's half acre just like a chicken with my head cut off wondering where I was going to get the money to get better.

WHO IS IT FOR?

One the most often-cited concerns about HAT programs is that people with addictions will forgo other treatment routes if this treatment is available to them. Importantly though, Heroin-Assisted Treatment is not a first-line treatment, but rather is a highly-regulated medical intervention. It is indicated only for patients who have not responded to standard treatments such as methadone, buprenorphine, or abstinence. Potential patients consult with medical professionals before entering HAT programs to see if the treatment is appropriate for them, inject in front of a doctor or nurse, and consult with medical professionals throughout the treatment to adjust dose and monitor positive and negative outcomes of the treatment.

HAS HEROIN-ASSISTED TREATMENT BEEN TRIED BEFORE?

Unsupervised prescription heroin has been available in the United Kingdom since the 1920s, being the main medication used for the treatment of opiate addicts up until the 1960s. The number of drug dependent people being treated was small, with the majority being middle-class, addicted to morphine, and in the medical or related professions. For a brief period in the early 1900s, many cities throughout the United States also had clinics providing supplies to addicts, with some offering maintenance treatment. At one time, there were clinics in 34 cities in 12 states, the largest number of clinics being in New York.

SWITZERLAND: THE FIRST MODERN HAT PROGRAM

In 1991, facing an increasing number of young addicts injecting heroin, emerging open drug scenes in Swiss cities, and increasing HIV infection rates, Switzerland created a national drug policy that included supervised prescription heroin. Prescription heroin was proposed as both a harm reduction measure and a means of providing access to medical care for addicts with severe health and social problems who were not benefitting from conventional treatment. A scientific study was designed to evaluate supervised injectable heroin treatment. Findings from the study showed positive health benefits. The World Health Organization (WHO) convened an expert committee to review the design, implementation, and results of the study, and they agreed with the results of the researchers.

HEROIN TRIALS: GERMANY, SPAIN, THE NETHERLANDS, BELGIUM, AND THE UNITED KINGDOM

The Swiss research trials prompted renewed interest in prescription heroin delivered in a supervised medical environment by other countries. Trials of supervised prescription heroin treatment based on the Swiss model were undertaken in Germany, Spain, the Netherlands, the United Kingdom, Canada, and Belgium over the next decade. All trials showed that these programs can improve the health of long-term heroin users for whom conventional treatment has repeatedly failed, and reduce illicit heroin use and criminal activity. This important research provided a solid base of evidence in support of this treatment.

Following completion of the trials, all countries except Spain and Canada implemented HAT programs. A research trial in Australia was closed before concluding due to political pressure and the trial in Belgium is continuing.

THE DANISH EXPERIENCE WITH HAT

In 2009, Denmark made the decision that there was sufficient evidence from the numerous trials around the globe to support opening a HAT clinic without conducting its own research trial.

HEROIN-ASSISTED TREATMENT IN CANADA

In Canada, researchers conducted the 2005-2008 North American Opiate Medication Initiative (NAOMI) study. NAOMI tested the efficacy of HAT for Canadian patients. Heroin was prescribed to approximately 100 patients in Montreal and Vancouver and compared with patients who only received "optimized" MMT. Despite the positive results of NAOMI, doctors were unable to secure approval from the federal government to either set up a permanent HAT clinic, or even provide continued access to heroin to the participants in NAOMI. Canada became the only country in the world to fail to provide heroin to the participants in a research trial. This decision was not based on evidence, but on ideology. As one male NAOMI participant and NAOMI Patients' Association member stated:

A decade and a half of studies in Europe and North America have produced a massive body of medical evidence in support of HAT.

If they give you a drug for – they're experimenting with a drug for cancer and it starts working. I mean, what are they – what are you going to do? Oh, no. You can't have it anymore; we're going to back off here.

Currently, another Canadian research initiative, the Study to Assess Longer-term Opioid Maintenance Effectiveness (SALOME) is ongoing. This three-year study is testing whether another opioid, hydromorphone (Dilaudid) is as effective as heroin in stabilizing patients.

To date, about 75 of the 322 anticipated study participants have completed their one-year on the study. Where appropriate, the clinical doctors of these participants have applied for special access to injectable heroin for patients leaving the study, so that they would not be required to return to medical treatments that they had previously failed on, such as methadone or abstinence.

In late September of 2013, Health Canada recognized the importance of continued care for this vulnerable population, and approved access to injectable heroin for 21 of these people for three months. However, within weeks, the federal government enacted new regulations that now prohibit Health Canada from approving access to heroin through the Special Access

Program. As a result, some existing applications were rejected, and it is expected that all applications coming before Health Canada for this purpose will be rejected, including applications for extending treatment for the 21 who had been approved for three months. Pivot Legal Society is exploring constitutional challenges to these regulations, which stand in the way of people receiving life-saving medical treatment, on the basis that they put the lives of SALOME patients at risk and are discriminatory.

IS HEROIN-ASSISTED TREATMENT EFFECTIVE?

A decade and a half of studies in Europe and North America have produced a massive body of medical evidence in support of HAT. All of the studies to date find that providing prescription pharmaceutical heroin to be injected in a medical environment reaches a particularly difficult group of patients and engages them in a positive health care relationship with a physician.

The programs have a strong and consistent record of decreasing crime and public disorder by reducing the need for heroin users to purchase street drugs

In 2010, the Cochrane Drugs and Alcohol Group published a systemic review of eight randomized controlled trials of heroin prescription around the globe, with more than 2,000 patients who had responded poorly to other treatments, including methadone. This review led the Cochrane Collaboration to conclude:

The available evidence suggests an added value of heroin prescribed alongside flexible doses of methadone for long-term, treatment refractory opioid users, to reach a decrease in the use of illicit substances, involvement in criminal activity and incarceration, a possible reduction in mortality, and an increase in retention in treatment.

