

# **Assessing the Future of Maintenance Treatment in Canada in an International Context: An Analysis of Current Initiatives and Historical Practices - 1900 to 2010**

by

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## **Abstract**

The treatment of addiction poses a significant challenge. This challenge is a result of the complexity of addiction itself as a health problem and because a full understanding of what causes addiction is something that still eludes researchers and clinicians. Add to this situation the reality that addiction is an issue with significant political, social and legal dimensions and its treatment becomes complicated. This complexity evokes questions about why different forms of treatment are advanced, accepted or rejected. This dissertation provides insight into this through an examination of heroin maintenance.

The dissertation is a study of the history of heroin maintenance, including present-day developments, across a number of nations. Its purpose is to identify a set of forces that can explain recent experimentation with heroin maintenance and offer insight into its sustainability in Canada. Six countries are included: Canada, the US, the UK, the Netherlands, Germany and Switzerland. A mixed method, qualitative approach is employed and relies on three data sources: 1) health and sociology-oriented literature, 2) archival data from government departments and addiction treatment agencies, and 3) interviews with heroin maintenance trial stakeholders.

Using the work of David Garland and the critical literature on harm reduction as a theoretical framework, a number of social and political forces have been identified as essential to the implementation of heroin maintenance. These include: 1) models of drug control, 2) perspectives on addiction and its treatment, 3) drug-related crises/epidemics, 4) pragmatism and evidence, 5) how heroin maintenance is framed, 6) local support and action, 7) political environments, 8) international developments/pressures, and 9) the extent of medical ownership of addiction, professional influence and expert advocacy. These forces all interact to produce conditions that are either favourable for introducing heroin maintenance or inhibit its use. An analysis of the current Canadian context based on these factors suggests that the sustainability of heroin maintenance is questionable. A drug policy environment increasingly guided by social conservatism and declining political, public and professional attention to heroin addiction may impede moving such a controversial and expensive service from a research setting to a routine treatment option in Canada.

**Keywords:** Maintenance Treatment; Heroin Maintenance; Addiction; Opioid Treatment; History of Drug Control

*To my dear friend Erin, your strength in overcoming  
addiction and adversity is truly inspirational.*

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## List of Abbreviations

ADARF	Alcoholism and Drug Addiction Research Foundation
ADC	Alcohol and Drug Commission
AMA	American Medical Association
BC	British Columbia
CMA	Canadian Medical Association
LAAM	L-alpha-acetylmethadol
NAF	Narcotic Addiction Federation
NAOMI	North American Opiate Medication Initiative
RIOTT	Randomized Injectable Opioid Treatment Trial
SALOME	Study to Assess Long-term Opioid Maintenance Effectiveness
UK	United Kingdom
US	United States

# **Chapter 1. Introduction**

## **1.1. Background and Study Premise**

The treatment of addiction poses a significant challenge. This challenge is, in part, a result of the complexity of addiction itself as a health problem. Addiction involves an interaction between a drug, an individual and their environment (Mate, 2008). A full understanding of how these three elements interact to produce addiction is something that still eludes researchers and clinicians in the field of addiction treatment. However, there is no shortage of theories of addiction that have inspired different approaches to treatment, some of which are more successful than others. When we add to this situation the reality that illicit drug addiction is an issue with significant political, social and legal dimensions, the treatment of addiction becomes complicated. This complexity evokes questions about how and why different forms of treatment are advanced, accepted or rejected at different times and locations. More broadly, how do the interactions among clinical evidence, theories of addiction, ideology and political and social forces shape the treatment of illicit drug addiction?

The present dissertation provides insight into the social and political forces that shape the treatment of addiction through an in-depth examination of one treatment modality – maintenance treatment. Maintenance treatment is the practice of prescribing drugs to persons dependent on a substance(s) with the purpose of managing their dependence and preventing withdrawal symptoms. Maintenance treatment is sometimes referred to as substitution or replacement therapy because the substance prescribed is often not the precise drug the individual is dependent on; frequently the substitute drug is from the same class of drugs but with more manageable qualities (e.g., produces less cognition or behavioural impairment or is longer acting) or the drug prescribed is the same drug but with a different mode of delivery (e.g., taken orally rather than smoked or injected). In other instances, maintenance treatment is simply the

provision of the substance an individual is dependent upon, delivered through the same modality but offered through legal and medically controlled channels.

The practice of prescribing drugs to substance dependent persons may seem counter-intuitive to some. For instance, those opposed to maintenance treatment for illicit drug users suggest it is merely facilitating or encouraging an individual's addiction. According to this view, maintenance treatment supports the very condition under treatment. However, pharmacotherapies, or any addiction treatment that involves the administration of drugs, are more common than might be expected and are used for a wide variety of purposes (Roberts & Ogborne, 1998). Maintenance treatment is simply one pharmacotherapy. Drugs, such as naloxone (Narcan), are administered to counteract opioid drug overdoses. Naltrexone can prevent individuals from feeling the pleasurable effects of opiates, thereby discouraging use. Drugs are also used to manage symptoms of withdrawal in detoxification. There is, for example, the common practice of administering diazepam (Vallium) to persons withdrawing from alcohol. Drugs may be prescribed for a short-time to gradually withdraw an individual from a drug, thereby avoiding acute withdrawal symptoms. For example, Zantex, Champix and other stop-smoking aids are often used for this purpose.

Maintenance treatment is more controversial than other pharmacological treatments because its end goal is not abstinence but controlled use and improved health and social functioning. Maintenance treatment broadens the conception of treatment beyond the idea of a 'cure' for addiction to more attainable goals such as continued engagement, improved health and quality of life, and reduced involvement in crime. Abstinence is, of course, a desired result of maintenance treatment but not its principal objective. Some maintenance programs require abstinence from illicit street drugs but still cannot be described as abstinence-based treatment because they involve the continued provision of mind altering substances.

Different forms of maintenance treatment are more widely accepted than others. Methadone maintenance, for instance, is well-established. Although there is still some controversy surrounding methadone, it is used in many countries worldwide (Matrnick, Breen, Kimber, & Davoli, 2009). Heroin maintenance, on the other hand, is one of the

most contentious forms of maintenance treatment. Heroin maintenance, or heroin assisted treatment as it is sometimes called, involves the medical prescription or provision of heroin to persons dependent on opiates, often in conjunction with other health and social services. Despite the controversial nature of heroin maintenance, there has been renewed interest in this treatment option in Canada and abroad, notably over the past three decades.

In the mid-2000s, Canada joined a handful of countries experimenting with heroin maintenance. Following the lead of Switzerland and the Netherlands, the controversial North American Opiate Medications Initiative, or the NAOMI project, established two clinics early in 2005. These clinics provided addicted individuals with a free and legal source of heroin. The two clinics, one in Vancouver and the other in Montreal, were modeled after similar Swiss and Dutch programs and were part of a randomized clinical trial, designed to assess the effectiveness of heroin maintenance in comparison to methadone maintenance. Participants in the NAOMI project were long-time injection heroin addicts who had previously failed in methadone programs. Approximately half of the participants were given injectable heroin up to three times a day for one year, a small number were given Dilaudid (10 per cent), and those remaining participants received oral methadone. These three groups were compared on their involvement with crime and the illicit drug scene, their employment status, personal health, and a variety of other indicators of social functioning (Oviedo-Joekes, et al., 2009; Gartry, Oviedo-Joekes, Liberte, & Schechter, 2009).

Published results of the NAOMI trial found that the individuals treated with heroin had more positive treatment outcomes than those treated with methadone. The heroin group had an 88% treatment retention rate compared to 54% in the methadone group. Likewise, 67% of participants in the heroin group showed reductions in illicit drug use and other criminal activities compared to 48% in the methadone group. The one indicator where those treated with heroin had more negative results than those treated with methadone was the number of serious adverse events (e.g., overdoses, seizures, infections). Throughout the trial there were 51 adverse events in the heroin group and 18 in the methadone group. In each of these events, staff successfully intervened and none of the participants involved required hospitalization. The number of participants in



the Dilaudid group was too small to test for significant difference from the other two groups but their results were very similar to participants who received heroin. Moreover, participants could not definitively determine if they were in the heroin or Dilaudid group (Oviedo-Joekes, et al., 2009).

The prescription of heroin as a form of maintenance treatment is not a novel idea. Providing narcotics to opiate addicts in order to avoid the experience of withdrawal and reduce the negative consequences of addiction has been discussed in Canada and elsewhere since the early 20<sup>th</sup> century. Methadone maintenance has been available in Canada since the mid-1960s (Paulus & Halliday, 1967; Fischer, 2000). In Britain, doctors were free to prescribe heroin to addicts until the practice was severely restricted in the late 1960s, in response to growing moralism surrounding this form of treatment, American pressure to abandon it, and fear that prescribed heroin was being diverted onto the black market (Berridge, 1984; Mold, 2004). Furthermore, in 1972, the Le Dain Commission recommended that a scientific experiment be conducted in Canada to determine the utility of heroin maintenance for addicts who did not respond well to methadone maintenance. The suggestion to test the effectiveness of heroin maintenance was not acted upon (Fischer, 2000, Fischer & Rehm, 1997).

More recently, in response to citizens' concerns about illicit drug addiction and the failure of various other interventions, Switzerland implemented a series of studies to test the effectiveness of heroin maintenance. The Swiss experiments, run from 1994 to 1998, found that heroin prescription treatment was successful in stabilizing addicts' lives and effectively reduced criminal behavior, health problems, homelessness, and contact with the illicit drug scene (Brehmer & Iten, 2001; Perneger, Giner, del Rio & Mino, 1998; Steffen, Christen, Blattler, Gutzwiller, & the PROVE team, 2001). In response to these successes, Switzerland has continued to use heroin maintenance and the Netherlands has established a similar program, again with favourable results (van den Brink et al., 2003; Central Committee on the Treatment of Heroin Addicts, 2002). Heroin maintenance trials were also recently run in Germany, Spain, Belgium and the United Kingdom (UK).

The NAOMI project was part of a growing trend that has placed an increased emphasis on treatment and public health approaches to addiction. The project was established in response to the acknowledgement that currently available treatment options are often unsuccessful in treating the most severely addicted or marginalized addicts (Fischer & Rehm, 1997; Gartry et al., 2009). The NAOMI project is an example of how strategies for addressing addiction are diversifying after over half a century of treatment interventions that have achieved only limited success and the growing recognition that drug addicts are not a homogeneous population whose problems can be addressed with a 'one-size-fits all' solution (Ogborne, Smart, & Rush, 1998; Roberts & Ogborne, 1999; Gossop, 2003).

Despite these new directions and insights into how to respond to addiction, the future of heroin maintenance in Canada is by no means stable. The NAOMI project was a limited-term experiment that is now complete. Another clinical trial, Study to Assess Longer-Term Opioid Medication Effectiveness (SALOME), designed to compare the effectiveness of heroin and Dilaudid maintenance, is now underway. Any future studies or use of heroin maintenance will depend on a variety of factors, such as the good will of key stakeholders and funding from government. Yet, the establishment of the NAOMI and SALOME trials represents a relaxation of the moral prohibition against providing addicts with their drug of choice to maintain their addiction and raises the possibility that this controversial form of maintenance treatment could be offered as a treatment option in Canada. It also suggests there is some recognition that traditional public health initiatives and treatment options often do not adequately address the needs of all addicted individuals (Gartry et al., 2009). Within this context of uncertainty, the present research will explore the continued viability of heroin maintenance in Canada through an examination of current developments and historical reactions to this form of treatment.

## **1.2. Research Purpose and Objectives**

As alluded to above, illicit drug policy and treatment is a highly politicized field that is not entirely governed by the effectiveness or efficiency of a given program or policy option. Political climate, institutional interests, and social attitudes all play a key role in whether a particular intervention will be instituted or even considered. An

accurate assessment of the viability of a particular treatment option (in this case heroin maintenance) necessitates an understanding of social and political attitudes, the agenda of relevant institutions, and current policy and legal environments. This dissertation, therefore, seeks to understand the future of heroin maintenance through an analysis of recent programs and the history of this treatment in Canada and abroad. A comparison of Canada's experience with heroin maintenance with other countries that have adopted or considered this treatment option will be carried out to gain insight into what forces or network of forces are crucial in the development of controversial maintenance programs. The primary objective of this research is:

- To identify what social and political forces or networks of forces are necessary for the introduction and continued use of heroin maintenance.

Six countries are included in the present study: Canada, the US, the UK, the Netherlands, Germany and Switzerland. These countries were principally selected because they had recently experimented with heroin maintenance treatment. The exception is the US. As part of NAOMI in its early days, a heroin maintenance trial was considered in the US but it soon became apparent such a trial was not feasible (Kuo, Fischer & Vlahov, 2000). As such, the US serves as a comparison case representing a country where heroin maintenance was considered but rejected. The experience of Australia is also briefly considered for this purpose. This is in keeping with the view that considering both similar and different cases adds greater depth of understanding in comparative research (de Vaus, 2008). Furthermore, the US has traditionally taken on a leadership role in the arena of illicit drug control and it would be somewhat remiss to fail to consider its role in the history of heroin maintenance. A comprehensive historical review was carried out with Canada, the UK and the US but not with the Netherlands, Germany or Switzerland. An effort was made to consider some of the history that preceded the recent use of heroin maintenance treatment in these countries but this was limited to information that could be collected through the English language literature on maintenance treatment and drug control.

### **1.3. A Note on Terminology**

The focus of this dissertation is on heroin maintenance. However, heroin maintenance is not a term that has been consistently used throughout the history of this intervention. Prior to the 1960s, there was no distinction made between different types of maintenance treatment. This treatment was more generally referred to as maintenance prescribing or treatment and included the prescription of any drug to an addicted individual to help them avoid withdrawal and remain functional, productive members of society rather than to treat any underlying medical condition. Morphine and heroin were the most commonly prescribed drugs for maintenance purposes but this term also included the prescription of other drugs such as cocaine. It was not until the introduction of methadone maintenance in the 1960s that there began to be a differentiation between specific types of maintenance treatment and we began to see proposals for heroin maintenance specifically. As such, when discussing the early history of heroin maintenance (pre-1960s) the term maintenance prescribing or maintenance treatment is used more generally. In discussions of later history (post 1960s) and current developments an effort is made to refer to heroin or methadone maintenance or other specifics of this form of intervention. Maintenance treatment is used as an umbrella term to refer to all different forms of this treatment.

### **1.4. Dissertation Organization and Overview**

To achieve the research objective set out above, this dissertation includes nine chapters. As described previously, Chapter One introduces the issue under study, and outlines the purpose and objectives of the research. Chapter Two discusses the analytical approach and theoretical framework adopted in the research, providing a brief overview of a comparative historical analytical approach, the work of David Garland and the critical literature on harm reduction. Chapter Two also introduces a set of social and political factors thought to be necessary for the introduction of heroin maintenance. Chapter Three provides a concrete discussion of the methodology used to carry out the research. This chapter outlines the process for collecting archival and interview data, the dissertation's two principal data sources. It also discusses the strategy for conducting a review of health and historical/sociological-oriented literature that was used

to supplement archival and interview data. The approach to analyzing and integrating data from these three sources is described.

Chapters Four and Five present the results of the archival research. Historical information is used to provide an overview of how and why maintenance prescribing was banned in Canada in the early 20<sup>th</sup> Century. It is also used to explore how, with social changes and increased drug use observed mid-century, perspectives on addiction treatment and drug control began to change, eventually allowing for the introduction of methadone maintenance. The focus of the historical analysis is on Canada's experience with maintenance treatment but also draws on the history of the UK and the US to illustrate how a particular social or political force has shaped experiences with this treatment. Including British and American history alongside Canadian history is done to highlight similarities and differences in experience and illustrate how particular social or political forces can lead to varying results in different contexts or situations. The information in Chapters Four and Five is meant to provide background information and insight into why heroin maintenance was not used outside of the UK until the 1990s and 2000s, as well as greater understanding of the origins of some of the social and political trends that eventually made heroin maintenance possible.

Chapters Six, Seven and Eight explore the results of the interview data to provide a detailed discussion of more recent events that led to consideration, and in some instances adoption of heroin maintenance. This information is related to the dissertation's primary research question of what social and political forces are necessary for the introduction of this treatment. The practical, political and legal challenges faced when establishing heroin maintenance programs in Canada, Switzerland, the Netherlands, Germany and the UK are discussed as well as the relationship between these challenges and local attitudes towards illicit drug use, addiction and its treatment. An attempt is made to connect these attitudes and conditions to the history provided in Chapters Four and Five. Where applicable, the political and social forces that led the US to consider but reject the idea of carrying out their own heroin maintenance trial provide a contrasting example. David Garland's work on changes in crime control in the last half of the 20<sup>th</sup> Century and the critical literature on harm reduction are used to

provide a greater depth of understanding of why Canada, after years of rejecting heroin maintenance, approved and funded two clinical trials on its effectiveness.

Drawing on the information presented in the proceeding chapters, Chapter Nine brings together the information presented in Chapters Four through Eight. This final chapter brings the research to a close by summarizing the research and presenting its overarching conclusions. The findings of this research are brought together in a discussion of the sustainability of heroin maintenance in Canada. Chapter nine concludes the research by highlighting lessons learned for Canadian and European experiences with heroin maintenance and by discussing potential policy implications.

## **Chapter 2. Analytical Approach and Theoretical Framework**

### **2.1. Introduction**

The design of a study and interpretation of its results are shaped by the analytical approach adopted, its underlying assumptions and the theoretical framework employed. This dissertation is premised on the assumption that the use or rejection of heroin maintenance is influenced by larger social, economic and cultural conditions and events. It also assumes that the history of maintenance treatment in a particular country or place shapes present day decisions on whether or not to use heroin maintenance. With these assumptions in mind, this chapter describes the analytical approach and theoretical framework employed in this research. The chapter begins with a description of the comparative historical analysis approach adopted and explains why this approach was chosen. Next, the role of theory in interpreting the results of the research is considered. The following section provides a short introduction to David Garland's work on recent developments in crime control as well as key observations from the critical literature on harm reduction. Concepts from Garland and the harm reduction literature inform the theoretical framework used in the dissertation. The chapter closes by briefly introducing the social and political forces that were identified, through the research carried out for this dissertation, as influencing the use of heroin maintenance.

### **2.2. Analytical Approach**

A comparative historical analysis approach was chosen to guide this research. This approach has its roots in the foundations of modern social science research and is linked to the work of the founders of sociology, such as Durkheim and Weber (Mahoney and Rueschemeyer, 2003; de Vaus, 2008). Comparative historical analysis is a form of

comparative research that emphasizes context and temporal sequence when making comparisons across cases, typically nations or cultural groups. Mahoney and Rueschemeyer (2003) suggest the approach includes three key elements: 1) a causal analysis, 2) consideration of temporal processes, and 3) systematic and contextual comparisons. Amenta (2003) provides a definition that fits well with the intent of this dissertation. He characterizes the approach as an “attempt to explain important historical differences or trajectories; and to appraise, modify, or produce something theoretically portable – a line of causal argumentation conceptualized so as to apply to other cases or time periods” (p.94). The goal of this research is essentially that. It is a study of the history of heroin maintenance, including present-day development, across a small number of nations with the purpose of identifying a set of factors that can explain recent experimentation with heroin maintenance and offer insight into the future feasibility of this form of treatment in Canada.

Mangen (2007) suggests that cross-national qualitative research often leads to greater methodological compromises than research done in a single location. A common solution to the need for methodological compromises is to use multiple methods or data triangulation. The strategy of data triangulation was used in the present research to ensure sufficient data was available for the countries considered here, and so both historical and present day comparisons could be made. A multi-method approach is compatible with comparative historical analyses which do not employ a specific set of techniques (Amenta, 2003; Mahoney and Rueschemyer, 2003). Considering multiple data sources is not only compatible with a comparative historical analysis approach but also necessary. In discussing her own historical research, Bosworth (2001) points out that archival data rarely provides a complete picture of topics being studied or continuous chronology of events. Archival data can be confusing, contradictory and ambiguous. To help interpret and make sense of spotty historical data Bosworth suggests considering the wider social and political context and consulting primary and secondary materials related to this context. This dissertation adopts Bosworth’s strategy of consulting contextual sources. The research principally relies on two data collection methods – interviews and archival research – but also uses present-day and historical literature to supplement data collected through these methods.



An exploration of the history of heroin maintenance is necessary for an in-depth understanding. This depth of understanding is essentially recognizing the principle that nothing - be it an idea, event, or phenomenon - is independent of its past. Drug control and maintenance treatment, more specifically, have a long history of controversy and institutional or professional power dynamics (Musto, 1999; Davenport-Hines, 2002; Giffen, Endicott, & Lambert, 1991). Exploring the history of heroin maintenance in Canada and abroad will bring to light the origins of current attitudes towards maintenance treatment, as well as addiction treatment and drug control more generally, and how these attitudes have evolved over time. The history of heroin maintenance will also draw attention to sequences of events that are important for the establishment of heroin maintenance programs. An understanding of sequences of events rather than focusing on a single event or time period provides a broader understanding of heroin maintenance. Mahoney (2004) suggests that *when* things happen impacts *how* they happen or the temporal location of events within a sequence can impact their outcome.

A comparative approach acknowledges that our understanding of an event or phenomenon is strengthened by examining similar events or phenomenon in different environments. The Canadian, Swiss, Dutch, German, and British heroin trials as well as the US's rejection of a similar trial provide the perfect opportunity to conduct this type of analysis. A comparative approach adds to a historical analysis by bringing into focus factors that are instrumental in the establishment of a particular practice by highlighting similarities across environments or places (Mahoney, 2004). It is an approach that can draw attention to factors that may have been overlooked in a single case study if they appear across multiple cases (Mabry, 2008). Comparative analysis also helps to distinguish between factors which were vital to the launch of the NAOMI trial and those that were primarily incidental. Conversely, a comparative analysis highlights factors that are locally influential or divergent paths that led to the adoption or rejection of heroin maintenance treatment.

A comparative historical approach has been used to study illicit drug control and has produced important knowledge on how global systems of drug control were

established (see Davenport-Hines, 2002 as an example) but has not been applied to heroin maintenance treatment specifically. A number of authors have addressed the history of maintenance treatment, typically in the context of larger studies of the advent of illicit drug control, but principally focus on a single nation. Key among these studies is Musto's (1999) history of drug control in the US, Berridge's (1999) account of this history in the UK, and Carstairs' (2006) and Giffen et al's (1991) Canadian history. Despite not offering systematic international comparisons, the work of these authors offers important insight into the forces shaping the history of maintenance treatment. For instance, in the North American context, Musto (1999), Carstairs (2006) and Giffen et al. (1991) imply that maintenance treatment was largely abandoned in the 1920s because of pressure by policing organizations on medical professionals to end the practice. Berridge (1999), conversely, argues that maintenance treatment, including heroin maintenance, continued in the UK after it was banned in other countries because of the medical profession's involvement and their greater organization and prestige in the UK at the time. More recently, other authors have documented the events leading to the establishment of present-day heroin maintenance trials in Canada and Europe (see Gartry et al., 2009 and van den Brink et al, 1999). These authors suggest that the growing recognition that methadone maintenance is not an effective treatment for some heroin addicted individuals and the HIV/AIDS crisis were key events in the establishment of heroin maintenance programs in the 1990s and 2000s.

A comparative historical approach will allow this research to build upon the work of previous authors by providing a systematic comparison of different countries experiences with heroin maintenance across time. In doing so, this research attempts to establish a connection between historical and present-day developments in heroin maintenance treatment. It also aims to provide greater clarity on the regimes of power and the dynamics of process implicated in the initiation, delivery and sustainability or abandonment of heroin maintenance treatment. Exploring national similarities and differences related to the use of heroin maintenance will shed light on the local context in Canada.

## 2.3. Theoretical Framework

The role of theory is to interpret facts and experiences with the aim of understanding social phenomena (Tavallaei & Abu Talib, 2010). Theory breaks down complex social phenomena into core elements and provides a deeper level of understanding and interpretation of the phenomenon being studied. Theory can play different roles in social science research. Research may focus on validating a specific theory within the topic of study. Alternatively, a theoretical framework may be developed to guide analysis and provide greater depth of understanding of the topic being studied (University of Southern California, January 5<sup>th</sup>, 2015). This latter description is how theory is used in the present research. The work of David Garland, particularly from his book *The Culture of Control: Crime and Social Order in Contemporary Society*, and key observations from the critical literature on harm reduction provide a theoretical framework for interpreting the results of this research and presenting findings in a way that is applicable beyond the specific topic of heroin maintenance.

When considered in the abstract, this dissertation is a study of the exercise of power in the name of drug control or how a particular 'deviant' behaviour (in this case, drug addiction) has been controlled across time and place. More specifically, it is a study of a particular strategy (i.e., heroin maintenance) for controlling the behaviour in questions (i.e., addiction) but also a study of how the intervention itself is controlled. Given this focus, social control theories provide a useful lens for interpreting information provided in this dissertation. David Garland can be characterized as a social control theorist who studies how systems of social control develop and function. In his book, *The Culture of Control*, Garland (2001) argues that crime control and criminal justice has undergone a significant and unexpected transformation in the time between the late-1970s and the turn of the 21<sup>st</sup> Century. He attempts to understand how and why crime control has changed through a historical and sociological study which situates these changes in the wider social, economic and cultural conditions of this time, providing what he refers to as a 'history of the present'. Garland's history of the present is not meant to provide an understanding of the past but to reconsider the present. He traces the forces that lead to present-day crime control practices and identifies the historical and social conditions they depend upon. As discussed above, the idea of understanding the

present through the past is essentially the same approach employed in this research, albeit on a much smaller scale and applied to a specific intervention – heroin maintenance.

Garland (2001) argues that crime control has been restructured, moving from what he terms ‘penal welfarism’ to a period of ‘late modernity’. According to Garland, crime control in late modernity is characterized by a return of harsh punitive sanctions and expressive justice, a focus on victims and protecting the public at all costs, and the reinvention of prisons, so their principal goal is now punishment and incapacitation rather than rehabilitation. This reinvention of prison is part of a larger decline of the rehabilitative ideal to the extent that it is no longer the overarching ideology of the justice system. Together these changes can be characterized as a rise of a law and order approach to crime control. At the same time, there is increased emphasis on crime prevention and protecting community safety through partnerships with groups outside the criminal justice system, the commercialization of crime control, new management styles and working practices in the field of criminal justice that focus on risk management and cost effectiveness. These changes in the field of crime control are all occurring in an environment where there is a perpetual sense of crisis and a pervasive fear of crime, which has come to set the tone for crime control policy. As a result, crime control policy has become increasingly politicized and populist. Garland also argues that within this changing environment there has been a transformation of criminological thought. It has shifted from the perspective of the welfare state where crime is seen as the result of some form of deprivation to the view that crime is a result of lack of control (be it social, situational or self-control) and is a normal, routine part of modern society.

As part of the larger field of crime control, drug control has undergone many of the same changes Garland discusses. For instance, on the one hand increasingly harsh sanctions have been introduced for drug trafficking, particularly for offences involving the sale of drugs to children and youth or near places frequented by children and for offences involving criminal organizations. Yet, on the other hand, there has also been a corresponding trend toward dealing with minor drug crimes in the community through programs such as drug treatment courts and diversion as well as the introduction of harm reduction interventions. Clearly, trends towards more punitive and expressive

response to drug problems have not encouraged the introduction of heroin maintenance. However, some of the other changes Garland (2001) mentioned have made the use of heroin maintenance more feasible than it has been in the past.

The first of these changes, somewhat paradoxically, is the decline of the rehabilitative ideal. In the field of drug control, this decline has meant a growing skepticism about the ability to cure addiction. This skepticism has led, in some instances, to calls to segregate and exclude addicted individuals from the rest of society. However, as we will see in later chapters of this dissertation, it has also shifted the goals of addiction treatment from focusing exclusively on abstinence and a cure to managing the harmful consequences of addiction, at both an individual and community or population level. This expansion of treatment goals has been facilitated by the growing acceptance of a chronic disease model of addiction and the recognition that there would be no 'cure' for this condition. With this understanding of addiction, the utopian goal of eliminating drug use becomes unrealistic. As a result, strategies to manage addiction and the harmful consequences of drug use, such as heroin maintenance, are required. When a cure is not forthcoming, managing symptoms and risks becomes the goal of treatment. Conceptually, the step from managing symptoms and risk for patients and managing risks at a population level is a small one; both require patients/drug users to actively promote their own health and wellbeing while supporting a particular vision of what it means to be 'healthy' or 'normal' (Netherland, 2011; O'Malley, 1999).

The requirement that drug users actively manage their own risks is often referred to as responsibility or the responsabilization of drug users in the harm reduction literature (O'Malley, 2008). At the same time, it is not only drug users that are tasked with managing their own risks. Through what O'Malley (2009) refers to as prudentialism and Garland (2001) calls responsabilization strategies, all individuals, communities, agencies and businesses are expected to protect themselves from becoming victims of crime or from the risks of illicit drug use. Individuals must manage their private risks through avoiding risky situations and behaviours, not interacting with high risk groups, and employing crime prevention technologies. Likewise, communities, agencies and businesses are expected to manage risk by modifying physical environments to prevent crime and discourage public disorder or drug use, to monitor and take action when these

behaviours are observed, and to provide or participant in programs/strategies designed to reduce risk and prevent crime. Therefore, not only are drug users expected to participate in treatment programs such as heroin maintenance to manage their own risks but communities are expected to support and promote such interventions to ensure community safety and public order. The larger trend towards risk management is discussed in more depth below.

Similarly, the focus on protecting the public that Garland argues is a feature of present day crime control has also, in a somewhat backwards way, helped make heroin maintenance more feasible than it has been in the past. Concern with protecting the public is often associated with the introduction of punitive and expressive responses to drug offences, or crime more generally. However, Garland (2001) argues that the perception that the criminal justice system has failed and will continue to fail to curb crime is pervasive in today's society and is linked to an exponential and sustained increase in crime since the mid-20<sup>th</sup> Century. As will be explored in Chapter Five, there has been an equivalent rise in drug use in the 1960s and 1970s, which has led to a persistent critique of drug prohibition and a purely criminal justice approach to drug control. Within an environment where it is increasingly recognized that law enforcement has not been able to protect the public from the negative consequences of drug use, the emphasis on protecting the public has sometimes led to the introduction of alternative strategies, such as heroin maintenance, when the case can be made that they prevent the spread of communicable disease and reduce crime and disorder problems.

Moreover, the perpetual stream of stories of new drugs threatening youth, fatal additives in street drugs, and spikes in use of specific drugs in today's media feed what Garland (2001) refers to a perpetual sense of crisis in this field. Media attention to drug issues also contributes to the fear of crime, much of which is believed to be associated with acquisitive crime of addicted individuals supporting their dependence and the illicit drug trade. This media attention creates an urgency to deal with drug problems and strengthens the perception that traditional criminal justice responses are not working. This urgency to respond to drug problems can sometimes translate into support for strategies for addressing addiction outside of the criminal justice system, such as heroin maintenance and other harm reduction initiatives. As Garland (2001) suggests, crime

control, or in this case drug control, is reactive and adaptive and, as will be discussed in more depth in later chapters, crises has been a major motivation for policy reform in the field of maintenance treatment.

The current focus on risk management and cost effectiveness that Garland observed in the criminal justice system, as well as wider society, has also encouraged growing skepticism of a criminal justice approach to drug control and has promoted the use of harm reduction initiatives, such as heroin maintenance, which readily align with a larger trend towards neoliberalism. Similar to Garland, Rose and Miller (2010), in proposing a new model of understanding and analyzing the exercise of political power, discuss the gradual shift from what they call welfarism (and others refer to as 'the welfare state') to neoliberalism. These authors describe neoliberalism as a model of governance where:

The state must be strong to defend the interests of the nation in the international sphere, and must ensure order by providing a legal framework for social and economic life. But within this framework autonomous actors – commercial concerns, families, individuals – are to go freely about their business, making their own decisions and controlling their own destinies. (Rose and Millar, 2010, pg. 269)

As such, neoliberalism is viewed as an approach to governance that emphasizes minimal state intervention and self-regulation (Petersen, 1997; Larner, 2000). Neoliberal strategies of governance exercise power by encouraging individuals to take responsibility for their own well-being. Individuals are encouraged to govern themselves by making choices that minimize individual risk and promote their health, economic and social well-being (Larner, 2000). However, authors such as Rose and Miller (2010), Larner (2000) and Peterson (1997) emphasize the distinction between 'government' and 'governance' and argue that although neoliberalism dictates minimal 'government', it does not lead to less 'governance' or the exercise of less power over citizens.

The suggestion that one of the reasons why heroin maintenance went ahead was due to a neoliberal political environment needs some explanation, as this suggestion may seem counter-intuitive, given that neoliberalism is associated with conservative political attitudes. However, neoliberalism is associated with an economic, rather than social, brand of conservatism that elevates cost-effectiveness and risk reduction above

other policy considerations. This focus on cost effectiveness and risk has contributed to the bifurcation Garland (2001) observed in crime control in late modernity. Heroin maintenance is sometimes thought of as a relaxation of or a move away from a strictly prohibitionist approach to illicit drug control, and typically associated with more liberal political attitudes. For instance, some critics of heroin maintenance have suggested that this form of treatment is the first step in the slippery slope towards the legalization of illicit drugs. However, as will be discussed in the following chapters, clinicians and researchers involved in setting up the first heroin maintenance programs took steps to distance their research from the issue of legalization by framing it as a highly specialized intervention for only a small number of addicted individuals who had failed in other treatment models. By framing heroin maintenance treatment in this manner, a discourse was constructed which made the intervention more appealing to mainstream political attitudes.

More importantly, heroin maintenance was framed as cost-effective and productive intervention for crime control and reducing the risk of HIV/AIDS. These issues are important in a neoliberal political environment and suggest a clear preference for population-level goals rather than individual level outcomes. For instance, one of the main selling points of heroin maintenance was that it would reduce drug-related crime and disorder by eliminating the need for addicted individuals to be a part of the illicit drug scene and commit crime to acquire drugs. Not only is there a reduction in public nuisance and increased public safety but, in the long run, money is saved due to decreased criminal activity and using less criminal justice resources. Furthermore, the tightly controlled using environment reduces the health care costs of addiction by ensuring sterile injection equipment, pure heroin and, therefore, fewer negative health consequences and a reduction in the use of costly health care resources by addicted individuals. These savings were expected to be greater than the costs of trials themselves (see Ficher & Rehm 1997; Kuo et al., 1999; NAOMI, 2006). As we will see in the proceeding chapters, the ability of supporters of heroin maintenance to frame this intervention as reducing the risk of communicable disease and crime and as cost effective were important to its adoption in the 1990s and 2000s.



It is not neoliberalism alone that has facilitated the initiation of heroin trials but rather neoliberalism combined with a policy environment that increasingly emphasizes evidence-based policies and programs. The current trend in policy is to have 'evidence-based' programs or initiatives that can demonstrate tangible, practical results (Sanderson, 2002). For instance, Garland (2001) suggests this focus on risk and cost effectiveness in criminal justice is rooted in a managerial perspective that is performance and outcome oriented. Within this environment, evidence-based practices that produce tangible reductions in risk and cost-savings are given precedence over ideology and morality. This demand for tangible results has led to the acknowledgement that criminal justice interventions can increase rather than reduce drug-related harms. Such interventions can drive drug use underground, thereby compelling risky drug taking behaviour and creating a criminal market for drugs. At the same time, criminal justice interventions are very costly. As such, the trend towards evidence-based policy dictates trying alternative strategies, such as heroin maintenance, that could prove more effective in reducing the costs of addiction and the risks of crime that flow from prohibition, even if not explicitly acknowledged as a consequence (Roe, 2005). Experimentation with alternative strategies is possible in a neoliberal political environment because of the relative abandonment of a brand of conservatism that is based on moralism. In a neoliberal political environment, monetary considerations take precedence over moral concerns, focusing instead on 'high risk' individuals and 'risky behaviours'.

A related development in crime control Garland (2001) observed, which also played a role in the introduction of heroin maintenance, has been the focus on prevention and community safety or the formation of what Garland calls 'preventative partnerships'. Garland (2001) argues that the focus on prevention and community safety has broadened the traditional goals of crime control from prosecution and punishment to include prevention, harm reduction, and loss-reduction and has also made it a local undertaking. In other words, it took on the mantle of risk management. Specific to drug control, this focus on risk can be observed in the recent popularity of public health perspectives and emphasis on mitigating drug related harms, as well as in the greater role of cities and communities in dealing with these harms. As Garland suggests, this trend has led to the involvement of other actors outside the criminal justice system in crime control. In the field of drug control, involving other actors outside the criminal

justice system is particularly true because drug use is not an activity as firmly rooted in the domain of the criminal justice system as are other more longstanding criminal behaviours. The focus on mitigating drug-related harms has meant greater involvement of health care providers, social services and non-for-profit organizations in drug control, to the extent that many of the interventions carried out in the name of reducing drug related harms do not involve, or involve in only a very limited capacity, criminal justice actors. Nor do they necessarily serve the same goals as a traditional criminal justice approach. This involvement of actors outside the criminal justice system has opened the door for health care professionals to take on a greater leadership role in drug control, leading to greater medicalization of this field.

In *The Culture of Control*, Garland discusses the expansion of crime control to include non-state actors (i.e., business, community groups). However, he does not discuss how other state actors outside of the criminal justice system have been drawn into crime control and the impact of this control. As alluded to above, this trend is particularly important for the introduction of heroin maintenance. The inclusion of health care professionals has not only led to increased medicalization of drug control but has brought harm reduction from a radical, grassroots movement to an approach that was increasingly integrated into different countries' national drug policies in the 1990s (see Roe, 2005; Smith 2012). For instance, Roe (2005) suggests that harm reduction began as a grassroots movement that viewed 'risk' and 'harm' as the result of social, economic, racial, and political inequalities. This original version of harm reduction advocated a radical restructuring of current drug control systems as well as larger social changes to address inequalities within society. However, as harm reduction became mainstream and public health professionals took up the cause, 'risk' and 'harm' were viewed as an objective phenomenon identifiable in specific individuals, groups, and populations. Medical rather than social solutions were advanced and harm reduction was re-defined as non-ideological. The focus was now on individual harms and societal costs rather than underlying social conditions. As such, responses to these 'risks' and 'harms' are focused on individuals identified as 'high risk' and on the promotion of individual agency. The goal of this new brand of harm reduction is to transform 'high risk' individuals into 'active citizens' capable of managing their own risk or the responsabilization of high risk drug users. Through responsabilization, harm reduction has provided a new avenue for

controlling drug users through the creation of new initiatives designed to facilitate healthy choices around drug use. Although the failure of this new brand of harm reduction to critique prohibition and the shift in focus from social to medical is lamentable on some level, it is a version that is more palatable to mainstream audiences and policy makers and, because of its medical focus, more compatible with heroin maintenance.

What some authors view as ‘the institutionalization of harm reduction’ has normalized drug use to a degree not achieved before. For instance, O’Malley (1999; 2008) suggests harm reduction discourse has moved away from the language of addiction, dependency and abuse, which suggest individual pathology, to a more general category of drug use. There is a continuum of use that can range from healthy or responsible use to excessive and problematic use, which O’Malley suggests is similar to how any ‘normal’ activity is conceptualized. Harm reduction also equates illicit drug use with legal drug use, suggesting the two are comparable and the only difference between them is the additional risks created by the system of prohibition in place to control illicit drug use. Moreover, harm reduction is premised on the view that drug use is a normal part of society and it is impossible to eliminate. As such, the goal of any intervention is to minimize and prevent the risks associated with drug use rather than end drug use by locating and eliminating its underlying cause. This process was instrumental for the introduction of heroin maintenance because under this supposedly ‘amoral’ or objective view of drug use the stigma traditionally associated with heroin becomes less relevant. From this perspective, heroin is a substance like any other with risks attached, many of which are a function of the mode of administration (i.e., injection) and the effects of prohibition rather than the drug itself. So long as these risks can be effectively managed there is no reason not to use heroin in the treatment of addiction.

Equally as important as specific changes in crime control that Garland highlights, is his more general observation that this change has not been totalizing and is incomplete. In *The Culture of Control*, Garland argues that up until the late 1970s, crime control had a settled institutional structure and underlying intellectual framework, which he refers to as penal welfarism. This is the perspective that crime control is the rightful jurisdiction of the state, that it is the state’s responsibility to care for and reform offenders as well as punish and control them. It is also rooted in the belief that criminal behaviour

stemmed from some type of deprivation and that social reform and improved affluence of a population would reduce the frequency of crime. However, this relatively cohesive vision of crime control has eroded. Garland suggests that the changes in crime control from the late 1970s to the turn of the 21<sup>st</sup> Century have not been guided by a unifying philosophy, nor have they been all pervasive. Rather, the current field of crime control is made up of old practices and perspectives of penal welfarism, as well as the new strategies for crime control discussed above. This mixed approach has resulted in the situation where there is now a variety of, sometimes competing or contradictory, crime control strategies that are no longer entirely viewed as the responsibility of the criminal justice system or even government.

Within the field of drug control, there has been a similar trend away from a relatively cohesive approach established in the first half of the 20<sup>th</sup> Century that focused on suppressing the illicit drug trade and punishing or treating individual users with the goal of achieving a drug free society. There is now a growing diversity of responses to illicit drug use and addiction, some of which do not serve the goal of a drug free society. The period between the late 1970s and the present has seen the introduction of harm reduction, more flexible addiction treatment programs and, in some countries, *de facto* decriminalization of minor drug offences or selective enforcement of drug laws by individual police departments. At the same time, prohibition persists as the dominant approach to drug control, increasingly severe sanctions for some offences have been introduced, and abstinence-based treatment continues to be widely available. In an eclectic policy environment such as this, heroin maintenance can be used without directly challenging prohibition. In the past, any suggestion to adopt heroin maintenance was a challenge to the abolitionist approach to drug control. Now, there is no challenge as there no longer a single, overarching philosophy guiding drug control does not exist. This absence has made heroin maintenance more palatable to a mainstream audience and, in many instances, supported by the law enforcement organizations. Organizational power struggles also become less salient. Responding to drug use and addiction no longer comes primarily under the purview of the criminal justice system. Rather it is the responsibility of a variety of actors, from health care providers, communities, and individuals to law enforcement and government bureaucracies. In this

environment, convincing local public and politicians about the need for heroin maintenance, that it is an intervention worth funding, becomes crucial.

## **2.4. Social and Political Forces Influencing the Introduction of Heroin Maintenance**

Considering the theoretical framework provided above and the recent experience of Canada and European countries with heroin maintenance and the history of this intervention in Canada, the US and the UK, a set of social and political forces that were necessary for the introduction of heroin maintenance were identified. First, a number of conceptual and systems forces that are fundamental to the use of any form of maintenance treatment, including heroin maintenance, were identified. They include the following:

- 1) A system of drug control that is not based on a purely criminal model of control or entirely focused on supply reduction but includes medical or public health controls and demand reduction measures.
- 2) Some official acceptance of a chronic disease model of addiction or a policy environment where interventions premised on this understanding of addiction will be supported.
- 3) A degree of official recognition that abstinence is not always a realistic treatment outcome for all addicted individuals and a policy environment that allows for the use of interventions that have improved health and social functioning at an individual level or reduced risk of crime and communicable disease at a community level as their end goal, rather than abstinence.

