In this issue of the Journal, Oviedo-Joekes et al. reported on the results of the North American Opiate Medication Initiative (NAOMI) trial comparing methadone with injectable diacetylmorphine (the active ingredient in heroin) for the treatment of heroin addiction. These data from North America point to a conclusion that has been widely supported, although not without controversy, by similar recent studies in Europe. The results of this trial may be added to those from Germany, the Netherlands, Spain, and Switzerland. Switzerland has 10 years of experience in the prescription of heroin, and in a November 2008 referendum, 68% of voters were in favor of its continued prescription.

The prescription of heroin is rigidly controlled, and some commentators have asked whether a less restrictive and more clinical approach might make a difference to the proportion of drug users who are treated with heroin. Guidance on the prescription of heroin published by Britain’s National Treatment Agency for Substance Misuse in 2003 stressed that the drug should be prescribed as a last resort and under the medical control of a specialist. The prescription of heroin is now recognized in some European countries as the optimal treatment for patients for whom options are running out and in whom methadone maintenance has not worked, and it keeps the user in contact with drug services.

What Ashton and Witton have called a “role reversal” from killer drug to medical treatment is historically paradoxical. The emerging consensus is that heroin is a treatment for a limited number of illicit-drug users who do not do well with other medicines. Historically, however, heroin was the main “drug of choice” for treatment. In the 1920s and earlier in Britain, it was the treatment or maintenance drug for compliant middle-class addicts, those who accepted the authority of the doctor to prescribe to them. The prescription of heroin was the basis of the so-called British system, which operated until the 1960s. This was not the case in the United States. The inability to conduct the NAOMI trial in the United States reflects a historically different attitude toward the medical prescription of heroin to addicts; this prohibition dates back to the implementation of the 1914 Harrison Narcotics Act before World War I. Doctors were prosecuted thereafter if they prescribed heroin for addicts. The cross-national difference in heroin prescribing and the continued prescription of heroin in Britain owed much to the power of the British medical profession and to the low number of mainly middle-class addicts in the United Kingdom who took heroin. The person with control of the drug and the sort of person who was addicted were important.

Contextual issues like these, not the intrinsic properties of the drug itself, affected different national responses to treatment and to the prescription of heroin; these issues also affected the change toward the use of methadone in the 1960s and 1970s. The switch from abstinence from illicit-drug use as the only legal option to the use of methadone took place under the influence of re-
searchers Dole and Nyswander in New York. In the United States, methadone was associated with the ethos of a “medical” drug, whereas heroin was not. In the United Kingdom in the 1970s, the change came from prescribing heroin to prescribing methadone. That switch was also legitimated by a trial carried out by researchers Mitcheson and Hartnoll in the drug-dependence unit at London’s University College Hospital. They found that, as compared with the prescription of heroin, the prescription of methadone was a more confrontational method of treating addicts. It could force change even if it also brought greater involvement in the black market for heroin. It is recognized that the evidence from this trial, which is widely cited as the motivating force behind a switch from prescribing heroin to prescribing methadone on a short-term basis, was pushing at an already open door. It legitimated a change that was already underway, which the psychiatrists who ran the clinics wanted. The drug-dependence units had filled up with long-term heroin users. As Stimson and Oppenheimer noted in their classic study of the period, this switch provided a rationale for clinic staff who longed for a therapeutic, rather than a shopkeeping, function. Professional interests again drove change.

This episode of research and its effect on practice 30 years ago tell us something significant. The rise and fall of methods of treatment in this controversial area owe their rationale to evidence, but they also often owe more to the politics of the situation — to the context within which the evidence is received and to the interests that are prepared to support or oppose it. In Britain, the prescription of heroin is taking place on a small scale. However, it is more costly than methadone, which matters in a cost-conscious centralized health system, and few patients are receiving these prescriptions. Meanwhile, the “harm reduction” consensus about maintenance treatment overall is being questioned, primarily in relation to methadone. As in the 1970s, clinic staff long for change, this time away from what one drug-treatment worker called “methadone, wine, and welfare.” Researchers have pointed out that most illicit-drug users say they want to stop taking drugs. Conservative politicians have championed abstinence from illicit-drug use, and the media has asked why the treatment budget is so large if addicts just continue to take drugs. Hence, a re-definition of the purpose of treatment and the nature of recovery is under discussion in the drug-treatment field. The consensus favoring maintenance with methadone as the major treatment option may shift.

The treatment of addiction is a controversial matter, and practices that were once managed by specialists in-house and that were the subject of clinical discussion or publication in medical journals are now more open to a sometimes uncomprehending public gaze. Results such as those reported in the NAOMI trial matter, but they do not operate in a vacuum. Countries have responded very differently to the findings reported so far. Switzerland and the Netherlands have integrated the prescription of heroin into their medical systems, while Germany and Spain have hesitated. In the mid-1990s, the Australian government discontinued a heroin trial. Will the “homegrown” results from the NAOMI trial have more impact in North America than the results from Europe? We will now wait to see what political or professional factors will support or oppose the conclusions of this study in its home territory, and whether the historical legacy of heroin will matter.

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Heroin, abuse of which has become an epidemic in the U.S in recent years, is not a new drug that just showed up in the late 1960's, nor are its negative effects unique to modern times. Heroin is an opium derivative and, as with any of the opium derivatives, there is a severe physical/mental dependency that develops when heroin is abused. The Birth of the American Heroin Addict. In the mid to late 1800's, opium was a fairly popular drug. Opium dens were scattered throughout what we know today as the wild west. The opium influx during this period was due in large part to the drug being brought in from China, and other opiates trace their origins to a single plant—the opium poppy. Opium has been used both recreationally and as a medicine for centuries. Opium derivatives, including morphine, became widely used pain relievers, particularly in the 1800s. Heroin was first synthesized for medical use before physicians realized its potent addictive properties. Heroin facts including the history of heroin, heroin statistics, how was first discovered, how it is made today and where it comes from. The Heroine Drug History & Facts. As early as 3400 BC, the opium poppy flowers were grown and harvested in Mesopotamia. Related Links. USDA Heroin info. National Drug Control Policy. Narcotics Anonymous. The Heroine Drug History and Heroin Facts. Heroin, also called "diacetylmorphine" is produced from the acetylation of morphine which is extracted from natural opium sources like poppy flowers. As early as 3400 BC, the opium poppy flowers were grown and harvested in Mesopotamia. Suddenly heroin prescription is back in the news, so here's an archaeological find from the hard-drive: an essay I wrote in praise of heroin prescription, for the "Roger Hole Essay Prize in Medical Scepticism", as a young undergraduate in medicine, in 1998. To begin, we must consider the history of opiate addiction and its treatment, in order to understand how and why politics intervened, and how we arrived at the state we are in today. A Brief History of Opiate Addiction and Rehabilitation. Heroin on Prescription. The current situation is that very little heroin is prescribed in the UK: it was estimated that 117 addicts were prescribed heroin in 1992, while 17,000 were prescribed methadone (Gossop 1995).