Consistent with the findings of this review, the Canadian NAOMI trial reported in the New England Journal of Medicine that: "Injectable diacetylmorphine was more effective than oral methadone." Additional publications from the NAOMI study report that HAT was successful in treating severe opioid addiction in particularly vulnerable sub-populations, including sex-workers, opioid addicted women, individuals with a history of physical or sexual abuse, and Aboriginal persons.

Specific Benefits include:

- Improved overall health status among patients
- No fatal overdose due to prescribed substances
- More stable housing, employment, and contact with family.

In the Canadian NAOMI study, researchers found that prescribing heroin in a supervised medical environment resulted in patients staying in treatment longer than "optimized" MMT (88% vs. 54%), spending roughly half the amount of money on illicit drugs as when they entered the study, reducing their use of illicit drugs, engaging in lower amounts of criminal activity, and improving in medical and psychiatric status, employment satisfaction, and family and social relations.

Studies also show clear community benefits from HAT programs. For example, in the Swiss study there was no noticeable disturbance in local neighbourhoods and criminal offences decreased by 68%.

HOW MUCH WOULD A HAT PROGRAM COST AND WHO WILL PAY FOR IT?

Although a HAT program is expensive, there is a financial case to be made in support of this treatment.

Costs of initial set up of a HAT program will be rapidly offset in other ways. This includes the economic benefits of reduced crime, criminal justice and prison, and lower long-term health care costs over time. Taking these long-term costs of remaining in one treatment over another, the NAOMI researchers learned that prescription heroin treatment is more cost-effective than methadone.

DOES LAW ENFORCEMENT SUPPORT THIS?

In every country in which HAT programs have gone forward, they have done so with the support of politicians, health officials, and law enforcement. Since the programs have a strong and consistent record of decreasing crime and public disorder by reducing the need for heroin users to purchase street drugs and in many cases helping them get off drugs altogether, it is reasonable to expect that law enforcement will be supportive.

HOW WOULD A HEROIN-ASSISTED TREATMENT PROGRAM WORK IN CANADA?

Diacetylmorphine (heroin) is a controlled drug in Canadian society and requires approval from federal regulatory bodies to administer, even in a medical or scientific setting. However, with some straightforward regulatory changes, heroin could become more easily available for use in medical environments and even production within Canada, reducing the costs of importing the drug from abroad. Simply put, establishing a HAT program involves 1) listing heroin on the federal and provincial "pharmacopeia" (i.e. approving it as a treatment drug under federal laws); and 2) authorizing physicians to prescribe the drug in certain circumstances.

ARE YOU TRYING TO SUPPORT THE LEGALIZATION OF HEROIN?

No. HAT does not promote the legalization of heroin. It is simply a tool to help reduce the harms caused by the use of illegal heroin by providing an empirically validated method for long-term users to reduce the harm of their use, access health and social services, and act as a bridge to treatment.

Heroin would remain very strictly controlled along every stage, from being supplied by an authorized manufacturer, being received by an approved medical clinic, to being prescribed by an authorized physician to an approved patient.

WHERE WOULD THE HEROIN COME FROM?

Currently, three countries - England, the Netherlands, and Switzerland - commercially produce pharmaceutical heroin that is available for heroin clinics. With appropriate federal government approvals, pharmaceutical companies in Canada could, in the future, produce heroin for use in HAT programs.

Canada is only now beginning a dialogue about the benefits of prescription heroin treatment, despite conducting a successful prescription heroin trial that ended in 2008. We know that prescription heroin treatment works for many people and there is ample evidence to support beginning a permanent HAT program in Canada. Despite the foreignness of the idea of prescribing heroin under medical supervision to people who have failed at other treatments, a clear look at the research demonstrates that this treatment works, and for all the right reasons.

WHERE CAN I FIND OUT MORE?

The SALOME Study official website:
http://www.providencehealthcare.org/salome/index.html

Heroin: A Hundred-Year Habit, by Ian Scott | Published in History Today Volume: 48 Issue: 6 1998
http://www.historytoday.com/ian-scott/heroin-hundred-year-habit

Heroin maintenance for chronic heroin-dependent individuals. Cochrane Database Systemic Review. August 2010. http://www.ncbi.nlm.nih.gov/pubmed/20687073 (Abstract)

New heroin-assisted treatment, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, April 2012.
http://www.emcdda.europa.eu/publications/insights/heroin-assisted-treatment

NAOMI Research Survivors: Experiences and Recommendations, NAOMI Patients' Association and Susan Boyd.
http://drugpolicy.ca/wp-content/uploads/2012/03/NPAreportMarch5-12.pdf

Heroin-Assisted Treatment FAQs. Drug Policy Alliance.
http://www.drugpolicy.org/docUploads/HAT_FAQs.pdf

A Constructed Solution: Heroin-Assisted Treatment (HAT). Drug Policy Alliance.
http://www.drugpolicy.org/docUploads/HAT_FactSheet.pdf

HOW CAN I SUPPORT A HAT PROGRAM IN CANADA?

- Write letters to Rona Ambrose, the federal Minister of Health, your MP, and your MLA saying how you support evidence-based treatment options such as HAT for people who are dependent on drugs
- Write letters to newspapers stating your support for medical interventions for people who are dependent on drugs instead of criminal prohibitions
- Talk to people about HAT and tell them what you've learned about this medical intervention
- Check out Pivot's Health and Drug Policy Campaign at pivotlegal.org

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