There are also a series of other forces related to understanding of heroin maintenance and the environment that the program is implemented in that are critical to its introduction and are more specific to this intervention. They include:

- 1) A drug related crisis or epidemic to motivate communities, governments, and professionals to innovate and to act.
- 2) A tradition of pragmatism and a high value placed on evidence-based practice.
- 3) The ability to effectively present heroin maintenance as a limited medical intervention for the most severely addicted, treatment resistant users and to distance it from the issue of drug legalization.

In addition, other forces related to action and resistance of different groups that have influenced the introduction of heroin maintenance in many of the countries are considered here. However, all of these forces may not be essential for its implementation in every situation. They are:

- 1) Support from local communities, user groups, and municipal governments for the introduction of heroin maintenance clinics in their city or neighbourhood.
- 2) An international arena that includes voices which support the use of heroin maintenance and who are willing to share their experience with and research on this intervention.
- 3) A liberal political environment with strong support for drug policy reform or a neoliberal political environment that supports cost-effectiveness and risk management over moralism regarding drug use.
- 4) A basic level of medical ownership of the problem of addiction and willingness of the profession to take on the role of treating this condition.
- 5) Minimal resistance to maintenance treatment at an organizational level from within the medical profession or from outside professions with a stake in drug control, such as law enforcement, combined with expert activism promoting the use of heroin maintenance.

These forces do not act in isolation. They all interact with one another to produce conditions that are either favourable for introducing or sustaining heroin maintenance or inhibit its use. Moreover, the strength of each of these forces is variable. It is rarely simply a question of whether they are in place or not but is almost always also a matter of degree. For instance, it is unlikely there will ever be a situation where an entire community supports the implementation of a heroin maintenance program. There will always be those who support such an initiative and those who oppose it. What is important is that there is a basic level of support and, ideally, on a balance there is greater support than opposition. The role that each of these forces has played throughout the history of heroin maintenance in Canada and abroad is explored in more depth in the subsequent chapters.

## **Chapter 3. Methodology**

### **3.1. Introduction**

The present research employs a mixed method, qualitative approach and relies on three data sources: health and sociology-oriented literature, archival data, and interviews. Together these data sources provide the information needed to examine the historical evolution of heroin maintenance and recent developments in this field. The method for collecting and analyzing each of these data sources is described below. This section is followed by a discussion of how these data sources are integrated for the comparative historical analysis undertaken in this research.

### **3.2. Literature Review**

#### **3.2.1. Health-Oriented Literature**

Reviewing the health-oriented literature on heroin maintenance provided background information on the clinical trials and research studies carried out in Canada and Europe as well as information regarding the effectiveness of this intervention. A systematic review of this literature was not done because the focus of this dissertation is not the effectiveness of this treatment option. Also, because any discussion of the effectiveness of heroin maintenance is primarily descriptive and provides context for the remainder of the dissertation, this literature is not engaged in a critical fashion. The search strategy for this part of the literature review was to carry out key word searches for 'heroin maintenance' or 'heroin assisted treatment' through Google, specific substance use or medical journals, and health databases, including:

- CINAHL (Cumulative Index to Nursing and Allied Health Literature)
- MEDline

- BioMed Central
- PubMed
- Cochrane Database of Systematic Reviews

Another key strategy was to identify articles of interest through the reference list of sources previously reviewed.

### **3.2.2. Sociological and Historical Literature**

Published materials on maintenance treatment and the history of drug control are used as an additional data source in this dissertation. It was not possible to carry out archival research in the US or in European countries other than the UK. As such, it was necessary to largely rely on published literature to document the history of heroin maintenance treatment in these places. There were some American documents in Canadian archives and historical information is increasingly available online but these sources did not provide sufficient information to adequately explore the history of heroin maintenance in the US or Europe. However, an effort was made to include historical publications whenever they were available. There are also significant gaps in historical data that were collected from archives in Canada and the UK (particularly, the UK where less time was dedicated to collecting the archival data). Where possible the work of previous authors was used to fill these gaps. More generally, the sociological and historical literature also provides important background information on the context in which the history of heroin maintenance has unfolded, information that may not be readily gleaned from archival data sources (e.g., political context, social attitudes of the day, or other developments in drug control and treatment). Literature that is not historical also provides an important source of information on current developments in heroin maintenance, supporting the data gathered through the interviews.

Ultimately, the literature was used to construct a comprehensive narrative of historical and present day developments in heroin maintenance when primary data were not available. To construct this narrative, three bodies of literature were used: 1) literature on the history of drug control in Canada, the US, the UK and to a lesser extent, other European countries, 2) literature on present-day developments in heroin maintenance, and 3) historical publications on drug control or addiction treatment. Table



1 provides the search strategies used to collect sources from each of these bodies of literature.

**Table 1. Sociological and Historical Literature Search Strategy**

Type of Literature	Search Strategy
History of illicit drug control/maintenance treatment	Target searches for specific publications
	University library catalogue subject searches
	Key term searches of the internet, journals and databases by country <i>Search Terms:</i> Drug control history, narcotics control history, Maintenance treatment history, Addiction treatment history, Heroin maintenance history <i>Databases:</i> EBSCO, Science Direct, Criminal Justice Abstracts, Sociological Abstracts
Historical literature on addiction treatment and drug control	Target searches for specific publications and legislation mentioned by previous authors
	Key term searches in journals and databases with historical content by country <i>Search Terms:</i> Narcotics, Opium, Heroin, Methadone, Addiction, Addiction Treatment, Maintenance Treatment <i>Databases:</i> Jstor, ProQuest
Present day developments in heroin maintenance	Target searches for specific publications mentioned by previous authors
	Key term searches of the internet, journals and databases by country <i>Search Terms:</i> Heroin Maintenance, Heroin Assisted Treatment, Heroin and Treatment <i>Databases:</i> EBSCO, Science direct, MEDline

### 3.3. Archival Research

This dissertation also uses archival data to explore the history of maintenance treatment in Canada and to place this history in a wider international context. Archival research was conducted in both Canada and the UK. Although the history of maintenance treatment in the US was included in this dissertation, no archival research was done there. Instead, as was mentioned above, discussions of American history

relied on previously published literature (current and historical) and, in some instances, information related to the US found in Canadian archives.

### **3.3.1. Data Sources**

Policy papers, institutional documents and memos, personal communications and notes, published literature, and media reports were gathered from archives in Canada and the UK from the beginning of the 20<sup>th</sup> century to 1980. Archival information was largely no longer available after the 1970s. In the UK, data were collected from the National Archives and from the British Library. The data were all publicly available, whereas in Canada most of the information collected was restricted and permission to use the data for this research was needed. This data were collected from Library and Archives Canada in Ottawa, BC Archives in Victoria and Simon Fraser University Archives. Appendix A provides a list of the archival information reviewed for this dissertation. Published government documents and reports as well as records of political debates (Hansards) were also collected from university and public libraries in both Canada and the UK.

### **3.3.2. Data Collection**

Collecting archival data begins with identifying archives that may potential yield relevant information. Data sources were identified either through the work of previous authors who wrote on the history of drug control or addiction treatment or by searching archive catalogues. In these searches, search terms such as narcotics, drugs, heroin, opium, and addiction were used. Once specific archives are identified, this form of research requires a long and detailed process of reading through boxes of documents to identify those that are relevant to the research at hand. Formal selection criteria were not used to decide what information to collect. The decision to record information was made on a case-by-case basis. However, the following questions provided some guidance on what information was included and what was not:

- Did the document mention heroin maintenance?
- Did the document mention methadone or maintenance treatment in general?
- Did the document discuss physicians prescribing narcotics to drug users?

- Did the document discuss pharmacists providing narcotics to drug users?
- Did the document mention legal or policy changes regarding physician's powers to prescribe narcotics to drug users?

The additional questions below guided the selection of documents that provided useful contextual information:

- Did the document discuss addiction treatment?
- Did the document address the concept of addiction?
- Did the document discuss different approaches for responding to addiction or drug use?

When documents of interest were identified notes were made on the document and when the option was available, photocopies or digital photographs were taken. The Simon Fraser University Archives did not allow photocopies or photographs<sup>1</sup> so detailed notes were relied on instead. The end result of this process was roughly 100 pages of notes and over 2000 pages of copied documents.

### **3.3.3. Analysis**

The archival research done for this dissertation generated a large amount of data and analyzing it was a multi-phased task. Many experts in qualitative research suggest that data analysis begins with data collection (Patton, 2002). This suggestion is true here. The analysis began with the process of sorting through the archives and deciding what information was relevant to this study and what was not, as well as the process of making notes on each file (see data collection above). The next step in synthesizing the data was to create what essentially amounts to metadata for each document. This metadata included the author of the document, organization or government department, date, country or location where the document originated, document type and subject(s). Carstairs (2008; personal communication) suggests that this technique allows large quantities of document data to be more easily organized and reorganized for the

<sup>1</sup> Simon Fraser University does allow copies to be made of the material held in their archive but the information reviewed for this research included personally identifying information of private citizens, and in some instances offenders, and the agreement I entered into did not allow information to be copied.

analysis. Once these metadata were created, it was possible to organize the data by time periods to create a narrative of how the history of heroin maintenance unfolded as well as consider the role of specific actors and organizations/government departments in this history. To a certain degree this analysis was an inductive process, with the data guiding what was included in these narratives. However, certain information was also sought out. For instance, the work of previous authors highlighted the importance of specific reports and if these reports were not forthcoming through the initial archival research they were sought out and included in the analysis (e.g., the Stevenson Report from British Columbia). Likewise, it was assumed there was a link between perspectives on addiction and its treatment and the availability of maintenance treatment generally, or heroin maintenance more specifically, so information that provided insight into addiction and its treatment was sought out and included in the narratives.

The data were also reorganized to consider specific themes of interest, such as the role of the medical profession in the use or rejection of maintenance treatment. These themes were identified from both from the literature or stakeholder interviews that were carried out and also emerged from the data itself. In this way the analysis was both deductive and inductive. Following the advice of Prior (2008), both evidence that supported the themes identified (and conclusions that arose from them) as well as evidence to the contrary were noted for a more systematic analysis of the documents.

### **3.3.4. Limitations of the Archival Data**

It should be noted that the majority of the archival data came from government department or treatment agency files. Some historical literature from medical journals and newspaper articles was also included. As such, the results of this analysis can be considered a formal or traditional history rather than a social history. It does not fully capture the perspectives of communities, drug users themselves, or municipal governments (although sometimes newspaper articles offer insight into these perspectives and there were some letters from municipal politicians or bureaucrats, concerned citizens and drug users in the government files). Also, it may not fully capture the perspective of the medical profession on heroin maintenance and addiction treatment as the files of medical organizations were not reviewed. Because of this lack

of information, the roles of certain groups in determining whether heroin maintenance treatment is offered may be understated. Moreover, archival information often does not provide a complete accounting of a particular event. Whenever possible information from literature published on the history of drug control was used to fill in gaps and gain a more well-rounded understanding of the events that shaped the history of maintenance treatment.

### 3.4. Interviews

To achieve a more nuanced understanding of present-day developments in heroin maintenance treatment a series of interviews were carried out with key leaders in the field from Canada and Europe. In total, 17 interviews were completed with individuals from Canada, UK, the Netherlands, Germany and Switzerland (see Table 2). The interview participants played a variety of roles in relation to the establishment, and in some instances the continuation, of heroin maintenance programs or clinical trials. Some were the principal investigators (PI) for the clinical trials/research programs and others were also directly involved as psychiatrists or clinical leads and researchers. Still others were politicians or public servants who oversaw the trials/programs or brought support from municipal, provincial or federal governments.

**Table 2. Interview Participants by Country and Professional Role**

Country	Number	Professional Role	Number
Canada	6	PI for Clinical Trials/Research Programs	5
United Kingdom	2	Psychiatrist/Clinical Leader	3
The Netherlands	2	Research Leader	4
Germany	2	Public Servant	4
Switzerland	5	Politician	1
Total	17	Total	17

These interviews are a crucial source of information on how the recent experimentation with heroin maintenance in each country came about, as well as the political, legal and practical challenges that these programs and trials faced when being implemented. In essence the interviews provide a ‘behind the scenes’ view that is often missing from published materials. Current literature largely focuses on the effectiveness

of heroin maintenance or commentaries that make the case for or against having this treatment available. There are a few exceptions that provide information on the political hurdles overcome to establish heroin maintenance trials (see van den Brink et al., 1999; Garty et al., 2009). For the historical content of this dissertation, the 'behind the scenes' information was collected from archival data, including unpublished government and organization memos, internal reports, communications and so on. However, as there is a necessary delay before this type of information is available through public archives an alternative source of information was needed for more current developments in heroin maintenance. Furthermore, because many recent developments have occurred in countries where English is not an official language information sources such as media reports or published government documents that may have provided information on key developments or reactions to heroin maintenance were not available.

### **3.4.1. Interview Process**

A qualitative, semi-structured interview method was chosen to allow for flexibility in the interview process as well as enough structure to facilitate comparisons between interview participants. Semi-structured interviews allow participants to respond to questions on their own terms but also let the interviewer guide the interview process as well as probe for further information (May, 1997). The interview instrument was designed to collect information on the current heroin trials/programs as well as the potential feasibility of stimulant maintenance. More specifically, the interviews cover the following areas: 1) background information about addiction and drug control in the country, 2) the heroin trial and its practical, legal, and political challenges, and 3) the feasibility and desirability of stimulant maintenance treatments (See Appendix B for a full copy of the interview instrument). Data on the potential feasibility of stimulant maintenance were not used in this dissertation.

Where possible, interviews were carried out in-person. In two instances in-person interviews could not be coordinated and were done over the telephone. In-person rather than telephone interviews were preferred because telephone interviews are more difficult to manage. Telephone interviews can more easily result in miscommunication as non-verbal information that helps the interviewer respond to the

participant in an appropriate manner is not available (Hermanowicz, 2002; Creswell, 1998). Each interview lasted approximately one hour and was carried out in a location of the interviewee's choice, typically their office. The interviews were audio-recorded and later transcribed to ensure that data were not lost and the interview was not hindered or slowed down by note taking. Prior to beginning the interview, each participant was presented with a description of the research as well as an informed consent form, which they were asked to sign. A verbal description of this information and the structure of the interview were also given.

### **3.4.2. Sampling Technique and Recruitment**

Interview participants were selected through purposive sampling. Purposive sampling is the practice of selecting information rich cases that can provide insights and in-depth information on the issue under study (Patton, 2002). This type of sampling is best suited for research, such as the present study, that does not intend to make generalizations from the sample to a population but which seeks to gain insight into a phenomenon, event, or person of interest (Onwuegbuzie & Leech, 2007; Patton, 2002). In this study, a list of potential interview participants was created. Participants on this list were identified through personal contacts, relevant government department websites, and a literature search for persons who had published in the field of heroin maintenance. These participants were contacted through email with a brief description of the research and a request for them to be interviewed. They were also asked for a referral to other persons who have done work in the field of heroin maintenance. Most referrals received were for individuals previously identified in the original list of potential participants.

In total, 24 individuals were originally contacted and 15 agreed to be interviewed. An additional two individuals were contacted and interviewed based on referrals from other interview participants. The most common reason for individuals declining to be interviewed was that they felt they were not the most appropriate person for the interview and identified individuals they thought were better suited for the research. Others simply did not respond to the invitation to participate or indicated that they had moved on professionally and were no longer involved in the heroin maintenance programs.

Individuals who did not respond to the first request to participate in the research were contacted on a second occasion to once again invite them to participate.

### **3.4.3. Selection Criteria**

Silverman (2000) suggests that selecting a sample is a major decision point in the research process as it affects the scope and quality of your data. As such, it is important to carefully consider what is an appropriate sample size as well as what criteria will be used to select your sample. Clearly defined sampling criteria that are rooted in the study's research objectives improve the reliability of the data collected (Onwuegbuzie & Leech, 2007). The principal criterion for selecting interview participants in this study was either current or past association with their country's heroin maintenance program. This requirement was necessary to maximize the likelihood that the interview participant would be able to provide detailed information about the program and the history behind establishing it. Interviews with frontline workers, such as nurses or social workers, and patients were not sought. These groups were excluded as participants because, although they may provide unique insights into certain aspects of the trial, they may not have enough information to respond to all questions, particularly those regarding challenges in implementing the program. For instance, although a nurse may be an excellent source of information about the day-to-day operations of the clinics they might not know about the any legal concerns that needed to be addressed before the program could be implemented.

Selection criteria can introduce bias into the results of research (Patton, 2002). An obvious critique of the present study in this regard is that by selecting individuals who work with heroin maintenance programs has resulted in the situation were only those supporting the use of, or at least experimentation with, heroin maintenance treatment were interviewed. As such, a diverse range of perspectives on heroin maintenance treatment was not collected. However, the objective of this research is not to assess the appropriateness of heroin maintenance as a treatment option (the recent series of clinical trials are better suited for this purpose) but to examine why its use has been adopted now after a long history of rejection in most countries and to assess its future viability in Canada.



Another concern with interview data often cited in the literature is that participants can present rehearsed narratives or information that presents a specific view of the individual or issue under consideration, which may not be entirely accurate or complete (see Nunkoosing, 2005 and Czarniawska, 2004). The selection criteria used here make rehearsed narratives a possibility. Participants were chosen because they had an extensive background in working with heroin maintenance programs or were instrumental in establishing these programs. As such, most of the participants had a professional interest in the success of the programs. Also, many of the interview participants were in effect spokespersons for the programs and undoubtedly had done other interviews and were well versed in communicating key messages about the programs. Although rehearsed narratives are something that must be kept in mind when analyzing the interview data it does not undermine its reliability. It is the role of the interviewer to move the interview beyond rehearsed narratives to the information needed for the research (Nunkoosing, 2005; Czarniawska, 2004). Moving participants beyond rehearsed narratives was done here through the questions asked and probing for additional information. Also, my role as a student, unattached to the program and, in some instances, from a foreign country, likely eliminated some motivation to only speak to the official view of the programs. Indeed, many of the interview participants were quite candid about the challenges and setbacks faced in establishing heroin maintenance programs and openly discussed some of the shortcomings of the treatment.

#### **3.4.4. Sample Size**

Selecting an appropriate sample size is necessary to ensure that enough data are collected to adequately address the study's objectives but valuable time and resources are not wasted (Onwuegbuzie & Leech, 2007; Guest et al., 2006). It is ideal to reach data or theoretical saturation (e.g., no new data categories or theoretical concepts are generated by including more participants) but avoid data redundancy. However, in reality, available time and resources often dictate sample size (Onwuegbuzie & Leech, 2007; Guest, Bunce, & Johnson, 2006). Because heroin maintenance is a specialized and largely experimental treatment option at the present time, there are a limited number of individuals intimately involved in the establishment of

these programs. As such, it was decided that a relatively small number of interviews would suffice to reach data and theoretical saturation. Moreover, it was felt that interviewing key individuals with in-depth knowledge of the heroin maintenance programs in their countries was more important than interviewing a large number of individuals who had experience with heroin maintenance but not detailed information on the establishment of these programs.

The original intent was to interview approximately 25 participants or 5 to 7 participants from Canada and 3 to 5 individuals from each of the UK, the Netherlands, Germany, and Switzerland.<sup>2</sup> However, these numbers were not reached for the UK, the Netherlands, or Germany. This failure was largely a result of initially identified participants declining the interview or not responding to the invitation(s) to take part in the study. Also, it was anticipated that the request for interview participants to suggest additional individuals who might want to participate would identify more participants than it did. Despite not reaching the initial intended number of interviews from the UK, the Netherlands, and Germany, the persons who were interviewed provided a rich source of information with detail sufficient for this study.

### **3.4.5. Analysis of Interview Data**

Qualitative data analysis should be guided by the purpose of the research and done with the desired end-product in mind (Patton, 2002). The purpose of conducting interviews for this dissertation was twofold. First, the interviews provide descriptive information on the establishment of the present day heroin maintenance programs. Second, they provide insight into why heroin maintenance programs began or what forces led to their establishment. As such, this analysis draws on both narrative and thematic analysis techniques. First, a narrative of the events that led to the establishment of the heroin programs in each country was created by combining the data from the interviews done within the country. Combining the data also offered the

<sup>2</sup> Although Spain also held a small heroin maintenance trial, interviews were not sought with participants involved with this trial because I was unaware of it when planning and budgeting for the interviews in Europe. As such, resources were not set aside for travel to Spain to carry out interviews there.

opportunity to check the degree to which information from interview participants was confirmed or disconfirmed by others, as a form of triangulation or means of assessing the quality and trustworthiness of the interview data or if there was missing or conflicting information (Mabry, 2008).

In addition to doing this initial analysis, a thematic analysis was also carried out. This type of analysis involves searching for common or re-occurring themes in data and is useful for theorizing across cases (Riessman, 2005). For this analysis, each interview was considered on its own (e.g., as a single case) and not categorized based on country until after key social and political forces and events which influenced the introduction of heroin maintenance were identified. The thematic analysis first involved coding each interview on issues that were easily categorized. The coding was guided by the interview instrument as well as the literature on heroin maintenance treatment and my own past research experience. Response categories were identified for each interview question and the participant's response was summarized. For instance, one question asked about the practical, legal, or political challenges faced when implementing their heroin maintenance program and included response categories such as 'Political Opposition', 'Access to Heroin', 'NIMBY', 'Participant Recruitment' and so on. Potentially useful quotes that illustrated a particular issue were also noted. The purpose of coding the interviews in this way was to organize the interview data in a more easily manageable and accessible format. Categorizing and summarizing responses to individual questions facilitates comparisons between interviewees as well as identifying common issues identified by the interview participants (Rubin & Rubin, 2005; May, 1997).

Next, larger themes that emerged from the data were identified. These themes were not restricted to responses to individual interview questions and often spanned a variety of questions. Themes were identified, in part, through the initial coding and categorization process as well as by reading and re-reading the interview transcripts. Themes are different from codes or categories because they represent a broader view of the overall issue and may encompass a variety of related categories. For instance, in the context of this research a category might be advocacy by municipal politicians to establish a heroin maintenance program, whereas a theme might be local support for

heroin maintenance which could include advocacy by municipal politicians as well as other categories such as support from local police or drug user networks.

### **3.5. Final Data Analysis and Integration**

As was discussed in Chapter 1, a comparative historical analysis approach was used to compare reactions to heroin maintenance treatment in the six countries considered here, with a longer and more in-depth history considered for Canada, the UK, and the US. To do this type of comparison, it was necessary to construct cases for analysis. Patton (2002) suggests that it is important to draw on all data collected when creating cases, including contextual information. Constructing cases provided an opportunity to integrate data from the interviews, literature review and archival research. The task of integrating the three data sources was made somewhat simpler by the fact that the archival research largely addresses the time period from the 1900s to 1980s and the interviews focused on the present. Any history discussed in the interviews typically focused on events in the 1980s and 1990s and occasionally the 1970s. However, it was not sufficient to simply add the interview data to the archival research. It was also necessary to include information from the literature.

Cronin, Alexander, Fielding, Moran-Ellis and Thomas (2008) suggest a three step approach to integrating multiple sources of qualitative data. First, they suggest analyzing the data on their own in manner that is best suited to the methodology employed. The details of how data was analyzed on its own in this research are discussed above. Second, they suggest identifying common threads or themes across the data and using these common themes as a place to integrate the results of the original analysis. In this research, the themes identified in the interviews and the archival research were used to integrated the results. Information from the literature was then considered to determine if these themes were also apparent in the literature or if the literature introduced alternative themes. Finally, Cronin and colleagues suggest creating a data repository that includes data from all sources, but not in their raw form. Instead, data are included in their already synthesized form and subject to further analysis and interpretation. This additional analysis offers an opportunity to look for similarities and differences. For this research, this additional analysis was also an

opportunity to make comparisons across time periods within each country, with particular attention paid to how forces that influenced reactions to heroin maintenance changed over time.

It was possible to make comparisons across countries through a similar process. First the cases created for each country were compared to consider common and divergent themes. By combining data on each theme from different countries it was possible to assess the strength of the evidence supporting or contradicting a specific theme. Because in-depth cases had been created previously, it was also possible to consider contextual factors that may have led to differences between the countries. Next, to determine if other themes were missed, previously synthesized data from each country were combined and reviewed once more.

## **Chapter 4. Establishing Drug Control and Criminalizing Heroin Maintenance, 1900 to 1950**

### **4.1. Introduction**

Heroin maintenance has the unfortunate status of being illegal in Canada, outside of a research setting. The history of how this intervention came to be criminalized and remained so for the next 100 years provides important insight into why heroin maintenance was not used in Canada until the introduction of the NAOMI trial in 2005. This history also contextualizes and provides greater depth of understanding of the challenges faced in implementing the NAOMI trial and why, despite a growing body of evidence supporting the efficacy and cost effectiveness of heroin maintenance, it has not been adopted as a routine treatment option in Canada. The present chapter explores the history of heroin maintenance in Canada, the United Kingdom (UK) and the United States (US) during the first half of the 20<sup>th</sup> Century. The primary focus is Canadian history but attention is paid to similarities and differences between events in the UK and the US, as well as experiences unique to Canada. The chapter begins with a discussion of how heroin maintenance was influenced by the introduction of a predominantly criminal model of drug control in Canada and the US and a criminal-medical model of control in the UK. This discussion includes a general overview of the early history of heroin maintenance and places this history in the larger social context of the time. Following this discussion, the role that international developments and pressure played in shaping reactions to this intervention is explored. Next, how earlier understandings of addiction shaped what was considered appropriate treatment for this condition are discussed. Lastly, the influence of the medical profession on the establishment of drug control is explored and how this influence (or lack of influence) shaped decisions to ban maintenance prescribing in Canada and the US and allow this practice in the UK is considered.

It should be noted that during the time period considered in this chapter there was no special consideration of heroin maintenance. Rather, there was a more general consideration of the practice of maintenance prescribing which could include any form of maintenance treatment. Moreover, heroin was generally not used by Canada's addicted population until the 1920s and was not the primary drug of abuse until after the Second World War. Prior to this time, first opium and then intravenous morphine were the most commonly abused opiates (Solomon and Green, 1982). Because of this pattern of drug use, the chapter provides a more general discussion of the history of maintenance prescribing or treatment rather than commentary specific to heroin maintenance. Historical information from both Canada and the US also often uses the term ambulatory treatment to refer to maintenance treatment. For instance, the US Bureau of Internal Revenue defined ambulatory treatment as "prescribing or dispensing of a narcotic drug to an addict, for self-administration at his convenience" (Prentice, 1921, p. 14-15). Sometimes, the term ambulatory treatment was also used to refer to both the practice of prescribing narcotics to an addicted individual without attempting to cure their addiction as well as the practice of gradually reducing the dose of narcotic prescribed with the hope of gradually weaning the individual off the drug in a community setting.

## **4.2. Early Models of Drug Control**

The global introduction of formal drug control in the early 20<sup>th</sup> Century has meant that the model of control adopted by a nation provides a framework within which all interventions in drug use must operate. This framework influences which interventions are accepted as a legitimate response to the problem of illicit drug use, including heroin maintenance. Each of the countries considered in this research have a system of control based on prohibition. More specifically, these countries all have laws that prohibit the sale and possession of drugs outside of medical practice. They can be described as having, at least in part, a criminal or penal model of administering and enforcing their laws. This common criminal model has resulted in the situation where each country has considered, and often reconsidered, whether maintenance treatment is a legitimate medical practice and allowable under the law. The answer to this question depends on how strongly a criminal or penal model of control is endorsed or whether it

has been hybridized to include medical or public health controls as well. As we will see in the following discussion, both Canada and the US endorsed a criminal model of drug control and subsequently banned maintenance prescribing in the early 20<sup>th</sup> Century whereas the UK adopted a medical-penal model of control and recognized maintenance treatment as a legitimate medical practice.

In writing about present-day crime control developments, Garland (2001) suggests that during the first half of the 20<sup>th</sup> Century crime control was a relatively cohesive undertaking guided by the perspective that it was the role of the state to both treat or rehabilitate and punish or control offenders. There was also confidence in the ability of the criminal justice system to control crime. The same situation existed with regard to drug control, which at this time was primarily guided by a philosophy of prohibition. This section will explore the events and conditions that led to Canada adopting two complementary strategies for controlling drug use – suppressing non-medical drug use and the illicit drug trade through criminal justice action (a law enforcement strategy) and controlling the legitimate trade in narcotics by closely monitoring the practices of physicians, druggists and drug wholesalers as well as establishing boundaries on what was considered a legitimate medical use of narcotics (a combined administrative/law enforcement strategy). Both of these strategies were rooted in a moral, prohibitionist perspective. By way of comparison, the US adopted these strategies but also used institutional treatment as another avenue for addressing addiction. None of the strategies used by Canada and the US or their underlying ideologies accommodated maintenance treatment. However, unlike their Canadian counterparts, the UK government did not attempt to define the boundaries of legitimate narcotics use and largely left this decision to the discretion of the British medical profession. Equally important, the UK adopted a more flexible perspective on drug control that supported both criminal and medical control. This more flexible perspective was compatible with maintenance treatment.

Garland (2001) also argues that developments in crime control are dependent upon, or a manifestation of, larger social, economic and cultural trends of the time in which they are adopted. This argument is certainly applies to drug control as well. The establishment of drug control in the beginning of the 20<sup>th</sup> Century in Canada was



influenced by larger societal trends such as growing urbanization of the Canadian population, increased immigration, economic downturns and industrialization of the Canadian economy. These social and economic changes stimulated concerns over social cohesion and fears that the dominance of White, Anglophone middle class morals and values were being threatened. There was a widespread perception that crime and vice were increasing as well as fears of family breakdown, changing gender roles and social class boundaries. These concerns led to a variety of social and moral reform movements, such as the social purity movement, the temperance movement and child savers movements, which shaped Canadian society at this time. These movements were influential in the development of a welfare state in Canada (Maurutto, 2005; Valverde, 2008). As both Maurutto (2005) and Valverde (2008) suggest, these movements aimed to both save individual's souls as well as 'raising the moral tone' of Canadian society. They also advocated a new approach to social problems that emphasized collective action and increased public and government responsibility as well as legislative reform. Similar social trends and movements were also occurring in the US and can account for much of the similarity between the strategies Canadian and American governments used to address drug control at this time. Conversely, although the early 20<sup>th</sup> Century was also a time of social change in the UK it was not as pervasive as it was in Canada and the US. Urbanization and industrialization occurred previously in the UK and the perception that the dominant British society was being threatened was not as strong (Valverde, 2008?). As a result, the British were not as inclined to respond to social problems, such as addiction and drug use, with the same moral fervour that was observed in the US and Canada.

#### **4.2.1. Conceptualizing Drug Control - Setting the Moral Tone**

It was in this context of social and economic change and movements to reform individuals and society that formal drug control was introduced in Canada. Given this environment, it is not surprising that, similar to our American neighbours, Canada adopted a criminal model of drug control. A criminal model signified the government's and Canadian society's moral condemnation of non-medical drug use. It also complemented other efforts to suppress vice that were occurring at the same time, such as alcohol prohibition and campaigns to promote sexual purity. For instance, similar to

the motivation behind early American drug legislation, the *Opium Act* (1908), Canada's first piece of federal drug control legislation, was motivated by anti-immigrant and racist sentiments. These sentiments contributed to a perspective on drug use that is best described as moral condemnation. The events that led to the enactment of the *Opium Act* began with Chinese labourers recruited to Canada to build the national railroad. Prior to the completion of the railroad there was a labour shortage and economic downturn. This labour shortage generated animosity towards Asian immigrants who were perceived as taking jobs from White Canadians. This animosity came to a head in 1907 with a riot in Vancouver's Chinatown. Asian businesses and property were damaged by White rioters (Giffen et al., 1991; Boyd, 1984; Solomon & Green, 1982; Carstairs, 1999).

In response to this incident, the Canadian government sent the then deputy minister of labour, Mackenzie King, to investigate the incident. During his investigation, King visited a number of opium factories and opium dens. His report revealed that there was an active opium importation and manufacturing industry in BC and as much opium was sold to White as Chinese customers. King (1908) interpreted this finding as evidence that opium smoking was becoming more common with not only White men and boys but also women and girls. From King's perspective, this increase in opium smoking was a situation that warranted government intervention. His abhorrence to the situation is clearly expressed through his discussion of two cases of young, White women being found in Chinese opium dens. He clearly viewed the issue as a grave moral concern, suggesting it was a threat to "the manhood of a nation" (King, 1908, p.6). King's overall recommendation to the federal government was that:

[T]he operations of the opium industry should receive immediate attention of parliament, and of the legislatures, with a view to the enactment of such measures as would effectually suppress the opium traffic in Canada, and wholly eradicate this evil and its baneful effects.

When opium smoking continued largely unabated by the *Opium Act* and the opium trade simply moved underground, Mackenzie King used the same argument that moral fiber of the nation was under threat to pass additional legislation. This time the appeal was to address a perceived epidemic of cocaine use in Montreal, where youth were believe to be enticed into drug use. For instance, in introducing the new *Opium*

*and Drug Act* (1911), Mackenzie King characterized cocaine as follows, “It is a real evil. It is a social plague, and it goes on spreading so fearfully that it is time for society to take marked notice....It is an agent for seduction of our daughters and demoralization of our young men” (King, January 26, 1911, pp. 2524-2525). The *Opium and Drug Act* was a much more comprehensive piece of legislation. The Act not only restricted trade in crude and prepared opium but also morphine, cocaine and the salts and compounds of these substances. It also included provisions to prohibit use outside of medical practice. At the same time, it instituted controls over physician prescribing and legitimate distribution through wholesalers and druggists.

These two pieces of legislation, with their appeal to anti-Asian sentiments and fear that Canadian society was under threat from moral corruption, set the stage for the next 40 years of drug control. By the time maintenance treatment became a concern to the federal drug administration after World War One (WWI), Canada was well on its way to implementing a criminal model of drug control that controlled both the legal and illegal drug trades. When a purely criminal model of control rooted in a perspective of moral condemnation is guiding drug policy, any form of maintenance treatment, including heroin maintenance, has generally been rejected as an illegitimate medical practice.

#### **4.2.2. Defining Drug Control and Deciding on the Legitimacy of Maintenance Prescribing**

The history of maintenance treatment in Canada, the US and the UK reveals that questions regarding the legitimacy of maintenance prescribing and its legal status were decided in the period between WWI and the Great Depression or roughly between 1918 and 1930. This time was a particularly active and defining period in drug control. Although Canada, the US and the UK all had drug legislation that pre-dated this period, it was at this time that the details of how to implement and enforce domestic systems of drug control were worked out. Each of these countries settled on an approach to drug control, established departments to administer their respective legislation, and developed systems for controlling the legal trade in narcotics as well as for suppressing illegal trafficking. As is discussed in the following section, the timing of these developments are related to the ratification of the International Opium Convention, which

set off a flurry of domestic activity to create systems of control that would meet intentional obligations. Canada was also under pressure to take additional action to prevent drugs from being smuggled from Canada to the US (Solomon and Green, 1982). Heightened activity in the field of drug control at this time was also likely a reflection of post-war anxieties and continued fears of the breakdown of social cohesion and moral order in each of these countries. Additionally, this time was the height of alcohol prohibition, in Canada and the US at least. Much of the ideology that guided alcohol prohibition was also applied to drug control.

As foreshadowed by the moral tone of previous legislation, Canada established a purely criminal model of drug control designed to eliminate non-medical drug use and the illicit drug trade as well as strictly control the legitimate trade in narcotics. To achieve this result, the federal drug administration relied almost exclusively on law enforcement and monitoring prescribing practices of physicians. Outside of some limited treatment programs in prisons, there were no government run or funded addiction treatment services available in Canada (Cowan, 1924; Sharman, 1928; Narcotics Division, 1935; Technical Advisory Committee on Narcotics Drug Addiction, November 20, 1947; Josie, 1948; Senate of Canada, 1955). For instance, in communications with various provincial officials and doctors, the Narcotics Division acknowledged the absence of addiction treatment:

In reply I am to state that this Department is not aware of any institution in the Province which specializes in the treatment of addiction other than the Homewood Sanitarium at Guelph, Ontario. There should, however, be no difficulty in having the patient admitted to any general hospital in any town or city throughout the Province, insomuch as the municipalities and the Provincial Government contribute towards the upkeep of persons who are unable to pay for treatment received in such institutions. (Cowan, November 20<sup>th</sup>, 1923).

Your remarks with reference to the difficulty of finding some place in which to have this man placed for treatment have been duly noted, and in reply I am to state that the same difficulty arises in nearly all the provinces throughout the Dominion, as unfortunately the Provinces have not as of yet seen fit to make some provisions for the treatment of these drug cases, and more particularly in the case of persons who are unable to pay for such treatment. (Deputy Minister December, 22, 1922, p. 2)

Probably one of the most urgent requirements at the present time is proper hospital accommodation, where drug addicts may be treated voluntarily or otherwise, with the view to curing them of the habit and the question of providing institutional treatment for these cases is, of course, altogether one for the provinces and municipalities to deal with, the same as they care for their insane and feebleminded cases, tubercular patients and V.D. cases, etc. (Deputy Minister, March 8, 1923 p.2).

As these quotes suggest, the absence of addiction treatment at this time was not the result of government opposition to treating addicted individuals but rather due to inaction motivated by disagreement over which level of government was responsible for delivering such a service. In keeping with a common approach to dealing with undesirable members of society at this time, the federal drug administration supported the use of institutional treatment; However, they viewed the provision of this treatment as a provincial responsibility. This support for institutional treatment is not at odds with the moral and social reform movements of this time. Valverde (2008) reminds us that these movements were not only repressive and designed to suppress vice but also meant to rehabilitate individuals. Institutional treatment fit with this agenda, particularly when the 'victims' of addiction were the 'non-criminal' type (i.e., Caucasian and often addicted through the course of medical treatment or due to easy access to narcotics). At first federal governments appeared amenable to the idea that they would have a role in providing institutional treatment. For example, in communications with provincial officials the drug administration indicated they were considering this issue:

I can quite understand the difficulty in dealing with this traffic, without having proper institutions in the various provinces, to care for these persons, while they are being treated at the public expense. This matter will have to be given some consideration, and it may be, at a later date, that the Federal Government, will have to grant aid to the various provinces to assist in establishing, and conducting institutions for the care of these addicts, something along the lines of the United States Government. (Officer in Charge, Opium & Drug Branch, March 26, 1920 p. 2).

With reference to the matter of providing institutional treatment for the drug habit; as previously advised the department is at the present time collecting information as to the number of addicts in Canada, together with their age and nationality, length of time addicted, etc. and when these returns have all been received and tabulated the Department will be in a much better position to advise the Government what action should be taken, if any, to treat these people. (Deputy Minister October 27<sup>th</sup>, 1920)

However, the drug administration soon changed their messaging on the topic and indicated the provision of this treatment was entirely a provincial responsibility:

From our point of view, there are two distinct sides to this question namely: the treatment of addicts with a view to curing him of the habit and restoring him to normal life. Secondly, removing the causes of drug addiction insofar as possible by controlling the sale of these delirious drugs, and by preventing illicit shipments from arriving in Canada through underground channels.

The first phase of the question, we consider is purely a provincial matter, and the latter phase of the situation is, of course, a Federal question, and is the one which we are trying to deal with at the present time. (Deputy Minister, December 2, 1922, p 1).

With this dual agenda of suppressing vice and reforming addicts, the Narcotics Division almost invariably recommended admission to hospital or psychiatric facility when approached by physicians or provincial governments regarding how to deal with addict individuals. However, these facilities were often not willing or able to take on this role (Manitoba Department of Health and Public Welfare, May 16<sup>th</sup>, 1939; Hossick, May 26<sup>th</sup>, 1939; Memorandum for the Deputy Minister, February 28<sup>th</sup> & March 8<sup>th</sup>, 1935; Sharman, 1928). For instance, in communication with the Narcotics Division, one Manitoban official suggested,

It will undoubtedly be necessary for us to have an Institution or Colony Farm to send these people to as it is not right to send them to the jails and have them associating with criminals. Ninety-five percent of them have no money and the general hospitals are not at all anxious to look after them and the only place for them is the jail. As it is often necessary to keep them in bed for three or four days a week at first, the jail authorities do not like to have them either. (Secretary of Narcotics Act, Manitoba September. 12, 1921, p. 2)

Likewise, writing to the Chief Medical Officer of Health from New Brunswick, the Deputy Minister of Health suggested:

While it is quite realized that many of the hospitals do not desire to admit this class of patient owing to the fact that they are very noisy, and in most instances require male attendants while undergoing treatment, and also having in mind the fact that the period of treatment is very lengthy in comparison to the general run of patients admitted to hospital; there would appear to be no good reason why a public hospital which receives

a grant from the province and municipality should not admit a patient of this nature, even though the patient is unable to pay for treatment, so long as the hospital would not be asked to care for too many of these drug cases at one time. (Deputy Minister, December 2, 1922, pp. 2-3).

Despite clearly recognizing the need to provide addiction treatment, no treatment institutions were established by either provincial or federal governments. It would appear that jurisdictional squabbling and the practical challenges of treating addicts in existing hospitals won over any moral and social reform agenda to save addicted souls. As a result, Canada's early system for controlling drug use can be characterized as entirely punitive and a more purely criminal model of control than even that of the US. In the US, some access to addiction treatment was provided through two federal narcotics farms or large treatment institutions as well as a few state run facilities in California and New York. The first of these federal institutions was opened in 1935 in Lexington, Kentucky and the second was opened three years later in Fort Worth, Texas. These facilities were essentially prison hospitals for addicts but did accept voluntary patients ("Federal narcotics farms", 1937; Winick, 1957; Campbell, Olsen, & Walden, 2008; Kolb, 1939). There is some evidence that addicted individuals could voluntarily admit themselves to Canadian jails to receive treatment as well. For instance, the drug administration recommended this option when their appeared to be no other treatment available:

In regard to the particular case mentioned in your letter, I can only suggest, that in the circumstances, it would be in the interest of [name of individual] and also the community, if he was committed (voluntarily) to the county jail for a period of say six months, where he might obtain treatment under supervision for the habit. This appears to be the only alternative, at the present time, and is adopted in most of the Provinces to meet a situation such as you have mentioned. (Deputy Minister, December 2, 1922)

Similarly, in describing the drug situation in Manitoba, a provincial government official also mentioned this practice:

In the meantime we have cured between twenty-five and thirty of these addicts ...they simply swear themselves into the jail for six or eight weeks and give them the treatment, and get them cured of the Morphine and Cocaine habit. Some of them are return boys, some of them are very well connected, but cannot afford to go into special institutions, several have

gone to Minneapolis to get cured, and I think that it is up to the Dominion and Provincial Governments to co-operate and arrange that these people are properly looked after, as they are not criminals and the majority have no money. (Secretary of the Manitoba Narcotics Act, March 18<sup>th</sup>, 1920).

