

Dr Clare Gerada

Heroin prescribing – why bother?

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Heroin prescriptions may benefit some users. But is it worth the risks asks Dr Clare Gerada.

Heroin prescribing is being promoted as a new and innovative way of dealing with drug misuse. The argument goes something like this, 'If they won't stop using street heroin, then let's provide it on the National Health Service.' What's more, many have been heard to say that 'general practitioners can prescribe it in between the sore throats and the brain surgery'. I jest of course, but have I missed something? Have I been misinformed?

Nothing new

Do we not *already* have heroin available as a treatment option for drug misuse? Are we not the only country in the world to have had this form of treatment available for nearly eighty years? Did not the 1926 Rolleston Committee, in defining the 'addict' as a medical concept as opposed to a 'moral failing', open the way for doctors to prescribe to such individuals for the 'alleviation of withdrawal symptoms'? Rolleston firmly defined addiction as a disease requiring treatment and legitimised maintenance prescribing of morphine and heroin to addicts who could not otherwise function and hence endorsed doctors prescribing of heroin in non-reducing doses – 'if attempts to reduce the dose left them incapable'. Rolleston was revolutionary – and symbolised an accommodation between penal and medical approaches to treatment, which has since been referred to as the 'British System' and has continued ever since. So heroin prescribing is not new, though since the introduction of other treatments, such as methadone and more recently buprenorphine, it has been a minority activity.

Prescribing heroin is limited to a few doctors, mainly working from specialised addiction services, all of who require Home Office licenses. Though providing heroin

on the NHS for the treatment of addiction is rare (where it comprises less than one per cent of all prescriptions), and not all the doctors that are able to apply for a license have done so, it is nevertheless available as a treatment option. So I really do not understand why we are questioning something that we already have. Why this sudden drive to increase the number of doctors and patients receiving it? Where is this being driven from?

The drive to prescribe

The pro-heroin prescribing camp state that by replacing illegal adulterated heroin with licensed or prescribed heroin will have major benefits for existing heroin addicts. This is undoubtedly true – the user would then have access to a regular secure supply of pure heroin and of clean needles and syringes. With current prescription charges at around £6 this would be a considerably cheaper option than paying the price the dealer demands. As a result lives will be less disrupted and the risks to their health considerable reduced. They however, would still be dependent on a highly addictive substance, but would be less at risk of dying from an overdose or from blood borne diseases. They would also, some argue, be able to keep down jobs or continue with their lives in other spheres. These are laudable harm reduction arguments and I am sure there are some users that would and have benefited, but at what cost? What cost to themselves, their families, friends and to society at large?

Small margin for error

In the short term the danger of heroin is overdose. The ratio between overdose and pain relief or between the dose that will produce a 'rush' and one that kills is very small – this is referred to as the therapeutic index. Someone can die with 6mg heroin taken intravenously if they are a completely naive user. Of course someone with a greater deal of tolerance can safely take 50 – 100mg or even more.

However, even in these individuals there are dangers. Despite the high tolerance – it can easily and rapidly be lost. How many users know that even within two to three days they can lose their tolerance? Tolerance is certainly gone by about two weeks of abstinence. This means that the same dose taken during normal circumstances will kill. Heroin kills through respiratory depression and through sedation that causes inhalation of vomit. Deaths from impurities are rare and sporadic – so let's be clear – pure heroin kills more than impure.

Leak to the street

Pharmaceutical heroin will have a high street value – this is a certainty. Unless consumed on the premises and under supervision, there is the real risk of diversion. Already patients are at risk from assault and theft when they leave treatment centres and general practitioners surgeries with their prescriptions for methadone or leave the pharmacy with their medication. Even if the prescription is not stolen, patients are often enticed to relieve themselves of their prescription – or am I the only one to hear 'anything to sell' or see blatant dealing and bartering outside pharmacists? This will get worse when it's known that the reward is pure heroin, rather than boring methadone linctus. Unless taken under supervision, how is the doctor going to ensure that the drug does not get diverted? For the purposes of urine testing, there is no way of distinguishing between prescribed heroin and heroin obtained to 'top-up'.

The grip of heroin

Heroin is highly addictive. Heroin is one of the strongest reinforcers of repetitive behaviour known – simply put, the user wants more and more. Like cigarettes once addicted it is very difficult to stop, yet most spend a lifetime trying. Heroin addiction has victims – even if prescribed. The victims are the users themselves, their families, friends and society.

Unfortunately, some people, especially journalists, just do not understand addiction, and do not understand that there is a compulsive element to it that can grow and grow, especially if it is only 'satisfied' rather than 'treated'. Sometimes it is helpful to provide someone with a controlled amount of an opiate – partly because opiate users can have a good quality of life with a controlled dependency, but we do so with caution. Few users given access to prescribed or cheap and plentiful non-prescribed heroin manage their intake well. Most, even informed and experienced users, take far too much – and spend their days clearly out of it for a lot of the time. Drooping eyes and speech at four words per minute are not attractive qualities and they do not make for good communication and exchange of ideas or for successful employment. There are exceptions – but they are just those, exceptions.

Supply will drive demand

There is a real risk that by increasing availability, either through diversion or through increased users in treatment, will create demand and increase the numbers that subsequently use the drug and therefore that will require treatment with it. Availability is the chief factor in determining demand.

Supervision

Heroin is far from suitable as a maintenance drug. It has a short duration of action – which means its effects do not last long and so has to be injected three times a day to prevent withdrawal. Strictly speaking, and in line with the Clinical Guidelines, this should be under supervision. We cannot have one standard for methadone and another for heroin. The Swiss study patients all take their heroin supervised. Attending a clinic three times a day and being watched injecting does not promote independent living nor is it compatible with holding down a job or running a home or family.