It is unclear how common the practice of voluntarily admitting addicted individuals to jail was in Canada as it was only mentioned twice in all the documents reviewed for this dissertation. The practice does speak volumes about the social context in which drug control was introduced, where the poor were forced to submit themselves to being incarcerated to receive a service that could be bought from a private institution for those who had the financial means to receive this care. This situation suggests a division between how working class addicts and upper-middle class addicts were treated. This division, combined with anti-Asian sentiments that motivated early efforts at drug control, facilitated the adoption of a criminal model of control. The practice of allowing addicted individuals to voluntarily admit themselves to jail for treatment also suggests that the need to reform addicts (and society) was valued above personal freedoms. This attitude is an ongoing theme in Canada's response to addiction that continues to the present day and is often used to justify highly repressive treatment interventions. It is also an attitude that is not compatible with maintenance treatment, which requires at least a modicum of respect for individual's control of their bodies and their addiction. This situation, combined with the fact that hospitals were refusing to treat addicted individuals, undoubtedly facilitated drug control being defined almost exclusively as a criminal problem in Canada for the next 30 years. It is difficult to define drug control as a medical problem, or even combined medical-criminal problem, when there were limited medical responses available to address addiction and those that did exist (i.e., publically funded general and psychiatric hospitals) were often unwilling to provide treatment.

Given the situation where there were essentially no treatment services available in Canada, it might have seemed that maintenance prescribing would be a humane means of addressing this shortage. Indeed, this line of reasoning was one rationale for allowing maintenance prescribing in the UK after their drug control legislation was implemented (Departmental Committee on Morphine and Heroin Addiction, 1926). Even in the US, a series of narcotics dispensing clinics were established across the country as



a solution to the large number of addicted individuals suddenly without a legal supply of narcotics after the implementation of the *Harrison Act*. For instance, a later memorandum to the League of Nations indicates these narcotics clinics were a humanitarian response to the situation where addicts were suddenly deprived of a legal supply of narcotics:

“[E]arly in 1919, there was a feeling among some members of the medical profession and officials in different parts of the country that it would relieve the suffering and distress of addicts who had been deprived of legal means of procuring if a cheap source of supply were to be made available to them” (Memorandum – Experience in the United States with Plan of Selling Drugs to Addicts at Low Prices ~ 1930s)

However, the clinics in the US were short-lived. Beginning in 1920, less than a year after they were opened, the American drug administration began to close the clinics down. By 1923, the clinics were all closed and idea of supplying narcotics to addicts through outpatient clinics was largely discredited among the US drug administration, the medical profession, and the public. In the short period of time the clinics were open, any sympathy for addicts among the American drug administration quickly disappeared (Lindsmith, 1965; Martin, 1978; Musto, 1999). The US turn to increasingly harsh crime control measures for controlling drug use at home and actively promoted this approach on an international stage as well.

Unlike their American counterparts, the Canadian drug administration was unwilling to even experiment with maintenance prescribing. Instead they preferred to simply suppress this practice by monitoring physicians' use of narcotics and reprimanding, or in some instances charging, physicians who they suspected of supplying narcotics to addicted individuals. By the 1920s, control of the legal drug trade was centralized within the Opium and Narcotics Drug Branch of the Ministry of Health (which later became the Narcotics Division). They restricted the amount of narcotics imported into Canada or manufactured to what they believed was needed for medical purposes and required importers, manufacturers, dealers and druggists to submit monthly or periodic reports to the branch on the amount drugs they bought and sold. Through these reports the Branch was able to identify physicians with suspicious prescribing practices (Canada, Parliament, March 18<sup>th</sup>, 1920, April 23<sup>rd</sup>, 26<sup>th</sup> & 28<sup>th</sup>,

1920; Cowan, 1924; Sharman, 1928). For instance, in a letter to the British Home Office, Sharman described Canada's system for monitoring physicians as follows,

In so far as legal traffic is concerned, upwards of one hundred and fifty wholesale druggists are licenced by this department annually, and they alone receive permits to import and export narcotics. They report monthly to this office every narcotic transaction, each of which is transferred to the personal card of the retail drug store, physician, dentist, etc., receiving any narcotics....So far as physicians, veterinary surgeons, etc., are concerned we write many scores of letters in inquiry to them when their card indicates that considerable quantities are being purchased. In most cases we find that there are medical conditions requiring same, but the enquiry itself acts as a check, and in some cases the replies indicate that there is no justification for the use of narcotics, the physician then being warned. There are, of course, other cases where the amount obtained, and the use to which it is put, is so unwarranted that police inquiries are made, and if the evidence obtained warrants it, the Department authorizes a prosecution. (Sharman, February 27<sup>th</sup>, 1928, pp. 1-2)

Ensuring physicians were not being too liberal in their use of narcotics and not prescribing purely for profit had become an accepted role for the federal drug administration, alongside suppressing the illicit drug trade.

There was nothing in early Canadian drug legislation that addressed maintenance prescribing. It gave very little guidance on what would be a violation of the law outside of the most blatant examples of physicians prescribing narcotics for profit and not medical treatment. For instance, under the *Opium and Drug Act* physicians were prohibited from prescribing narcotics "unless such drug is required for medical purposes or is prescribed for the medical treatment of a person who is under professional treatment by such physician" (*Opium and Drug Act*, 1911, Section 5(2)). This provision was largely unchanged until the enactment of the *Narcotics Control Act* in 1961. Despite the law making no reference to addiction or its treatment, the federal drug administration interpreted the legislation as outlawing maintenance prescribing by arguing that it was not a medical treatment. In a letter to the Canadian Medical Association Journal, Dr. Amyot, the deputy minister of health, argued:

The law takes into consideration these two methods [sudden and gradual withdrawal] and does not consider that anyone is justified in supplying the drug for the continuance of the addiction, just to keep the addict at work or comfortable. (Amyot, 1927, p. 521)

Likewise, in a later letter to a physician, the assistant chief of the Narcotics Division, Ken Hossick, explained their interpretation of the law:

[W]hile a physician is entitled to relieve the suffering by personal administration of narcotics, in cases where a definite medical condition is present, he cannot and should not furnish or prescribe narcotics for addicts simply for gratification of the narcotics appetite. (October 3<sup>rd</sup>, 1938)

Through this interpretation of the law, the Narcotics Division banned maintenance prescribing by first overtly policing physicians, charging those suspected of being an addict themselves or supplying drugs to addicted individuals with no intention of curing them (“Use of drugs on increase in Canada”, May 20<sup>th</sup>, 1922; Assistant Deputy Minister, February 21<sup>st</sup>, 1920, September 20, 1921; Cowan, February 24<sup>th</sup>, 1920). Later, they reverted to more subtle means of controlling doctors’ use of narcotics.

Conversely, when a criminal model of drug control is softened by the inclusion of some elements of medical or public health control there is greater acceptance of maintenance treatment. The experience of the UK in the first half of the 20<sup>th</sup> Century provides an example of such an approach. The British approach to drug control at this time is typically described as a medical-penal (criminal) model of control. It exhibits clear elements of control by both law enforcement and the medical profession. For instance, the UK had similar drug control legislation to Canada and the US, including criminal sanctions for personal possession (Strang & Gossip, 2005a; Berridge, 2005; 1999; 1984). The principal difference in their system of drug control was largely a function of the interpretation and implementation of their respective legislation. During the first 40 years of drug control in Canada and the US, crime control and moralism around drug use took precedence. As a result, medical control over drug use was restricted or not established. Conversely, the UK’s *Dangerous Drug Act* (1920) was interpreted in a manner that strengthened rather than diminished medical control, leading to a more balanced system of criminal and medical control. The reasons for this difference are varied. To begin with, there was no widespread problem with addiction in the UK. The enactment of the *Dangerous Drug Act* was strongly influenced by international pressures and colonial concerns rather than pressing issues at home or moralist views of drug use (UK, Parliament, 1912, 1913; ‘The abuse of opium’, 1913, ‘The dangerous drug bill’, 1920; Ministry of Health Papers, 1924; UK Parliament, June

10<sup>th</sup>, 1920). Most importantly, medical jurisdiction over drug addiction in the UK predated the introduction of formal drug control. It originated in the 1800s and did not simply appear with Britain's first attempt at criminal control of narcotics (Berridge, 2005; 1999). When the British Home Office attempted to implement a purely criminal model of drug control similar to what was observed in Canada and the US, the medical profession resisted.

The British medical profession resisted a purely criminal model of control by making their voices heard on the issue of drug policy through participation on government committees, consultation on policy questions and regulations, and advocacy for retaining professional autonomy with regard to the use of restricted drugs (Committee on the Draft Regulations Under the Dangerous Drug Act, 1921; UK Parliament, February 17<sup>th</sup> & 24<sup>th</sup>, 1921; "The great drug delusion", 1922; "The drug panic", 1922). For instance, at the urging of the Home Office, the newly established Ministry of Health appointed the Departmental Committee on Morphine and Heroin Addiction in 1926 to provide a medical opinion on if, and when, it was ever appropriate to prescribe narcotics to drug addicts. The Committee, made up entirely of medical professionals, eventually became known as the now infamous Rolleston Committee after its chairman. After hearing from experts on addiction, most of whom were also physicians, the committee endorsed a disease model of addiction and maintenance prescribing in limited cases. They advised physicians first try to cure their patients through gradual withdrawal but recognized that maintenance prescribing was necessary in some cases. If gradual withdrawal failed, the patient should be maintained on a minimum dose sufficient to live a normal life. Through the Rolleston Committee and similar decisions made in the UK, physicians retained the authorization to use restricted drugs as they choose in the course of their medical practice. They also retained the authority and discretion to treat addiction based on their clinical judgement. This authority and discretion included maintenance prescribing. Because physicians kept this authority, they played an integral role in controlling access to a legal source of narcotics after international prohibition.

### **4.2.3. Enforcing the Status Quo**

Beginning in roughly the 1930s, there was a period of relative quiet in the field of maintenance prescribing, as well as drug control in general. This period of quiet occurred in Canada and the US as well as the UK. By this time, the challenges of implementing a national system of drug control had been worked out and a dominant model of control was settled on in each of these countries. Any organizational struggles that occurred when drug control was first implemented were largely solved. In Canada and the US, a purely criminal model of drug control was in place. With regard to maintenance treatment in North America, any opposition to the ban on maintenance prescribing largely died away and support for this treatment option quickly became a radical position. With this change in perspective came a move away from the heavy handed approach to suppressing maintenance treatment to a more discrete approach to discouraging physicians from this practice. For instance, by the 1930s, physicians in Canada were rarely charged but were warned if they were suspected of unsavoury prescribing practices or of being addicted themselves. If these warnings were not heeded the doctor was placed on the 'confidential restricted list'. Being placed on this list in effect revoked the physician's authority to use narcotics for any purpose. Pharmacists and drug wholesalers were instructed not to sell narcotics to doctors on the list or to honour their prescriptions. Provincial Colleges of Physicians and Surgeons were also notified (Brown and Sharman, 1936; Narcotics Division, n.d.; Wodehouse, February 11<sup>th</sup>, 1937; "The fight against the traffic in narcotics", 1940, "The illicit traffic in narcotics", 1941). Similarly, in the UK, there were no further efforts on the part of the Home Office to infringe on the autonomy of the medical profession or to re-examine the issue of maintenance prescribing. This state of calm and promotion of the status quo in the field of maintenance prescribing persisted until the end of the Second World War and even into the 1950s in North America and the 1960s in the UK.

This period of calm was not only the result of widespread acceptance of ban on maintenance treatment in North America or the approach to maintenance treatment laid out in the Rolleston Report in the UK. It was also a reflection of global events that captured the world's attention focusing it on larger concerns brought on by the Great Depression and the Second World War. It seems reasonable to assume that rather than

focusing on the minutiae of what was an appropriate treatment for addiction or the appropriate approach for discouraging physicians from maintaining drug addicts, the governments resources were instead directed towards dealing with the sudden rise of unemployment and poverty brought on by the stock market crash in 1929 and later managing the war effort. Moreover, it appears rates of drug use and addiction declined, at least during WWII, as illicit supplies of narcotics declined due to disruptions in trade and shipping routes as a result of the war. For instance, in Canada, the supply of illicit drugs dried up across the nation except in Vancouver where drugs were sporadically available at exceedingly high prices. In this environment, incidents of addiction dwindled and convictions under the *Opium and Narcotic Drug Act* declined. Law enforcement was largely credited with this situation (Canadian Medical Association Journal, 1934, May 1940, June 1941, 1942, 1943). With a shortage of illicit drugs and doctors unwilling to prescribe narcotics to them, addicts became increasingly desperate. Thefts from wholesalers, pharmacists and doctors increased, as did prescription fraud (CMAJ, 1942, 1943). The shortage of commonly abused narcotics also changed patterns of drug use. It led to a shift from smoking to injection as well as increased heroin use (CMAJ, 1943; Solomon and Green, 1982).

Because doctors were the only available supply of narcotics in most places across the nation, the Narcotics Division reasoned that if physicians supplied drugs to addicts they would simply be prolonging a problem that was well on its way to be eliminated. To communicate this message to physicians, Browne and Sharman (1936), in an article in the Canadian Medical Association Journal, detailed the circumstances that could lead to a physician being investigated and when they might be placed on the confidential restricted list. These circumstances included what they referred to as the “improper and often illegal treatment of addicts by the ambulatory method” (p. 201). They also wrote that “the Department is ‘playing fair’ with the medical profession, and if a physician already under suspicion, chooses to sell narcotics to a definitely healthy person and gets into trouble as a result, he cannot blame the authorities for putting a stop to his activities” (p. 202). Quoting the deputy minister they also added, “Practice legitimate medicine and you will not even have to think of the law” (p. 202). With physicians under either the direct threat of criminal prosecution or at risk of losing their

authority to use narcotics in their practice, maintenance treatment of any kind was not a feasible treatment option during this period of Canadian history.

Moreover, much of the social change and upheaval that was occurring in the beginning of the 20<sup>th</sup> Century had settled by this time. It was not until the social changes brought on in the 1960s and 1970s that there was any real change to the government's approach towards maintenance treatment. Likewise, many of the moral and social reform movements that were particularly strong in the early years of the 20<sup>th</sup> Century had faded away (Valverde, 2008; Maurutto, 2005). For instance, alcohol prohibition was ended in the late 1920s in Canada and early 1930s in the US. Without the pressure to save individuals and society from the ills highlighted by these movements it was no longer necessary to use the force of the criminal law against doctors to demonstrate the states disapproval of maintenance prescribing.

### **4.3. International Developments, Pressures and Influence**

The situation where Canada, the US and the UK all made decisions on the legitimacy and legality of maintenance treatment at roughly the same time is not mere coincidence. Nor is it simply a reflection of similar social and cultural trends. Rather, the timing of these decisions is related to efforts to implement an international system of drug control. Efforts to design such a system began in 1909 with the Shanghai Opium Commission. This Commission achieved few tangible results but was followed by a series of meetings held in The Hague which lead to the creation of the Opium Convention, 1912. Signatories of the convention were expected, among other things, to enact laws (if they did not already exist) to limit the use of opium, morphine, cocaine and heroin to "medical and other legitimate purposes" (UK House of Commons Parliamentary Papers, 1912b, section 9). The First World War delayed the ratification of the convention but at the end of the war it was appended to the Treaty of Versailles. Because the convention was included as part of the peace treaty that ended the war, it likely had greater international influence than it may have otherwise had. This situation resulted in very similar legislation prohibiting narcotics possession and trade being enacted in all of the countries considered in this research. Ratification of the Convention was also one reason why the 1920s were a particularly active time in the field of drug

control in Canada, the US and the UK. Each of these countries enacted various pieces of legislation to ensure they were meeting their international obligations and established departments to administer these laws. The Convention also stimulated debate over the legitimacy and legality of maintenance treatment.

Like the domestic legislation in Canada, the US and the UK, the Opium Convention did not address the issue of maintenance prescribing or even mention addiction treatment. At this time, treatment of addiction was generally viewed as a domestic rather than international concern as it did not directly impact the narcotics trade. However, the requirement that narcotics use be limited to “medical and other legitimate purposes” (UK House of Commons Parliamentary Papers, 1912b, section 9) raised the issue of whether maintenance prescribing was a legitimate medical practice, both domestically and, later, internationally. The Treaty of Versailles led to the creation of League of Nations which was tasked with overseeing international drug control and the ratification of the Opium Convention. The League’s Opium Advisory Committee provided an international forum for debating issues related to drug control, including the legitimacy and legality of maintenance prescribing. Although not a member of the League of Nations, the US used the Opium Advisory Committee as a platform for promoting their view on maintenance treatment on an international stage. For instance, after briefly experimenting with narcotics clinics, the US drug administration not only promoted the view that maintenance prescribing was illegal domestically but, with the support of Canada, actively lobbied other countries to adopt this view as well. They argued that maintenance treatment was an illegitimate medical practice that contravened the Opium Convention and opposed any suggestion that maintenance prescribing be allowed (League of Nations, June 2<sup>nd</sup>& 6<sup>th</sup>, 1939; Rogge, August 22<sup>nd</sup>, 1939; Anslinger, February 1, 1940).

For example, the Mexican government notified the League of Nations that they intended to pass legislation that would allow drug addicts to purchase small amounts of morphine with a physician’s prescription as a means of removing them from the illicit drug trade. In response, Anslinger, the American representative, argued that “This scheme did not meet ‘a medical requirement’ within the meaning of the Convention” and went on to suggest “The United States had reduced addiction by strict application of the



terms of the Convention and rigorous police supervision” (League of Nations, June 2, 1939, p.5). He later added “He did not believe that morphine addiction could be cured by continuing to give morphine to addicts. His experience was that drug addicts were criminals first and addicts afterwards” (League of Nations, June 2, 1939, p.5). Sharman, as the Canadian delegate, voiced his support for Anslinger’s position, suggesting “He was convinced that addicts could not be cured by giving them drugs, and that the Mexican system would increase addiction” (League of Nations, June 2, 1939, p. 6). To support their position, the US also submitted a Memorandum on their experience with narcotics clinics which concluded, “It was soon obvious that the maintenance of clinics tended to spread addiction rather than to reduce it and provided a cheap supply for illicit traffic, which increased rather than decreased under the system” (Memorandum – Experience in the United States with the Plan of Selling Drugs to Addicts at Low Prices, n.d., p. 2). This pressure was undoubtedly instrumental in creating the situation where there was almost a worldwide ban on maintenance treatment, with the UK being the only country to allow maintenance prescribing, during the first half of the 20<sup>th</sup> Century.

It was not only international pressure to prohibit maintenance prescribing that influenced Canada’s decision to implement such a ban. The domestic political capital that came from having to comply with the International Opium Convention was equally, if not more, important. In Canada, the need to comply with the provisions of the International Opium Convention was used to justify further drug legislation and policing the prescribing practices of physicians. For example, in 1920 when the *Opium and Narcotic Drug Act* was enacted, the debate in the Canadian House of Commons focused on the need to monitor and control the legal trade in narcotics. In the view of some Members of Parliament, one facet of this control was to ensure physicians were not being too liberal in their use of narcotics and not prescribing purely for profit. They used examples of doctors writing large numbers of prescriptions to support increased controls,

One member of the [medical] profession is reported to have issued over 1,200 prescriptions in a month, and I am sure the minister will himself admit that this number of prescriptions, issued in so short a time, is at least sufficient to create suspicion. (Pedlow, April 26, 1920, p. 1638)

Other MPs suggested this perspective was an unjustified criticism of the medical profession. They questioned government interference in medical practice,

Now it is proposed to pass legislation which will enable you to go into places of business of people; to go into doctors' offices and demand to know what they have been doing with their drugs. I do not believe that you can enforce it, because a doctor's practice is necessarily secret and confidential. These repressive measures are altogether out of place. (McGibbon, April 28, 1920, p. 1748)

In the end, the legislation's sponsor, the Minister of Health, justified this infringement on the grounds that it was an obligation under the International Opium Convention (Canada, Parliament, March 18<sup>th</sup>, 1920, April 26<sup>th</sup> & 28<sup>th</sup>, 1920). He suggested,

Quite apart from any question of public interest, we are obligated by the terms of this [International Opium] convention, which was approved by the Government in 1914 and which did not go into effect until the ratification of the Treaty of Peace, to put this legislation through. (Rowell, April 28, 1920, p. 1749)

This rationale was then adopted by the Canadian drug administration in their campaign to define maintenance prescribing as an illegal and illegitimate medical practice (Amyot, 1927; Brown and Sharman, 1936).

Similar reasoning was also used in the UK to support the introduction of their drug control legislation, the *Dangerous Drug Act* (1920), and subsequent regulations. For instance, when the *Dangerous Drug Act* was passed there was no widespread problem with addiction in the UK. Rather the enactment of domestic laws was strongly influenced by international pressures and colonial concerns rather than pressing issues at home or moralist views of drug use. For instance, in a submission to the Rolleston Committee, one physician suggests:

It seems clear that the Dangerous Drug Acts, and the regulations made thereunder, were mainly political in origin, and were not the outcome of any great demand for legislative measures to combat a widespread prevalence of drug addiction in this country. (Ministry of Health Papers, 1924a, p.1)

Indeed, in debating the Act, the legislature itself made it clear that the Act was required to fulfill the UK's obligations under the Treaty of Versailles that ended WWI (UK House of Commons Debates, June 10<sup>th</sup>, 1920; British Medical Journal, 1920). For example, the Under-Secretary of State for the Home Office argued,

We believe that the only effective control can come from international co-operation. The Allied Powers attached so much importance to this question that the ratification of the International Convention to which I have referred is made one of the conditions of Peace, and is embodied in Article 295 of the Peace Treaty which binds the contracting parties to bring the Convention into force, and for that purpose to enact the necessary legislation without delay, and in any case within 12 months of the coming into force of the Treaty. That is an obligation which we have entered into. (Baird, June 7, 1920, p. 714)

After the Act was in place, consideration of drug control in the UK became more focused on domestic policy issues rather than international control but compliance with the International Opium Convention was still cited as reason for further legislative amendments and regulations. For instance, shortly after the *Dangerous Drug Act* came into effect draft regulations governing medical prescriptions and dispensing were introduced. Both the medical and pharmacists professions had reservations about the proposed regulations. Their concerns were brought to the Home Office and Parliament (UK House of Commons Debates, February 17<sup>th</sup> & 24<sup>th</sup>, 1921). There were also warnings in the media against adopting what was seen as American style control over medical practice in the UK (see the English Review, 1922a, b). In defending proposed regulations for the *Dangerous Drug Act*, the Under-Secretary of State for the Home Office again argued,

I may remind the House that the regulations are proposed in order to carry out the obligations which the Government have undertaken, by the International Opium Convention and the Treaty of Versailles, to confine the use of the drugs in question to medical and other legitimate uses. Parliament gave express powers for the purpose in the Dangerous Drug Act of last session. I imagine that the need for additional restrictions, in view of the prevalence of the drug habit, will be generally admitted. At the same time, it is not my right hon. Friend's desire or intention to impose any restrictions beyond what are absolutely necessary to effect this purpose. (Baird, February 21. 1921, p. 254-255).

Although international obligations clearly influenced the introduction of drug control in the UK, there were limits to how influential international developments were on domestic drug policy once initial legislation and regulations were in place. Unlike Canada, the UK did not use the argument that maintenance prescribing violated their international obligations under the Opium Convention to support banning this practice. The British Home Office initially adopted the view that maintenance prescribing was not

a legitimate medical practice. For instance, their position, as outlined in a memorandum to the Rolleston Committee, was that the intent of the *Dangerous Drug Act Regulations* was to restrict the prescription of drugs to “bona fide medical purposes”, although this restriction was not explicitly stated in the regulations. They held, “the supply of drugs by a doctor to an addict to enable him to indulge his addiction would be an offence punishable under the Acts” (Home Office Memorandum, 1924, p.1). However, as will be discussed in more depth later, resistance by the medical profession prevented this view from becoming policy.

An international system of drug control not only provided a forum for debating the legitimacy and legality of maintenance treatment but also promoted information sharing among participating countries on how they implemented their drug legislation and treatment interventions they employed. This forum contributed to not only uniformity in drug control legislation but to similarities in practice as well. For instance, Canada communicated with the UK but did not follow their lead of allowing maintenance prescribing. Shortly after Canada banned maintenance prescribing, Sharman, the head of the Narcotics Division, provided a detailed description to his British counterparts on how they monitored physician prescribing practices and developments in Canadian drug control (see previous section for description). In response, Sharman was informed that the UK did not have a comprehensive system for monitoring physicians’ prescribing and was provided with a copy of the Rolleston Committee’s report. Perrins, an official from the British Home Office, provided the following description of how the UK monitored physicians,

It is evident from your account of your system of control of doctors and chemist etc., that you from headquarters exercise a more direct supervision of their transactions than it is possible for us to do here....Doctors, chemists, etc., are so numerous in this country that we cannot attempt to check their sales in this office by a personal card system. We utilize police in the case of chemists and the medical inspectors of the Ministry of Health in the case of doctors and dentists, to check the record of sale periodically. Our own investigators exercise general supervision and investigate any difficult cases. (Perrins, March 21, 1928, p. 2)

Although clearly aware of the British practice of allowing maintenance prescribing, Canada chose to endorse the American approach instead. The Narcotics

Division also communicated with their American counterparts on their response to maintenance prescribing as well as visited American treatment facilities to learn about institutional treatment (Hossick, April 19<sup>th</sup>, 1948; Anslinger, February 1, 1940). For instance, faced with a proposal in the Opium Advisory Committee by Swiss and Polish representatives to endorse narcotic clinics, Anslinger expressly invited Sharman to visit their institutional treatment facilities to oppose this suggestion,

I should like to revert to the discussion on the ambulatory treatment of drug addiction which took place at the last meeting of the Opium Advisory Committee, particularly with your observations concerning the proposals made by the Polish and Swiss representatives.

As this discussion on addiction was merely the opening debate on a problem with which we shall be confronted for some time, we would be grateful if your government can see its way clear to approve your visiting our Federal Institutions at Alderson, West Virginia and Lexington, Kentucky, where considerable effort is spent and expense incurred in the institutional treatment of drug addiction. We feel that it would be useful if a dispassionate survey of what was being done were made by our Canadian colleagues on the Advisory Committee for the purpose of rebutting arguments which have been made that ambulatory treatment is to be preferred over institutional treatment. (Anslinger, February 1, 1940, p.1)

It seems it is no coincidence that Canada and the US had a very similar approach to responding to addicted individuals. Likewise, when the Rolleston Committee was considering the issue of maintenance treatment in the UK, they considered other treatment options that were widely used in the US, including sudden and gradual withdrawal.

Clearly, international developments and pressures encouraged the introduction or further development of domestic systems of drug control. These systems provided the framework for criminalizing maintenance prescribing by requiring a physician's prescription for the legal possession of a narcotic and dictating that narcotics only be used for medical purposes. In Canada at least, the Opium Convention was used to justify monitoring physicians prescribing practices and restricting their autonomy with regard to the use narcotics. However, Garland's (2001) reminder not to overstate the impact of policy transfer seems equally as applicable to the drug control in the first half of the 20<sup>th</sup> Century as it is to his analysis of crime control in late modernity. Then, as

now, similar policies are also a reflection of shared social and cultural conditions. As such, international developments and pressures are perhaps best viewed as a catalyst for action in the field of drug control. What form that action took was influenced by domestic politics and social conditions. Information about other countries practices and treatment interventions were clearly well known to the Canadian drug administration and likely informed, at least in part, the decision to criminalize maintenance treatment. However, then, as now, there was a diversity of practices and opinions regarding addiction treatment and maintenance prescribing. As such, the path that Canada endorsed seems just as much, or more, a reflection of the dominant attitude toward addiction and its treatment as international pressure. As we will see in the next section, a moral perspective on addiction was well ingrained in Canada before the Opium Convention was ratified.

#### **4.4. Perspectives on Addiction and its Treatment**

The only period in Canadian history when there appeared to be a near consensus on how to treat addiction was in the first 40 years of drug control when a moral understanding of addiction was widely accepted. Prior to the introduction of drug control, despite widespread availability of opium products, opiate addiction did not appear to be a great a concern in Canada. Similar to the situation in the US and the UK, opiates were widely available through patent medicines and frequently used in medical practice (Murray, 1988; Solomon & Green, 1982). As such, self-medication and cases of opiate addiction undoubtedly occurred. There were a few private sanatoriums that treated narcotic addiction, typically alongside mental illness and what were referred to as 'inebriates' (i.e., alcoholics; Giffen, et al., 1991; Lett, 1900). Even so, there was no widespread concern about addiction as is evidenced by the lack of debate over Canada's first drug control legislation, the *Opium Act (1908)*, in either the House of Commons or media (Canada Parliament, 1908; "A remarkable address", June 6<sup>th</sup>, 1908; "Chinese send petition", June 27<sup>th</sup>, 1908; "No more opium", July 4<sup>th</sup>, 1908; "The opium traffic in Canada", July 8<sup>th</sup>, 1908; "Only three months", July 19<sup>th</sup>, 1908; "Druggists were alarmed", August 26<sup>th</sup>, 1908). This lack of concern meant that there was no widely

accepted conception of addiction to compete with the moral perspective adopted when legislation was recommended to control the opium trade.

Mackenzie King's (1908) perspective on opium addiction, which suggested it was "bondage which is worse than slavery" (p. 9), set the tone for drug control in Canada, which, as discussed above, was focused on eliminating the drug trade and drug use. It also signified the beginning of a growing moral perspective on addiction. Very generally, this is the view that addiction is the result of a moral shortcoming, a character defect, or lack of willpower. This view of addiction has its roots in the temperance and moral reform movements that were popular at this time and is grounded in the perspective that the nonmedical use of drugs is in and of itself an immoral act. As Carstairs (2006) suggests, there was little tolerance for what was viewed as overindulgence and a symptom of weak will power. For instance, after the enactment of the *Opium Act*, drug users were increasingly portrayed as criminals and 'fiends' who had sunk to the depths of humanity (Canada Parliament, November 25, 1910 & January 26, 1911). Addressing cocaine traffic in Montreal one Canadian Member of Parliament suggested, "For months the streets in certain parts of the city have been infested with men peddling the drug to victims, and even children, whom they teach how to use the drug" (Lewis, November 25<sup>th</sup>, 1910, p. 261). Similarly, it was also widely accepted that addiction was contagious or that new addicts were created through associations with existing addicts. For example, in a letter to a provincial counterpart, the Deputy Minister of Health indicated,

Drug addicts breed drug addicts, the more you have in a community, the more you are likely to have, as they seem to derive some pleasure out of having others acquire the habit, more particularly with a view to being able to replenish their supply of these drugs for their own personal needs. (Deputy Minister, March 8, 1923, p.2)

This perspective is not an understanding of addiction that can accommodate heroin maintenance, or any form of maintenance treatment for that matter. Rather, this perspective was used to justify the criminalization of individual drug users and the subsequent ban on maintenance prescribing.

The situation in the US was somewhat different. Although the early years of drug control in the US are known for the aggressive promotion of a moral perspective on drug

use in support of prohibition being adopted both nationally and international, their initial response to addiction was shaped by both a moral and medical understanding of addiction. Similar to the situation in Canada, recreational opium smoking had spread from an activity of exploited Chinese labours to White Americans (see Courtwright, 1982 and Davenport-Hines, 2002 for a detailed history). Reaction to this development was guided by racist-sentiments against the Chinese and was treated as a moral issue. It became the impetus for the first pieces of federal legislation aimed at banning narcotics use in the US. However, unlike the situation in Canada, there was also a corresponding concern regarding iatrogenic addiction and the habitual use of patent medicines containing opiates that predated federal drug control. This form of opiate abuse was viewed as a medical problem rather than a moral one and was a significant motivation behind restricting the availability of narcotics to physician's prescriptions (Courtwright, 1982; Conrad and Schneider, 1992).

When drug legislation was passed and a federal system of drug control established in the US these dual perspectives on drug use were brought together through the idea that there were different types or classifications of addicts. For instance, it was widely accepted that there were three types of addicts – criminal, professional and therapeutic (Flowers & Bonner, 1923; Musto, 1999). This understanding of addiction was in large part based on the social status of the addicted individual and was used to support differential treatment of these groups. Arguably this perspective is why, on one hand, the US implemented strict criminal sanctions to control drug use and trafficking but on the other hand experimented with narcotics dispensing clinics. For instance, when the clinics were opened they were envisioned as a resource for individuals who were addicted in the course of medical treatment or for middle class addicts who were suddenly deprived of a legal supply of narcotics. The clinics were also viewed as a humane response to addiction and a means of preventing addicts from becoming a menace when they no longer had legal access to narcotics rather than a treatment service (Lindsmith, 1965; Musto, 1999). In this regard, maintenance prescribing was not understood as an intervention limited to the most problematic group of addicts but a means for all addicted individuals to access the narcotics they were dependent upon.



However, shortly after the clinics were opened the American drug administration was reorganized, becoming part of the department responsible for alcohol prohibition. With this move, the American drug administration quickly took on the perspective of their counterparts in alcohol prohibition. They adopted a more hard line stance against drug use and promoted the belief that drug use caused moral degradation and criminal behaviour (Lindsmith, 1965; Anslinger & Tompkins, 1953; Musto, 1999). Under this perspective, abstinence and a cure for addiction were viewed as the only legitimate goal of treatment. With this change in perspective, the clinics were closed. This view of treatment was used to discredit and prohibit maintenance prescribing in both Canada and the US by suggesting it ineffective and was not treatment at all but a *de facto* narcotics distribution system. For instance, throughout the 1920s and 1930s the Canadian Narcotics Division promoted this perspective in reports, medical journal articles and communications with individual physicians and provincial health administrators (Hossick, October 3<sup>rd</sup>, 1938; Sharman, April 12, 1938; Brown & Sharman, 1936). In a letter to an Ontario physician Cowan, the head of the Narcotics Division, suggested:

The so-called ambulatory method [maintenance prescribing] or gradual reduction treatment has long since been discarded by the medical profession as being of any practical value in-so-far as benefiting the patient is concerned or affecting a cure of the habit. No person will ever be benefited or cured by furnishing them with large supplies of narcotics to be administered by themselves at their convenience. (Cowan, November 20<sup>th</sup>, 1923)

Maintenance prescribing was also closely linked with 'script doctors', thereby undermining the therapeutic value of the practice (Greenfield, 1919; Kane, 1919; Cowan February 24<sup>th</sup>, 1920; Assistant Deputy Minister, February 21<sup>st</sup>, 1920). For instance, a member of the American Medical Association's Committee on Narcotic Drugs of the Council of Health and Public Institutions suggested, "a physician who supplies narcotics to an addict, or who connives with or condones such an act, is either grossly ignorant, or deliberately convicts himself as one of those who would exploit the miserable creatures of the addict world for sordid gain" (Prentice, 1921, p. 15). By making this link to script doctors, American and Canadian bureaucrats were successful in presenting maintenance prescribing as merely feeding an individual's addiction and supporting their moral shortcomings or lack of willpower.

Rather than ambulatory treatment, the Narcotics Division advocated addicted individuals be committed to an institution similar to what was done with mental health patients. They felt the best hope of affecting a cure was through a controlled treatment environment (Sharman, 1928; Cowan, 1924). Likewise, the Deputy Minister of Health suggested,

It is admitted by medical authorities, the world over, who have had any experience in the treatment of these drug addicts, that it is practically impossible to treat this class of patient successfully, with the view of effecting a cure, unless the patient is confined to some hospital, or institution, where there are proper facilities for the care of the patient while undergoing treatment for the habit. (Deputy Minister, March 8, 1923, p. 2).

In this regard, the Division recommended that all provinces enact legislation and provide hospitals for the compulsory treatment of non-criminal addicts. They were of the view that criminal, or what they called 'underworld addicts', were better treated in prisons rather than psychiatric facilities. From their perspective, it was nearly impossible to cure a criminal addict but they felt hospital treatment could be reasonably effective with addicts who had no contact with the underworld (Memorandum for the Deputy Minister, February 28<sup>th</sup> & March 8<sup>th</sup>, 1935). The Narcotics Division felt that allowing doctors to maintain patients would undercut calls for provinces to enact legislation and establish treatment facilities as well as patient's motivation to attend institutional treatment (Cowan, 1924).

Also, the belief that addiction was contagious meant that doctors who prescribed narcotics in the treatment of addiction were viewed as not only prolonging their patient's addiction but they were also putting others at risk of becoming addicts through association with their patient. In the end, little was achieved in the field of addiction treatment during the early years of drug control in Canada. In a context of a politically popular law enforcement approach to drug control, proposals to fundamentally change this approach to a more medicalized system, where physicians rather than law enforcement are key players, were roundly rejected. At the same, there is no evidence that the Ministry of Health formally approached the provinces about passing legislation to compel addicts to treatment or to provide institutional care. Nor did the federal government take it upon themselves to establish institutions for the treatment of

addiction. As discussed above, maintenance prescribing was effectively ended and institutional treatment was not provided. As a result, addicts were largely left on their own unless they had an encounter with the criminal justice system.

Early drug control in the UK provides another example of how the status of addicts in society can shape commonly accepted understandings of addiction but in this case in a way that supports rather than discredits maintenance prescribing. Unlike Canada and the US, when Britain's drug legislation was implemented there was not a strong link between drug use and an immigrant or minority group. Rather, addiction was either viewed as a foreign problem, impacting other countries or British colonies but not the UK itself (UK Parliament, 1912 and 1913). Alternatively, it was also viewed as a problem experienced by individuals who had access to drugs through their profession or association with other addicts or who became addicted in the course of medical treatment or self-medication for physical pain or emotional distress (Departmental Committee on Morphine and Heroin Addiction, 1926). For instance, in discussing Britain's addiction problem or lack thereof, the Departmental Committee on Morphine and Heroin Addiction (1926) suggested that the class of criminal addicts observed in the US simply did not exist in the UK. They also suggested the number of addicts was decreasing. Similarly, in a letter the Canadian Narcotics Division, an official from the Home Office suggested:

Our addicts, who are not very numerous, are, apart from a few of the degenerate type common to all large cities, either doctors, nurses, etc., whose daily life must necessarily bring them into contact with the drugs, or persons who have become addicted as the result of medical treatment, sometimes injudicious (Perrins, March 21<sup>st</sup>, 1928, p.3).

The small number of addicts and the perception that most addicted individuals were medical professionals or became addicted as a result of medical treatment in the UK facilitated official endorsement of a disease model of addiction. The criminal law was generally not viewed as an appropriate tool to deal with the type of addict found in the UK. In defining addiction the Rolleston Committee disregarded the notion that addiction was simply a form of immoral behaviour, indicating:

[T]here is general agreement that in well-established cases the condition [addiction] must be regarded as a manifestation of disease, and not as a

mere form of vicious indulgence. In other words, the drug is taken in such cases not for the purpose of giving positive pleasure, but for the purpose of relieving an imperious craving. (Departmental Committee on Morphine and Heroin Addiction, 1926, p. 8)

The Committee also suggested that most addicts suffered from mental instability independent of their drug use but recognized that individuals who were not 'mentally abnormal' could become addicted after prolonged use. They reported there were more addicted individuals in urban areas and professions that involved 'nervous and mental strain'. They viewed the medical profession as falling into this category and suggested this strain, along with the accessibility of drugs to doctors, was the reason for higher rates of addiction in the medical profession.

This perception shaped the UK's response to addiction. Their approach was primarily to treat the problem rather than relying on the criminal law to end drug use. Under a disease model of addiction, the goal of treatment is to reduce or prevent negative symptoms of dependence (i.e., avoid withdrawal) and to improve health and functioning. This improvement can be achieved through abstinence but it can also be attained through controlled use. Like Canada and the US, the UK endorsed abstinence as the primary goal of addiction treatment; however, because they did not hold the view that addiction was a moral problem, or link it to a stigmatized group in society, they were not as adamant that abstinence was the only goal of treatment. Through the Rolleston Committee, it was acknowledged that in limited cases abstinence could not be achieved. In these cases, the goal of treatment was to help addicted individuals to be functional, productive members of society. This slightly wider perspective on the goals of addiction treatment was compatible with the use of maintenance treatment, including heroin maintenance if heroin was the individual's drug of choice. As is discussed in subsequent chapters, this wider perspective is also similar to the perspective on addiction treatment that allowed heroin maintenance to be implemented in Canada, Switzerland, Germany and the Netherlands decades later.

## 4.5. Professional Influence and Medical Ownership

Throughout history, professionals and experts have played a critical role in determining whether heroin maintenance would be used. As authors such as Garland (2001), and Rose and Millar (2010) suggest that professionals and experts played a key role in the welfarism or penal welfarism (which Garland discusses). They were responsible for developing knowledge about the causes of social problems, such as addiction, as well as designing, supporting or carrying interventions and policies to address these causes. When drug control was first implemented the role of expert in this field was, to a greater or lesser degree, open in Canada, the US, and the UK. As will be discussed below, whether the medical profession took on this role significantly impacted the future of maintenance prescribing.

It can be argued that the medical profession, in an attempt to protect their professional autonomy to decide how and when to use narcotics, became the primary expert on addiction in the UK. The most obvious example of this position is the role the medical profession played in guiding drug policy in the UK through their participant on the Rolleston Committee. However, medical leadership in the UK on the question of maintenance prescribing was not an isolated episode of the profession's involvement in drug control. When drug prohibition was introduced in the UK, the medical profession actively resisted efforts by the Home Office, which was responsible for implementing the provisions of the *Dangerous Drug Act*, to establish an entirely criminal model of drug control. For instance, when draft regulations for the Act governing medical prescriptions and dispensing were introduced, the medical profession, along with pharmacists, brought their concerns to the Home Office, Parliament and the media. This action forced the government to establish a special committee which eventually ended up addressing most of the medical professions concerns with the regulations. Later, when the Home Office announced their intention to ban heroin from medical practice, there was vocal opposition from physicians. The Home Office was forced to abandon this course of action. Through these and other actions, the British medical profession closely guarded their autonomy in medical practice and clinical discretion on when and how to use narcotics. As part of this larger struggle, the medical profession also established their jurisdiction over the treatment of addiction by suggesting individual physicians should

retain the discretion to treat addiction as they saw best, including maintenance prescribing.

Similar to the situation in the UK, Conrad and Schneider (1992) argue that before the *Harrison Act* was passed in the US, opiate addiction was considered a medical condition and maintenance prescribing was a common means for at least middle class addicts to access narcotics. However, after the implementation of the *Act*, addiction was largely treated as a moral or criminal problem. Conrad and Schneider (1992) argue this response was the result of an organizational power struggle between the federal drug bureaucracy and law enforcement and the medical profession to establish 'ownership' of addiction. They also suggest that the role the medical profession played in the creation of addiction through over prescribing narcotics was a key factor leading to law enforcement becoming the primary response to addiction after the *Harrison Act* was passed. It brought into question the legitimacy of the profession's ownership of opiate addiction. These questions resulted in the profession attempting to distance itself from the issue of addiction and generated reluctance among physicians to treat addicted individuals. As a result, when the American drug administration defined maintenance prescribing as an illegitimate and illegal medical practice, after their brief experiment with narcotics clinics, they faced little resistance from the medical profession.

In the US, there were incidents of individual physicians requesting exemptions from the drug law for addicted patients and a number of court cases considering whether it was within the federal government's jurisdiction to limit how narcotics could be used in medical practice. For instance, in the late 1930s there were a number of publications (pamphlets and journal articles) that argued physicians were being unfairly prosecuted, citing the figures that 25,000 physicians had been charged since the enactment of the *Harrison Act* and 5000 convicted (Anti-Narcotics League, 1937; Roswell, 1939). These publications suggest that at least some physicians' resisted restrictions being placed on their discretion to treat addiction. However, it was not organized nor did it appear to come from the profession's leadership or professional organizations. Part of the reason for this lack of leadership was because the American Medical Association (AMA) appeared to support the drug bureaucracy's interpretation that maintenance prescribing was not a legitimate medical practice. Indeed, it was not until drug prohibition had been

in place for ten years and the Federal Bureau of Narcotics persisted in prosecuting physicians that the American medical profession began to voice their concerns about law enforcement encroachment on their field of practice to their congressmen and professional organizations (Musto, 1999). However, by this time maintenance prescribing was largely a discredited practice.

The same organizational struggle for ownership between the federal drug control administration and law enforcement and the medical profession observed in the US also occurred in Canada. As discussed above, the Canadian government monitored physician prescribing practices and in some instances charged physicians they felt were abusing this authority. However, this struggle should not be interpreted as a situation where both the medical profession and the federal drug administration/law enforcement were actively trying to establish their ownership over addiction. Rather, law enforcement was actively establishing their ownership of addiction whereas the medical profession in Canada was largely disinterested in the issue of addiction. The profession became involved in this issue because legislation named them as the only legitimate avenue for accessing narcotics. They were in some senses a reluctant participant in this struggle. For instance, various drug laws were passed in the first 40 years of drug control in Canada that progressively restricted the medical profession's use of narcotics. None of these restrictions appeared to have attracted much attention from the medical profession. There is no indication that the medical profession sought to provide input into the legislation or the corresponding system for controlling the legal trade in narcotics. Like the US, there were, however, examples of individual physicians requesting exemptions from the drug laws so they could continue to maintain addicted patients. For instance, after actively prosecuting physicians for providing drugs to addicted individuals the Narcotics Division received a "flood of applications" from doctors requesting an exemption from the law for their patients (Assistant Deputy Minister, September 25, 1926, p.1). This situation is essentially the opposite of what occurred in the UK where after some initial attempts institute a purely criminal model of drug control the Home Office appeared to have little opposition to the physicians retaining ownership over opiate addiction. In Canada, like the US, these events had the effect of limiting any progress towards the widespread adoption of medical control or a disease model of addiction by discouraging physicians from treating addicts. In terms of maintenance

treatment, it had the effect of making it possible for the federal drug bureaucracy to define maintenance prescribing as an illegitimate medical practice with little resistance.

There are a number of reasons why medical resistance to banning maintenance prescribing was not as strong in Canada as it was in the UK. To begin with, in Canada, law enforcement and the drug control bureaucracy guarded their role as leaders in this field much more vigorously than was done in the UK. As was discussed previously, the Canadian drug administration actively policed the prescribing practices of physicians and charged some who were found treating addicts with narcotics or removed their authority to use narcotics for any purpose. The Home Office in the UK appeared more willing to give up sole leadership of this issue, likely because the medical profession already had an established role in this field, as was noted above. Moreover, acceptance of a disease model of addiction and medical control of narcotics predated drug prohibition being introduced in the UK. This prior involvement meant that the British medical profession already had an established role in the drug control field. Their inclusion in decisions on maintenance prescribing was a natural extension of this history. In comparison, there is little indication of medical control of addiction predating the introduction of drug control legislations. Furthermore, the medical profession in Canada did not have same level of respect as its more established counterpart in the UK. For instance, in Canada, script doctors were often blamed for contributing to the country's addiction problem.

Additionally, the medical profession was less established in Canada compared to the UK. The medical profession was just beginning to organize itself when the drug laws were first introduced in Canada. For instance, the Canadian Medical Association was not formally formed until 1907 and the Canadian Medical Council, which was responsible for licensing, investigating, and disciplining physicians, was not established until 1906. The Royal College of Physicians and Surgeons took over this role in 1929. Prior to this time, physicians were licensed by provincial or municipal bodies or automatically licensed if they held a European degree (Duffin, 2010). As such, these professions did not 'own' access to narcotics to the same degree that physicians did in the UK or even in the US. It was, therefore, a non-issue for the professions when law enforcement became gatekeepers to access to narcotics because this role was not 'taken' from them.



Given this situation, it is understandable that the issues of addiction and maintenance prescribing were not afforded much attention in Canada.

## **4.6. Conclusion and Discussion**

The early history of maintenance prescribing highlights the importance of a country's overall approach to drug control, understanding and attitudes towards addiction, international pressure and the role of the medical profession in decisions to use or reject this treatment. As the above discussion indicates, drug control was introduced in Canada when there was heightened concern about social cohesion and the moral tone of Canadian society. Early efforts at drug control adopted the perspectives of social and moral reform movements of this time and focused on eliminating drug use and the illicit drug trade. During this time, the Canadian federal drug control bureaucracy dominated the course of maintenance treatment. Their dominant position was supported by international pressure to establish domestic systems of drug control that limited the use of narcotics to medical and scientific purposes and suggested maintenance prescribing as not a legitimate medical practice. Also influential was the perspective that drug use and addiction were a vice or a moral weakness as well as contagious. This perspective supported a criminal justice approach to drug control and was not compatible with maintenance treatment. From this perspective, maintenance treatment is merely supporting an addict's vice or giving into their moral degradation. Moreover, if addiction is viewed as contagious, maintenance prescribing puts others at risk due to the threat of contagion. It is perhaps not surprising that the focus of this period of history was on eliminating and discrediting the practice of maintenance prescribing.

Unlike the situation in US and the UK, addiction was not defined as a medical problem prior to the introduction of drug control. Also, the Canadian medical profession had no real claim to ownership of the problem of addiction. Because this claim to ownership existed to some extent in the US and the UK, the medical profession was involved in the debate over establishing legal restrictions on the use and availability of narcotics in these countries. Conversely, the Canadian medical profession was largely silent on the issue of drug control until legislation was in place for over 10 years and a

system for controlling the licit trade in narcotics was implemented. This silence allowed the federal bureaucracy and law enforcement to establish themselves as key players in drug control to the extent that there was little room for others to play a role in guiding how Canada responded to drug use and addiction.

Even after the federal drug control bureaucracy established a system for policing physicians' prescribing and actively began prosecuting doctors for maintaining addicts or being too liberal in their use of narcotics, opposition from the medical profession was muted. There were a number of reasons why this occurred. First, the medical profession was in its infancy at this time. Because of this, the medical profession did not have the degree of influence in Canada as they had in the UK or even the US. Moreover, the Canadian medical profession did not appear to have the same level of ownership over access to narcotics. As a result, maintenance prescribing did not become an issue of professional autonomy the same way it did in the UK. Indeed, the role of gatekeepers in access to narcotics was something thrust on Canadian doctors by the introduction of the *Opium and Drug Act*. When opposition was voiced about government interference in medical practice, this intrusion was justified on the grounds that it was required by international conventions.

Indeed, addiction treatment was not part of Canada's response to illicit drug use for the first half of the 20<sup>th</sup> century. Although the federal government paid lip service to the idea of addiction treatment they did little to support the development of such services. This situation was different from both the American and British experience. The American federal government was involved in addiction treatment almost from the beginning of drug control in that country. First with the opening and subsequent closure of the narcotics clinics in the 1920s and then through the federal treatment institutions at Lexington and Fort Worth. Unlike the US, the Canadian federal government only involvement in addiction treatment was enforcing the law against maintenance prescribing. Instead, they preferred to take the position that providing treatment was the responsibility of the provinces. Similar to the situation in Canada, British governments had little involvement with addiction treatment; however, the difference was that they did not interfere in the medical profession's discretion to treat addiction through maintenance doses. Because of the Canadian medical profession was generally

disinterested in addiction, it was easy for maintenance treatment to be dismissed in Canada. There was no network of addiction experts or service providers to question the federal government's stance on maintenance treatment. In absence of the medical profession weighing in on addiction treatment, the federal government took on the role of experts in the field and drew upon information from the US to support their position that maintenance prescribing was not legitimate medical practice and institutional treatment was the preferred method for treating addiction.

## **Chapter 5. Expanding Drug Control and Considering Heroin Maintenance in the Time of Methadone, 1950-1980**

### **5.1. Introduction**

The events in the first half of the 20<sup>th</sup> Century led to the introduction of a system of drug control that is still in place today. However, like any large policy area, this system has expanded and diversified in response to changing social, economic and political conditions. Drug control policies and practices are informed by new knowledge of addiction, patterns of drug use and perspective on how to respond to social problems. This chapter will explore how changing social, economic and political conditions in the mid-20<sup>th</sup> Century diversified drug control to the extent that the ban on maintenance prescribing was ended with the introduction of methadone maintenance. It will also consider how, despite massive social change and rapidly rising rates of drug use, the basic features of drug control established in the 1920s remained, preventing heroin maintenance from also being used. Similar to Chapter Four, the focus of this discussion is Canadian history of maintenance treatment but the experiences of the US and the UK are also included to illustrate how varying conditions and events can lead to differences in approaches to maintenance treatment. The chapter begins with a discussion of how the social changes in the 1950s, 1960s and 1970s impacted drug control in these three countries. This section is followed by a discussion of how advances in understanding of addictions and growing skepticism about the effectiveness of treatment led to a renewed interest in maintenance treatment. Next, the defining role that rapidly rising rates of drug use played in both how addiction was understood and drug policy is explored. After this discussion, the impact of changing actors in the field of drug control on maintenance treatment is considered. The chapter ends with a discussion of how the medical profession came to play a greater role in the addiction treatment field in Canada and the

US at this time and how their autonomy related to maintenance treatment was curtailed in the UK.

## **5.2. Expanding Models of Drug Control**

The extent to which a particular model guides a country's approach to drug control does not remain static but evolves and changes over time. This change is often cyclical in nature; there may be a move towards a more liberal approach to drug control followed by a return to a more repressive approach. Change can be driven by resistance to or criticism of established mechanisms of control, societal change, advances in understanding of addiction and its treatment, shifting patterns of drug use, and so on. Changing models of drug control are apparent in each of the countries considered in this research and have impacted the feasibility of heroin maintenance. Chapter Four outlines how social and moral reform movements, combined with an active drug administration, international pressure, and disinterest on the part of the medical profession, resulted in the introduction of a criminal model of drug control and a complete ban on maintenance prescribing in Canada. By the mid-20<sup>th</sup> Century this approach began to change. Canadian and American drug bureaucracies began to acknowledge that law enforcement alone could not deal with their countries' drug problems.

This acknowledgement occurred in a social environment of relative upheaval in Canada and the US. The time after WWII ushered in a period of widespread prosperity, economic development, expansion of transportation and social liberalization. The feminist movement was particularly active at this time and women were becoming increasingly involved in public life. Minority groups, such as Aboriginal Peoples, were becoming increasingly more vocal in their demands for equality and fair treatment (Hebert, 1990; Garland, 2001). Also, a youth counter-culture movement which questioned conventional values and challenged traditional authorities developed in the 1960's and carried on into the 1970's, recruiting a wider variety of individuals (Carrigan, 1991). This time in Canadian history can also be characterized as a period of criminal justice liberalization. During this time, capital punishment was abolished, attempted suicide and vagrancy offences were repealed, the sale of birth control was also legalized

and therapeutic abortion and homosexuality, in private, between consenting adults, was decriminalized (Hebert, 1990). Simple possession of a drug under the *Narcotics Control Act* was also changed from an indictable offence to a hybrid offence, altering the penalties available.

In this changing and increasingly liberal environment, discontent with a traditional law enforcement approach to drug control grew and generated considerable interest in the so-called 'British System' in North America. International efforts to have all participating countries implement similar drug legislation resulted in a considerable degree of uniformity in drug policy and practice globally. The UK's policy of allowing maintenance prescribing stood out as an example of a different approach to dealing with addiction. North American critics of drug prohibition often proposed adopting the 'British System', suggesting it was the reason for the UK's miniscule drug problem (for example see Schur, 1961). Governments searching for strategies to cope with rising rates of drug use sent delegates to the UK to gather information on their approach or invited British representatives to provide information on their system of drug control. For instance, in Canada, when the Le Dain Commission recommended studying heroin maintenance the Department of National Health and Welfare sent delegates to the UK to study the 'British System' (Health Protection Branch, n.d. & March 6<sup>th</sup>, 1973). Likewise, the US drug administration also sent representatives to the UK to study heroin maintenance, as did New York State (Larimore, & Brill, 1962; Lewis, 1973). However, in each of these incidences, government delegates recommended against adopting the 'British System', suggesting that rates of drug use in their respective countries was not comparable to the UK, which had almost no drug problem.

Both countries' strictly law enforcement approach to drug control was diversified to include a greater emphasis on treatment and prevention (Musto, 1999; Giffen et al., 1991; Carstairs, 2006; Narcotics Addiction Foundation, 1967; Rankin, 1976). This diversified approach to drug control corresponded with the introduction of methadone maintenance and proposals to experiment with heroin maintenance in both Canada and the US (Kreek, 2000; Robinson, 1978; Paulus & Halliday, 1967; Narcotics Addiction Foundation, 1967; Commission of Inquiry into the Non-Medical Use of Drugs, 1973; Thomas, October 25<sup>th</sup>, 1973). Although this change cannot accurately be described as

the introduction of a hybrid system of criminal-medical control as seen in the UK, it was a step in this direction.

For instance, in Canada, the establishment of provincial agencies such as the Narcotics Addiction Foundation (NAF) in BC, was an important step in advancing the cause of addiction treatment. As discussed in Chapter Four, there was essentially no state-funded addiction treatment available in the early years of drug control, largely due to disagreements between provincial and federal governments over which level of government was responsible for providing this service and the federal government's ban on maintenance prescribing. This situation persisted after the Second World War and into the 1950s. For instance, the situation in BC in the early 1950s was described as follows:

It is rather remarkable that although B.C. has 2/3 of all Canada's addicts in the Vancouver area, there is no place in the province where such persons can be treated if they desire to be treated. The general hospitals refuse them, except for emergency treatment in the case of coma by overdose, the private sanitarium has been reluctant to take them even if they can pay for their care, which is rare, and the Provincial Mental Hospital declines to receive them under any circumstances. Gaol is the only place willing to receive them, and crime has to be committed before they can be received there. (Stevenson, 1954, p. 26)

After years of the federal government insisting addiction treatment fell under provincial jurisdiction, as a health care service, a provincial government had finally accepted this responsibility. In 1955, the BC government established the NAF to provide treatment, rehabilitation, research and educational services (Narcotics Addiction Foundation, 1967). Other provinces soon followed the lead of BC. For example, Ontario expanded the mandate of the Alcoholism Research Foundation to include drug addiction and changed its name to the Alcohol and Drug Addiction Research Foundation (ADARF) in 1961 (Rankin, 1976). These agencies were established to advise provincial governments on issues related to illicit drug use and administer treatment services. Their primary responsibility was to promote the health and welfare of addicted individuals and their communities rather than to control the trade in narcotics (as was the responsibility of the federal drug administration). The establishment of these agencies was an important change for not only increasing the availability of treatment but also establishing the

expectation that treatment would be a part of any response to drug addiction in the future and recognizing it had a role beyond a crime control agenda (i.e., improving the health of drug users and their communities). This expectation made heroin maintenance a more realistic possibility in Canada than it had been in the past.

At the same time, there was greater federal interest in treatment as well. Beginning in the 1950s and continuing into the 1960s, the Canadian federal government explored opportunities for treating addiction (Senate of Canada, 1955; Stevenson, 1956; NAF, October 9<sup>th</sup>, 1968; Commission of Inquiry into the Non-Medical Use of Drugs, 1973; Alcohol and Drug Commission, March 15<sup>th</sup>, 1974). Principal among these occasions for expanding treatment were revisions to the drug law and their regulations designed to create more opportunity for the medical treatment of addiction. In 1961, the *Opium and Narcotics Drug Act* was replaced by the *Narcotics Control Act*. The regulations for the new Act clarified when it was acceptable for a physician to prescribe narcotics:

No practitioner shall prescribe, administer, give or sell or furnish a narcotic to any person or animal unless

- a) the person or animal is a patient under his professional treatment and
- b) the narcotic is required for the condition for which the patient is receiving treatment. (Section 38, Narcotics Control Regulations, 1961)

The regulations also specified the burden of proof was on the physician to establish that a narcotic was required for the condition being treated. Physicians who failed to establish that a narcotic was required for treatment could be referred to their provincial licensing body or have their narcotics privileges revoked. Carstairs (2006) argues this provision opened the door for methadone maintenance. From her perspective, if a physician could make the case that maintenance prescribing was necessary for the treatment of addiction there was nothing in the new law that restricted this treatment option.

It was in this context that methadone maintenance was first introduced to Canada. The dual research and treatment mandate of BC's NAF provided the opportunity to test different treatment models. Shortly after it was founded, the



organization's clinical director, Dr. Robert Halliday, began to experiment with methadone as an aid for withdrawal treatment. Observing that methadone was effective in easing withdrawal symptoms but that many individuals returned to using and went through the withdrawal program multiple times, the initial experimentation with methadone was expanded to what was referred to as 'prolonged withdrawal' (Paulus and Halliday, 1967; NAF, 1967). Although the name is somewhat misleading, the 'prolonged withdrawal' pilot was Canada's first methadone maintenance program, implemented a year before Dole and Nyswander began their methadone maintenance program in New York. Under the pilot, addicts were provided methadone "until such a time as he or she can function without a narcotic" (NAF, 1967, p. 7). Eligibility for the program was based on the criteria laid out in the UK's Rolleston Report, namely "Where it has been clearly demonstrated that the patient, while capable of leading a useful and relatively normal life when a certain minimum dose is regularly administered, becomes incapable of this when the drug is entirely discontinued" (as cited by NAF, 1967, p.8). In publishing results from the pilot, Paulus and Halliday (1967) were clear that their study was an experiment with the 'British System'. After years of the federal drug administration refusing to even consider such an approach, maintenance treatment was allowed in the guise of a research project.

Shortly after Halliday's prolonged withdrawal program began, Doctors Vincent Dole and Marie Nyswander began experimenting with methadone as a substitute for heroin in New York. Their study achieved very positive results that were widely publicized (Dole and Nyswander, 1965 & 1976). As a result, there was considerable excitement and enthusiasm for methadone maintenance and the treatment was quickly introduced in other areas of Canada, the US and Europe. These events may seem to suggest that Canada's ban on maintenance prescribing had ended and its system of drug control had diversified enough to allow for the introduction of heroin maintenance. This interpretation turned out not to be the case. Although Halliday's prolonged withdrawal program was established "in co-operation with the Division of Narcotic Control in Ottawa" (Paulus and Halliday, 1967, p. 655), precisely how the Narcotics Division was involved is unclear. It is clear that they were aware of the program and did not prevent it from taking place. However, it was also not long before the federal government took steps to control and limit methadone maintenance.

The federal government begrudgingly accepted that methadone maintenance was the most effective treatment available but viewed it as substituting one addiction for another. For instance in discussing methadone maintenance, the Health Protection Branch<sup>3</sup> wrote, "For better or for worse, methadone maintenance provides to date the cheapest and most effective weapon we have for dealing with large-scale heroin dependence" (Heroin Maintenance, n.d., p.3). From their position, they conceded that methadone addiction was preferable to heroin addiction but were sceptical about its effectiveness for other than highly motivated addicts and questioned its use with young users. They also raised concerns about methadone being diverted to the black market. This unease quickly turned to action. In 1970, the Special Joint Committee on Methadone of the Food and Drug Directorate of the Department of National Health and Welfare (DNHW) and the Canadian Medical Association (CMA) was formed to develop guidelines for the use of methadone. In 1972, the Canadian *Narcotics Control Act Regulations* were amended to restrict methadone prescribing to physicians authorized by the Food and Drug Directorate. At the same time, the Special Joint Committee on Methadone issued their guidelines. The new guidelines dictated that whenever possible, methadone maintenance treatment be limited to structured programs, such as those run by the Narcotics Addiction Foundation in BC and the Addiction Research Foundation in Ontario (Health Protection Branch, 1972; Special Joint Committee of the CMA and the DNHW, Food and Drug Directorate, 1971). Through these changes and subsequent revisions to the methadone guidelines, the federal government restricted autonomy of physicians to use methadone in the treatment of addiction and reasserted their control over maintenance prescribing.

At the same time, the federal government rejected the idea of heroin maintenance. The rapid rise of methadone maintenance and subsequent recognition of its limitations lead to a number of proposals to experiment with heroin maintenance. The most well know of these proposals came from the Commission of Inquiry into the Non-Medical Use of Drugs or the Le Dain Commission. This Commission was appointed in

<sup>3</sup> The Health Protection Branch was a division of National Health and Welfare that was responsible for drug control and included the Bureau of Dangerous Drugs, formerly the Narcotics Control Division.

May 1969 in response to rising rates of drug use and was led by Justice Gerald Le Dain, Dean of Osgoode Hall Law School. In their final report, the Commission reasoned:

If methadone maintenance is to be generally available, the question that inevitably arises is, why not heroin maintenance? In approving methadone maintenance we have approved a policy of legal availability of an opiate narcotic for maintenance purposes. Why not, then, heroin maintenance as well? (Commission of Inquiry into the Non-Medical Use of Drugs, 1973, p. 168)

Some members of the Commission had reservations about recommending heroin maintenance citing the dangerous nature of intravenous drug use, anticipated difficulties in stabilizing doses for patients, and difficulties in detecting illicit heroin use. They did all, however, agree to recommend a trial to compare its effectiveness to methadone maintenance. They pointed out that the Vera Institute for Justice had recently recommended a heroin trial in the US. Borrowing from Vera's idea, the Commission suggested that heroin maintenance need not be a long-term treatment. Instead, as was being done in the UK, it could be used to attract opiate addicted individuals to treatment and once they were stabilized they could be transitioned to oral methadone and then, ideally, to abstinence (Commission of Inquiry into the Non-Medical Use of Drugs, 1973).

The Commission first recommended a heroin maintenance trial in their Treatment Report released in 1971. The federal government rejected this suggestion almost out of hand. Shortly after the Treatment Report was released, the Minister of National Health and Welfare, John Munro, issued a statement against heroin maintenance suggesting "there is no place for such a treatment in the Canadian setting" and that "if a patient must be maintained on an opiate drug, use of methadone is to be preferred, on both medical and social grounds, to the use of heroin" (Statement on Heroin Maintenance Program, February 29, 1972, p. 1). In this way, the introduction of methadone maintenance both inspired interest in heroin maintenance but was also used to as a justification for not experimenting with heroin maintenance.

Perhaps anticipating that a simple statement would not be enough to close the door on the idea of heroin maintenance or reflecting a new, more open minister in Marc

Lalonde<sup>4</sup>, the ministry sent a contingent of federal experts to the UK to study the 'British System'. In April 1973, members of the Health Protection Branch spent a week in the UK with officials from the Home Office and the Ministry of Health and Social Security, as well as visiting clinics and talking with physicians. They were interested in both the use of intravenous methadone and heroin in the treatment of narcotics addiction (Health Protection Branch, n.d.; Carruthers, 1973). In their report back to Ministry of National Health and Welfare, they reasoned that the UK had a relatively small drug problem, concentrated primarily in London. By comparison, incidences of drug addiction were roughly eight times greater, per capita, in Canada and there was an organized black market for drug distribution that did not exist in the UK (Health Protection Branch, n.d.). They acknowledged that the British approach to treatment likely played a role in the small number of addicts there and the limited black market for drugs as well as its success in attracting addicts to treatment. However, they argued that because there were already many more addicts in Canada and an established black market a similar clinic system here would be very costly to implement and would have little chance of success (Health Protection Branch, n.d. & March 6<sup>th</sup>, 1973). This argument was commonly used by American opponents of heroin maintenance (see Lewis, 1973) that Canadian officials appeared well acquainted with, as evidenced by American reports and literature in government archives. It also indicates that the value of heroin maintenance was being judged on its ability to further a crime control agenda (i.e., to end the black market for drugs) rather than its potential to improve the health and function of addicted individuals. This perspective on heroin maintenance suggests that although addiction treatment was now encouraged and methadone maintenance was allowed, the Canadian drug administration's perspective continued to be one predominantly preoccupied with crime control.

Indeed, diversion of prescribed drugs to the illicit market was of particular concern to this group. They suggested that intravenous methadone and heroin was currently being diverted to the black market in UK and made the point that in New York, because of diversion, there were more methadone addicts than heroin addicts (Health

<sup>4</sup> Marc Lalonde became Minister of National Health and Welfare after the election in 1972, taking over the position from John Munro.

Protection Branch, n.d.). From their perspective, diversion was a foregone conclusion, “Diversion of heroin and intravenous methadone to the street would inevitably occur if we moved towards the British system” (Health Protection Branch, n.d., pp.7 & 8). Similar to how concern over diversions was used to justify federal action to restrict the availability of methadone maintenance, it was also cited as a reason to reject heroin maintenance. It would appear that although Canada’s system of drug control had diversified enough to allow methadone maintenance, albeit in a restricted form, the rationale of needing to eliminate any potential supply of heroin (in this case through diversion) was still strong enough to deny the introduction of heroin maintenance.

The 1960s also began a period of change to drug control in the UK. The *laissez faire* model of medical control that had existed until this time was restricted with the addition of greater government control over maintenance prescribing. Responding to rising rates of drug use and a small number of doctors supplying large quantities of narcotics to London’s burgeoning user population, the government restricted heroin and cocaine maintenance to specialized addiction clinics (Interdepartmental Committee on Drug Addiction, 1965; Stimson & Oppenheimer, 1982). By doing so, the almost complete clinical discretion to decide how to treat addiction and when to use narcotics previously enjoyed by physicians was constrained. Moreover, in years to come these constraints were followed by greater central direction on the treatment of addiction, including maintenance treatment (Stimson & Lart, 2005; Strang & Gossip, 2005b; Social Services Committee February, 6, March 13, May 22, 1985). This did not end medical control but significantly curtailed it, bringing the UK’s approach more in-line with North America’s recently adapted model of drug control. Consequently, the maintenance treatment landscape also became progressively similar. Although heroin maintenance was still permitted in the UK, it became increasingly uncommon. Methadone quickly became the prevailing form maintenance treatment and there was a trend away from maintenance treatment toward abstinence-oriented interventions (Willis, 2005; Mitcheson, 2005).

### **5.3. Advances in Understanding of Addiction and Its Treatment**

Rising rates of drug use in North America, particularly among youth resulted in calls to enhance treatment services and to experiment with different treatment modalities, including proposals to establish narcotic distribution clinics or to adopt the 'British System'. At the same time, there was growing scepticism about the effectiveness of institutional and involuntary treatment. This scepticism eventually grew into a more general attitude of 'nothing works' in the field of addiction treatment in both Canada and the US (Giffen et al., 1991; Musto, 1999; Musto & Krosmeier, 2002; Clague, 1973; Chartock, 1974; Kleber & Klerman, 1971). Moreover, American history suggests that at this time, use of medication in the treatment of medical conditions and, particularly, psychological problems, was increasing. This focus on medication sparked interest in pharmacological treatments for addiction, including research on opiate antagonists and medications to ease withdrawal symptoms (Lennard, Epstein & Rosenthal, 1972; Eddy 1963). These changes coalesced to make the advent of methadone maintenance possible. Interest in enhancing treatment services and scepticism about the effectiveness of traditional models of addiction treatment (i.e., abstinence-based, institutional care) encouraged innovation in this field. A growing interest in pharmacological interventions for addiction guided innovation towards a renewed interest in maintenance treatment.

This interest pharmacological interventions coincided with growing popularity of theories emphasizing the physical or biological aspects of addiction. For instance, in the US, Dole and Nyswander (1967) advanced the theory that addiction was a metabolic disorder. They suggested some individuals had a neurological susceptibility to addiction and neurons changed after exposure to drugs. They argued that this neurological susceptibility led to what they termed 'addictive traits' (i.e., criminal behaviour, psychological problems) rather than some pre-existing personality defect. Given this view of addiction, a pharmacological treatment made sense. Methadone was chosen by Dole and Nyswander as drug that would prevent withdrawal symptoms, reduce cravings, and normalize the physiological functioning of addicts. Although Dole and Nyswander's research was carried out in the US, their work was also influential in Canada and Europe

as evidenced by the rapid spread of methadone maintenance. In Canada, Dr. Halliday, who introduced methadone maintenance, suggested addiction had both biological and social dimensions. He also advanced the view that addiction was a chronic, relapsing disease (Halliday, 1964). This perspective of addiction is compatible with the idea that abstinence may not be an achievable goal for all individuals. It can also support treatment models that are designed to treat symptoms (i.e., prevent withdrawal or control cravings) rather than cure the condition. This understanding of addiction supported the introduction of methadone.

When first introduced, there was considerable enthusiasm that methadone maintenance would be the solution to rising rates of heroin addiction. When methadone failed to curb rates of heroin addiction pessimism about the effectiveness of addiction treatment returned. This pessimism inspired proposals for what were seen as even more extreme or controversial interventions. For instance, in 1973, the BC Minister of Rehabilitation and Social Improvement, Norman Levi, announced the newly formed Alcohol and Drug Commission (ADC) would be tasked with studying the possibility of providing heroin maintenance in BC. This announcement incited a storm of controversy. The government, however, was quick to point out that it was one possibility among other options, including compulsory treatment. For instance, in a letter responding to the concerns of the New Westminster Police, the government's position was explained as follows:

it is tragically apparent that our present system for control of heroin addiction (and for the treatment of heroin addicts) simply does not work and therefore that we must study alternatives to the present system. One such alternative that he [Levi] mentioned was the legal supply of (not necessarily free) heroin to those residents who are known to be addicted....I can assure you that no one in the government has made up their mind on this subject. (Ministry of Health Services and Hospital Insurance, March 14 1973, p.1-2)

This assurance appeared to appease opponents of heroin maintenance. The issue, however, surfaced again later in 1973 when Peter Stein, the chairman of the ADC, announced to the media that the Commission was studying the possibility of establishing a clinically controlled program that compared methadone and heroin maintenance. In an interview with the Vancouver Sun, Stein outlined his vision for a possible heroin

maintenance trial. He envisioned it as an extension of existing methadone programs. It would be experimental and strictly controlled. In his words, "It certainly would not be a matter of doctors being allowed to prescribe heroin willy-nilly" (Thomas, October 25<sup>th</sup>, 1973). Clients would be carefully screened and there would be no take home prescriptions. The clinic model (initially proposed by the VERA Institute in the US) where clients would visit a clinic daily was recommended. Stein also suggested that the ADC was realistic about what heroin maintenance could achieve. Like methadone, it would not be a 'cure' for addiction but would only be useful for "stabilizing some addicts at a level where they will not have to involve themselves in criminal activities to continue the drug habit" (Thomas, October 25<sup>th</sup>, 1973).

The initial impetus behind the ADC's proposal to study heroin maintenance was driven, at least in part, by disappointment in the ability of methadone maintenance programs to attract and retain clients in treatment. By this time there was a noticeable decline in the number of heroin addicts receiving methadone and an increasing drug user population (Health Protection Branch, February 12, 1973; Hammond, 1969). Also, there was considerable pessimism about the success of any addiction treatment option. For instance, just weeks before announcing the ADC was considering heroin maintenance, Stein suggested the currently available treatment options had only a 10% success rate. Given this situation, Stein advocated an alternative approach to addiction treatment. Rather than using abstinence or a 'cure' as the single measure of success, he suggested it was more realistic to help heroin addicts manage their addiction to become more productive members of society ("Cures not drug group's target", October 12<sup>th</sup>, 1973). This philosophy fit well with maintenance treatment, particularly heroin maintenance. It is also a perspective that we can see reflected in present day ideas that improved health and social functioning are equally as valid goals as abstinence.

There are a number of reasons why proposals to study heroin maintenance or to experiment with narcotics clinics or the 'British System' were rejected at this time. One reason is the existence of competing theories of addiction. For instance, in the mid-1950s, the federal government financially supported research into drug addiction in BC with the aim of developing recommendations on how to effectively treat and prevent addiction. The research, led by G.H. Stevenson, involved a series of studies of addicted



inmates at Oakalla Prison Farm in the Lower Mainland, as well as a more general review of the drug problem in Vancouver. Stevenson viewed addiction as a manifestation of an underlying personality deficit. Addicts, according to his research, were child-like and refused to accept adult responsibilities. He was also a strong proponent of the view that many 'criminal addicts' were involved in crime before they became addicted. Based on this understanding of addiction, he reasoned that treatment should address the addict's personality disorder and teach them to be responsible members of society (Stevenson, 1954; 1956).

Stevenson was a strong advocate for addiction treatment. He was, however, also a known opponent of narcotics clinics. Stevenson's principal argument against maintenance treatment was it did nothing to address the individual's underlying pathology and was therefore counterproductive. For instance, in response to the suggestion that physicians should be authorized to provide maintenance doses, Stevenson argued:

That is, of course, a serious debasing of the concept of 'medical treatment', as it is the duty of the physician to treat the patients in the hope of ameliorating or curing the pathological conditions. To ask physicians to be dispensers of narcotic drugs is to ask them to take on the function of the 'beverage room' or liquor store. (1955, p.485)

Rather than maintenance treatment, Stevenson supported a model of treatment that began with withdrawal, followed by a period of residential rehabilitation and follow-up. This model of treatment has been widely accepted and continues to be used to the present day. It is also a model of treatment that suggests it is only possible to treat underlying pathologies if an individual is no longer using drugs. As such, it has preserved abstinence as the overarching goal of addiction treatment.

The idea that addiction is the reflection of some underlying pathology or personality disorder was also used later to discount proposals to experiment with heroin maintenance. For instance, as was mentioned above, after the Le Dain Commission recommended studying heroin maintenance, the Ministry of National Health and Welfare sent delegates from Health Protection Branch to investigate the 'British System'. These delegates appeared troubled by their finding that British clinic physicians were content to

settle for lesser treatment goals than abstinence. British doctors would continue long-term maintenance if patients managed relatively stable social relationships, were employed and stayed away from the illicit drug scene. Indeed, the delegates' interpretation of the success of the British clinics suggests a view of addiction that was not particularly compatible with heroin maintenance. For instance, they acknowledged that the provision of sterile injection equipment led to minor improvements in health but they suggested that patients in British clinics were mentally unstable:

The apparent precarious mental and psychological health of the addicts interviewed cannot be over-emphasized. None were completely normal; some were very hostile, one girl was obviously filled with self-hate, another boy was a rather obvious homosexual. This is of course typical of addicts in many countries, and only serves to illustrate the fundamental personality disorders apparent in the majority of addicts, many of which antedate drug use. (Health Protection Branch, n.d., p. 5)

Similarly, they also acknowledged that maintenance treatment likely reduced acquisition crime among patients but made the point that many addicts "exhibited anti-social and criminal tendencies before getting involved with drugs" implying that they would continue to commit crimes (Health Protection Branch, n.d., p. 7). Together, these quotes suggest these delegates viewed addiction as a reflection of an underlying mental abnormality. This view implies it is not possible for addicts to live productive, crime free lives even if they had regular access to legal narcotics.

Taken together, early experiences of the UK and North America suggests that there needs to be at least some official acceptance of a disease model of addiction for heroin maintenance to be feasible. A moral model simply is not compatible with maintenance treatment as its end goal is not abstinence. Other treatment outcomes such as improved health and social well-being must be valued as an end result of an intervention for heroin maintenance to be accepted. However, endorsement of a disease model does not necessarily equate a progressively liberal approach to maintenance prescribing. For instance, in 1960s the practice of prescribing heroin and cocaine to treat addiction in the UK was severely restricted by the second Brain Committee by limiting it to specialized clinics. At the same time, this Committee strongly endorsed a disease model of addiction arguing that an addicted individual should be viewed as sick rather than criminal. Rather than relying on maintenance prescribing as

a response to addiction, the Committee advocated enhancing treatment services to include in-patient and out-patient care and long-term rehabilitation along-side maintenance treatment (Interdepartmental Committee on Drug Addiction, 1965). These recommendations suggest that trend towards a more nuanced understanding of addiction and desire for innovation in its treatment that took place in North America also occurred in the UK. This trend, however, had the opposite result of restricting maintenance treatment rather than loosening controls over it.

Similarly, although there has been a general trend towards greater acceptance of a disease model of addiction in Canada from the 1950s onwards, maintenance treatment has not enjoyed a similar trend of increased support. As discussed above, initial enthusiasm for methadone maintenance dwindled fairly quickly. The Canadian federal government restricted access to this treatment option in the 1970s and again in 1980s by first requiring physicians to have a special license to treat addicts with methadone and then limiting the number of licenses given out as well as by establishing strict admission criteria, dosing limits and so on (Health Protection Branch, 1972 & February 12, 1973; Special Joint Committee of the CMA and the DNHW, Food and Drug Directorate, 1971; Fishcer, 2000; Reist, 2010). At the same time, the BC provincial government also attempted to limit methadone by restricting it to provincially run addiction centres (Alcohol and Drug Commission, 1977; BC Legislative Assembly, April 14<sup>th</sup>, 1986; Alexander, 1990). Moreover, as discussed above, proposals to experiment with heroin maintenance were rejected at both the provincial and federal level. This rejection has, in part, been due to a periodic revival of support for a moral model of addiction as well as adherence to the view that addiction is a function of an underlying pathology that can only be treated when drug use has stopped and a reluctance to give up abstinence as an end goal of all treatment interventions.

#### **5.4. A Rising Crisis: Expanding Rates of Drug Use**

Many of the changes in drug control and addiction treatment were the result of rapidly rising rates of drug use in the mid-20<sup>th</sup> Century. Like the experience in other countries, drug use patterns in Canada began to change in the 1950s, with the greatest increase in use occurring after the mid-1960s. This change was threefold. First, rates of

illicit drug use increased significantly. Although there were not good statistics available on the number of addicts or rates of use, the Narcotics Addiction Foundation in BC reported that in 1966 they admitted 40% more new addicts than they had the previous year (NAF, 1967). Likewise, federal statistics estimated that the number of known street or criminal addicts rose from 2947 in 1964 to 6425 in 1971. Convictions under the *Narcotics Control Act* increased from 402 in 1961 to 1779 in 1968 (Hammond, 1969; Levi, March 2<sup>nd</sup>, 1972). Second, the socio-demographic profile of users changed. There was an upsurge in youth drug use that was not only limited to lower socio-economic youth. Third, drug use diversified. Drugs of abuse were no longer principally limited to opiates. Cannabis quickly became a favourite drug of youth and surpassed opiates as the most commonly abused illicit drug. New drugs such as hallucinogens, amphetamines and barbiturates were also introduced. Moreover, new users typically did not limit themselves to one drug. Poly substance use became the norm (Canadian Medical Association Special Committee on Drug Misuse, 1969; NAF October 30, 1969, February 1968 & April 1969b). Together these changes elevated the issue of drug use to a national concern and inspired a degree of urgency to prevent rates of use from rising even further.

The Canadian government came under increasing pressure to address the country's rising drug use problem. Youth drug use was receiving significant media and public attention. During this period of heightened awareness of drug use, there were many, often times conflicting, solutions proposed. Youth, activists and drug users themselves called for a more liberal approach to drug use. The legitimacy of the drug laws was questioned and the legalization of illicit drugs, particularly cannabis, was advocated. On the other hand, traditionalists called for greater enforcement, harsher penalties and coerced treatment. More moderate commentators supported additional treatment and education along with fewer penalties for users and greater sanctions for traffickers (NAF April 1969a, February 1968 & October 30<sup>th</sup>, 1969; Cox, March 8<sup>th</sup>, 1963; Kirkpatrick, 1960). Without a clear solution to the drug problem, the federal government was more willing to experiment with different options for addressing addiction than they had been in the past. This more open approach facilitated the rapid expansion of methadone maintenance. As discussed above, the federal government did not prohibit or attempt to control methadone maintenance treatment until the 1970s when they

issued guidelines that restricted but did not ban this treatment. Rising rates of drug use also inspired calls for experimenting with heroin maintenance, which never materialized, but planted the seed for the later clinical trial in Canada. After years of active opposition to maintenance prescribing, the Canadian government conceded to demands to do more to address drug addiction and tentatively endorsed methadone maintenance.

The UK responded to this crisis in a somewhat different manner. Because maintenance treatment was a legally available treatment option, there was not pressure to experiment with it or expand its use. The opposite was the case. The practice of maintenance prescribing was at first blamed for rising rates of drug use. As was the case in other parts of the world, social change was afoot in the UK. These changes lead to increasing drug use and a shift in the profile of the typical drug user. Whereas in the past drug users were typically middle aged individuals, who were often introduced to dangerous drugs through the course of medical treatment, new drug users were more commonly youth who came to their addiction through non-therapeutic paths. This shift and the accompanying youth subculture garnered media attention and inspired fear over degrading values and societal change (Stimson & Oppenheimer, 1982; Mold, 2004). Occasional or recreational use was becoming more common and there was an increasingly wide array of drugs available. Rates of heroin addiction also began to rise. There were a number of so called 'junkie doctors' in London that were prescribing large amounts to addicts and who had attracted the attention of the Home Office and the media (Stimson & Oppenheimer, 1982). In response to these concerns, the Brain Committee, which had just years earlier indicated it was not necessary to institute controls over maintenance prescribing, was reconvened in 1964 to once again consider the issue. Reflecting rising rates of drug use, the Committee's second report was a reversal of their previous position (Interdepartmental Committee on Drug Addiction, 1961 & 1965).

The second Brain Committee suggested the principal supply of heroin and other drugs to new addicts was a small number of physicians who were prescribing indiscriminately and excessively. They pinpointed the problem to six doctors who were prescribing large amounts of dangerous drugs but also suggested these doctors were not contravening the *Dangerous Drug Act Regulations* because they were following their

own professional judgement. To rectify this situation, and in an effort to curb rising drug use rates, the Brain Committee recommended the prescription of heroin and cocaine in the treatment of addiction be restricted to specialized clinics (Interdepartmental Committee on Drug Addiction, 1965). The Brain Committee's recommendations were welcomed by the both the Home Office and the Ministry of Health who were under political pressure to respond to what was beginning to be viewed as a drug epidemic (UK, Parliament, February 14 & November 24<sup>th</sup>, 1966; UK House of Lords, May 11<sup>th</sup>, 1966). Although there were some delays in doing so, this recommendation of the Brain Committee was implemented. Despite restricting heroin and cocaine maintenance to specialized clinics, the upward trend in drug use continued. It was becoming increasingly apparent that this increase in drug use could not be controlled by instituting greater medical controls. Furthermore, there was increasing evidence of a black market for illicit drugs, which lead some observers to discount the clinic system as a failure (UK Parliament, March 25<sup>th</sup>, 1970; UK House of Lords, March 26<sup>th</sup>, 1969).

## **5.5. Redefining the Jurisdictional Boundaries of Drug Control – Politics and Local Action**

Looking back in time suggests local advocacy has not always played a role in decisions on whether or not to allow maintenance prescribing but in these situations this treatment was not approved. For instance, in Canada, there was little advocacy for maintenance prescribing until the 1950s from any group. The idea was periodically raised and there were some concerns about infringements on physician's freedom to practice medicine; however there was no concerted action on the part of cities or provinces to deal with drug use problems. Moreover, there were no local organizations that took ownership of the issue of drug use. At the same time, there was no vocal opposition to this practice either. Limited local interest in addiction or maintenance prescribing was in large part due to the fact that there was little drug use in Canada at the time. Although Vancouver had the largest concentration of drug users, addiction was not an issue that received significant attention from the city or the province. This lack of local demand for a solution to drug use problems made it easier for the federal

Narcotics Division to dictate drug control policy, including banning maintenance prescribing.