High costs

A year's supply of oral methadone costs around £2000. The equivalent for heroin is around £10,000–£15,000 per year. Of course, cost must not dictate treatments – but realistically unless there is proven value for money, and there is evidence for its use, then with today's cost pressures on the NHS, I cannot see the average Primary Care Trust commissioning manager investing in this treatment. In today's NHS, NICE (National Institute of Clinical Excellence) would have to agree that it was an effective and evidence based treatment to justify this cost – and one suspects given the evidence and alternatives they are unlikely to give it the 'thumbs-up'.

What's the evidence?

The Swiss studies show it only as effective as oral methadone in a limited number of patients, and in a study situation. Translate this into the real world of a cash starved NHS unable to provide three times a day supervision and unlimited counselling and I predict we will see different outcomes. Finally all the programmes that have successfully used heroin for positive and sustained change have done so through close supervision and a lot of other supportive services.

So let me nail my colours to the mast. Methadone maintenance has repeatedly shown to reduce users' street drug use and other criminal activities and to improve health and social behaviour. So where is the need for heroin prescriptions?

I agree that there is a need for injectable prescriptions for some users – for patients that have persistently failed at oral treatment. The ACMD as early as 1988 recommended that we should have limited heroin prescribing in order to move away from sharing equipment and provide treatment which may facilitate a gradual change away from injecting use, though with the caveat that 'when provided it should be normally undertaken for a short period of term, rarely more than three months'. While therefore, I see a need for injectable drugs, why heroin? Why not, if we do need an injectable form of treatment – use methadone?

Finally, and so we don't lose sight of the key issue, what is important is to make sure every drug user has access to good care, care that encompasses all of their needs, delivered by staff trained and skilled to do the job and is available throughout the country. At the moment drug users have piecemeal access to even basic standards of treatment – so let's concentrate on the basics – and get them right first.



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The policy for the fight against drugs and drug addiction in Portugal: recent developments

In Portugal drugs and drug addiction are commonly identified in opinion polls as one of the citizens' greatest concerns. Of course, people have hazy opinions on the problem and often confuse some aspects that are not strictly caused by addiction and the consumption of illicit drugs. For example, petty crime, which has only slightly increased in a country with low indices of criminality, is the crime that is most commonly felt by the citizen in the street and it is normally associated with drug addicts.

The subject of drug addiction raises fears and insecurities. It is not by mere chance that it is repeatedly regarded as an issue that should not be fought on a party-political and ideological level. This is also why there is a constant appeal for agreement rather than disagreement. This is an area where radicalism is undesirable. Whosoever adopts this stance will be regarded as an outsider in the discussion both by the citizens and by politicians in general.

Based on these premises any reform in this area requires a special strategy. Fanning the fire of people's fears should be avoided. The approach, even if based on concrete steps forward, needs to have a conservative anchor. Let us take a look at what this means in the case of Portugal.

A new paradigm – sick not criminal

Let us review the essence of the reform carried out in Portugal in 2000 and 2001.

The approval of Law no. 30/2000 of 29th November, which came into force on 1st July 2001, established a new paradigm in which the consumer or drug addict is essentially considered to be sick rather than criminal.

Consumption continues to be prohibited by law, although it is considered illicit merely in administrative terms and is subject to penalties and specific measures by administrative rather than judicial authorities. Therefore, it was decided not to send consumers to prison but rather to consider them as people requiring treatment or, should they refuse it, to sanction them by administrative means namely through community

work as a penalty for illicit behaviour.

It should be noted that, in taking this approach, the message that drug consumption is prejudicial, prohibited and not socially acceptable has not been abandoned.

Likewise trafficking continues to carry penalties, ensuring that the police forces can carry out an increasingly determined fight. The positive results of this policy have become evident over the last years.

There are many reasons for this new approach and it cannot be denied that it is an option that carries risks although these are consciously taken.

A failing system

The fact is that the situation that existed until quite recently was no longer acceptable and was the equivalent of 'hiding one's head in the sand'. The previous legal framework, which labelled the consumer a criminal, existed for around 30 years without producing clear results in controlling the systematic increase of consumption. It therefore became evident that the desired dissuasive effect did not work and that the law enforcers, the police forces and law courts, saw their hands increasingly tied in applying it. The idea that repressive measures were useless gradually established itself.

As an example of the situation regarding the application of the old law it is sufficient to say that few consumers of illicit drugs were ever detained by the police. Of these only a minority were charged and a very small percentage of them were brought to court and sentenced.

In 1999 only 1074 people were

subject to a penalty for consumption. Less than 7% of these were sent to prison and the overwhelming majority (over 90%) were given fines, warnings, suspended prison sentences and suspended fines.

Furthermore, it became evident that the illicit drug consumer was either sick or a person at risk of becoming sick however much the law insisted in classifying him as a criminal.

This opinion gained increasing social support except in some fringes of the more conservative political spectrum and even here, the rejection of this stance became less strident. Much of this was due to the great contribution made by the scientific community as well as by the debate which gained pace in society namely through the support of the President of the Republic.

Many in the Catholic Church also made their contribution, some for, some against and others raising doubts.

Consequently the new framework, born of humanist principles, rests on the cornerstone of treatment, prevention and the attempt to dissuade new consumers rather than on punishment.

This paradigm shift rests on the view that the legal apparatus should concentrate its attention and employ the resources available first and foremost in the fight against illicit trafficking of drugs and money laundering while the fight against consumption should be carried out above all in terms of prevention, treatment and social reintegration.

Compatibility with international treaties

Concern has been expressed in relation to the possible incompatibility between this option and international treaties to which Portugal is bound.

We believe that these concerns are unfounded. The solution adopted scrupulously respects the international