It was only when drug problems began to increase and become more concentrated in specific areas that local demands for action emerged, including proposals for maintenance treatment. For instance, in the face of rash of drug related crime in Vancouver and perceived government inaction, the Vancouver Community Chest and Council's Narcotics Committee, chaired by Dr. Lawrence Ranta, suggested establishing narcotics dispensing clinics as a solution to illicit drug traffic. The Committee, in what became known as the Ranta Report, reasoned:

This action would within a reasonable amount of time eliminate the illegal drug trade...no addict would be willing to strive for \$20 to \$50 per day through criminal activities, if unaltered drugs could be obtained for a few cents from government-operated clinics. (Community Chest and Council of Greater Vancouver as cited in the Vancouver Province, July 30<sup>th</sup>, 1952)

After the Ranta Report and its proposal to establish narcotics dispensing clinics gained significant publicity, the Senate Special Committee on Illicit Drug Trafficking in Canada took it upon themselves to address the topic. They concluded:

[T]he establishment of such clinics or the provision of any other legalized supply of drugs for the purpose merely of supporting addiction would be a retrograde step. The Committee is therefore of the opinion that the narcotic drug problem cannot be solved by the creation of government clinics where addicts could obtain their supplies. (Senate of Canada, 1955, p. XIII)

They also rejected proposals to adopt the 'British System' on the grounds that there had never been a serious drug problem in the UK and the situation there was therefore not comparable to the Canadian context.

In the end, the Ranta Report's recommendation to establish narcotics distribution clinics was unsuccessful. However, it did signify the beginning of BC becoming more vocal in its demands for the federal government to do more to address drug problems, as well as initiating their own response to these problems. For instance, as noted above, in the mid-1950s the BC government established the Narcotics Addiction Foundation which actively lobbied for greater treatment resources throughout its 15 year

existence, including the expansion of methadone maintenance both in Vancouver and other areas of the province. Indeed, escalating drug problems in Vancouver and few effective treatment options motivated Dr. Halliday's initial experimentation with methadone maintenance. After a long period of setting drug policy with impunity, the federal government's longstanding ban on maintenance prescribing was successfully challenged in part by activism of organizations such as the NAF and provincial governments' willingness to assume some responsibility of the problem of addiction.

Local support also appeared to play a role when methadone maintenance was introduced to the US. When Dole and Nyswander began their research in New York City, the ban on maintenance prescribing was increasingly questioned in the face of rising rates of drug use. Nevertheless, the Federal Bureau of Narcotics continued to actively oppose maintenance treatment and the practice was not supported by the American Medical Association (AMA). In this situation, local support for Dole and Nyswander's research was vital to it being able to proceed. Similar to the situation in Vancouver, New York City had the largest drug problem in the country. City and State leaders were seeking solutions to this problem and had previously considered but did not follow through with re-introducing narcotics distribution clinics and a small experiment with heroin maintenance. Methadone maintenance offered a less radical alternative and received support from both city and state governments as a potential solution to their drug problem.

The experience of Canada and the US suggests local governments and organizations became involved in the issue of maintenance treatment because their communities were directly impacted by rising rates of drug use and drug-related harms. Their involvement changed the face of drug control in both countries by introducing new actors to the field beyond federal bureaucrats and law enforcement. Local support also made the idea of maintenance treatment less politically risky for federal political actors. When allowing methadone maintenance, federal governments were simply responding to a regional demand rather than implementing a radical initiative from the top down. Moreover, responsibility for maintenance prescribing no longer lay exclusively with the federal government. This responsibility was now shared with provincial or state governments.



Similarly, in 1971 the Vera Institute for Justice<sup>5</sup> wrote a proposal to study heroin maintenance for the city of New York, clearly suggesting city officials supported exploring the potential of heroin maintenance. However, when it was leaked to the press, the proposal garnered local, national, and even international attention. Within the US much of the attention was negative, particularly on a national level (Robinson, 1978). There was a barrage of media reports on the issue and the city of New York soon distanced itself from the proposal. Despite a lack of support from the city, the Vera Institute proceeded to advocate for the research and brought together a medical team to redevelop the original proposal. The re-developed proposal, entitled "*Proposal for the Use of Diacetyl Morphine (Heroin) in the Treatment of Heroin Dependent Individuals*" (1972), was eventually submitted to the Food and Drug Administration for approval but did not proceed beyond this point (Robinson, 1978). The proposal was never approved and nationally, a number of democratic and republican congressmen from New York formed an ad hoc congressional committee to write and introduce legislation that would prohibit experimentation with heroin maintenance. This legislation was never enacted despite having the support of President Nixon; however, its introduction does indicate the level of opposition to heroin maintenance that existed at the national level (Robinson, 1978).

An inhospitable federal political environment has also been responsible, at least in part, for the failure of past proposals to study heroin maintenance in Canada as well. For instance, as discussed above, when the Le Dain Commission proposed studying heroin maintenance the federal government reject the proposal almost out of hand. Sensing a simple statement would not be enough to end the discussion of heroin maintenance, the federal government sent delegates to the UK in what appeared to be an effort to discredit the idea of studying heroin maintenance in Canada. Likewise, when the BC government proposed studying heroin maintenance it was later revealed that the federal government had been consulted and they did not support the proposal. In the words of Norman Levi who initially announced the plan, "they weren't ready at that time" (British Columbia Legislative Assembly Debates, July 15, 1980, p. 3313). However, even

<sup>5</sup> The Vera Institute for Justice was (and is) an non-profit agency that advocated for criminal justice reform and delivered programs designed to divert persons from the criminal justice system.

if this proposal had the support of the federal government it is not clear that it would have had sufficient local support to allow it to proceed. Negative reactions to the Alcohol and Drug Commission and the BC Rehabilitation and Social Improvement Minister's announcement that they were considering an experiment with heroin maintenance in 1973 also resulted in the minister backing down from this course of action. Instead, he suggested that heroin maintenance was only one of many potential responses to their drug problem that was being explored.

Although unsuccessful, these examples reinforce the importance of local support from politicians, media and the public in efforts to expand or introduced heroin maintenance. Conversely, local opposition to maintenance treatment can also result in the practice being curtailed. For instance, rising rates of drug use in the UK in the 1960s resulted in restrictions being place on maintenance treatment rather than relaxations. Like the situations in Vancouver and New York, drug use was concentrated in London and there were increasing demands for the government to address this situation. Unlike the situation in Vancouver and New York, overprescribing by a small number of physicians was initially blamed for this increase. This increase being attributed to physicians led to restrictions being placed on their freedom to prescribe heroin and cocaine in the treatment of addiction.

## **5.6. Professional Influence**

Eventually, the medical profession in North America did become more involved in addiction treatment which facilitated the introduction and spread of methadone maintenance. For instance, in the US there was a movement for the medical profession to regain ownership over what was considered legitimate treatment of addiction, beginning in the 1950s. The AMA advocated for greater medical involvement in responding to drug use, suggesting that they, rather than courts and various experts, should determine 'legitimate' practice in the treatment of addiction. Similarly, in Canada, the Department of National Health and Welfare came under increasing criticism for interfering in the medical profession's discretion to treat addiction in the 1950s. By the early 1960s, the federal government was taking steps to encourage physicians to become more involved in responding to addiction. Provisions of the newly enacted

Narcotics Control Act were meant to clarify what was legal in the treatment of addiction and to give physicians more freedom in deciding how to treat addicted patients. It was in this environment that methadone was introduced in both countries. Authors such as Carstairs (2006) and Musto (1999) suggest that greater involvement of the medical profession in the treatment of addiction was instrumental in the introduction of methadone. Nonetheless, the influence of the medical profession should not be overstated.

In both Canada and the US, the medical leaderships had issued statements against maintenance prescribing. For instance, in Canada, a member of the BC legislative assembly, Ernest Winch, and the Victoria Medical Society proposed establishing narcotics dispensing clinics in 1948. In an effort to judge support for his proposal, Winch surveyed physicians from across the province. Although approximately 78% of 325 physicians surveyed supported this idea ("E.E. Winch attacks", March 16<sup>th</sup>, 1948), the BC College of Physicians and Surgeons opposed this suggestion. They wrote to the Narcotics Division saying they did not support this proposal and advising against establishing such clinics (MacLachlan, May 13<sup>th</sup>, 1948). However, methadone offered something new. The medical professions in both countries were quick to change their view once it was introduced. In 1965 the CMA tentatively endorsed methadone maintenance and in 1967 the AMA did the same.

The Canadian Medical Association addressed the issue of maintenance treatment in 1965 when they published their position on what constituted good medical practice in the treatment of addiction. In response to increased national attention on the issue of drug addiction, recent changes to the drug law regulations and a conference on narcotics addiction sponsored by the Addiction Research Foundation, the CMA appointed a special committee to study and report on the treatment of narcotics addiction (Ferguson, Ettinger, Joron, Lederman & Mackenzie, 1965). The Special Committee was tasked with considering whether it was ever good medical practice to prescribe maintenance doses to a narcotic addict. Their report was the first time the CMA formally published their position on maintenance prescribing and essentially discouraged heroin maintenance. Later, they also discouraged the use of heroin

maintenance by speaking out against the Le Dain Commission's proposal to study heroin maintenance.

The position advanced by the CMA Special Committee was that the prescription of narcotics to addicts should be limited to methadone, whether for alleviating withdrawal symptoms, maintenance, or pain management. The report also cautioned that most addicts were not interested in the becoming abstinent or regarded themselves as sick and were highly skilled at manipulating doctors to obtain prescriptions. They conceded that, in limited circumstances, methadone maintenance may be justified but it should be done through specialized clinics that could offer additional supports and services. The Special Committee suggested:

it may, in certain circumstances, be good medical practice to prescribe maintenance doses of narcotics for long periods of time to an addict at liberty, if other components of good medical treatment are also provided. If they are not, the doctor may be guilty of trafficking. Our advice to general practitioners is that they should, if possible, avoid prescribing narcotics for a long period for addicts under their care. (Ferguson et al., 1965, p. 1043)

In addition, they advised that if a physician decided maintenance doses were necessary, they should seek a second opinion from a colleague experienced in the treatment of addiction. To protect themselves and their patients, physicians should also report the use of maintenance treatment to the Narcotics Division (Ferguson et al., 1965). These recommendations closely reflect recommendations made by the UK's second Brain Committee two years later.

When the medical profession was beginning to play a greater role in addiction treatment in North America, greater government controls over maintenance prescribing were being introduced in the UK. Heroin and cocaine maintenance were restricted to specialized, government run drug dependency clinics. Similar to the North American rationalization for restricting methadone maintenance, the clinic system was introduced to stop a small number of doctors from indiscriminately prescribing vast quantities of narcotics to drug users. It was also driven by concerns over rising rates of drug use. Physicians in the UK were not opposed to this new restriction. Issues around medical autonomy in the use of narcotics had previously been worked out and it was felt that this

change would impact a very limited number of physicians and was not a threat to the independence of the profession. However, government control over maintenance prescribing stopped there in the UK. Unlike North America, restrictions were not placed on methadone maintenance. British physicians retained their clinical discretion in how and when to use methadone to this day. Even within drug dependency clinics, there was no government direction on maintenance prescribing other than the specification that other support services should be provided. Details of when and how to maintain patients on heroin continued to be left to individual physician's discretion. Physicians kept this discretion until the 1980s when greater central direction on the treatment of addiction was introduced.

## **5.7. Discussion and Conclusion**

The 1960s ushered in a new era of drug control in Canada and abroad. Arguably the basic conditions required for heroin maintenance to be considered as a legitimate treatment option existed from this time onwards. Similar to the situation in the US, Canada's predominantly criminal model of drug control was diversified to include treatment and prevention measures. After years of leaving the issue of illicit drug use to the federal government, provincial governments began to establish agencies to provide publically funded addiction treatment. Provincial government involvement led to the growing expectation that treatment was a necessary part of any successful model of drug control. This expectation, combined with a growing interest in pharmacological interventions and the view that addiction is a chronic brain disease, led to the introduction of methadone maintenance. At the same time, there was also considerable pessimism about the effectiveness of addiction treatment, prompting calls to experiment with alternative interventions. There were a number of proposals in both Canada and the US to experiment with the 'British System' and heroin maintenance. It also caused others to rethink the purpose of addiction treatment. Treatment success began to be defined not only in terms of abstinence but also improved health and social functioning and crime prevention. However, proposals to study heroin maintenance did not go ahead in Canada at this time.

Although a chronic brain disease model of addiction was advanced and the ability to cure addiction was questioned, these views were in their infancy. A chronic disease model of addiction had gained enough popularity to allow for the use of methadone maintenance but not more controversial intervention such as heroin maintenance. It took over 20 years and an epidemic of drug-related harms for this perspective of addiction and its treatment to gain enough popularity to allow for the use of heroin maintenance. Moreover, there are always competing perspectives on the underlying causes of addiction and the best way to treat it. The perspective that addiction was a function of an underlying pathology or personality disorder was popular in the mid-century and held more sway over federal policies. As a result, abstinence-based treatments were preferred over interventions such as heroin maintenance. Indeed, perspectives on addiction have never been unanimous. In the context of no clear consensus on the nature of addiction, maintenance treatment, but particularly heroin maintenance, has been and will continue to be a controversial and disputed intervention.

## **Chapter 6. Controlling and Understanding Addiction: Conceptual and Systems Forces Influencing the Use of Heroin Maintenance**

### **6.1. Introduction**

Heroin maintenance is only feasible when specific systems and conceptual factors exist. For instance, information in this chapter will be used to argue that the use of heroin maintenance requires a system of drug control that is not based on a purely criminal model of control or entirely focused on supply reduction but includes medical or public health controls and demand reduction measures. Likewise, it will also suggest there has to be some official acceptance of a chronic disease model of addiction or a policy environment where interventions premised on this understanding of addiction will be supported. There also needs to be a degree of official recognition that abstinence is not always a realistic treatment outcome for all addicted individuals and a policy environment that allows for the use of interventions that have improved health and social functioning as their end goal, rather than abstinence. Arguably, these conditions did not exist in Canada, at least to any great degree, until the late 1980s and 1990s when harm reduction interventions and philosophy were introduced to the field of drug control.

Building on the discussion of Canadian, American and British history of maintenance treatment provided in the previous two chapters, this chapter explores the changes that occurred in drug control and understanding of addiction in more recent times. As we will see, many of the changes that took place in field of drug control and understanding of addiction that occurred in the mid-20<sup>th</sup> Century were the building blocks for what occurred in the late 1980s, 1990s and 2000s. This connection is a reminder that it is important to realize that change to systems of drug control and understanding of addiction takes time and is often incremental. As such, a longitudinal view is needed to

fully understand how different systems of control and evolving perspectives on addiction have influenced the use of heroin maintenance.

This chapter relies on both interview data and published literature. Often interview participants did not discuss, at least in any comprehensive manner, how systems and conceptual factors influenced the use of heroin maintenance in their country. Nevertheless, these forces are important factors for setting the stage for the use of heroin maintenance as well as understanding why heroin maintenance was used at this particular time after years of rejecting the intervention. Also, up until this point, Canada's experience has been compared to that of the US and the UK. This and subsequent chapters also consider the experience of Switzerland, Germany and the Netherlands with heroin maintenance. These countries were the first to experiment with and adopt this intervention as a routine treatment option outside of the UK since the 1920s. The chapter begins by exploring how systems of drug control have changed and evolved since the 1980s to allow for experimentation with heroin maintenance and subsequent adoption of the treatment, in some instances. Changes since the introduction of heroin maintenance in the 1990s and 2000s are also discussed to understand the future sustainability of this treatment in Canada. This section is followed by a discussion of how changing understanding of addiction and perspectives on treatment have facilitated these systems changes and contributed to the creation of a policy environment favourable to the introduction of heroin maintenance. David Garland's theories on recent developments in crime control and perspectives from the critical literature on harm reduction are used as an analytical guide to contextualize and bring greater depth of understanding to these discussions.

## **6.2. Models of Drug Control**

The history explored in the previous two chapters suggests that the use or rejection of heroin maintenance is a function of the dominant approach to drug control. In Chapter Four, we saw that, in the Canadian context, a moral perspective on addiction combined with an uninterested medical profession and a policy environment dominated by the federal drug administration, which preferred a criminal approach to drug control, led to a complete ban on maintenance prescribing. This ban included heroin



maintenance. In this context the desire to suppress the 'other' and the belief that addiction could be cured in the strictly controlled environment of an institution won over any pleas to allow maintenance prescribing on humanitarian grounds. Likewise, Chapter Five describes how criticism of traditional responses to addiction and subsequent diversification of drug control to include treatment and prevention alongside law enforcement led to the introduction of methadone maintenance. These changes, however, were not sufficient to support experimentation with heroin maintenance. Continued confidence in the ability to rehabilitate addicted individuals and optimism about the effectiveness of methadone maintenance prevented such experiments from occurring. In the 1990s, drug control underwent another transformation in both Canada and Europe and to a lesser extent in the US. This time drug control expanded to include a public health perspective, which led to the introduction of harm reduction.

This expansion of drug control to include harm reduction can be viewed, in part, as a function of the larger restructuring of criminal justice and crime control that Garland (2001) argues has been taking place since the late 1970s. Most notably, the expansion and bifurcation of criminal justice and crime control that Garland observed also occurred in the drug field. Garland argues that there has been simultaneous growth in what he refers to as 'punitive segregation', or increasingly harsh and expressive responses to crime, and the practice of 'defining down' minor crimes, where laws are either not enforced or sanctions are carried out in the community. In some instances, defining down minor crimes places responsibility on communities and the private sector for policing and addressing these offences, which in turn has led to greater control being exercised over citizens. Garland (2001) refers to this relationship where communities and the private sector take on responsibility for preventing, policing or responding to crime as 'preventative partnerships'. He also suggests that the introduction of crime control strategies such as defining down minor crimes and preventative partnerships are premised on a perspective of managing rather than eliminating crime.

In the field of drug control, a similar trend toward expanded and bifurcated control can be observed in the increased popularity of the perspective that drug users and addicts should be treated differently than individuals involved in the sale, cultivation or production of drugs. This perspective was introduced in the 1960s when drug use

became more pervasive among middle class youth but was significantly strengthened during the 1990s and the HIV/AIDS crisis. With this crisis, addiction treatment and harm reduction interventions were increasingly used to address the negative consequences of drug use. Managing drug-related harms rather than eliminating all drug use became a key goal. Although somewhat different from the inclusion of the private sector in crime control that Garland discusses, greater reliance on addiction treatment and harm reduction has expanded drug control beyond the criminal justice system to include health care providers, social services, non-for-profit organizations, and even drug users themselves. As discussed in Chapter 5, the inclusion of health care providers in Canada's response to drug use and addiction began in the 1950s when publically funded treatment became available. However, recent changes in drug control built upon this trend by continuing to expand the breadth of actors involved in drug control as well as the extent of their involvement. At the same time, prohibition continued to be the dominant approach to drug control. Outside of personal possession, most drug offences continued to be highly punitive and guided by a 'war on drugs' mentality.

This bifurcated approach to illicit drug problems where on one hand negative consequences of drug use are managed through health interventions and on the other hand drug prohibition continues unabated created a policy environment where heroin maintenance was feasible outside of the UK for the first time. In this environment, interventions such as heroin maintenance, which seemly violate the spirit of drug prohibition, are allowed under the auspices of protecting public health and community safety. The disparate approaches of dealing with the negative consequences of drug use through health interventions that seem to undermine the prohibitionist goal of eliminating drug use while maintaining the dominant system of prohibition are often brought together under some version of a four pillars drug policy. Such policies are premised on the perspective that drug related problems require a comprehensive approach to drug control and simultaneously promote prevention, treatment, harm reduction and law enforcement.

### **6.2.1. Heroin Maintenance and Drug Control in Switzerland – A Bifurcated Approach**

Switzerland's experience with heroin maintenance provides the best example of this bifurcated approach to drug control that emphasizes management rather than eliminating drug use. Faced with the spread of HIV/AIDS, and a growing open drug scene in Zurich and other large centres, Switzerland's drug policy went through a period of transformation beginning in 1986. As one interviewee suggests,

[T]he government's idea was basically a concern to reduce problems associated with drug use and concern to decrease HIV infections and of course to take care of the social problems associated with drug use. So the social problems and the drug use problems.

To address these drug related harms, Switzerland adopted a multifaceted approach which eventually become known as the 'four pillars' policy. A variety of harm reduction initiatives ranging from needle exchanges to supervised injection facilities were implemented. The use of methadone maintenance also increased exponentially, tripling from 1986 to 1990 (Klingemann, 1998, 1996). This increase was, in part, a result of efforts to make methadone more accessible. 'Low threshold' models were promoted. Social integration and early entry to treatment were accepted as goals even when abstinence seemed unlikely. Other treatment options diversified as well. There was less emphasis on residential treatment, although specialized services continued to expand (i.e., culturally specific services, programs for women) and more resources were dedicated to outpatient services (Uchtenhagen, 2002; Klingemann, 1996). One interviewee described the Swiss governments approach as follows:

We have a public health priority, and this means that the federal government has issued a national drug policy in 1991, the so called 'four pillar policy', introducing harm reduction as an equal pillar in addition to law enforcement, prevention, and treatment and .... The general thing about this is not only the harm reduction element but the will and the action which followed to evaluate, to well document and evaluate every new intervention. They also called for innovative approaches, especially in treatment and in prevention. In prevention of so-called secondary prevention, targeted prevention and in treatment an increase in substitution treatment, including heroin prescription for opiate users but a lot of other things as well. One of the more prominent ones being the early interventions, motivational interviewing in alcohol users and abusers, introduction of behavioural, cognitive behavioural therapies.

Switzerland's response to the problem of HIV/AIDS and open drug scenes was, however, not limited to innovations in harm reduction, treatment and prevention. They also adopted more repressive policies that intruded on the freedom of drug users. For instance, although a policy of tolerance towards the open drug scenes in Zurich's Platzpitz or 'Needle Park' and other cities was initially adopted, it was soon abandoned. By the early 1990s, there was growing public awareness and controversy around the open drug scenes, where conditions had significantly deteriorated. Initial attempts by police to shut down the drug scenes were unsuccessful and only managed to displace drug users to other public areas. In Zurich, the drug scene shifted from the Platzpitz to Letten, an abandoned train station. Further efforts to disperse the open drug scenes were more comprehensive with a high level of cooperation between police, social services, and the medical profession. Treatment services were decentralized and the first experiments with heroin maintenance were initiated. Police also stepped up raids on dealers. Harm reduction services were restricted to residents of the cities where they were located. Drug users who were not residents of major cities where they were found were detained and forcibly returned to their home communities. By 1995, the Letten drug scene in Zurich was dispersed (Klingemann, 1998, 1996).

The Swiss approach to disbanding open drug scenes indicates that although their government was willing to experiment with liberal interventions, such as heroin maintenance, they were not opposed to employing more repressive interventions as well. The use of repressive interventions alongside heroin maintenance suggests that adopting heroin maintenance did not signify a move away from drug prohibition. For instance, one interviewee argues that although progressive initiatives, such as heroin maintenance and supervised injection facilities, had been adopted, there was not a substantive change to the country's dominant drug policy where all forms of drug possession remain illegal. He suggests,

Switzerland is, comparative to other countries, it is a bit liberal but it is not really a liberal policy [the four pillars policy] and it is also, how do you say...Switzerland has to solve a problem but it is not a change in the mentality that changed the drug policy it was pragmatic way to solve the difficult problem and it was not really a cultural or social approach that changed, an understanding to something, or a different understanding...And, so in fact, Switzerland I think remains conservative. It was only because of the open drug scene, the fear of the upper class

that their kids can be involved in the drug problem and the HIV problem....So I think Switzerland is a bit, from outside many people think that Switzerland, in this field, is a progressive country but it's not at all. It is an illusion. It was, we had city, the financial centre of Zurich was spoiled by the drug addicts. They were in the centre and we had all TV, international TV, newspapers, they run all the pictures, from Japan to the USA, all around the world. That is not the best reputation for the financial centre of things. That was one, and then the fear of the upper-middle class that their kids could start to consume drugs and get HIV. That was really, I think that was the main reason why the central authorities started to change their attitude. Not their attitude. They wanted to solve the problem. Not because of a different understanding of the [problem].

The perspective of this interviewee illustrates a key observation that Garland (2001) made regarding recent changes in crime control. Garland (2001) argues that the practice of defining down minor crimes and the formation of preventative partnerships has more to do with the practicalities of responding to high crime rates and protecting the public rather than a move to more permissive approach to crime control or humanitarian concerns regarding the criminalization of minor crimes. Likewise, even without significantly changing their dominant approach of drug prohibition nor adopting an attitude of greater tolerance towards drug use, Switzerland continued to endorse heroin maintenance as a practical solution to open drug scenes and the spread of communicable diseases after initial experiments with the intervention. In 2010, they permanently changed their drug laws to allow the treatment to be used outside of a research setting. Switzerland now offers heroin maintenance in 23 clinics, primarily in German speaking regions for the country. These clinics provide over 1400 treatment slots although just over 1300 are now being used (ECMDDA, 2012).

### **6.2.2. Heroin Maintenance and Drug Control in the Netherlands: Normalizing Drug Use**

Similar to Switzerland, the Netherlands has also amended their drug laws to make heroin maintenance a routine treatment option. There are currently 17 clinics offering heroin maintenance in 15 different cities across the Netherlands (ECMDDA, 2012). Indeed, although the Netherlands began experimenting with heroin maintenance after Switzerland, they were the first country to make a permanent change to their drug law, making the treatment available outside of a research setting. Official endorsement

of heroin maintenance was undoubtedly facilitated by the country's traditionally liberal approach to drug use. Of all the countries considered in this research, the Netherlands has taken the practice of 'defining down' minor drug crimes the farthest, to the extent that the well-being and care of drug users appear to be given a similar priority as supply reduction and law enforcement activities. For instance, one Dutch interviewee described their country's approach to drug use and addiction as follows:

The government's approach is probably well known. Sometimes people would wish it was slightly less well known. These are two things; one is their approach to drug use and to drug addiction. I think they have a combined approach, so very much like the models that are being used in Switzerland, they are called the four pillars approach I think...We try to discourage any using in children, to postpone use. Prevention is an important thing...But with regard to use, or people who are using, you could say that we are quite liberal. But possession and use, it is illegal, even cannabis is illegal, but it will not be prosecuted, it is not penalized. But it is not legal, it is illegal but not being penalized

The Netherlands' policy of not prosecuting drug users, which is rooted in a perspective that distinguishing between individual drug use and involvement in the illicit drug trade, is not new but was expanded shortly before their heroin maintenance trial began. Since the mid-1970s, the possession and sale of small amounts of cannabis were classified as misdemeanour offences and prosecutorial guidelines were issued specifying that these offences would not be prosecuted, resulting in *de facto* decriminalization. In 1996, their prosecution guidelines were revised and possession of small amounts (less than 0.5 grams) of hard drugs, such as heroin, is also no longer prosecuted (European Monitoring Centre for Drugs and Drug Addiction website, n.d.[b]). Prior to the introduction of these guidelines, although there was no formal decriminalization of hard drugs, Boekhout van Solinge (1999) suggests that the laws against possession of hard drugs were often not enforced. Now, police have been given formal directions to confiscate drugs and refer users to care agencies (European Monitoring Centre for Drugs and Drug Addiction website, n.d.[b]). At the same time, there was also a concerted effort to engage illicit drug users in treatment services (Blanken et al., 2010). This approach to drug control is tolerant of individual use and suggests a move away from more repressive forms of state control. The Netherlands has essentially redefined minor drug offences as a problem more appropriately dealt

with through treatment or public health interventions rather than criminal justice responses. For example, one Dutch interviewee suggested,

I think that there is a strong emphasis on providing treatment for those who want to be in treatment. So basically, there is addiction treatment available for all those who want it, basically free of charge. It is accessible.

He also indicated that engaging heroin addicts in treatment was not only viewed as a response to drug-related health problems but also to public nuisance problems created by drug use:

We are in contact with about 70% of all the heroin addicts in the Netherlands, so that is very different. [This] can't only be explained by the health care problem, but also the public nuisance problems that lead to this interesting situation 20 years ago.

The Netherlands' approach to drug control, which has abandoned some repressive criminal justice interventions in favour of managing drug-related harms through treatment, is linked to the normalization of drug use philosophy. This view is essentially that drug use is a normal feature in modern society and questions the idea that a drug free society is possible. This philosophy was increasingly integrated into the Netherlands approach to drug control in the late 1970s and early 1980s and was a predecessor of harm reduction. By the late 1980s when HIV/AIDs became an increasing concern, harm reduction practices became a central piece of the Dutch response to drug use (Koft et al., 1999). The normalization of drug use philosophy is related to Garland's (2001) observation that, in late modernity, crime has become viewed as a part of everyday life and criminal justice efforts to eliminate crime are increasingly seen as a failure. As Garland (2001) argues, according to this perspective crime, or in this case drug use, is a function of everyday social and economic routines rather than an individual pathology and everyone is susceptible to these influences. This perspective has eased some of the moral prohibition against drug use, opening the door to practices such as heroin maintenance, where ending drug use is not the primary goal. Rather, reducing the negative consequences of drug use on the wider community or public becomes the key concern.

### **6.2.3. Rejecting Heroin Maintenance and America's Continued War on Drugs**

Conversely, the US provides a counter example to the experience in the Netherlands and even Switzerland. Drug control in the US did not undergo the same level of bifurcation in the period between the late 1970s and the turn of the 21<sup>st</sup> Century. There is very little tolerance of individual drug use and less of a trend toward defining down minor drug crimes than observed in Switzerland or the Netherlands. The predominant response to drug use and addiction remains criminalization and expressive justice interventions. America's war on drugs continues unabated. This approach is supported by a very large and active federal Drug Enforcement Agency. In this environment, harm reduction interventions and a risk management perspective have largely remained at the fringes and have not gained federal support in the field of drug control. Even the growing recognition of HIV/AIDs as a serious public health concern linked to intravenous drug use did little to soften the country's approach to drug control. For instance, the American federal government even now refuses to fund basic harm reduction services such as needle exchanges (Small & Drucker, 2006). This refusal does not mean harm reduction initiatives are not taking place in the US but initiatives tend to be locally driven and typically do not receive federal endorsement or funding.

Despite the less than enthusiastic reception harm reduction has received in the US, there have been some advances in the field of maintenance treatment. In 2001 the system for regulating methadone established in the 1970s was partially dismantled and changed to a system of accreditation with the hope accreditation would improve quality and consistency of care in methadone programs (Center for Substance Abuse Treatment, 2005). Private physicians were also allowed to administer methadone within primary care settings, rather than limiting it to clinic settings that specialized in addiction treatment (National Alliance of Advocates for Buprenorphine Treatment, 2010). Buprenorphine was also approved for the treatment of addiction in 2004 (Center for Substance Abuse Treatment, 2005). The approval of buprenorphine indicates an interest in expanding maintenance treatment and willingness to consider alternative pharmacological treatments to methadone but, as the experience of NAOMI demonstrates, this willingness does not extend to heroin maintenance in the US.



In 1998, a group of treatment experts and academics from the US and Canada came together to form NAOMI. Through this group the idea of heroin maintenance was advanced in both countries. Protocols for clinical trials comparing heroin maintenance with methadone maintenance were developed and three cities in each country were identified as potential sites for these trials. However, similar to previous proposals to evaluate the effectiveness of heroin maintenance, NAOMI did not get far in the US. The America contingent of NAOMI left the initiative after it became apparent that there would be no funding available for the clinical trial and political will necessary to support the research did not exist (Gartry, et al, 2009; Kuo et al., 2000). A Canadian interviewee also indicated that not only was funding not available for the trial, but future funding for other projects may not be available to those researchers and clinicians pursuing the trial:

When the study was designed in the New York Academy of Medicine with all kinds of American sites and the practical challenges, what happened to them? Right? They all disappeared because they got the word. If you ever want NIDA money again you will forget this.

This quote indicates there was political opposition to the trial and it was not only fiscal constraints that prevented it from happening. It would appear heroin maintenance continues to be at odds with America's dominant approach to drug control which has remained firmly rooted in a criminal model.

At first glance, easing some of the restrictions on methadone maintenance and approving buprenorphine maintenance yet adamantly rejecting heroin maintenance appears to be a policy response inconsistency. However, this situation is more a matter of policy stagnation rather than an inconsistency. Unlike the situation in Switzerland and the Netherlands where a risk management perspective has been integrated into their approach to drug control, in the US drug control appears to continue to be guided by what Garland refers to as penal-welfarism. Applied to the field of drug control, penal-welfarism is the perspective that drug use can be eliminated through a combination of state actions designed to repress drug use and reform drug users. Methadone and buprenorphine maintenance are supported under this perspective because, although they do not end an individual's addiction, these substances are considered medications and are designed to end illicit drug use. Conversely, American law does not recognize that heroin has any medicinal value. It is included on Schedule I of the *Controlled*

*Substance Act* which essentially means it is banned from medical practice (Katz, 2010). Moreover, beginning in the 1920s, the American drug administration has actively campaigned to demonize heroin. This campaign had a lasting impact on American drug policy and perceptions of heroin. In the European countries considered in this research, heroin appears to be viewed as any other powerful opiate, albeit more frequently abused, whereas in the US it has remained highly stigmatized. This stigma validates continued moral and normative opposition to heroin maintenance.

#### **6.2.4. Heroin Maintenance and Drug Control in Canada: Wavering Support for a Bifurcated Approach**

Drug control policy in the Netherlands, Switzerland and the US can be seen as different positions on a continuum between a relatively amoral, risk management approach and a penal welfare approach rooted in a moral, prohibitionist perspective. Canada's approach is somewhere between that of Switzerland and the US. Unlike the Netherlands, the recent history of drug control in Canada is not one that can be characterized as particularly tolerant of drug use. For instance, the time between the drug use crisis in the 1960s/1970s and the HIV/AIDS crisis in the late 1980s/1990s can be characterized as maintaining the status quo with periodic resurgences of a hard-line approach to drug control (Ericson, 1992; Fischer, 1997). At the same time, it was widely accepted that addiction treatment should be available and a growing realization certain groups had unique treatment needs. Treatment services expanded and became more specialized and tailored to the needs of specific groups, such as women and Aboriginal people (Ogborne et al., 1998). However, support for specialized services did not extend to methadone maintenance and the availability of this treatment was severely limited at this time due to highly restrictive federal regulations (Fischer, 2000).

By the late 1980s, HIV/AIDS was spreading rapidly through intravenous drug using populations and BC was experiencing a rash of overdose deaths. Similar to Switzerland and the Netherlands, this crisis in drug related harms widened Canada's response to illicit drug use to include harm reduction services and public health goals. This change, however, took time and repeated calls for action that often fell on deaf ears. For instance, drug overdose deaths began to rise exponentially in BC in 1988 but

it was not until 1993, after significant media attention, that a provincial inquiry into these deaths was announced. Vince Cain, the province's chief coroner and a former police chief, was appointed to head the inquiry. Cain was unwavering in his position that a punishment and a criminal justice approach to addiction was not working. Cain's final report recommended a radical new approach to the province's addiction problems, including a recommendation to evaluate various treatment modalities including heroin maintenance, alongside recommendations for increasing penalties for traffickers and decriminalization of personal possession of all drugs. Although Cain's recommendations were not implemented, his report represents advocacy for a bifurcated approach to drug control from a provincial official. In the end, what was implemented in Canada was much more moderate than recommended by Cain. For instance, in 1996 Canada replaced the *Narcotics Control Act* with the *Controlled Drug and Substances Act* but declined the opportunity to make substantive changes to the country's drug laws and drug prohibition remained intact. The federal government did, however, transfer responsibility of methadone maintenance to the provinces which led to a significant increase in the availability of this treatment (Reist, 2010). Also, borrowing from similar policies in Europe, Canada's Drug Strategy was expanded in 1998 to include a four pillar's approach, which endorsed prevention, treatment, law enforcement and, for the first time, harm reduction. However, at the same time, funding for the strategy was significantly reduced. Advocates in the field of addiction suggested this reduction in funding undermined the effectiveness of the strategy (Collins, 2006). Despite this lack of funding, a number of harm reduction initiatives were introduced, ranging from widespread use of less controversial harm reduction services, such as needle exchanges and outreach programs, to more limited experimentation with more controversial interventions, such as the supervised injection site in Vancouver (Campbell et al., 2009). In 2005, the NAOMI trial began.

The introduction of heroin maintenance and other harm reduction initiatives does suggest a step in the direction of integrating a risk management perspective in the field of drug control. However, the inclusion of risk management should not be overstated. Similar to Switzerland, Canada's experimentation with heroin maintenance did not signify a major change to the country's dominant drug policy. As one Canadian interviewee bluntly stated, "Canada's approach to drug use is prohibition". Others were

a bit more generous in describing the federal government's approach to drug control. According to one interviewee, the Liberal government that was in power when the NAOMI trial was initiated "was going health and social" and another indicated "the previous government, sort of, gave it [harm reduction] minimal support". In this environment of at best moderate federal support for harm reduction, it took seven years to initiate the NAOMI trial. This delay is indicative of the time and effort required and complexity of initiating the trial, but also of the controversy which continued to surround heroin maintenance. Clearly, the level of commitment to address drug-related harms through innovative interventions such as heroin maintenance that Switzerland exhibited was not as strong in Canada.

Although Canada's system of drug control had been diversified first in the 1960s to include prevention and treatment and then in the 1990s to include harm reduction, these changes are perhaps best viewed as additions to Canada's system of drug control rather than true reforms. The predominant system of drug control based on a criminal justice approach has remained unchanged. Drug users and addicts continue to be charged with offences and are often imprisoned. Clearly, minor drug offences have not been defined down to the extent they have been in the Netherlands, where they are no longer prosecuted. The critical literature on harm reduction suggests that as harm reduction becomes more mainstream it has taken on a more value-neutral stance and distanced itself from critiques of drug prohibition (Roe, 2005; Smith, 2012; O'Malley 1999; 2008; Hathaway, 2002). This value-neutral stance has allowed harm reduction and prohibition to co-exist. Authors such as Roe (2005) and Smith (2012) also suggest a value-neutral version of harm reduction enables drug prohibition by mitigating some of the more negative consequences of this policy, thereby isolating it from widespread criticism. Mitigating the negative consequences of prohibition allows the ideology and understanding of addiction that supports a criminal model of drug control to remain largely unchallenged in Canada. This perspective cannot easily accommodate heroin maintenance. As a result, there has been initial support for experimenting with heroin maintenance but little indication this treatment option will be made a routine treatment in Canada.

The Canadians interviewed for this research gave mixed options on whether they thought heroin maintenance would be made a routine treatment in Canada. However, they were unanimous in expressing the view that the current conservative federal government supported a law and order approach to drug control. For instance, Canadian interviewees described the current federal government's approach to drug control as "ideological" or "they are the 'just say no crowd'" and another interviewee said "now with the Harper government in place it's gone back to the law and order, anti-drug, criminalization [approach]". As another interviewee explained, a law and order approach has led to a withdrawal of federal support for harm reduction,

The Conservatives, when they announced their new anti-drug strategy... when they came out with their so-called anti-drug strategy last September, they dropped harm reduction. They talked about enforcement, prevention and treatment, they dropped harm reduction. Stephen Harper, in the previous Federal election campaign, basically said he would close down Insite. He hasn't been able to do it because it's had such broad public support but he sees this as the antithesis to their law and order agenda, right...

The current government gives it [harm reduction] no support and, in fact, they're going in the opposite direction...I mean, we have this Bill in Ottawa now, Bill C26, which is minimum mandatory sentences for drug crimes, which we're fighting against. Ironically, they're going in the same direction that the US has taken, where even in the US they're now re-examining the whole minimum mandatory sentencing regime as a complete failure. There are States that are re-examining, you know, the positions that they took about a decade or two decades ago. So, yes, the huge battle here, in terms of the Federal Government being diametrically opposed to harm reduction.

Despite actively opposing harm reduction, the federal government did not act to prematurely end the NAOMI trial. Nonetheless, when the NAOMI trial was nearing completion, its investigators requested its participants continue to have access to heroin maintenance under Health Canada's Special Access Program.<sup>6</sup> This request was a plea on humanitarian grounds to allow participants to continue with a treatment regime that

<sup>6</sup> Health Canada's Special Access Program is designed to give individuals access to medications that are not yet approved for use in Canada if their condition has not responded to conventional therapies or such therapies are unavailable or unsuitable. It is also only available to individuals with a serious or life threatening condition (Health Canada, 2013).

was positively impacting their lives. The request was denied. All participants were instead transitioned to methadone or offered detox or other available addiction treatment (Gartry, et al., 2009). It would appear that NAOMI's impact on participants' health and involvement in crime and the drug scene was not sufficient for the federal government to endorse heroin maintenance outside a research setting. Somewhat surprisingly, the completion of the NAOMI trial did not end the use of heroin maintenance in Canada. Just a year after refusing to allow NAOMI participants to continue to be maintained on heroin, Health Canada approved and funded the Study to Assess Long-Term Opioid Maintenance Effectiveness (SALOME) which was designed to compare hydromorphone (Dilaudid) and diacetylmorphine (the active ingredient in heroin). They also licensed buprenorphine for maintenance treatment in 2008. These developments suggest that the federal government was not entirely opposed to expanding maintenance treatment.

When the Conservatives won a majority government in 2011 they took further action to advance their tough on crime agenda, including the introduction of mandatory minimum sentences for some drug offences. This tough on crime agenda clearly signifies a shift towards a more prohibitionist and less public health model of drug control, thereby creating an environment that is not particularly conducive to heroin maintenance. In this regard, the Canadian federal government has recently sent a clear message that they do not support heroin maintenance, despite having approved and funded the SALOME trial just a few years before. Recruitment into the SALOME trial is staggered and some participants in the trial have already completed the treatment phase of the research. Recognizing that some participants would not function well if transferred to methadone or other available treatment interventions, physicians associated with the research applied for permission to continue to provide heroin to 36 individuals exiting the research through Health Canada's Special Access Program. Unlike in the case of the NAOMI trial, this request was granted for 21 of these individuals to continue to receive heroin for an additional 90 days. However, almost immediately after this access was granted the Federal Minister of Health, Rona Ambrose, spoke out against this decision, "This program provides emergency access to life-saving medicine. It was never intended to provide heroin to addicts, and we are taking action to close this loophole" (Ambrose, October 3<sup>rd</sup>, 2013). The Health Minister also made it clear abstinence-based treatment was her government's priority, "Drug treatment and

recovery programs should be focussed on ending drug use. We do not support programs which do not have a return to a drug-free life as their ultimate goal” (Ambrose, October 3, 2013). In less than a month, new regulations were in place that prevented restricted drugs from being provided through the Special Access Program.

Canada’s withdrawal of support for harm reduction, denying heroin trial participants continued access to heroin, and failure to take steps to make heroin maintenance a routine treatment option suggests continued tension between the trend toward using health interventions to address drug related harms and drug prohibition. According to Garland (2001), crime control in late modernity is shaped by both the practicalities of dealing with rising crime rates in rapidly changing societies and the increased politicization of crime control, which can result in the introduction of highly punitive, expressive responses to crime. The combined politicization of crime control and rising crime rates has resulted in the situation where there are no longer monolithic or overarching approaches to crime control, such as the previous approach of penal welfarism. Rather, a variety of some times competing approaches co-exist to meet the growing complexity of crime control. Because of this complexity, it is possible that heroin maintenance can continue to be offered even in an increasingly conservative environment where there is growing support for a law and order approach to drug control. However, it is also possible that the federal government will choose to abandon heroin maintenance in favour of more punitive responses to drug addiction to satisfy their own political agenda.

#### **6.2.5. Introducing Heroin Maintenance in the Name of Crime Prevention: The UK’s Experience**

The recent experience in the UK provides an example of heroin maintenance being used under a predominantly criminal justice approach to drug control. Unlike the other countries considered here, the UK’s RIOTT trial (Randomized Injectable Opioid Treatment Trial) was introduced in a drug policy environment that interview participants described as “an American-style war on drugs” or that was focused on crime control. For instance, one interviewee described how prior to the introduction of the RIOTT trial

the focus of drug control in the UK shifted from health and preventing the spread of HIV/AIDS to crime prevention,

I think, HIV was a big issue back then and in fact what happened in the 1990s was extraordinary in a way, it was agreed that harm caused by drug use was worse than the drug use itself so funding went into HIV, funding went into harms. So that is how we got all of these. Now it is very different, it is very different. We now have a war on drugs. Which is hateful and awful but any ways now all policies and treatment goals are based around this notion that we are at war with drugs. So, the emphasis has changed now onto crime, the legislation and policy is now about crime and health is less of a focus. It has had an impact. But basically has had good impact for us, or those of us who feel that heroin treatment should be looked into and should be accessible and should be considered as a treatment option. We, with the new labour government, that is when it started. I can't think of when that is now, 1997-8, that's when it started, we had a drug Czar....And it's the focus was trying to get people to stop crime and treatment was to try to get people to stop crime. There was a fundamental belief for a variety of reasons that treatment reduced crime, so yeah, and so treatment was seen as a good thing. Money was put into treatment services in the same way that when the emphasis was on HIV so we have had money pumped in.

As this quote suggests, the trial went ahead because addiction treatment was viewed as a useful tool in overcoming drug-related crime. When Swiss and Dutch research found heroin maintenance reduced patients' involvement in crime the British government proposed studying the effectiveness of the intervention. Although heroin maintenance is most commonly adopted in a liberal drug policy environment, it is possible for it to be used when drug policy is focused on crime control. However, the unique history of maintenance treatment in the UK also likely had a role to play in their government proposing a study of the effectiveness of heroin maintenance. Heroin maintenance was never banned in the UK as it was in all other countries considered here, which undoubtedly made it easier for their trial to be carried out. It was also the case that both British interviewees indicated that there continued to be widespread support for harm reduction in the UK despite the recent emphasis on crime control. As one interviewee aptly put it, "We have a war on drugs but it is softer around the edges".

The UK's initiation of the RIOTT trial and the larger trend towards providing treatment in the service of crime control that British interviewees observed is a reflection of what Garland (2001) sees as a re-definition of rehabilitation. Garland (2001) argues



that when treatment is provided to offenders in late modernity it is no longer focused on the individual's wellbeing or the promotion of social welfare but rather on the exercise of social control in the name of promoting the safety of the public, protecting future victims and reducing the risk of the offending behaviour. The re-orientation of addiction treatment goals toward risk management is discussed in further detail in the following section, but here it is sufficient to point out that this focus on risk management creates an avenue for apparently liberal interventions such as heroin maintenance to be used in situations where a criminal justice approach to drug control is adopted. Although a criminal justice drug control in Canada is clearly being strengthened, this trend does not necessarily imply that there will be no future potential for the use of heroin maintenance treatment, as the experience of the UK indicates. However, as we will see in Chapter Eight, the continued use of heroin maintenance depends upon whether the current trend towards a criminal justice approach to drug control is based on the ideals of neoliberalism (i.e., cost effectiveness, risk management, and the responsabilization of drug users) or social conservatism (i.e., a moral perspective on drug use).

### **6.3. Perspectives on Addiction and Its Treatment**

The above discussion indicates that, at least to some extent, the introduction of heroin maintenance and the larger changes in drug control that accompanied its adoption suggest these interventions were a solution to highly visible drug problems and the threat of HIV/AIDS. In most instances, the introduction of heroin maintenance was not indicative of a widespread trend to more liberal or tolerant attitude towards drug use or addicted individuals. When change is conceptualized in terms of prohibition versus legalization it is certainly true that the adoption of heroin maintenance does not suggest a trend toward a more liberal approach. In most of these countries, and particularly in Canada, prohibition remains unchallenged as the dominant approach to illicit drug use. Nevertheless, experimentation with heroin maintenance is a reflection of a different kind of change. It broadened a purely abolitionist or penal welfare perspective to include a risk management perspective. More specifically, it signifies an evolution away from the perspective that addiction can be cured and drug use eliminated to one where addiction must be managed and the risk of use reduced.

This trend is not unique to the field of drug control and is linked to a number of changes Garland (2001) has identified as influencing crime control. According to Garland, there was a rapid and sustained increase in crime rates in the 1960s and 1970s linked to the widespread social and cultural changes that were occurring at this time. He suggests that crime rates increase to the extent that crime became a part of everyday life rather than a phenomenon that primarily impacted poor, working class and minority populations. This expansion of crime led to a growing belief that the criminal justice system had failed, and would continue to fail, to control crime as well as growing criticism of the idea that offenders could be rehabilitated. This rise in crime, combined with growing skepticism about traditional responses to crime control, placed a burden on individuals and businesses to manage their own risk of crime and to take steps to prevent their own victimization, or what some authors refer to as prudentialism (Garland, 2001; O'Malley 2009). Increased individual and private efforts to prevent victimization resulted in different crime control strategies such as target hardening (changing the environment to reduce opportunities for crime) and, as discussed above, defining down minor crimes and the formation of preventative partnerships, as well as the growth of what Garland calls criminologies of everyday life, or theories that do not see crime as the result of an underlying pathology or motivation but as a function of routines of every social and economic life.

As discussed in Chapter Five, these trends also occurred in drug control. Rates of drug use increased exponentially in the 1960s and early 1970s and remained high. Drug use shifted from being a phenomenon primarily associated with working class and minority groups to an activity of people from all walks of life, including middle class youth. Changing patterns of drug use were accompanied by growing criticism of prohibition or perspective that a strictly law enforcement approach to drug control was a failure. At the same time, there was increased skepticism about the ability to cure drug addiction. This skepticism led to a search for alternative strategies to deal with drug problems and experimentation with different treatment modalities. Within this context, the goals of treatment began to change from being focused almost exclusively on abstinence to placing greater importance on health and well-being of addicted individuals. Over time, these trends persisted and took root to the extent that where heroin maintenance seemed like a radical suggestion in the 1960s and 1970s by the

1990s it was less radical, particularly when faced with growing HIV/AIDS epidemic and highly visible open drug scenes.

### **6.3.1. Changing Treatment Goals and Support for Maintenance Treatment in Europe**

Indeed, it was not until the HIV/AIDS crisis in the 1990s that perspectives on addiction treatment change enough to accommodate heroin maintenance. This crisis combined with an increasingly visible and severe addiction problem resulted in an expansion of treatment goals even further beyond traditional abstinence-oriented expectations of treatment to include a risk management perspective. As one British interviewee suggests, the HIV epidemic changed the overall approach to treatment. Rather than focusing primarily on abstinence, the goals of addiction treatment broadened to include stabilization, management and reducing drug-related harms. Later, treatment goals were expanded even further to include crime prevention. This interviewee describes the change as follows:

And the goals of treatment have changed on a number of different factors including HIV and then crime is the latest one. In the 90s the reduction of HIV was the main thing so we, therefore, had a lot of harm reduction measures, a lot of talk about harm reduction. So instead of having a hierarchy back in the 90s, sorry the early 90s, where abstinence is the only goal, we have in the 90s there is sort of a hierarchy of goals where abstinence may be there but one was also to reduce injecting, etc.

Changing treatment goals led to much broader support for maintenance treatment overall, to the extent that it now appears to be considered the most appropriate and effective treatment for heroin addiction in some countries. For instance, one Dutch interviewee described their approach to addiction treatment:

[I]f you look at the heroin treatment it is non-abstinence and is directed towards methadone maintenance...Which is in line with what we know about efficacy. There is not much to be expected from abstinence-oriented treatment. Ninety-five or 99% are relapsing after detox, even detox followed by some sort of aftercare. So, I think more and more we start to view the situation as if you are a heroin addict then the first thing is to get in high dose methadone maintenance. If you do very well in that than you will pick up the things that you have to pick up like a better social life, personal life, get your health care together. Always you have to

reach that, get in a stable situation. We would not even advise you to go into our abstinence-oriented treatment but we would not be against it. So abstinence-oriented treatment is for people who have been stabilized on methadone most of the time.

The degree to which a risk management perspective guides addiction treatment varies from place-to-place and as a result acceptance of maintenance treatment is not uniform across the countries considered here. Based on the interviews conducted for this research, Switzerland, Germany and the Netherlands appear to be the most accepting and make the greatest use of maintenance treatment. In each of these countries it was suggested that at least half of heroin dependent individuals were enrolled in maintenance programs. One Germany interviewee suggested,

[W]hen we are talking about opiate addiction and there is 150,000 opiate dependent persons in Germany. About half of them are in maintenance treatment. Mostly with methadone....Of those who are on maintenance treatment, about 70% receive methadone, about 15% receive legal methadone, and another 15% receive buprenorphine.

Likewise, one Swiss interviewee described their treatments services as follows:

Okay, there are, there is roughly 33 to 35,000 drug users, an estimated number is 33 to 35,000 depends on the way of estimating the drug users. But there are around 20,000 in methadone maintenance programs. So roughly or a little bit more than half of drug users are enrolled in methadone maintenance. And roughly there are 1200 or 1500, it depends on the fluctuating number of heroin maintenance and there are about 1200 treatment slots available in abstinence-oriented treatment, like supportive communities and in-patient treatment. And then there is of course some part of the drug using population is in and out of prison. So of the total prison population 25% or so are in prison because of drug use or drug dealing or something that is related to drug use...But you can estimate 20,000 in methadone, 1200 in heroin maintenance, 1200 something in in-patient treatment and another 1000 or so in prison. So of the 33,000-38,000 drug users roughly 2/3 are in some form of treatment, if you consider a prison term a form of treatment. So it is quite a large coverage of drug users.

In the UK, it was suggested that up until the early 1990s there was some hesitancy about methadone maintenance but that there was a growing acceptance that evidence supported this treatment option. One interviewee described this change as follows:

[W]e have had, we have had a change in attitude about methadone maintenance as well. It was back in probably around the early 1990s, it was not particularly acceptable for methadone maintenance. It was a huge debate. In the 80s it was a huge debate about where this has harm reduction measure, whether this was a good thing...So, putting heroin aside, we have, we have anyway a shift in policy and a shift in beliefs about methadone maintenance from the 90s where it is not seen as particularly acceptable to now where it is considered acceptable for people to be on oral methadone maintenance. And the fact that specialist clinics or well the fact that the government would recommend that maintenance is a good thing and there is evidence behind it. I think that we have recommendations that are supposed to be based on evidence and there is supposedly more evidence now. But I think people have been very nervous in the past about using maintenance as a treatment and never understood it either. But as I say now maintenance is acceptable. We have a very complicated drug treatment because the goals have changed, or the goals of treatment have changed so that means that treatment had changed as well.

### **6.3.2. Transitioning Treatment Goals in Canada: A Tentative Endorsement of Risk Management**

Similar to the UK, the 1990s were also a period of growing acceptance of methadone maintenance in Canada. After various federal and provincial efforts to restrict methadone maintenance in the 1980s and early 1990s, the federal government divested their authority to regulate methadone maintenance to the provinces in 1996. In BC, similar to other provinces, the College of Physicians and Surgeons were given responsibility for regulating methadone (Reist, 2010; College of Physicians and Surgeons British Columbia, 2009). The College's guidelines for methadone maintenance are less restrictive than the earlier federal guidelines. They are also rooted in best practice from the research literature in terms of what is known to be effected in maintenance treatment. For instance, the College removed the maximum daily dose of 100mgs specified in the federal guidelines and reduced the training required for physicians to be authorized to prescribe methadone. Perhaps the most significant change was that the College fully endorsed long-term maintenance as the principal goal of treatment rather than stabilization leading to abstinence (College of Physicians and Surgeons British Columbia, 2009). This shift in regulatory authority combined with increased funding for methadone maintenance as a means of trying to address rising HIV/AIDS rates in injection drug users has led to the rapid expansion of this treatment.

For instance, in BC the number of methadone patients increased from 2,827 in 1996 to 9,601 in 2006. The number of doctors prescribing methadone also rose from 238 to 327 during the same time period (Reist, 2010).

Despite the increased availability of methadone maintenance, abstinence also continues to be widely embraced goal of addiction treatment in Canada. For instance, one interviewee mentioned that some people do not view methadone maintenance as treatment and that “Over here you say drug treatment, people see a building, with some beds, and its abstinence. Its recovery type treatment”. Other interviewees also described addiction treatment in Canada as primarily abstinence-based. For example one suggested:

I think that by and large the Canadian model is heavily sort of abstinence and 12-step based for drugs. It relies on a series of steps from the addict or the user or the problematic drug user to progress from step to step. So you'll classically go into detox, which is a kind of social cleansing thing; you're in there for a number of days and then you'll be out of there and you'll be expected to be clean for 30, 60 or 90 days, depending on the particular principles and practices of the unit.

Then you'll be admitted to maybe a 28 or a 30 or a 40-day residential program which is sort of psychological stuff, so very little of that has anything to do with withdrawal management for polydrug users, cognitive behavioural therapy, motivational interviewing, relapse prevention, any of the tools that have been actually developed by the sort of scientific side.

Likewise, one interviewee provided a similar perspective on addiction treatment in Canada but went even further suggesting that it was not only abstinence-based but was also often punitive in nature. He suggested:

I think, the treatment movement is getting better, but it's still sort of stuck in the abstinence base camp where you know, yes, you can come to treatment, but you have to be clean before you come. You know, which...90 out of 100 users will say well, I guess that doesn't include me, because I'm really, you know, I'm in between. I'm in between those two places...I think it is still a little too high-threshold for many of the people we see on the streets and in our countryside.

And we send very punitive...I think we have a very punitive treatment system. Our notion of detox is, you know, somewhere to go and sort of be ill for a few days, you know. There's not a lot of sense of healing, of laying the hands on, massaging people, treating people, you know,

acknowledging that a lot of people are in their addiction because they are or have been abused or abandoned or... so there's not a tender loving sort of care to our detox, it's more of a, you know, go lie on a bed for five days and writhe and moan and groan and go through your withdrawal. We'll maybe help you with a few meds, but... you know, it's too bleak, right?

So I think there's a...I think there's an underlying residual approach to our treatment which comes from the old alcohol movement of you're going to have to hit rock bottom before you're... well, rock bottom with drugs is different, you know? It's death. It's death, it's HIV, it's Hep C, you know. They don't want to have that attitude at all. You want to... you want to help people, protect [them]...We know they're going to relapse, know they're going to use drugs. Don't, you know, don't necessarily abandon them for six months because they fucked up, you know? So I think there's still a fairly punitive approach to, you know, the so-called drug addicts, you know, in society. More so than there would be if people who are just as addicted to benzodiazepines, or alcohol, or legal drugs.

However, this perspective was not unanimous among the Canadian interview participants. One interviewee suggested that in Vancouver at least there was a wide variety of addiction treatment and harm reduction services available, some of which he suggest are designed to reduce crime and engage addicted individuals:

There's a pretty comprehensive range of publicly funded treatment services in Vancouver; less so in other parts of the province. The range though is geared towards out-patient services. So there are eight community health centres in the city. They all have alcohol and drug counsellors, needle exchange, prevention workers, methadone maintenance and health clubs. Only five funded support recovery homes, which are sort of a low intensity residential addiction treatment, and there's one residential addiction treatment facility that's funded by Vancouver Coastal Health. In Vancouver there's one facility that's funded by the provincial health authority, just for women. This centre takes both genders. So I think we're short on residential treatment options.

And there's a lot of innovative approaches to crime reduction and engagement, efforts to reach out and connect with drug users, rather than having a treatment system that just relies on them to come looking for care. Needle exchange, for example, decentralised over 40 different locations including peer-based exchange and supervised injection by health contact centre and life skills centre, the provision of primary care within low pressure housing. The town runs the community traditional care team with a lot of interventions that are designed to connect with drug users who aren't necessarily seeking treatment, but then to be facilitators of transferring to treatment once it's available.

Another interviewee described the situation somewhere between these two perspectives. He suggested attitudes towards addiction treatment had shifted in the past decade, particularly in urban centres. He indicated there was growing recognition that prohibition is not working and a greater willingness to be pragmatic, which had translated into improved support for harm reduction. Even so, he also made the point that, in general, treatment services in Canada were high threshold, had long waits, were under funded and not integrated with other services. At the same time, Canadian interviewees also suggested perspectives on treatment vary across municipal, provincial and federal levels of government. For instance, one Canadian interviewee made the point that “The federal government supports addiction treatment, but has a narrower view of what addiction treatment means”, suggesting they only supported abstinence-based treatment. Conversely, they indicated that the BC government is supportive of a wider range of interventions and that there was even more support for heroin maintenance from the City of Vancouver:

The provincial government is very open to a continuum of addiction services, and their policy, every door is the right door, I think is a positive way of looking at ensuring access to mental health and addiction treatment. And the city, they don't spend any money on treatment, it's not part of their mandate, but they're certainly very supportive of changes for treatment. And treatment is also funded by the provincial government, the provincial mandate.

Taken together, the results from Canadian interview participants suggest that perspectives on addiction treatment are in a period of transition in Canada. Clearly abstinence-based treatment philosophy continues to guide many programs but there is some indication of change. The different services available in Vancouver and increased number of addicted individuals receiving methadone maintenance are examples of this transition, as are the NAOMI and SALOME trials themselves.

Similar to Garland's observation that the changes occurring in crime control in late modernity have not ended the use of penal welfare practices, the introduction of a risk management perspective has not resulted in a complete abandonment of abstinence-based treatments in Canada or even in Europe. As the above descriptions of addiction treatment in Canada suggest, the rehabilitative ideal remains strong in the addiction treatment field as does a moral model of addiction. Abstinence-based treatments are



premised on the idea that drug addicts can be reformed or cured. Likewise, the characterization of addiction services as being 'punitive', equated with 'social cleansing' and linked to 12-step treatment philosophy and the alcohol treatment movement is indicative of the continued influence of a moral model of addiction. The continued influence of a moral model of addiction is likely the result of the salience of a this model throughout the history of drug control in Canada. It is unlikely that a perspective will be quickly or entirely abandoned when it is entrenched in policies and programs supporting drug control, even in the face of evolving understanding of addiction and pressure to protect the public from drug related harms. Moreover, change is also likely slow because of the structure of addiction services in Canada. Until relatively recently, addiction treatment systems were separate from other health care services. This separation undoubtedly slowed the medicalization of addiction, allowing a moral model of addiction or that view that addiction is a result of an underlying personality or pathology to influence policy and practice longer than it many have in other countries.

Despite the continued influence of a moral model of addiction and faith in the belief that addicted individuals can be reformed or cured, Canada did experiment with heroin maintenance suggesting some degree of change. It is clear from interviewee's description of treatment services provided by their respective countries that all of the countries that experimented with heroin maintenance had, to some degree, incorporated a risk management perspective into their treatment services. The inclusion of risk management was a key change in creating situations more amenable to heroin maintenance. If abstinence or a cure is the only recognized goal of treatment, heroin maintenance will not be viewed as an appropriate intervention. However, in a treatment system that recognizes other goals such as improving the health and well-being of drug users and minimizing crime and disorder in the community as equally important as abstinence than heroin maintenance is a feasible intervention. Treatment goals now included not only improved individual health and well-being but also the larger public health goal of infectious disease prevention and reducing public disorder and crime. It is this focus on the wider societal benefits of treatment (i.e., infectious disease prevention, reduced public disorder and crime) that appear to have made the difference in allowing experiments with heroin maintenance to proceed where they had been rejected in the past.

The adoption of treatment goals that are more aptly characterized as risk or symptom management rather than individual reform reflects an evolving understanding of addiction and greater normalization of drug use. For instance, by the mid-20<sup>th</sup> Century, drug use had increased to the extent it was difficult to define it as a problem of the proverbial 'other'. It had become a problem of the masses or a fact of everyday life. This prevalence has had the effect of destigmatizing, to some degree, drug use and has been instrumental in the move away from the ideal of achieving a drug free society. With this changing view of drug use, maintenance treatment has become viewed as a more routine and less radical intervention. Also, changing perspective has encouraged a growing accept of the view that addiction is a chronic disease. A chronic disease theory of addiction supports a risk management perspective and heroin maintenance treatment. Under the auspices of a chronic disease model of addiction, treatment is the management and reduction of negative symptoms and consequences of addiction rather curing the condition.

In an environment that supports significantly different approaches to addiction treatment and on a whole, appears to continue to rely most on abstinence-based interventions, the future of heroin maintenance is uncertain in Canada. As Garland (2001) suggests, the lack of unifying framework, or a common knowledge and values base, for those working in the field of addiction treatment suggest change will continue to occur. However, it is difficult to assess whether future changes will result in more or less support for heroin maintenance. For instance, on one hand, the current trend toward integrating addiction and mental health services and delivering addiction treatment through the health care system will likely further a disease model of addiction and promote further medicalization of this field. Increased medicalization would create an environment more conducive to heroin, which is a quintessential medical intervention. On the other hand, as was alluded to in the previous section, Canada's approach to drug control is getting decidedly more focused on crime control.

## **6.4. Discussion and Conclusions**

Heroin Maintenance is a limited intervention. Its use impacts relatively few drug users because it is a second-line treatment option designed to treat only the most

severely addicted and treatment resistant drug users. Even so, the above discussion suggests the adoption of heroin maintenance provides an excellent case study of the changes in the wider field of drug control and evolving understanding of addiction and its treatment. The introduction of heroin maintenance in the 1990s and 2000s was facilitated by larger social, cultural and economic changes that impacted crime control, and, as part of crime control, drug control. As the above discussion indicates, there were a number of changes in drug control that facilitated the introduction of heroin maintenance, including a trend towards a bifurcated approach to drug control where drug users and addicted individuals are treated differently than those involved in the illicit drug trade, the integration of a risk management perspective into both the larger field of drug control and addiction treatment, and the decline of the ideal of a drug free society.

Although these changes in the larger field of drug control supported the use of heroin maintenance, these conditions are all a matter of degree, not an either or situation. As Garland (2001) points out, crime control today includes elements of the previous model of penal-welfarism as well as strategies unique to late modernity (e.g., preventative partnerships, defining down minor crimes). As such, drug control has been bifurcated; that a risk management perspective guides responses to drug control; and the salience of the ideal of a drug free society varies from country-to-country. As drug control, like crime control, becomes more eclectic and no longer governed by a unifying or hegemonic model of control such as penal welfarism, it must be recognized that there is no single path to introducing heroin maintenance. The experience of the European countries considered in this research suggests that both a liberal model of drug control characterized by a high degree of normalization of drug use and abandonment of some elements of a more punitive elements of prohibition as seen in the Netherlands can facilitate the introduction of heroin maintenance. However, as the experience in the UK illustrates, so can a conservative model emphasizing crime control. One element that does appear necessary is the redefinition of goals of treatment beyond abstinence or, in other words, some level of adoption of a risk management perspective. As the experience of the US demonstrates, when drug control remains guided by penal-welfarism, heroin maintenance is not feasible because it violates the guiding goal of a drug free society.

## **Chapter 7. Accepting Heroin Maintenance: Epidemics, Pragmatism, Evidence and Messaging**

### **7.1. Introduction**

The previous chapter argues that a bifurcated system of drug control that includes elements of a risk management perspective and addiction treatment services that not only focus on abstinence but also reducing negative health consequences and crime associated with drug use provides the foundation for heroin maintenance. These conceptual and system level forces provide a sense of whether heroin maintenance is at all feasible but they do not provide a complete picture of what lead to recent use of this treatment. Other social and political forces have clearly influenced the use of heroin maintenance. This chapter first explores the role crises and epidemics have played in advancing controversial interventions such as heroin maintenance and what happens to such interventions when the crisis recedes or the epidemic is brought under control. It then turns to a discussion of the role evidence and research have played in the introduction and continued use of heroin maintenance as well as how a tradition of pragmatism can strengthen this role. This discussion is followed by a review of the various ways heroin maintenance, or maintenance treatment in general, has been conceptualized and considers how specific messaging around the intervention has been instrumental in its recent use.

### **7.2. Crisis and Epidemics**

Drug control is often reactionary. New policy directions or initiatives are frequently introduced in response to real or perceived increases in drug use or concerns about public health, welfare or rising incidences of drug-related crime. Epidemics or crises have the effect of raising the political and public profile of drug use and related

problems, putting pressure on governments to act. They can also shed light on the shortcomings of existing efforts to control drug use and are accompanied by demands for new solutions to the problem. This reactionary approach overlies what Garland (2001) suggests is a perpetual sense of crisis that characterizes crime control in late modernity. He argues that there is both a perpetual sense that crime is a constant threat or increasing as well as a crisis in confidence that the state can effectively address these problems. In late modernity, the criminal justice system's failure to control crime is no longer seen as a temporary problem but a problem with the system itself. This perception has encouraged many of the changes in crime control that were discussed in the previous chapter such as punitive segregation, defining down minor crimes, and involving actors outside the criminal justice system in crime control.

It can certainly be argued that the same chronic sense of crisis plays a role in late modern responses to drug use as well. Just as there is the sense that society is constantly under threat from crime, there is the view that drugs are rampant in today's society and a growing problem. Media reports perpetuate the view that youth are at constant risk of exposure to drugs, that drug use is an increasing burden on health care resources, and that citizens are at risk of becoming victims drug related property crime or violence related to the illicit drug trade. Garland (2001) suggests that in an environment of perpetual crisis, policy making has become much more political and populist than it has been in the past. Decision making power has been taken out of the hands of the criminal justice officials and there is a greater propensity to discount the views of experts. This situation often results in the introduction of highly punitive, expressive responses when a new crime crisis appears. Although it is certainly true that drug control is not isolated from these types of responses, the introduction of heroin maintenance in response to rising rates of HIV/AIDS and open drug scenes provides a counter example to this type of reactionary, repressive response.

Commentaries on heroin maintenance often link recent experimentation with this intervention to the HIV/AIDS epidemic and problems with open drug scenes in the late 1980s and 1990s (Uchtenhagan, 2011; Gardry et al., 2009; Blanken et al., 2010). Many of the individuals interviewed for this research also made this connection. In the words of one Canadian interviewee, "the HIV crisis woke up the idea of heroin maintenance

again". Similarly, a German interviewee suggested, "The key issue, from my point of view, the key issue to understand the whole heroin problem in our major cities and heroin assisted treatment is the problem of open drug scenes in our major cities in the beginning of the 90s".

### **7.2.1. The HIV/AIDS Crisis and Open Drug Scenes in Switzerland**

The link between the introduction of heroin maintenance and the problem of open drug scenes was particularly strong in Switzerland. Heroin maintenance was one of a number of different interventions, such as safe injection sites, expansion of methadone maintenance, and deporting drug users to their home communities, that were meant to disband the open drug scenes and control rising rates of HIV. For instance, one interviewee from Switzerland described why heroin maintenance programs were established in the 1990s:

[A]t that time there was a tremendous drug problem. There was people using, heroin addicts totally socially marginalized, living in very poor health conditions, very poor social environments, very poor housing conditions and this was, this was of course not in agreement with the understanding of Switzerland as a state that takes care of its citizens... I mean it was a problem from an ethical point of view, it was a problem from a social point of view, it was a problem from a public health point of view because these people are very sick, have a high HIV and hepatitis problems, lots of uncared for wounds and really were in very poor health. This was not tolerable any more.

Another interviewee suggests, this situation led to both the initial research into heroin maintenance but also the decision to continue to offer the treatment after it was proven successful:

[Y]ou have to realize that before that we had a catastrophe in our cities with the open drug scenes and people were really feed-up with all of these injecting drug users sitting around, dying on the streets, pimping around, prostituting around, snatching purses or what have you. And, it was a misery, a terrific misery, we had television, TV's from all over the world coming to see these open drug scenes, we had the tourists coming to see it, the famous Zurich needle park. So people were feed-up with all of that. At the peak time we had about 80 trafficker gangs in the drug scene fighting each other, with murder cases, people being thrown into the river, threatening the police. This was completely unacceptable.

So people were very happy when this new policy came up, and the heroin prescription clinics took away from the drug scene the almost heavily involved. You know the number, 1000 or now it is 1200, it doesn't look much but those who really had heavy involvement in drug trafficking and delinquency and so on. So when you take out these, you can see the difference. At the same time methadone maintenance came up by 10-fold. This helps of course, and we have a new practice of police, which was allowed to repatriate everybody who came not from the city. And we had up to 90% of the people in the drug scene not from the city, 1000s and 1000s. All of this came together to make living again nice and good quality, and people honoured that by saying yes, we want you to continue.

This quote suggests that heroin maintenance, along with other harm reduction initiatives, was a solution to a crisis situation. Intuitively, the idea that heroin maintenance is a crisis driven intervention also makes sense. In a crisis, clinicians, researchers, politicians and even the public are more open to innovative solutions to problems that traditional responses are failing to control. They are more willing to try interventions that might be considered too risky or drastic when not faced with a pressing public health problem that demands immediate action.

### **7.2.2. The HIV/AIDS Crisis and Open Drug Scenes in Germany**

Recent literature discussing heroin maintenance suggests the HIV/AIDS crisis inspired the greatest change in Germany. Up until the early 1990s, Germany had one of the most repressive drug control regimes in Western Europe. No form of maintenance treatment was legally allowed and their drug policy focused on law enforcement and a narrow range of abstinence-oriented treatment (Fischer, 1995; Gerlach, 2002; Vogt & Schmid, 1998). However, with the HIV/AIDS crisis, rising rates of drug-related crime and an increasingly severe and visible drug problem, Germany reversed this approach. As one interviewee describes,

In the beginning of 90s, end of the 80s they recognize that, especially with the background of HIV, they recognize that it is necessary to do something in the treatment area, in the harm reduction area. So Germany, together with the Netherlands and Switzerland, were in the first row of developing a harm reduction system and also substitution programs.

He later went on to suggest:

It is the same as I mentioned, it is the same as in Switzerland and other parts, there were open drug scenes and other problems in the metropolitan areas. And they said, at least in the public, people said there should be something for them. There should be a change in the treatment approach or whatever. It is a mess, it is a problem, a lot of criminality, a lot of really ill people, drug related. So this was a key issue in my mind. At least a lot of cities like Zurich and Amsterdam had problem with their tourism. People won't go there. Also, it is a mess if their nice new camera or car is stolen or whatever. It was an economic interest to change things.

Yes [the same thing was happening in Germany]. In some areas. For instance there was some no go areas. And the key issue for at least the most redneck, narrow minded politicians was the strong correlation between HIV and drug use. They had to address that. There was exploding numbers in the end of 80s in this area. So, okay. Without HIV or AIDS, even methadone wouldn't have succeeded or wouldn't be available worldwide, I am sure. It is not an issue of addicts. They are not interested in addicts. They can do whatever they want but HIV. That is a problem of other people.

In response to this crisis Germany implemented a variety of harm reduction initiatives, including low threshold social services, needle exchanges and later safe injection sites. These changes were driven in large part by advocacy by cities, grassroots action and court decisions (Fischer, 1995; Gerlach, 2002; European Centre for Monitoring Drugs and Drug Addiction, n.d.). The laws prohibiting methadone maintenance were retracted and access to the treatment expanded quickly. Shortly after this law was retracted, LAAM and buprenorphine were approved for maintenance prescribing. At the same time, there were a number of proposals to experiment with heroin maintenance. The first was in 1992, when the city of Hamburg asked the Upper House of the German Parliament to change the *Narcotics Law* to allow for heroin to be used as a medical treatment. Similarly, in 1993 Frankfurt submitted a proposal to the Federal Ministry of Health to implement a program that would allow the prescription heroin. Both of these initiatives were rejected. However, when Switzerland released the results of their first study in 1997 a more concrete plan for a German heroin trial was sought. The federal government along with a number of cities that were in favour of having a heroin trial asked for specific protocols to be developed (Michels, 2002). The clinical trial was approved and first clinic was opened in 2002 (Nabor & Haasen, 2006).



### **7.2.3. The Netherlands: Addressing Unmet Treatment Needs**

Conversely, literature from the Netherlands have suggested that their heroin maintenance trial was not motivated by the HIV/AIDS crisis but rather an identified treatment need. Similarly, some authors have suggests that the Dutch heroin trial rose out of a longstanding debate on the potential for prescribing opioids other than oral methadone for maintenance treatment (Brink, et al., 1999). The Netherlands was not as hard hit by the HIV/AIDS crisis as other countries because injection drug use was not as prevalent (Central Committee on the Treatment of Heroin, 2002). Dutch drug users mostly smoke heroin. As one interviewee suggested, HIV/AIDS motived some users to switch to smoking,

So there is all of these factors, in the 1980s or mid-80s there is the problem with HIV infection. If you have a problem with smoking it is known that people want to move from injecting to smoking to reduce the risk of the infection.

Also, beginning in the 1970s, the Netherlands adopted a progressively more liberal drug policy, as discussed in Chapter 6, and experimented with different forms of maintenance treatment (Kroft et al., 1999; Brink et al., 1999; Blanken et al., 2010). For instance, one interviewee described how heroin maintenance was considered but rejected in the 1980s but other research on maintenance treatment went ahead:

Yes, the discussion probably started in 1980 when the municipal health services in Amsterdam began the discussion that not all patients did well on methadone maintenance. That we had to think about new options or additional options for those treatment areas. So this was there first time heroin prescription was thought to be a possibility. And it was rejected quite quickly at that time. It is impossible, it is ridiculous, and all of that. So they still had problems with these people so they went on doing something else. They went to prescribing intravenous methadone with a small 40-50 patient project in Amsterdam. Not well evaluated for patients that didn't do well. Very problematic patients. Then they moved on to prescribing dextromoramide.

Indeed, many of the changes that occurred in other countries as a result of the HIV/AIDS epidemics also occurred in the Netherlands. For instance, harm reduction initiatives were embraced, including the restructuring and expansion of methadone maintenance programs. Traditionally, methadone maintenance programs in the Netherlands used a

reduction model and suffered from high treatment attrition. These programs were replaced with low threshold services that had greater success attracting and retaining clients in treatment. As a result, the number of users in treatment climbed significantly. Additional experiments with other forms of maintenance treatment were also initiated, eventually including heroin maintenance (Brink et al., 1999; Blanken et al., 2010). Whether these developments were the direct result of the HIV/AIDS crisis or not, the Netherlands ended up in the same place as Germany and Switzerland, with an approach to drug control that emphasized harm reduction and the introduction of heroin maintenance.

#### **7.2.4. The HIV/AIDS Crisis in the US: Continuing with the Status Quo**

The US provides an example of how, even in the face of an HIV/AIDS epidemic, not all countries are moved to experiment with heroin maintenance. Unlike the Netherlands, the US was not spared the full impact of HIV/AIDS on its heroin using population. Even so, the crisis inspired only limited reform to the American approach to injection drug use. Although local harm reduction initiatives were initiated, the US did not add harm reduction to its drug strategy or adopt a four pillars framework as the other countries considered here did (Small & Drucker, 2006). As discussed in the previous chapter, the American federal government did take steps to expand the availability of maintenance treatment by approving buprenorphine maintenance and revising how methadone was regulated. However, the US had just experienced a particularly harsh period of drug control in the 1980s (Musto & Korsmeyer, 2000); the divide between the policies of this period and heroin maintenance were too great for the NAOMI trial to even be considered seriously in the US.

#### **7.2.5. The HIV/AIDS Crisis in Canada: A Slow and Wavering Response**

Like the US, Canada has also traditionally embraced a criminal model of drug control but was eventually moved to experiment with heroin maintenance. Similar to other countries, Canada was beginning to feel the effects of the HIV/AIDS epidemic by the late 1980s. At the same time, BC was experiencing a rash of overdose deaths.

Both problems were particularly acute in Vancouver, where a state of emergency was declared in 1997. Indeed, the HIV outbreak in Vancouver was one of the fastest spreading epidemics in the developed world (Wood et al., 2009). For instance, Canadian interviewees described this epidemic in Vancouver as follows:

[I]n the Downtown Eastside 40% of them are positive for HIV and 96% have Hepatitis C. It's a disaster. Okay? So, the epidemic... In that one year around 95/96 the epidemic of HIV injecting drug users would cost the health system \$2 billion to provide care.

[T]he fact that Vancouver citizens were dying at a tremendous rate. There was an HIV epidemic occurring, there was totally open and horrible drugs market, all along Hastings Street, from Victory Square to Verdon Avenue, or Clark Avenue, really, in the old days.

At this time, approximately 25% of Vancouver's injection drug using population was HIV positive and 80% was Hepatitis C positive (Wood et al., 2009). At the height of the overdose epidemic, there was upwards of one overdose death in the province a day (Campbell, Boyd and Culbert, 2009; Millar, 1998). Throughout this crisis there were repeated calls for action but these calls often fell on deaf ears. For instance, a series of provincial reports on the drug problems in Vancouver's Downtown Eastside all recommended experimenting with heroin maintenance (see Task Force into Illicit Narcotic Overdose Deaths in BC, 1994, Whynot, 1996; Millar, 1998). Despite repeated calls to study heroin maintenance, it took seven years to plan and implement the NAOMI trial which finally began in 2005. Moreover, the trial was not a provincial or federal government driven response to the HIV/AIDS and overdose crisis but rather study initiated by a group of independent researchers and clinicians.

It is clear from the descriptions provided by the interviewee participants and from the literature that this crisis had all the characteristics of events that often inspire politicians to introduce harsh and punitive criminal justice responses. Namely, it involved an illicit behaviour that was threatening the health and safety of the larger community and the public. Yet, the predominant response in Canada, Germany and Switzerland was a public health one. This response could simply be because the primary consequences were the spread of communicable disease and over dose deaths, although crime and disorder were also a significant concern in open drug scenes.

However, it also seems the focus on a public health response is related to Garland's (2001) observation that the criminal justice system is seen as failing, and will continue to fail, to address crime problems. It is certainly true that there is growing acceptance that prohibition is a failed response, and as was mentioned previously, even contributing to the negative consequences of drug use. This skepticism and perpetual sense of crisis encouraged the use of public health interventions and the opinions of health experts being favoured. Moreover, the high profile of this crisis meant it had to seem, from a political perspective, that something drastic was being done. Heroin maintenance fit this profile, as an intervention that had not been used before that targeted the most chronic, treatment resistant and marginalized drug addicted individuals, or the group most closely linked to this crisis.

The introduction of heroin maintenance can also be seen as an extension of the earlier crisis in rising rates of drug use that occurred in the 1960s and 1970s that led to the introduction of methadone maintenance. These two crises have many similarities but more importantly the earlier of the two initiated the perpetual sense of crisis in the drug field that has been instrumental in furthering criticism of prohibition and the introduction of harm reduction. Garland's discussion of the impact of this perpetual sense of crisis in the crime control field primarily focuses on the negative impact of this trend but in the field of drug control the continued high profile of drug problems has contributed to the normalization of drug use. More than simply introducing methadone maintenance, the drug use crisis in the 1960s and 1970s was a reflection of a wider social change which had a profound impact on how drug use was viewed. Drug use shifted from being largely viewed as a deviant act to something more routine or normal. Normalization of drug use is a gradual process and is arguably still taking place today. Without the normalization of drug use, it would not have been possible to implement heroin maintenance in the 1990s and 2000s. A similar process can be seen as taking place with maintenance treatment as well. With the introduction and subsequent proliferation of methadone, maintenance treatment has become progressively normalized whereas in the past it was viewed as an extreme and even criminal intervention. The normalization of maintenance treatment has had the effect of making heroin maintenance a little less controversial compared to when it was first proposed in Canada in the 1970s.

Clearly crises and epidemics can be a significant catalyst for change. However, the change they inspire depends on local conditions and perspectives on drug control. As such, they are only one consideration when trying to make a projection on whether heroin maintenance will become a routine treatment option or if further clinical trials will be carried out in Canada. Moreover, it is difficult to predict when the next major crisis or epidemic will arise in the drug field, what it will be, and what impact it may have on maintenance treatment. It should be noted that although both the drug use crisis in the 1960s and 1970s and the HIV/AIDS epidemic have generally moved maintenance treatment forward, it is not always the case that crises lead to advances in maintenance treatment. As discussed in Chapter Five, the crisis of rising rates of drug use among youth in the 1960s and 1970s led the British government to limit heroin and cocaine maintenance. Future epidemics and crisis could have the effect of re-introducing greater restrictions on heroin maintenance.

#### **7.2.6. Continuing Heroin Maintenance after Crises have Waned**

The idea that heroin maintenance is part of a response to a crisis situation offers a good explanation of initial willingness to experiment with heroin maintenance but does not account for continued interest in this treatment. Some control over soaring rates of communicable diseases among drug users has been achieved. In Europe, at least, open drug scenes have been disbanded or are more controlled. Even in Canada, one interviewee suggested that the open drug scene in the Downtown Eastside of Vancouver is not as chaotic as it was in the 1990s.

People say it's, you know, it's worse than ever now, but I say, okay, let's go back to 1995, 1996, 1997, people were dying on the streets, there were drug markets from... all along Hastings. It was a three-ring circus. Police were just containing it in that one spot. And heroin... first of all, alcohol was the major drug of choice when I moved into the Downtown Eastside in 1987, then something happened, and, you know, in 1987 I think there were 16 overdose deaths in Vancouver, and by 1993 there were 200. So something happened.

However, another Canadian interviewee described Canada's drug problem as "a free-for-all. It is an unmitigated disease". In Europe, Swiss and Dutch interviewees made the argument that their heroin problem was largely under control. They suggested that there

were few new heroin users and their heroin dependent population is getting progressively older. The average age of heroin users in treatment was increasing by approximately 11 months each year. For instance, one Swiss interviewee suggested:

We had heroin problem that dominated for a long time and beside this, or it was also in the center of the, how do you say, the focus of people. The drug problem was heroin problem for a long time and this changed a lot just [now]. I could give you the numbers of addicts in the 90s, beginning of the 90s we had 850 new addicts in the canton of [unclear], in the state of [unclear]. Now we have less than 750 new heroin addicts so you see the heroin problem is over. Heroin is not cool any more. It is not attractive for young people in the region of Zurich of course but generally in Switzerland I think the heroin epidemic is finished or nearly. Group of heroin addicts, most of them remain in their addiction and they come older and older. The group in the clinics, every year they are 11½ months older. So you see they are a constant group.

Similarly, a Dutch interviewee also suggested they had few new heroin addicts but also thought it was possible that in the future this number might increase again:

In Rotterdam, The Hague, and other cities is that the number of, or the average age of heroin users that are in treatment is raised each year by almost a year and hardly any young heroin users entering treatment. Not like I said at the beginning because you really want to know what is going on you don't focus on the treatment system you look into the drug user scene, their natural living habitat. When I was working in Rotterdam, almost a decade ago, also what we noticed on the street was that the population of problematic heroin users was getting older and older. It was only occasionally that we saw young heroin users....

It has been shown in history that drugs come and go and some times, some periods, one is popular and then another. It wouldn't be a surprise if there would be a new wave of heroin users. I think that they are seeing in England and the UK already. I read some signs about New York and I don't know how it is in other places in the USA. But at least at the moment in Holland, in the Netherlands, and restricted to treatment, the group is really getting old. There are now rarely any new, young heroin users coming to treatment.

Swiss interviewees suggest that heroin maintenance, and their larger drug policy, has contributed to the declining number of new heroin addicts. For instance, in the words of one interviewee:

Right now we don't really have that much of a problem anymore with heroin addicts but we have few new addicts, people that start to use heroin right now. It depends, some say it is the result of this policy, some say maybe it is just a trend and that this would have happened anyway but we like to think it is our policy.

British and German interviewees, on the other hand, indicated that heroin use was still their largest drug problem but crack cocaine use was becoming a greater concern. Dutch and Swiss participants also mentioned the trend toward crack cocaine use.

In Canada, this trend was viewed as more pronounced. To a certain degree, heroin is a problem of the past. Literature from Canada suggests crack cocaine use and prescription opiate abuse were the principal problems now. For instance, in one study of drug use in Vancouver's Downtown Eastside there was a noticeable increase in crack cocaine smoking and, to a lesser extent, crystal methamphetamine use. This increase has corresponded with a reduction in cocaine and heroin injection use (Wood et al., 2009). As a result, some attention has shifted towards developing strategies for addressing the harms of crack cocaine use, including distribution of safe crack use kits, advocacy for inhalation rooms, and some interest in developing stimulant maintenance programs. At the same time, there has been a notable reduction in new cases of HIV/AIDS in injection drug using populations throughout the province and some indication that new cases of Hepatitis C are also declining (Gilbert, Buxton & Tupper, 2011). Moreover, the number of overdose deaths has declined in both Vancouver and the province since the late 1990s (Fischer, Popova, Rehm & Ivins, 2006; Wood et al., 2009). In essence, the crisis that facilitated the introduction of the NAOMI trial has subsided or has been brought under control. Indeed, it can be argued that NAOMI, as well as other harm reduction initiatives such as the supervised injection site, needle distribution programs and expanding access to methadone, have contributed to the reduction in communicable disease rates in injection drug using populations as well as continued low levels of drug overdose deaths in the province (Gilbert et al., 2011). This finding provides a strong rationale for continuing to offer heroin maintenance. However, it may also have eased some of the political pressure to address drug-related harms through innovative interventions such as heroin maintenance.

### 7.3. Pragmatism and Evidence

As was alluded to above, heroin maintenance was viewed as a pragmatic solution to very real drug problems with concrete and visible results, such as crime and disorder, overdose deaths, and communicable diseases. Nonetheless, there was not a willingness to simply implement heroin maintenance widely without first determining its effectiveness and safety in any of the countries considered here. The need to study the effectiveness and safety before committing to the intervention is a reflection of the current trend towards evidence-based practice and the neoliberal environment which heroin maintenance was introduced into. In *The Culture of Control*, Garland explores how and why crime control shifted from a penal welfare model in the mid-20<sup>th</sup> Century to the expanded and bifurcated approach in late modernity. A central argument of his book is that this change was the unintended consequence of criticism of penal welfarism and pessimism that abounded in the late 1970s and 1980s about the ability of the state to control crime. The 'Nothing Works' pejorative that came to dominate corrections and later other areas of criminal justice had a demoralizing impact on criminal justice systems and brought into question the effectiveness of individualized treatment. As discussed above, drug control was not insulated from this pervasive pessimism. For instance, as was mentioned in Chapter Five, the 'Nothing Works' perspective did gain some popularity in the addiction treatment field. This skepticism, as well as the growth of neoliberalism and its tenancy towards minimal state intervention or government, led to what to a management style in criminal justice that Garland (2001) suggests focused on performance and outcomes, or what others observe as a trend towards evidence-based practice (Sanderson, 2002). In an environment of pervasive skepticism of state interventions, there is greater pressure to establish the value and effectiveness of any intervention that relies on public funding. This pressure is particularly strong for new, expensive and controversial interventions such as heroin maintenance.

Up until Switzerland began their research in 1994, there was very little information on the effectiveness of heroin maintenance. In the UK, Hartnoll et al. (1980) carried out a small study on patients from three drug dependency clinics in the late 1970s but its findings were inconclusive on whether methadone or heroin maintenance was a more effective intervention. Moreover, although years of research on methadone



suggest it is effective, the value of this treatment is still questioned. Having learned from the experience with methadone, the clinicians and researchers pursuing heroin maintenance realized that they would have to generate evidence of its effectiveness if it was going to be even minimally accepted. This realization led to a rigorous test of heroin maintenance in all the countries considered here (except the US). In the words of one German participant:

I don't know if there is any other kind of treatment in the field of addiction so evaluated and so sophisticated as heroin assisted treatment. A randomized clinical trial with over 1000 patients never, was never done in any other area of addiction in Germany or in Europe.

### **7.3.1. The Effectiveness and Cost-Effectiveness of Heroin Maintenance**

The results of this research suggest that heroin maintenance is both an effective and cost-effective intervention. Although the oldest effectiveness study done by Hartnoll et al. (1980) found inconclusive results, subsequent research has made considerable headway in establishing effectiveness of this intervention. Current research into heroin maintenance began with a series of research projects carried out in Switzerland. In 2001, Rehm et al. reported on six years of data from the original Swiss cohort study and found that treatment retention was relatively high; at three months 86% of patients remained in treatment, 70% after one year, and 34% after three years. Over half of the patients (60%) who were discharged left treatment for another program such as methadone maintenance or abstinence-based treatment. Other outcomes included improved physical and mental health, reductions in criminal activity and illicit drug use, and improved social situations. A series of other studies were also carried out and found heroin maintenance had a positive impact on incidences of infectious diseases, risk-taking behaviours, and mortality rates, among others (Brehmer & Iten, 2001; Steffen et al., 2001; Rehm et al., 2005; Killias, et al., 2000). The Swiss research also included a randomized clinical trial that compared a small group of heroin maintenance patients with a control group who were encouraged, but not required, to enrol in other treatment programs. The tentative conclusion of this trial was that heroin maintenance is a useful intervention for users who have failed in conventional drug treatment programs (Perneger, Giner, del Rio & Mino, 1998). In terms of economic considerations, the

Swiss programs have been found to be cost-effective and resulted in a net savings related to reduced health and criminal justice cost (Brehmer & Iten, 2001).

The Swiss experimentation with heroin maintenance generated interest worldwide and other countries soon began their own research into this treatment option. Clinical trials have now been completed in the Netherlands, Germany, Spain, the UK, Belgium and Canada. These studies varied from country-to-country in terms of their design and the treatment interventions or groups to be compared. For instance, Germany compared methadone and heroin maintenance combined with either psycho-education or case management. They also compared individuals who were in methadone treatment but unsuccessful (e.g., continued to use illicit heroin) versus users who were not in treatment (Haasen, et al., 2007). The Dutch trial assessed the effectiveness of smokeable heroin as well as injectable heroin maintenance compared to methadone. One unique aspect of the Dutch trial was that all trial participants were current methadone maintenance patients (Brink, et al., 1999). The heroin trial in the United Kingdom compared injectable heroin with injectable methadone and oral methadone was used as a control group (Strang et al., 2010). In Canada, the NAOMI trial included a three-way comparison of injectable heroin, oral methadone, and Dilaudid (Oviedo-Joekes et al., 2009). The Spanish and Belgian trials were smaller and only included a comparison of injectable heroin and oral methadone (March et al., 2006; Demaret et al., 2013). Each of these trials provided oral methadone to patients in the heroin groups and all groups were provide additional supports (e.g., psycho-social counselling, medical supports). They also all targeted chronic, treatment resistant users, although how this group was defined varied from study to study.

Despite being carried out in different countries with slightly different designs, these clinical trials arrive at the same conclusion. They concluded that heroin maintenance is a more effective treatment than methadone for high risk, treatment resistant patients (see Haasan et al., 2007; March et al., 2006; Strang et al., 2010; Oviedo-Joekes et al., 2009; van den Brink et al., 2003; Demaret et al., 2013). These trials found that both methadone and heroin maintenance groups benefited from the intervention across social and health domains but generally observed a greater effect in heroin maintenance groups. One outcome where heroin maintenance appears to

achieve significantly more positive results is reduced illicit drug use. For example, in the NAOMI trial 67% of the heroin group were classified as treatment responders in this domain compared to 48% of methadone patients (Oviedo-Joekes et al., 2009). Each of these trials, with the exception of the Dutch study, found that heroin maintenance had a more positive effect on treatment retention rates than methadone. For instance, in the German trial, treatment retention rates were found to be higher for heroin (67%) compared to methadone (40%). This benefit is realized early in treatment but also becomes more pronounced as treatment continued (Haasen et al., 2007; Verthein et al., 2008). The prevalence of adverse events is an outcome where heroin maintenance does not fare as well. Although adverse events were rare in both heroin and methadone treatment groups, there were more incidents with patients enrolled in heroin maintenance. Incidents were most commonly overdoses and, in the case of the Canadian trial, seizures. However, because heroin was delivered in a highly controlled environment, program staff were able to respond to incidents and avoid serious consequences (Haasan et al., 2005; Oviedo-Joekes et al., 2009).

The variations in clinical trial design also lead to additional information on the impact and effectiveness of heroin maintenance. For example, Haasen et al. (2007) found that that heroin maintenance was more effective than methadone regardless of the treatment group (unsuccessful in treatment or not in treatment) or supplemental treatment condition (psycho-education or case management). These findings provide further evidence of the effectiveness of heroin maintenance independent of accompanying treatments and supports. Strang et al.'s (2010) comparison of injectable methadone and injectable heroin found a greater proportion of patients responded to injectable heroin which suggests mode of administration is not a significant factor in the superior effectiveness of heroin maintenance compared to methadone. Supporting this conclusion is their additional finding that injectable methadone did not achieve more positive results than oral methadone.

### **7.3.2. Pragmatism and the Practical Benefits of Introducing Heroin Maintenance through Research Studies**

The desire for scientific evidence on the efficacy of heroin maintenance was not the only reason for first introducing the treatment in the form of clinical trials. Introducing heroin maintenance through clinical trials was also motivated by practical concerns. In all the countries considered here, with the exception of the UK, it was illegal to prescribe or administer heroin in medical practice. The only instance when heroin could be used was in the context of a scientific study. It was through this mechanism that the clinical trials in Switzerland, the Netherlands, Germany and Canada were implemented. Although there were many hoops to jump through to get the clinical trials approved, this avenue was likely more feasible than trying to first change the narcotics laws to introduce the treatment. Moreover, the results of the research provided the case needed to convince governments to revise their drug laws. As one German interviewee mentioned, trials were also a way of gaining social acceptance for heroin maintenance:

[T]he political question was do you need to have a clinical trial to show that heroin assisted treatment is effective or is it not sufficient that the effectiveness has been proven by other countries? And then all you need is just a change of the laws and can have it introduced. So that was a political debate in the 1990s. But I think, to those that were in favour of just changing the laws it became quite clear to them that this was the way to go through. That going through a clinical trial you will get more acceptance in society.

The above quote suggested an expectation that decisions to use heroin maintenance would be, in part, pragmatic and based on the available evidence rather than driven entirely by ideology. However, there was some suggestion among Canadian interviewees that although European countries were pragmatic in their approach, Canada was not,

Because in Europe, they have this great ethic, you know, they try stuff. Doesn't work? They stop it. We can't even try stuff. Oh no, can't do that. Oh no, no, no. This might happen. There's 101 reasons why you can't do an injection room. There are 101 reasons why you can't do NAOMI. In Europe it's more like, well, let's see if this works. And they try it. Oh, that didn't work. There's needle park in Zurich. Oh, that didn't work. Let's get rid of that idea, and come up with a better one, right? We don't have that ethic over here. We're way too cautious.

Other Canadian interviewees were more hopeful. They saw the NAOMI trial as part of a growing trend in the addiction treatment field towards more evidence-based practice and thought that heroin maintenance would become a routine treatment option in Canada, assuming the results were positive (as they were). For instance, when asked if he felt heroin maintenance would be adopted as a routine treatment, one interviewee responded,

Yes, I hope that it would [become a routine treatment]. If the study shows, if the study follows the same kind of outcome or gets the same kind of outcome as the Dutch and Swiss and other studies have, then I think ethically and clinically it clearly demonstrates that there is an alternative treatment modality there.

Another reason for introducing heroin maintenance through clinical trials was that heroin is not an approved medicinal product in the countries considered here, other than the UK. For heroin to be used in medical practice outside a research setting it must be registered. If it is not, physicians who use it face the risk of being accused of malpractice by their College of Physicians and Surgeons. To have heroin registered as a medicinal product for use in the treatment of addiction, it was first necessary to establish its effectiveness and safety profile. Indeed, participants from Germany and the Netherlands, who had just completed, or were working on, getting heroin registered at the time of the interview, felt this registration was a far larger hurdle to overcome than amending the drug law. One Dutch interviewee indicated:

Let say it is technically accepted. But the registration authority didn't want to fully register it because they still have some legal procedures that they have to finish. Like, it says in their jurisdiction, it says that heroin cannot be prescribed as a medication. Many other opiates can but this one cannot. So they have to change that part of the law. Which is very simple to do because it is being registered so it has been shown to be effective and safe so they just have to make this little change.

He went on to suggest, "you don't want to know what registration needs. You can fill the whole room, not the floor but the whole room with the amount of paper to get through a registration. It is unbelievable". Once heroin was registered, the change in the drug law was relatively simple. It was more a matter of politics than science. A German interviewee suggested, "Now the situation is that you have a big trial, international trials. Evidence at the highest level of methodology and they know now that it is a political decision. It doesn't have anything to do with addiction treatment".

The UK, of course, was in a different situation. Heroin could be legally prescribed in the treatment of addiction by specially licensed practitioners. In their case, they were interested in testing the Swiss model of supervised heroin maintenance. Traditionally, drug users maintained on heroin in the UK were allowed take home doses or received daily doses from pharmacists. The Swiss model required patients to visit heroin clinics two-to-three times a day for onsite administration in a highly controlled clinical environment. It also targeted a small subgroup of addicts. The interviewees from the UK suggested one of the reasons why heroin maintenance had become increasingly rare was that doctors were uncomfortable prescribing it because of the risk it would be diverted to the black market. For instance, one interviewee suggested,

[D]octors really didn't want to prescribe heroin before so it was a bit ridiculous that the home office came up and said that you should have more heroin prescribing but actually doctors were never happy to do it and they weren't happy to do it because of the concerns around diversion that had started back in the 60s because all of this time clients were able to take their drugs home and none of it has ever been supervised so you can see that it has been a huge concern and also dosages have been fairly low in comparison to Swiss doses and Dutch doses etc. They were an average of 200mg a day in comparison to 500mg a day was very rare. This was because doctors were very concerned about divergence so they were keeping the doses down.

There was reluctance to use even methadone maintenance because of highly publicized incidences, such as children getting into their parents' methadone supply and methadone overdoses for which doctors were blamed.

[T]here was a big outcry in early 2000 about drug related deaths, this was related to methadone. Methadone was being diverted and doctors can be pulled up in front of our GMC, general medical council, and can't practice. So this is a concern for some doctors, they don't want to do what is wrong and they don't want their clients to then be feeding someone else's habit and the drug related deaths, there have been reports in the newspapers about kids getting hold of things.

The Swiss model of heroin maintenance was, therefore, an opportunity to test a solution to these concerns. Moreover, the Swiss model of heroin maintenance provided greater opportunities for accompanying psychosocial interventions which was in keeping with the official position on addiction treatment and maintenance prescribing in the UK.

As the above discussion indicates, the initial decisions to experiment with heroin maintenance were driven, in part, by a shortage of evidence on the effectiveness of the intervention. Later, the results of this research, as well as politics, influenced the decision to make heroin maintenance a routine treatment option. However, evidence on the effectiveness of heroin maintenance, or maintenance treatment in general, has played a somewhat limited role in the history of this intervention until relatively recently. For instance, there were no scientific studies on the effectiveness of maintenance treatment prior to Paulus and Halliday's (1967) and Dole and Nyswander's (1965) research on methadone maintenance in the 1960s. This situation indicates that consideration of effectiveness had little to do with initial decisions on whether to allow or ban maintenance prescribing. Somewhat ironically, the very drug control legislation that provided the framework for banning maintenance prescribing also provided the avenue for introducing methadone maintenance and heroin maintenance. The drug laws in each of the countries considered here included provisions for the use of restricted drugs for scientific research. In both Canada and the US, methadone maintenance was introduced through research studies. After initial studies by Paulus and Halliday (1967) and Dole and Nyswander (1967), the provisions for using restricted drugs for scientific research were used as an avenue for employing this treatment on a large scale. It became increasingly clear that the exemption for using narcotics in scientific research was simply a pretense for establishing methadone maintenance programs.

It is possibly that a similar strategy is being used with heroin maintenance today. For example, heroin maintenance was introduced in Switzerland, Germany, the Netherlands and Canada through the same exemption for scientific research. Although the intervention was limited to two clinics in Canada, in Switzerland it was used much more often with 23 clinics. Additionally, Switzerland's original research began in 1994 whereas a permanent change to their drug law to allow for heroin maintenance to be used outside of a research setting was not made until 2010 (Switzerland Federal Office of Public Health, 2010). Although there was a genuine interest in assessing the effectiveness of heroin maintenance, it was also apparent that these provisions were widely used as an avenue for making the treatment available. If there continues to be an increasing number of clinical trials on heroin maintenance it may be safe to conclude that history is repeating itself.

On the other hand, governments and drug administration agencies allowed both methadone and heroin maintenance to be introduced and expanded through research studies because the treatment could be used without making a lasting commitment to it. Exemptions to the drug law for scientific research are time limited and making heroin maintenance a routine treatment option requires a permanent amendment to drug control legislation. As such, research studies designed to assess the effectiveness of maintenance treatment were a means of testing the water for public and political receptiveness to this intervention. An added benefit to this approach is that the government can be seen as adopting an evidence-based approach to drug policy. Perhaps more importantly, it was also an opportunity to portray governments as actively responding to drug use crisis in 1960s and 1970s and communicable disease crisis in the 1990s. For instance, as discussed above, in Switzerland, heroin maintenance was presented as a key initiative in the country's efforts to disband open drug scenes and respond to rising rates of HIV/AIDS. In this way, even research and evidence on effectiveness of maintenance treatment is political and has been employed to advance a particular drug control agenda.

Once evidence on the effectiveness of maintenance treatment begins to accumulate it becomes increasingly difficult for governments to abandon this treatment option. Abandoning maintenance treatment is particularly difficult in the current environment that demands state funded programs and initiatives produce evidence of their performance and outcomes. For instance, methadone maintenance's beginning as a series of research studies resulted in a large body of evidence on its effectiveness. In the 1970s and 1980s, both Canadian and American governments were sceptical of this treatment. It did not fit with their traditional prohibitionist approach to drug control and they showed signs that they would like to abandon the treatment. Nevertheless, they could not completely ignore the growing body of evidence that this was one of the only ways to effectively treat heroin dependence. Because of this, there was a grudging acceptance of the treatment. Rather than returning to a complete ban on maintenance treatment, methadone maintenance was severely restricted by limiting its use to authorized clinics and physicians and implementing entrance criteria and dosing limits (Rettig & Yarmolinsky, 1995; Heroin Maintenance, n.d.; Health Protection Branch, 1972; Fischer, 2000).



Official skepticism of the value of methadone maintenance also led to further research on this intervention. Indeed, the need to prove the value of this treatment has resulted in methadone maintenance being the most studied addiction intervention. Overall, methadone is considered an effective treatment for opioid dependence. The research evidence appears to be strongest with regard to methadone's positive impact on treatment retention and reduced illicit heroin use (Amato et al, 2005; Connock et al., 2007; Health Canada, 2002; Mattick, et al. 2009). There is also some evidence that methadone maintenance leads to improvements in physical and mental health, social functioning, quality of life, criminal involvement, use of other illicit drugs (other than heroin), risk for communicable diseases, and reduced mortality (Health Canada, 2002; Maremmani, Pani, Pacini, & Perugli, 2007; Ponizovsky & Grinshpoon, 2007). The strength of evidence on the effectiveness of methadone maintenance has, in some regards, paved the way for heroin maintenance. If methadone can achieve positive outcomes it is reasonable to assume that other forms of maintenance treatment, including heroin maintenance, will also achieve positive results. However, despite the overall effectiveness of methadone, a significant proportion of opioid dependent persons do not respond well to this treatment. These individuals tend to be chronic, treatment resistant users or individuals who simply cannot tolerate the drug (Fischer et al., 2002; Veilleux, Colvin, Anderson, York & Heinz, 2010). Awareness of the limitations of methadone has motivated calls to experiment with other forms of maintenance treatment, including heroin maintenance. The idea that heroin maintenance can be used to fill in a treatment service gap left by methadone maintenance is explored in greater detail below.

#### **7.4. Framing the Intervention**

How heroin maintenance is framed is important to whether it is accepted as an appropriate addiction intervention. For heroin maintenance to be adopted, it needs to be understood as an intervention that is compatible with commonly accepted views of addiction and drug control. History has shown that it must be framed in a manner that is palatable to key players in this field, such as politicians, government bureaucrats, law enforcement and professionals interested in addiction treatment. Failure to situate

heroin maintenance in the dominant discourse on addiction and drug control of the day can, and has, led to this treatment option being rejected. Failing to situate maintenance treatment in the dominant discourse is one reason why any form of maintenance treatment was largely unavailable until 1960s and why heroin maintenance was not used outside of the UK until the 1990s. Present day advocates of heroin maintenance have been successful in making this treatment more acceptable to a mainstream audience by constructing it as a highly specialized, medical intervention.

In this regard, heroin maintenance can be viewed as part of a larger trend toward harm reduction becoming more mainstream. Some authors have argued that as harm reduction has been taken up by public health professionals it has been constructed as a value neutral, non-judgemental response to drug use. In doing this, the harm reduction movement has distanced itself from earlier critics of prohibition and calls to respect the rights of drug users once associated with the movement (Roe, 2005; Smith, 2012; Hathaway, 2002). Also, as harm reduction has become more mainstream it has increasingly focused on the most severely addicted, problematic drug users rather than promoting responsible drug use in general (O'Malley, 2008; Roe, 2005). Focusing on the most problematic users has resulted in the further medicalization of drug control and aligned harm reduction with a chronic disease model of addiction. This alignment with a chronic disease model has led to an increase of control over drug users (albeit medical control) rather than the reduction of control some advocates of harm reduction initially envisioned. Some authors suggest aligning with a chronic disease mode has also come at the expense of recognizing the social conditions and inequalities that influence addiction (Roe, 2005; Smith, 2012; Hathaway, 2002). This approach of focusing on a small group of the most severely addicted and problematic users is similar to a larger trend Garland (2001) observed in crime control in late modernity. He argues that in an increasingly politicized and populist policy environment crime control efforts (at least those undertaken by the state) have focused more on extreme forms of criminal behaviour (i.e., violent attacks or child abductions by strangers) that are viewed as the greatest threat to public safety, even if they are a rare occurrence. In this environment, the perceived need to protect the public from these types of crimes can result in interventions that would have seemed unjust or uncalled for under a penal-welfare model of crime control.

#### **7.4.1. A Highly Specialized and Limited Intervention**

Similar to the trend noted by Garland and the critical harm reduction literature, heroin maintenance, as it is understood today, is designed for the most problematic heroin user. A number of interviewees suggested the recent success of heroin maintenance is due to the intervention being effectively constructed as a highly specialized and limited treatment. In all countries, the treatment is only available for the most chronically dependent, treatment resistant individuals. Some interviewees made it clear that it was only a small percentage of heroin addicts who would be treated in these clinics. For instance, one Swiss interviewee suggested,

[I]t is about 5% of the heroin addicts are in the heroin maintenance treatment. So it is a small group. About 18000 or 17000 methadone maintenance treatment, 1300 [in] heroin. So it is a very small selection. ...at the beginning it was for the heavy users and really heavy users with the also the mental disease and the mixed consumption. They are not able to enter in such an organized institution, you have to come three times a day if you are injecting. You have to keep all the appointments with everybody, doctors, psychotherapists, social workers, and so on. So, a lot of the real heavy drug addicts they are not for, for them it is not possible to receive heroin. So it is the selection for most of them methadone failed and it is an alternative but in this way, how it is prescribed, it is only for a small group.

In Canada, the NAOMI study had a long list of eligibility criteria that severely restricted who could participate in the trial (Gartry et al., 2009). The study was restricted to individuals who were 25 years or older; who had been addicted to heroin or other opiates for the past five years; who had been injecting heroin for the past year; who had tried but failed in addiction treatment twice and who were not enrolled in methadone maintenance in the prior six months; and, initially in the Vancouver site, lived within one mile of the clinic (NAOMI, October 17, 2008). Indeed, extremely restrictive eligibility criteria contributed to difficulties recruiting participants to the NAOMI trial and excluded individuals who may have benefited from the treatment (Gartry et al., 2009). For instance, one Canadian interview indicated that some of the NAOMI trial's problems were related to their eligibility criteria as well as misinformation about the study and difficulties reaching the appropriate participants:

First of all leading up to it in all the consultation we did everybody from the drug users to treatment providers to researchers all said, there's no problem, there's going to be a lot of people, as soon as you start the trial you're going to be flooded with requests. It turned out not to be the case. We had thought that the media coverage, that would get the information out. Most of the target population for the study apparently don't read the newspapers or watch TV very much, so we had to find different ways of communicating with that community. There was a lot of mistrust amongst the community about what the study really was about. There were a lot of rumours that had to be dispelled that weren't true about the study. And then there were criteria built into the study, some for scientific reasons, and some for political reasons.

So we required that people had been on methadone previously, but were not currently on methadone, and that when they were on methadone before they'd had an adequate period of dosing 60 milligrams a day for 30 days in a period of 40. So we operationalised that in the end. And the, lots of people who called and wanted to volunteer were ruled out because they were currently on methadone and injecting heroin every day. They would have been eligible for the German or Dutch trials, but they weren't eligible for ours. They were on methadone in the past, not of methadone now, but they hadn't ever been on 60 milligrams a day for long enough, or they'd never been on methadone and they weren't going to ever go on methadone. So those were big challenges around recruitment.

Other studies also had difficulty recruiting participants. Similar to Canada, strict eligibility criteria created some problems in recruiting participants into the German trial. One German interviewee suggested,

The problems we had with recruitment had to do with the exclusion and inclusion criteria. You know it was pretty high and a lot of things were expected of these people. When we included them for instance there was very extensive testing of every part of their bodies and there were many meetings they had to come to. We are talking about the most severely dependent patients. For them to be in such a structured environment, it didn't go very well. We had, the initial plan was to get the recruitment finished within half a year in each centre. Then what happened, each centre started at different times so that expanded the recruitment time and then the recruitment in Hamburg took over a year and a half instead of half a year. So there we had, we definitely had a lot of problems. We basically had to go out into the drug scene and talk to people and ask them whether they had heard about this site. There were a lot of myths about heroin not being good stuff in the trial and all these things like that.

Conversely, other studies did not appear to have the same problems recruiting patients. For instance, one Dutch interviewee suggested they had no difficulty recruiting

participants to the smoking arm of their trial but had some difficulties with recruiting injection drug users for the other arm. This difficulty, however, was not the result of strict eligibility criteria but was due more to the small number of injection drug users in the Netherlands. For instance, this interviewee suggested:

No, that is to say, not with the smokers. With the injectors yes because when we started we still thought that it was about 30 to 70% but by the time we actually did the study it was 10 to 90%. So injectors were very scarce at that time. So we planned to have 250 in the injector study and we had 175 and we planned to have 375 and that is just what we got so it worked out nice. It was not difficult to recruit people. I must say it is not like everybody wants. Some people think that if you offer it that they will all come. That they will all want to go to the heaven drug addiction, that is not true. Many people don't want. There are many people who come and they see it and then they say it is not my piece of cake. So it is not, definitely not, something for everybody but it wasn't difficult to recruit people.

Another Dutch interviewee suggested they did have challenges in recruiting participants, which took longer than expected:

Well, not problems but what has been shown over and over is that recruitment goes slowly. And maybe problems in the sense that the treatment organization, they are maybe over estimating or too optimistic about recruitment of. So in all the cities, all treatment slots will be filled up. It will take more time at least for the treatment organizations expected it to take. It is partly because one of the criteria for being included will be eligible for heroin treatment is that they have been treated with adequate methadone doses and except for Amsterdam, but all other treatment organization in the Netherlands have had a long history of prescribing relatively low methadone doses.

#### **7.4.2. A Second Line Treatment Option**

The idea that individuals treated with heroin maintenance must have tried and failed in more mainstream treatment services was also important for the acceptance of this intervention. As one Swiss interviewee suggested, "it should never be the first line treatment. It should only be for people who have tried other treatment before and failed". In this regard, it is not meant to replace other forms of maintenance treatment but to supplement them. Many of the programs or clinical trials also include in their eligibility criteria that prospective patients must have been maintained on an adequate dose of

methadone in the past and continued to use street heroin. Consistent with the literature, many of the interviewees made the point that there were a significant number of heroin dependent individuals that did not respond well to methadone maintenance. Addressing this service gap was the underlying rationale for heroin maintenance.

For those people who methadone doesn't work, what are we going to do with them? You know, I mean, methadone physicians someone will say, oh, we didn't try hard enough. No. Some of them just don't want it. So, what are you going to do with them? This is a way out.

In this way, heroin maintenance is being presented as the last resort treatment, something akin to chemotherapy for cancer patients or a drastic surgery. One interviewee from the Netherlands describes his view of the treatment in this regard:

We don't think that heroin prescription treatment is a nice treatment. It is an ugly treatment, a ridiculous treatment. People have to come to your treatment unit three times a day...so it is not fun. We are not propagating it. It is for those patients who have been, it is the last resort...you are not proud of it, you do this because it is what is left for these people.

This perspective undoubtedly alleviates fears that heroin will become widely available to addicted individuals or youth and others using heroin recreationally. Under this new model of heroin maintenance there is no risk of returning to the days of script doctors where unscrupulous physicians were prescribing purely for profit or where physicians were responsible for creating new cases of addiction. Heroin maintenance is justifiable on the grounds that it is only available for the most hopeless of individuals.

### **7.4.3. Treatment Not Legalization**

By limiting the target population for the treatment, researchers and clinicians have also distanced heroin maintenance from the issue of legalization. Because the modern model of heroin maintenance is so specialized and limited, it is not easy to make the leap that it is a step in the direction of legalization. One interviewee from the Netherlands described the link between heroin maintenance and legalization:

I know there are people because they see treatment of these people as maybe a detour to get all drugs legalized. We are not belonging to that church. So if it doesn't work, okay we will stop...even if it works and it

works very well for treatment resistant heroin addicts it doesn't have any meaning for legalization of heroin...the results of this treatment study have no bearing on that issue...It is a very specific population and again they get their heroin in a very specific combination.

This quote reflects the larger trend within the harm reduction movement towards a value neutral approach to problematic drug use that was noted in the literature. Moreover, when heroin maintenance is understood as a limited intervention it does not pose a significant challenge to the dominant system of drug prohibition that exists in all the countries considered in this research. Rather, it is viewed as an additional tool to respond to drug related harms.

Present day understand of heroin maintenance also illustrates how harm reduction is becoming more medicalized. The clinicians and researchers involved in the NAOMI and SALOME trials, for example, speak of diacetylmorphine maintenance (the active ingredient in heroin) rather than heroin maintenance or even heroin assisted treatment, a term commonly used in Europe. These clinicians and researchers suggest diacetylmorphine is a medication and different from street heroin which includes additives. They are also vocal that the trials are not a step towards legalization, suggesting that only about 10% of the heroin addicted population would be eligible for this type of treatment (Gartry et al., 2009; NAOMI, October 17, 2008; Providence Health Care, n.d.[a]). Likewise, construing heroin maintenance as a limited, medical intervention does not undermine the position of abstinence as the gold standard in addiction treatment. It necessitates admitting that there are some individuals who will never overcome their addiction yet still preserves abstinence as the goal of most treatment programs.

Moreover, rather than increasing freedoms around illicit drug use, one interviewee suggested it is "depriving patients of some part of their independence" because of the onerous requirements of participating in the treatment. In this regard, heroin maintenance is a limited intervention not only in terms of the number of addicts this treatment is suitable for but also in the amount of control exercised by patients and physicians. Our experience with methadone maintenance has shaped modern conceptions of heroin maintenance. Methadone maintenance provided a model of treatment that could function within the confines of a predominantly prohibition or law

enforcement approach to drug control. It incorporated a high level of control of both addicts and physicians by only allowing registered physicians to prescribe methadone for maintenance treatment and only allowing limited quantities of the drug to be taken home by addicts who proved themselves trust worthy. A similar but even more restricted treatment model is now associated with heroin maintenance. In all of the countries that studied heroin maintenance, specialized clinics are used where patients inject or smoke heroin under the supervision of the clinic's staff. No take home doses are allowed other than methadone in most countries. One exception is that oral heroin tablets are available for take home in Switzerland. Heroin maintenance is not part of the regular interaction between physician and patient but is much more tightly controlled.

Heroin maintenance, and maintenance treatment in general, has been equated with harm reduction. Although maintenance treatment was clearly used prior to the advent of harm reduction, it fits very well with the idea of trying to prevent and manage drug related harms through the promotion of responsible use rather than ending all use. Given the controversy that still surrounds harm reduction, association with this movement may have the effect of inhibiting the use of heroin maintenance rather than promoting it. Moreover, it may also undermine efforts to frame heroin maintenance as a medical intervention as harm reduction initiatives are not often conceptualized in this manner. However, advocates of heroin maintenance have consciously branding heroin maintenance as treatment rather than simply harm reduction. For instance, one Swiss interview indicated,

[W]e have the four pillars program in Switzerland. So we focus on four different topics. Prevention of course is a big topic, than the therapy. Heroin Assisted Treatment is in it. It is different because in other countries it is in harm reduction. We have it in the therapy because for us it is a therapy, with, here with, the heroin. With the heroin program we have a lot of psycho-social therapy and psychiatric therapy in the program, so we designate it therapy.

Similarly, a Canadian interviewee suggested heroin maintenance should be part of the treatment continuum,

And, actually, one of the things I learned was that the heroin maintenance programmes there that originally were... I mean, the blur between what's harm reduction and what's treatment is very, you know, I mean, we draw



these boundaries, right. I mean, in Hartford [?] in Switzerland and other places, I mean, the heroin maintenance programmes are, in effect, part of the treatment programmes. They just become part of the continuum and that's what we haven't done so well at here.

Constructing heroin maintenance as treatment rather than simply harm reduction has, arguably, been important to the present acceptance of the intervention. For instance, in countries that have adopted four pillar drug policies, heroin maintenance is included under the treatment pillar rather than the harm reduction pillar (Collins, 2006; Switzerland Office of Public Health, 2006). This alignment with treatment is important because treatment is a more traditional response to addiction. It enjoys wider acceptance than harm reduction. Greater support for treatment is particularly the case in Canada and the UK where harm reduction interventions are not as widely used. Treatment also implies recovery, whereas harm reduction suggests management, which is still an unacceptable end result for some. The provision of supports and services alongside heroin has also been instrumental in gaining acceptance for this treatment. In the words of one Canadian interviewee, "It's not the heroin that's making people better, it's the treatment. It's the programme. It's the contact with counsellors and physicians and all that sort of stuff".

#### **7.4.4. Heroin Maintenance as Crime Prevention**

Another common way advocates of the intervention have framed heroin maintenance has been to stress its crime prevention potential. Emphasizing the crime prevention potential of heroin maintenance aligns the intervention with the goals of drug prohibition which include crime and disorder reduction. It was argued that the treatment eliminated the need for acquisition crime and would remove individuals from the drug scene. For example, one Canadian interviewee made the point that "[Heroin maintenance] takes them out of the street trade and, you know, reduces that market, which is what it's intended to do". Likewise, speaking about Switzerland's research, one interviewee suggested, "Also important was that we had a study that proved that criminal actions really were reduced very good, or much....So this also helped them to convince people that it was really beneficial". Taking this even further a British interview

suggested heroin maintenance crime prevention potential was the primary motivation behind returning popularity of heroin maintenance in her country,

This sudden reintroduction to the idea that heroin prescribing might be a good thing and my belief is because of the crime agenda. So, with that we have the national guidelines, we have these recommendations for supervised clinics and everyone can agree that we should have one.

The crime prevention potential was important because heroin maintenance was now constructed as a small undertaking and not a rival to the predominant system of prohibition. Rather, it could facilitate the goal of law enforcement through crime prevention. Moreover, the crime prevention argument gave this treatment option value beyond the individual, extending its utility and benefit to the community. It also aligned it with the currently popular crime control goal of protecting public safety. This perspective was used to support the introduction of the heroin trials in 1990s and 2000s. For instance, the crime prevention angle was crucial to the RIOTT trial in the UK. In this case, the trial was initiated by a government interested in the crime prevention potential of heroin maintenance. Later, it was also instrumental in having the treatment move beyond clinical trials to an accepted second line treatment option in Germany, Switzerland and the Netherlands. Similarly, this argument used to support earlier proposals to experiment with heroin maintenance in Canada, such as that made by the Le Dain Commission and subsequent proposal by the BC Alcohol and Drug Commission in the 1970s (Commission of Inquiry into the Nonmedical Use of Drugs, 1973; Thomas, October 25<sup>th</sup>, 1973). In these cases it was not successful. This failure suggests that although emphasizing the crime prevention potential of heroin maintenance can be important to the intervention being implemented, it is not always sufficient. As discussed above, a variety of other factors also influence the use of this treatment.

## **7.5. Discussion and Conclusions**

The current use of heroin maintenance suggests that drug-related crises and epidemics can promote innovation in the field of addiction treatment. Both the results of the interview data and literature suggest the HIV/AIDS epidemic and problems with open drug scenes were the primary impetus behind research into heroin maintenance in

Canada, Switzerland and Germany. In these countries, the HIV/AIDS crisis sparked the realization that something other than law enforcement and abstinence-based treatment was needed to reduce drug-related harms. This realization, in turn, motivated drug policy reform, which included experimenting with heroin maintenance. The use of heroin maintenance stands out as a positive example of the impact of crises in an environment where there is a perpetual sense of crisis that often leads to highly punitive or repressive responses to crime and contributes to pervasive skepticism about the ability of governments to address drug problems. In countries that already had a more liberal approach to maintenance treatment, such as the UK and the Netherlands, this crisis was not viewed as critical to the introduction of heroin maintenance. For instance, the Dutch trial had more to do with an identified treatment need and longstanding interest in alternatives to methadone maintenance. Likewise, the RIOTT trial in the UK was introduced because of an interest in testing Switzerland's more controlled model of heroin maintenance and because of its crime prevention potential.

The HIV/AIDS epidemic did not prompt the US to re-think its longstanding ban on heroin maintenance. Their refusal to adopt heroin maintenance suggests that even in times of crisis, past traditions and entrenched approaches to drug control can limit what is considered an appropriate intervention. Clearly, ideology can stifle innovation. Indeed, a number of interview participants suggested a growing emphasis on evidence-based practice in the addiction treatment field paired with a tradition of pragmatism was also influential in the recent use of heroin maintenance. Where the US continues to base its drug policies on ideology, other countries were willing to take a more neutral view, testing the effectiveness of heroin maintenance before deciding to reject or implement the intervention. Arguably, pragmatism and the trend toward evidence-based practice in addiction treatment are more advanced in Europe than Canada. Because Canada's approach to drug control remains more cautious and ideologically driven, it is not clear whether heroin maintenance will be sustainable here. The sustainability of heroin maintenance is even more questionable now that rates of HIV/AIDS and overdose deaths have been brought somewhat under control and trends in drug use have moved away from heroin to crack cocaine and prescription drug abuse.

Heroin maintenance was first introduced as clinical trials or research studies to satisfy a tradition of pragmatism and establish its effectiveness, but also to be more politically and publically acceptable. A clinical trial is a time limited intervention and requires no lasting commitment. It can, therefore, be used to test reactions to heroin maintenance before fully endorsing it. Because of this tentative endorsement, there is less political risk for governments approving a clinical trial. Indeed, there is a certain amount of political capital in introducing heroin maintenance through a clinical trial. In an environment that values evidence and science, this approach allows governments to suggest their approach to drug problems is neutral and evidence-based. It also provides a positive response to the widespread pessimism regarding government's ability to effectively address drug problems. From the perspective of clinicians and researchers, clinical trials can be a means of making a controversial intervention such as heroin maintenance available in situations it might otherwise not be possible. It is also a way to work around drug laws rather than having to go through the process of amending the legislation. A similar strategy was used when methadone maintenance was first introduced to North America. In the case of methadone maintenance this strategy was highly effective, both in terms of the rapid spread of the treatment and in a establishing a strong evidence base for the intervention. There is also some indication it will be successful with heroin maintenance, at least in Europe. To date, many of the countries that have studied the effectiveness of heroin maintenance have made it a routine treatment option.

The successes and limitations of methadone needed to be established before heroin maintenance was truly feasible in Canada and abroad. Experience with methadone provided evidence that maintenance treatment was an effective intervention for heroin dependence. For the first time, there was research available supporting the use of maintenance treatment. As this body of research grew, it became increasingly difficult for those opposed to maintenance treatment to reject it on purely ideological grounds. This research also highlighted the limitations of methadone maintenance and it was not long before heroin maintenance was suggested as an option for addressing some of these limitations. At the same time, the introduction of methadone maintenance shifted the understanding of maintenance prescribing from a system of distribution to a treatment option. From this point forward, those advocating heroin maintenance have

framed it as a highly specialized and limited intervention, an avenue for crime prevention, and later as a means of preventing the spread of communicable diseases. This perspective does not challenge the dominant system of drug prohibition that exists in all the countries considered here, making it more palatable to key decision makers in drug control and addiction treatment.

## **Chapter 8. Action and Resistance: The Influence of Politics, Professions and Communities on the Implementation of Heroin Maintenance**

### **8.1. Introduction**

As described in the previous chapter, crises and epidemics can be a catalyst for change and motivate governments to experiment with controversial interventions such as heroin maintenance. When such experiments occur, evidence on the effectiveness of heroin maintenance and messaging around the nature of the intervention and anticipated outcomes are important for justifying the use of such a contested intervention. However, governments rarely act alone. The introduction of heroin maintenance required support and advocacy from a variety of stakeholders. This chapter explores the role of different actors in encouraging or inhibiting the use of heroin maintenance. It begins with a discussion of the role of local support and advocacy by communities and municipal governments. Next, it considers the impact of changing political environments and how the election of new governments can shape the course of heroin maintenance. At a broader level, the influence of international developments and pressures on the use of heroin maintenance is explored. Finally, the chapter ends with a discussion of the role that professions and experts have played in the use of heroin maintenance, considering issues related to competition among professions for ownership of addiction and protecting professional autonomy as well as having professional ambivalence toward addiction.

### **8.2. Public Perception, Local Support and Action**

As discussed in Chapter Six, a central tenant of Garland's (2001) characterization of crime control in late modernity is the trend toward an increasingly

bifurcated response to crime. He suggests there are simultaneous trends toward punitive segregation and preventative partnerships. He argues that as law enforcement focuses on more serious types of crime, communities and businesses have taken on a greater role in preventing and responding to minor crime and public disorder, sometimes in partnership with law enforcement. Heroin maintenance can be viewed as such a partnership, where medical and public health professionals have taken on a greater role in addressing the negative consequences of drug use. Preventative partnerships tend to be localized, or at least begin that way. This is certainly the case with heroin maintenance and, as such, it is important to consider the local conditions that facilitated the introduction of heroin maintenance in Canada and abroad.

### **8.2.1. Public Support for Harm Reduction and Treatment**

Results of the interviews carried out for this research suggest that in the cities where heroin maintenance studies were initiated there was a high degree of acceptance that there was some public or community responsibility to prevent drug-related harms and address the drug problems they were experiencing. There was almost unanimous agreement among individuals interviewed that there was a significant amount of public support for addiction treatment and harm reduction. For instance, one Dutch interviewee suggested, “there is no question that harm reduction is an accepted thing” and that “there are very few people who doubt that there should be treatment facilities for heroin or alcoholics”. Similarly, a Swiss interviewee suggested, “these days harm reduction is completely accepted”. Another Swiss interviewee indicated, “I think most of the people know now that harm reduction is something that we need”. Even in Canada and the UK, where harm reduction interventions are not as established, it was felt there was significant public support for harm reduction (even if it did not achieve the same level of political support). For instance, one Canadian interviewee suggested, “there is a growing recognition that prohibition is not working and willingness [to] be pragmatic. Harm reduction interventions could improve the situation”. To a certain degree, it appears past experimentation with other harm reduction initiatives and widespread acceptance of methadone maintenance eased some of the controversy around heroin maintenance. For instance, speaking of the Canadian context, one interviewee suggested, “by the time NAOMI came along, there was really not much controversy over it”.

## 8.2.2. Public Support for Heroin Maintenance

Widespread public support for treatment and harm reduction, of course, does not translate into unanimous support for heroin maintenance. Although the intervention enjoyed some support there were always pockets of opposition. For instance, one interviewee from the Netherlands described the issue of public support as follows:

Of course there will be those who disapprove and have the opinion that drug addicts should stop or be forced to stop. Should make themselves profitable for society. But I think there will also be groups of inhabitant who see or who are aware of the conditions that some of the addicts are living in and are willing to do studies to see what can be done to at least alleviate the problems.

Another Dutch interviewee made a similar argument but also indicated that overall there was significant support for heroin maintenance:

I think what you could say is also because like I said in December last year heroin was registered as a medicinal product and a famous internet company, planet internet, and on the day that it was announced they had it on the internet and also they wanted to know more about it and they did kind of a poll asking, what was the statement, government prescribing heroin should not become more crazy in this country. I mean scientifically it is not sound but there were two answering options. One was against and was in favour. And of course it is not a representative sample but almost 59% of them, it was almost 1000 homes, 59% were in favour of prescription heroin. But of course it is not everybody is in favour of it. There is also a group of citizens, in habitant of the Netherlands that will say, well it is nonsense, we just have lock them up and treatment them and they should live happily ever after. Ignore all the evidence from studies that have been built around heroin dependencies, or other kinds of dependencies, that have been kind of saying that you might be able to control but unlikely disappeared or cured.

Some opponents suggested heroin maintenance was not treatment but a continuation of addiction. In the UK, public opposition also appeared to be linked to the cost of the heroin clinics:

So, this is from the national newspapers and local people writing in, or people writing in, in general, saying this is a bad idea why are we spending all of this money giving people heroin and you should be spending it on curing people with MS or Alzheimer's or whatever.



Switzerland is in an interesting situation because they had a nationwide referendum in 1999 to decide whether to continue with heroin maintenance after their initial studies were complete. The country as a whole voted in favour of continuing the treatment (54%). In Zurich, the Swiss city with the largest open drug scene, 75% voted in favour of continuing the treatment. In the words of one interviewee, "Acceptance here in Zurich is really high. Seventy five percent, you never have it. That is how, only if you build a new school or something. That was really fantastic and we were surprised". This quote nicely illustrates the point that a number of interviewees made. They suggested that at a broad level there was mixed support for the idea of heroin maintenance. However, at a local level, there is greater support in those communities that were dealing with the effects of problematic drug use, such as public nuisance related to an open drug scene and public health crisis with high rates of hepatitis and HIV. It is this support that has been instrumental in establishing the heroin maintenance trials and, in the case of Europe, the continuation of this treatment. For instance, drug problems have been particularly acute in Vancouver and their municipal government has actively promoted harm reduction and supporting the NAOMI trial before it began. In 2001 the City of Vancouver's introduced 'A Framework for Action: A Four Pillar Approach to Drug Problems in Vancouver' (MacPherson, 2001). It brought the issue of harm reduction to the Vancouver public and became the city's guiding document on drug policy. It recommended expanding methadone maintenance, research into alternative maintenance medications for both heroin and stimulant users, and for the city to support a proposed heroin maintenance trial (i.e., NAOMI).

Local support for maintenance treatment has not always been forthcoming, even in the face of rising drug use or drug-related harms. For instance, the absence of local support for heroin maintenance played a role in the recent rejection of this treatment in the US. In June 1998, David Vhohov, from John Hopkins School of Public Health and who was also involved in NAOMI, originally proposed a heroin trial in Baltimore, Maryland. This proposal was quickly rejected by the state governor and bureaucrats. They suggested it sent to 'wrong message', particularly to youth. Initially, the mayor of Baltimore, who was a well-known advocate of liberal drug policy, suggested he was in favour of heroin maintenance but following significant public outcry withdrew his support. He reassured opponents of the treatment that no city funding would be given to such a

trial ('Test of heroin maintenance', June 10, 1998; 'Heroin maintenance quickly stirs outrage' June 12, 1998). He also censured his health commissioner from endorsing Vhohov's proposal. This situation suggests local support that was often vital to the implementation of the Canadian and European heroin trials was not forthcoming in the US, or at least not Baltimore. As such, academics, such as Vhohov, who supported assessing the value of heroin maintenance through a clinical trial, had little support to stand against critics from federal and state governments.

### **8.2.3. Media Coverage of Heroin Maintenance**

Media reports on heroin maintenance can shape and influence public perception of this intervention. News coverage of the establishment of heroin maintenance programs varied somewhat from country-to-country. In Switzerland, it was suggested that overall media coverage was positive from the beginning of their research into heroin maintenance. One Swiss interviewee made the point this positive news coverage was largely because of public pressure for the government to address the open drug scenes, "But really because of the big pressure that we had from the bad situation in public areas the coverage was very good... Of course you always have critics". Indeed, the extensive national and international coverage of Switzerland's drug problem moved the government to take action. Conversely, media coverage in Germany changed overtime. It became progressively more positive, "In the beginning, when the trial started the media was 50-50. Basically over the years it has become more and more positive. When the results came out it was far more positive, all positive". German interviewees also suggested their research received a significant amount of attention, as did the trials in Switzerland, the Netherlands and Canada. In Germany, the media even played a more active role in getting heroin maintenance established as a routine treatment option. One interviewee describes his experience with the media:

When I do interviews the journalists, they basically want to find ways to convince politicians that this is the right way. We get tips from the media on which politicians think maybe a little bit differently and maybe I should talk to him and stuff like that. So there is a lot of support for this treatment in the population in general. The opposition, despite the fact that it is very small, unfortunately is in control.

According to interviewees from the UK, the lead up to their trial did not receive a significant amount of media coverage. When information about the research did appear in the news, the coverage made implementing the clinics more difficult because it stirred up controversy over the location of the clinics and government funding for a program that provided heroin to drug addicts. For instance, one British interviewee suggested,

Up until recently there wasn't any, no one really mentioned it and then suddenly we had all this media and we would see things like, secret trial going on. You know that's stupid, it is not secret. So no one has really bothered about it particularly, besides locally, until of course the media has got hold of it but it has all died down again and there are other things that take its place.

#### **8.2.4. Choosing Locations and NIMBYism**

Although strong local support facilitated the introduction of heroin maintenance in Canada, Switzerland, Germany and the Netherlands, neighbourhood opposition to proposed locations for clinics was a significant barrier. This neighbourhood opposition was an issue in all five of the countries considered here in at least some of their sites. There were concerns that patients and their associates would hang around the clinic contributing to public disorder and crime in their neighbourhood. For instance, one Dutch participant described their experience with this opposition:

So then of course there was the opening of the treatment units. The NIMBY problem comes up. We are very much in favour of the treatment but not in my street because you know our street is very special. So it took a long time sometimes to get treatment units started.

Opposition was so strong in some instances that initially chosen locations had to be given up. In one site in Germany, a citizen's group took legal action to try to prevent the heroin clinic from opening in their neighbourhood. This legal action was unsuccessful and the clinic was eventually opened:

In Frankfurt they had a local, they had neighbourhood opposition to the clinic where it is now but there they basically went through. It took them sometime because they went through the legal dispute with the citizen's initiative about the location. They tried through the court to stop the opening of the clinic there. The courts said no it can be opened there and then the politicians said we are going to open it there and we are going to

have more police security in that neighbourhood. It took maybe two or three weeks and then there was no complaints anymore.

Given this opposition, significant effort went into consulting with neighbourhoods and quelling their fears about the clinics. Community liaison workers were hired, neighbourhood committees were formed to create a forum for community members to voice their concerns and receive information on the clinics. Mechanisms for making complaints were set up and rules were put in place to prevent public disorder problems around the clinics.

Similarly, securing sites for the clinical trial turned out to be one of the most significant challenges for the NAOMI trial. In Montreal securing a site was not an issue but in Toronto significant delays in renovating the proposed site contributed to the trial not going ahead there. In Vancouver, it took two years to select a site with a number proposed and abandoned. In one instance there was opposition from the surrounding neighbourhood that the site was too close to a daycare and that it was adding another service for drug users in an area that was already saturated with such services (Gartry et al., 2009). When a location for the clinic was finally identified there were still concerns from the surrounding neighbourhood that the clinic would act as a 'honey-pot', attracting additional drug users and crime and disorder to the area. Because of this concern, the City of Vancouver imposed a number of conditions on the clinic which Gartry et al. (2009) suggest reflect institutionalized discrimination against illicit drug users. The conditions included 1) establishing a 24 hour phone line for neighbourhood complaints, 2) a commitment that there would be no lines outside the clinic, 3) study participants all had to sign a 'good neighbour agreement' where they agreed not to loiter in the neighbourhood, line-up or meet people by the clinic, or deal drugs in the surrounding area, 4) setting up a neighbourhood advisory committee where community members could voice their concerns about the clinic, and 5) requiring that all participants in the study must live within one mile of the clinic.

Through these measures, the clinic overcame the longstanding argument against adopting heroin maintenance – namely that it would be a hotspot for public disorder, drug dealing and crime. The participants in this research were unanimous in suggesting that there were no or very few public disorder problems arising from the heroin clinics.

Any problems with aggression and overdoses occurred within the clinics themselves and were not common or overly serious incidents. Relatively quickly, community members quit attending neighbourhood committees. Very few complaints were received about the clinics. Any complaints were made were received shortly after the clinics opened and then disappeared. For instance, in Vancouver there were no calls to the 24 hour phone line and the neighbourhood advisory committee did not bring forward any concerns about the clinic. Moreover, a study of the community impact of the NAOMI trial found that the Vancouver clinic had no impact, either positive or negative, on drug use, public disorder or crime in the neighbourhood (Boyd, McLean, & Huhn, 2008). There were also no incidents of heroin being smuggled from the clinic, no overdose deaths and no serious incidents of aggression. The interviewees attributed the lack of any public disorder problems to the efforts of staff and patients taking ownership of the clinics. For example, one interviewee from Switzerland suggested:

And what you have to get at is that the patients are willing to take care of their clinic. They have to protect the clinic. And to do that they have to take care of the clinic. They can learn that, they do learn that. So that is not really a problem.

Neighbourhood opposition did not persist after the clinics were opened. Indeed, as one German participant pointed out, "All communities, there is not even one city in the Netherlands, Switzerland or Germany, that said, no we don't want this program any more. Not even one". A number of interviewees also suggested that initial opposition evolved into support for heroin maintenance and in some instances even advocacy for the program. Speaking about a clinic in Rotterdam, one interviewee accounts what happened when the program was discontinued for a brief time:

And during the third phase when they had to stop the treatment the neighbourhood was really mad at the CCBH. Saying what are you doing, you prescribe heroin and you can see that everyone is doing well and now you go take the heroin away and everyone knows what will happen. They will deteriorate. They will go back to stealing or what have you. So they really got the idea that the neighbourhood was considering the patients, as our patients.

This ongoing local support for heroin maintenance clinics undoubtedly contributed the success of European countries making heroin maintenance a routine treatment option.

### **8.3. Politics, Ideology and Political Change**

As the above discussion suggests, local support can go a long way in facilitating the introduction of heroin maintenance. However, in each of the countries considered here, the final decision on whether to allow heroin maintenance to be used in either a research setting or as a routine treatment was a decision made by federal governments. Because federal approval was needed for heroin maintenance, national political environments are also critical to the use of this intervention. The importance of federal support can perhaps be best illustrated by the recent experience of the NAOMI trial in the US. Not only did heroin maintenance lack local support, as discussed above, but there was also no national appetite for the intervention. For instance, shortly after the first Swiss heroin maintenance studies were completed, two well know opponents from Switzerland were invited to speak to a federal House of Representatives subcommittee. Their perspectives, as well as two American opponents of heroin maintenance, condemned the Swiss studies. Both Democrats and Republicans alike seemed to welcome their perspective (Reuter & MacCoun, 2002). In this environment, the NAOMI trial did not move beyond the preliminary planning phase in the US.

#### **8.3.1. National Political Environments and Federal Support for Heroin Maintenance**

Fortunately, in the other countries considered here, opinions on heroin maintenance were not always so one sided at the national level. For instance, Swiss interview participants noted that when heroin maintenance began in their country they experienced significant opposition from one conservative political party. One interviewee suggested, “We had a problem with heavy opposition from one political party, a very conservative one”. Because the trial was a government led initiative it went ahead despite this opposition. One Swiss interviewee indicated,

We have always had opponents, of course, but the full support of the government and maybe I can mention this. The government got courage when three of the major political parties made a common drug policy platform asking for harm reduction and new initiatives. Then the government figure out.

As discussed above, heroin maintenance was part of a larger drug policy reform meant to deal with HIV and open drug scene crisis in Swiss cities. This reform was driven by organizations working with drug users and municipal governments who advocated for a national drug policy that expanded treatment options and included harm reduction. Responding to this pressure, heroin maintenance was one of a number of new initiatives to be adopted under the country's four pillars drug policy, which was put forth by a coalition of three main political parties. According to one Swiss interviewee, it was quite unique to have three parties come together and support a mutually agreed upon drug policy. This political cohesion was instrumental in establishing heroin maintenance clinics despite opposition from the political right as well as neighbouring countries and the international community. This interviewee describe the coalition government responsible for as follows,

You had a coalition between the left parties and the parties in the middle at this time. They wanted to change the law completely and they wanted to stop the liberal approach and the central parties wanted to solve the visible problem. So we had for about 10 years we had a coalition between these two groups, these are not two parties, they are [a variety of parties]...So we have two main parties in the middle, one main party on the leftwing and one main party in the right wing. So the middle parties had a coalition, now it is over because at the end of the 90s the government wanted to allow, to stop the punishment of the consumption and they wanted to allow so, they wanted to control the cannabis plantation or [cultivation and trafficking]. And that was at the end of 90s there was majority agrees with this approach but....they couldn't realize this law at this time so the years past and the political coalition [ended].

The UK's heroin maintenance trial was also a government driven initiative but did not receive a considerable amount of national opposition. However, the circumstances surrounding the UK's trial were significantly different. For instance, one interviewee from the UK described how their trial was initiated as a crime control measure:

There was a fundamental belief for a variety of reasons that treatment reduced crime, so yeah, and so treatment was seen as a good thing... So now in 2001 the Home Secretary suddenly, and very bizarrely to all of us, came up with the idea that there should be an expansion of heroin prescribing. This sort of knocked everyone back. We have had no evidence for that at all but I am assuming that this came because of the Swiss and Dutch studies as well. I think particularly the Dutch study showed that there is a big reduction in crime and the home secretary and his team put together a though and said 'hey this is a good idea'.

In this regard, the UK trial was not the result of grassroots pressure for reforming drug policy nor was it a response to a specific crisis. It was also unique in the sense that it was implemented at a time when the British government was moving away from a more liberal drug control policy that emphasized harm reduction to what both British interviewees referred to as a 'war on drugs' or crime control model. The British experience suggests that heroin maintenance can garner some support other than simply from a harm reduction or disease control agenda. It can be feasible in policy environments that are less tolerant of individual use because of its crime prevention potential.

A favourable political environment and timing appear to have been instrumental in the establishment of heroin maintenance clinics in Canada, Germany and the Netherlands. Like Switzerland, there was pressure from municipal governments and organizations and individuals working in the addictions field to address high rates of communicable diseases, overdose deaths and public nuisance related to illicit drug use. Both German and Dutch participants noted that on a local level even conservative governments supported heroin maintenance because they had to deal with drug problems directly. One participant from the Netherlands describes their experience with support from local conservative governments,

I must say on a national level the Christian Democrats were very tough. On a local level they were not actually. They were dealing with it. It was a real problem for the alderman and the local political organizations. So I must say that on a national level it was difficult and on a local level we had very good collaboration with people of the Christian Democrats. And they were basically Christians who wanted to do good to their fellow countrymen. Be friendly and supportive to people who have a less good life than themselves. So actually this kind of Christian attitude was translated here in helpfulness but not on a national level where the ideology was more important than the actual.

On a national level, opposition to heroin maintenance primarily came from right wing, conservative parties. In the Netherlands there was also some opposition from their far left party as well. Fortunately, at the time the heroin trials were approved liberal governments were in power in Canada, the Netherlands and Germany. For example, one participant from the Netherlands suggested their heroin trial was possible because of a unique governing coalition at the time:



And it was in the mid-1990s that we had a government which was quite unique for Holland. It was composed of labour party and two kind of democratic, a little bit maybe conservative, liberal parties. For the first time, or at least the as far as I remember since the Second World War when we had the government without the Christian Democratic Party. It was quite a unique combination. And it was their government, the liberal government, who decided to set up the trial for prescribing heroin. So that was a political climate that was quite favourable to do all kind of new studies and interventions. It was not only heroin prescription; it was also a study that was initiated in the effectiveness of prescribing high dose methadone. Also, a study in the effectiveness of ultra-rapid detoxification, which is detoxification with naltexone under anaesthesia. So they really had a broad view, we were trying all these new things.

There was agreement among interviewees from each of these countries that had conservative governments been in power their heroin trials would not have went ahead.

### **8.3.2. Changing Governments and Waning Federal Support for Heroin Maintenance**

Although not one of the countries considered in this research, the experience of Australia nicely illustrates how a change in government was able to derail their proposed heroin maintenance trial. Similar to the countries considered here, Australia became interested in carrying out a heroin maintenance trial in the late 1990s. Motivated by widespread concern about illicit drug use, increasing numbers of overdose deaths, and HIV/AIDS, a governmental committee was appointed to inquire into illicit drug use, prostitution, and HIV/AIDS. They recommended establishing a trial to assess the feasibility of providing heroin to addicts on a controlled basis (Ostini & Bammer, 1993; Ali & Gowing, 2005). To this end, a four-year feasibility study on the proposed heroin trial was conducted and concluded that the benefits of such a trial would outweigh the potential risks. Two small-scale pilot projects were recommended to assess the safety of heroin maintenance and to offer a preliminary assessment of the effectiveness and feasibility of the treatment. Pending positive preliminary results and no pressing safety concerns, a larger randomized clinic trial would be carried out to compare methadone and heroin maintenance (Bammer & Douglas, 1996). Although the proposed trial was controversial, it had the support of many professionals, including the Australian Medical Association, police commissioners, prosecutors, and policy experts as well as local governments and many drug users themselves (Bammer & Douglas, 1996; Dance et al.,

1997). At this point, it seemed the necessary conditions to begin heroin maintenance existed. The principal difference appears to have been the election of a conservative federal government prior to the beginning of the trial. The new Australian government advocated a 'get tough' approach to illicit drug control that was supported by a conservative segment of the population that was increasingly opposed to harm reduction initiatives. They advocated increased enforcement and a greater emphasis on abstinence-oriented treatment. The new Prime Minister was opposed to the trial, claiming that it 'sent the wrong message'. Other opponents equated the trial with the legalization of heroin (Ali & Gowing, 2005; Wodak, 1997). In the end, the Australian federal cabinet stopped the trial suggesting that for it to proceed government would need to pass special legislation to import heroin. Apparently, they were not willing to pass such legislation. However, there was some debate over whether such legislation was actually needed. Both the Federal Attorney General and the Health Minister did not think it was (Wodak, 1997; Hall et al., 2002). This finding suggests that ideology and a changing political landscape prevented Australia from experimenting with heroin maintenance.

In the case of the Netherlands and Germany, a change in political landscape from a liberal governing coalition to a conservative coalition occurred while the trials were underway. This change in government meant that there were significant delays in getting the law changed to make the treatment available on a permanent basis. Interview participants from these countries indicated part of this delay was related to registering heroin as a medicinal product and determining how heroin maintenance would be funded. However, another significant reason for the delay was that a segment of conservative politicians did not support amending the drug laws to allow for heroin maintenance treatment to continue. As a result, it took significant effort and pressure from municipal governments to get the laws amended. Another challenge that Swiss, Dutch, and German interview participants all noted was a changing political agenda. In the years between when these countries began their research on heroin maintenance and when they reached the stage where they were advocating the programs be made a permanent treatment option, priorities in the drug abuse field had shifted. Problems with open drug scenes and communicable diseases had been brought under control. The focus was no longer on heroin dependence but had shifted to either growing crack

cocaine problems or youth alcohol and tobacco use. In Switzerland, it was suggested that heroin maintenance and drug policy in general was no longer on the political agenda. Being a low priority contributed to the delay in getting the drug laws amended. In this regard, it was not so much political opposition to heroin maintenance but its low priority that was the challenge.

Changing political environments and a declining urgency to address harms related to heroin abuse have also influenced heroin maintenance in Canada. Preparations and advocacy for the NAOMI trial began in the late 1990s under a liberal federal government. This government eventually agreed to grant the project an exemption from the *Controlled Drug and Substances Act* and fund the trial. However, a year into the three year trial the liberal government was defeated and a new conservative government took power. This change in government resulted in a shift in how the Canadian government responded to drug use and addiction. Similar to what occurred in Australia when they abandoned their trial, the current conservative government steered drug policy away from a public health model back towards a criminal justice model. For instance, as discussed in Chapter Six, they introduced a new Anti-Drug Strategy which no longer included harm reduction. They also withdrew federal funding for Vancouver's Safe Injection Site and actively tried to close the site down but were opposed, and unsuccessful, in the courts. With regard to heroin maintenance treatment, this government has taken action to ensure that former participants from the NAOMI and SALOME trials cannot receive heroin through Health Canada's Special Access Program.

Taken together, recent experience with heroin maintenance in North America, Europe and Australia suggests at least some level of federal support is necessary for this treatment to be adopted. A liberal political environment where there is strong support for reforming drug policy seems most conducive to introducing heroin maintenance. However, the experience of the UK suggests introducing heroin maintenance still may be possible in a conservative political environment if the view that treatment, and heroin maintenance in particular, is a useful crime prevention intervention. It should be noted that in this situation, the UK was not really 'introducing' heroin maintenance for the first time as the other countries considered here were.

Rather they were reintroducing the treatment and testing a more tightly controlled model of heroin maintenance. In this regard, the UK's experience is more akin to Swiss, German and Dutch efforts to have heroin maintenance approved as a routine treatment option. Conservative governments may be unlikely to initially approve heroin maintenance, as was the experience in Australia, but can be persuaded to allow the treatment to continue after it is adopted.

Alternatively, the difference in experience with conservative governments and heroin maintenance in these countries may be a matter of what 'brand' of conservatism is endorsed. Based on the information collected for this research, it would appear the European governments who made heroin maintenance a routine treatment (or reintroduced the treatment in the case of the UK) were neoliberal conservatives. A neoliberal political environment emphasizes fiscal responsibility and population-level goals rather than individual level outcomes. It also emphasizes risk management and responsible citizenship over moral agendas. In this environment, framing heroin maintenance as cost-effective and as an effective intervention for crime control was important. For instance, as discussed above, one of the main selling points of heroin maintenance was that it would reduce drug-related crime and disorder by eliminating the need for addicted individuals to be a part of the illicit drug scene and commit crime to acquire drugs. Not only is there a reduction in public nuisance and increased public safety but, in the long run, money is saved due to decreased criminal activity and using fewer criminal justice resources. Furthermore, the tightly controlled using environment reduces the health care costs of addiction by ensuring sterile injection equipment, pure heroin and, therefore, fewer negative health consequences and a reduction in the use of costly health care resources by addicted individuals. Results of research on heroin maintenance have shown that these cost savings are greater than the cost of the intervention itself.

Conversely, the Australian government that refused to endorse their proposed heroin maintenance trial was socially conservative. They were increasingly skeptical of harm reduction and placed greater emphasis on law enforcement and abstinence-oriented treatment. These developments suggest their drug policy was guided more by a moral perspective on drug use than by fiscal concerns or the need to reduce

population level risk. It appears Canada is now following a similar path as Australia. The Canadian federal government also appears to be returning to a moral model of drug control which may indicate a move away from a neoliberal political environment to one characterized by social conservatism. Rather than emphasizing the need to control drug-related harms through risk management strategies such as harm reduction, the federal government has returned to a discourse of eliminating drug use. This discourse has been accompanied by increased support for harsher penalties for drug offences and abstinence-based treatment. In this environment, even the crime prevention and cost effectiveness potential of heroin maintenance will be unlikely to persuade the federal government to make heroin maintenance a routine treatment option.

Nevertheless, although the current Canadian political environment is not particularly supportive of heroin maintenance, a court challenge to the recent changes the Health Minister made to the Special Access Program has the potential of ensuring the treatment continues to be available, at least to participants of the SALOME trial. Shortly after the change to the special access program was announced, Providence Health Care (who is also funding SALOME) and five trial participants initiated a constitutional challenge to this amendment to the Food and Drug Regulations. Currently this challenge is awaiting consideration by the BC Supreme Court but in the meantime the court has issued an injunction against the regulation which allows physicians to continue to apply to the Special Access Program for permission to treat patients exiting the SALOME trial with heroin (Providence Health Care, n.d. [b]; *Providence Health Care v. Canada*, 2014). Depending on the outcome of this decision and whether any additional court challenges are initiated to make heroin maintenance available to others in the future, this ruling, if set down by the Supreme Court, has the potential to shift decision making authority away from the federal government to provincial governments or health authorities. If the federal government is forced to allow heroin maintenance by the courts it will be incumbent on provincial governments and health authorities to fund the treatment.

## 8.4. International Pressure and Influence

Addiction treatment is, in many ways, a very local undertaking. Treatment services are often initiated in response to local needs and pressures. That being said, as part of a larger system of drug control, international pressures and developments also influence what treatment services are available. International influences have played a greater role with heroin maintenance than other treatment options because of concerns around whether it violates international conventions. The contested nature of heroin maintenance has also contributed to its international profile. In some situations its use has garnered international media attention and it often attracts both international opponents and supporters. International influence can have either a positive and negative impact on decisions to use heroin maintenance.

Recently international influence has been primarily a positive force, encouraging the adoption of heroin maintenance. For example, a number of interviewees mentioned that the ability to drawing on the experience of others has been instrumental in recent developments in heroin maintenance. The Canadian, British, Dutch and German trials were all motivated by the original Swiss studies. There was significant international interest and media coverage of Switzerland's initial research. Others soon became interested in building on the knowledge base Switzerland had started to develop by beginning their own research into the efficacy of heroin maintenance. There was also the need to determine if Swiss results could be achieved in different social settings with unique drug problems. In this regard, Switzerland was a pioneer in the field. At the same time, Switzerland also drew on the experience of the UK in setting up their research. Although heroin maintenance was rarely used in the UK, a limited number of physicians still prescribed heroin. According to one interviewee, one doctor in particular attracted the attention of Swiss clinicians and researchers. The doctors practice of prescribing heroin seemed to be associated with low HIV and crime rates in the region where his clinic was located. These low rates of crime and HIV sparked the idea that heroin maintenance might be a useful strategy for addressing Switzerland's drug-related problems. He suggests:

But, then in 1990 we heard about John Marks in Liverpool and he as prescribing and he was most of the time a consultant of a psychiatrist in

Warnington which is a region of Liverpool and surroundings. And he worked with drug addicts roughly 1 day a week and he had a number of people on heroin prescription and he also was very convincing because of his conceptual framework. He says that to go from consultancy, he originally wanted to start a heroin prescription program based more on methadone and he thought that before I do it I will collect some data to prove it is best so if he prescribes heroin and then he finds out that, interestingly, the only district there was no heroin seen and it was not possible to buy heroin was the district where he was prescribing heroin. This was a police statistic. So the police were very fond of John Marks' prescription.... then finally Uchtenhagan went to visit him in Liverpool and then there was more and more pressure politically because of the open drug scene so the idea was to test new ways to deal with the problem and to test new ways meant that there should be an evaluation of safe injection facilities and to look at all of these projects and that we could start a heroin trial.

Similarly, establishing heroin maintenance programs was being discussed in other countries when Switzerland began their research but none had moved ahead to realize the idea. Switzerland, in essence, broke the moratorium on heroin maintenance. The introduction of the Swiss research had a domino effect. Once one country adopted heroin maintenance without any significant problems and positive results it became easier for other countries to follow suit. For instance, heroin maintenance was being considered in Germany from the early 1990s but initial proposals were rejected. The Swiss, and later the Dutch, research emboldened German scientists to take up the issue again and this time the federal government approved a heroin maintenance trial. Likewise, German interviewees felt that the fact the Netherlands had registered heroin as a medicinal product would lend support to their efforts to do the same. Similarly, interview participants from Canada suggested because they were able to learn from their European colleagues there were few practical challenges they were not prepared for when they established the NAOMI clinics.

International developments have not always had been a positive force supporting the adoption of heroin maintenance. For instance, Switzerland experienced significant political backlash for choosing to study heroin maintenance on an international level. One interviewee mentioned they experienced "heavy counter attacks from America and the WHO" to the extent that they were kicked off of international committees. The World Health Organization (WHO) tried to find every international law to stop the research but

eventually had to accept the trial. One interviewee described how events with the WHO unfolded:

And then we had a WHO committee, they invited a committee to have a look at these programs and they looked at everything and they formed standards, standard operating procedures for every detail in the trials. Finally, they couldn't find anything bad so they criticized the research protocol because it basically had no proper control group, which is true. And then they recommended that, despite the fact that it worked for Switzerland, no other countries should copy it. And if you really want, if another country wants to start heroin prescription, they should also do it in a [clinical] trial. So, that is why we have a repetition of this trial in Holland, in Germany, in Canada, in Spain.

Although other countries had to deal with international opposition to heroin maintenance, it was not as intense as what Switzerland experienced. All of the trials or programs are monitored by the International Narcotics Control Board.

## **8.5. Professional Influence, Expert Activism and Medical Ownership**

As the above discussion indicates, many different groups ranging from community organizations to international agencies can influence the introduction of heroin maintenance. The role of one group not yet discussed is that of professionals and experts in the field of addiction treatment or drug control. As discussed in Chapter Four, advocacy (or the lack there of) by the medical profession for maintenance treatment to be allowed appears to be the principal reason for the difference between the UK's approach to this treatment compared to Canada and the US in the early 20<sup>th</sup> century. Yet by the mid-20<sup>th</sup> Century organizational struggles over ownership of addiction and drug control had largely ended. Rising rates of drug use made it increasingly obvious that the expertise and resources of various different professions were needed to address this problem. Moreover, this was the height of what Garland (2001) refers to as penal welfarism, which is a system of control that relies heavily on experts.



However, Garland (2001) also argues that in late modernity the role of experts and professionals have been devalued. He suggests that this is linked to the trend toward increasingly political and populist policy environments and sustained skepticism of the criminal justice systems ability to address crime problems. However, it is arguable that experimentation with heroin maintenance in the 1990s and 2000s was in large part an expert driven initiative to consider this treatment modality, particularly in Canada. For instance, Canadian interview participants made the point that the NAOMI trial was planned, initiated and run by a group of private clinicians and researchers. Although the Canadian Institute of Health Research funded the trial and Health Canada provided the necessary approvals to run a clinical trial and to import heroin for the study, NAOMI was not a government run initiative. No government agency or health service administered the trial. Indeed, in Vancouver at least, the clinic where the heroin maintenance program was delivered was a standalone service. The Canadian trial was unique in this regard. This may suggest that professionals continue to play a greater role in drug control in Canada than Garland found they played in crime control in the UK and the US. It is perhaps not coincidental that the RIOTT trial in the UK was initiated by the national government and that the US chose to abandon the NAOMI trial early on in the planning process, seemingly on political grounds.

The role that experts played in the introduction of NAOMI may simply be attributed to the continuation of some elements of penal welfarism where the role of experts and professionals are elevated above others. This explanation seems unlikely because of the incongruity of elements of penal welfarism with heroin maintenance discussed above. A more plausible explanation is that public health experts have come to replace criminal justice experts on issues related to the harmful health impacts of illicit drug use. This can be seen as an extension of the trend toward defining down minor drug offences which have moved addiction further into the domain of medical or public health control. In this regard, the transfer of expert authority from criminal justice actors to health care providers is not akin to the power struggles that took place in the first half of the 20<sup>th</sup> Century. Rather, this transfer of authority is perhaps more aptly described as the voluntary relinquishment of this role. This can offer some explanation as to why police have generally been supportive of heroin maintenance treatment. This support is

particularly strong at a local level where the police are feed0up with dealing with illicit drug user and the accompanying harms and public disorder.

### **8.5.1. Support for Heroin Maintenance from Addiction Service Providers and Other Advocates**

Even in Europe, where the trials were often part of larger programs of drug policy reform and were often linked to existing addiction or health care services, the initial idea that heroin maintenance might be a useful way of addressing drug related harms came from addiction service organizations. For instance, one interview participant from Switzerland suggested that the initial idea to experiment with heroin maintenance came from non-governmental organizations providing services to addicts and physicians who were beginning to realize the shortcomings of the model of methadone maintenance used in Switzerland at the time. According to this participant, it took years and problems with open drug scenes and HIV to get the government to seriously consider this suggestion. He describes this situation as follows:

And, initiatives to change the treatment came from GPs and private institutions. For a long time we had to fight against the government to run the clinic. And, step by step they started to accept these forms of treatment. Low threshold methadone maintenance treatment. We started it and a couple of years later the governmental run clinic they started too. They changed the system. So, we had these two all new approaches, not out of the official medicine, medical clinics. The politicians, they started to accept these new forms of treatment or approaches. With the first injecting room, it was an illegal injecting room in the youth center in the ... of Zurich. And, this center was destroyed by the government. One part was because of this illegal injecting room. Ten years later the town started with the official injecting room. So, that was the normal development. So, the official or governmental run clinics they were always one step behind.

The situation in the UK was somewhat different. Their government came up with the idea of studying heroin maintenance and approached the research and clinicians involved to develop a clinical trial.

Moreover, from the 1960s onwards other players were increasingly involved in the field of drug control and addiction treatment. These other players included

academics and researchers as well as non-medical service providers (i.e., social workers) or treatment organizations. These new players are now recognized as experts in the field of addiction treatment. As such, their opinions on maintenance prescribing are listened to and given some credence. Indeed, when the heroin trials were introduced in Europe and Canada, it was not the medical profession alone that spurred this intervention. Academics and service providers (proponents of harm reduction) played a large role in establishing the trials as well. Organizations working with drug users were vocal in advocating for heroin maintenance. The involvement of different players suggests advocacy from a professional group with expertise in the field of addiction treatment is necessary for heroin maintenance; however, the profession involved does not need to be the medical profession. Medical profession leadership was important in the past when there were no other groups to advocate for drug users. It is less important now when there are other experts in the field that can take on this role. Of course, the medical profession will always play a key role in maintenance prescribing because they are the only group allowed to prescribe narcotics. However, academics and other service providers can play an important role in advocating for maintenance treatment.

The methadone providers, the clinical community, weren't very supportive in some places, especially Vancouver. They argued that we should have more availability of methadone and better quality methadone before we spend money on researching other options. That doesn't apply in any other part of medicine. If we took that approach to hypertension we'd only have diuretics and no other blood pressure pills. So I think they were challenged around values and philosophy of addiction treatment. For some of them there was concern about income, competition, treatment, but mostly it was a philosophy kind of thing.

### **8.5.2. Police Support for Heroin Maintenance**

The 1960s and 1970s not only saw greater involvement by the medical profession in the treatment of addiction in North America and the introduction of some restrictions on maintenance prescribing in the UK, but also marked the end of the Canadian drug administration and law enforcement actively trying to prohibit maintenance treatment. Indeed, there was agreement among the interview participants that the police were supportive of studying heroin maintenance and this support helped

convince governments to adopt this treatment. For instance, one Canadian interviewee suggested, “The police have been very supportive of NAOMI. So that’s ideal, you know, you have an intervention, it’s an innovation, and controversial, yet the police get it, that it will reduce crime if it’s successful”. Similarly, other Canadian interviewees indicated:

And the RCMP supported it, whereas they opposed the supervised injection site. The Vancouver Police Department was supportive. The justice people had no trouble seeing this as a treatment and understanding that if you provide people with drugs and they don't have to commit crimes to go in and buy drugs, it's going to be helpful from their perspective.

The RCMP who sort of seem to sway the Conservative Government a lot, actually found it a lot more acceptable to have people taking medically supervised heroin under care and supervision than they did having them... injecting illicit drug through clean needles.

Interviewees from Switzerland and Germany suggested that there was some initial opposition from police, particularly on a national level. Similar to local politicians, local police were more supportive because they were dealing with open drug scenes directly. According to one Swiss participant:

The local police were usually quite in favour of these programs because they didn't know what to do with all these drug addicts hanging around in their parks. But it was more at the conceptual level that there was a lot of problems with the police.

Swiss and German interviewees also suggested that police were sceptical at first but as research on heroin maintenance progressed, support grew among law enforcement. All the individuals interviewed for this research reported that there were almost no public disorder problems associated with the heroin clinics and only minimal difficulties with aggression in the clinic. Moreover, there were few incidents of staff or patients trying to smuggle heroin out of the clinics. Security protocols were extensive in every country. This high level of security likely contributed to support among police for heroin maintenance.

## 8.6. Discussion and Conclusions

This chapter outlined the roles different groups can play in supporting or opposing the use of heroin maintenance. Some of these groups clearly have more power to influence decisions on whether to use heroin maintenance or not. For instance, in all countries considered here research into heroin maintenance needed the approval of federal governments. Because federal approval is needed, national political environments can play a large role in whether heroin maintenance is adopted or not. Both the experience of the US and Australia demonstrate that a lack of federal support can end efforts to implement heroin maintenance. Liberal governments were in power when research into heroin maintenance was initiated in Canada, Switzerland, Germany and the Netherlands. It appears a liberal government that is supportive of reforming drug policy may have been necessary for heroin maintenance to proceed. However, the UK began their research and Switzerland, Germany and the Netherlands made heroin maintenance a routine treatment when conservative governments were in power. The experience of these countries suggests heroin maintenance is feasible in apparently conflicting political environments. Nonetheless, when the experience of Canada and Australia are considered, it becomes apparent that the likelihood of heroin maintenance being adopted in a conservative political environment will depend on the brand of conservatism espoused. Heroin maintenance can fit in with neoliberal ideals such fiscal responsibility and achieving population level goals through risk management and responsible citizenship if its crime prevention and cost effectiveness potential are emphasized. It is less compatible with social conservatism, which tends to be associated with a moral perspective on drug use and addiction.

Seemingly unfavourable federal political environments do not need to end all hope of adopting heroin maintenance. Governments will rarely adopt controversial initiatives on their own volition and other actors can have success in influencing government decisions to use heroin maintenance. For instance, the experience of NAOMI in Canada suggests that clinicians and researchers can be largely responsible for implementing heroin maintenance with significant time, effort and activism. Likewise, physicians and organizations working with drug users in Switzerland were also instrumental in getting their federal government to include heroin maintenance in their

larger drug policy reform. Similarly, the support of local governments and communities can also sway governments to adopt heroin maintenance, as occurred in Germany and the Netherlands when they made heroin maintenance a routine treatment.

Indeed, some of the information presented in this chapter suggests that the controversy surrounding heroin maintenance may be more political than an indication of widespread opposition to the use of heroin maintenance. There are, of course, always individuals and groups that will oppose the use of heroin maintenance. For instance, Switzerland experienced significant international pressure not to study heroin maintenance from the US and the WHO. In Canada, similar to other countries, studying heroin maintenance was opposed by methadone maintenance clinicians and other service providers on the grounds that it would take money away from already underfunded addiction treatment services or that it was not needed because methadone was already available and the full potential of methadone had not been realized. Similarly, in the UK there was some opposition to their trial because of its costs and the options of using taxpayer dollars to provide heroin to heroin addicts. Critics suggested these funds would be better used to treat other health conditions.

Despite this opposition it is arguable that on a balance there is more support for its use than opposition. For instance, interviewees suggested the public generally had a favourable opinion of heroin maintenance and this support was strongest in communities dealing with drug related harms. The experience of Switzerland nicely illustrates these different levels of support. In a national referendum 54% of citizens supported the continued use of heroin maintenance. In Zurich, where problems with open drug scenes had been particularly acute, 75% of citizens supported using heroin maintenance. Moreover, given time and increased familiarity with heroin maintenance, support for this treatment seems to expand. For instance, when heroin maintenance was first proposed media and police organizations in some countries were skeptical of the treatment but became more supportive over time. In other countries they were supportive from the beginning. Likewise, one of the principal challenges to implementing heroin maintenance after the research studies had been approved by government was finding a location for the clinics. There was considerable opposition to some of the chosen locations, for example, in Vancouver and Germany. However, after addressing neighbourhood

concerns and implementing heroin maintenance this opposition largely disappeared and some communities even became vocal supporters of their clinics. For instance, when the Netherlands stopped providing heroin maintenance local communities protested, questioning why a treatment that was helping individuals and communities would be ended.

## **Chapter 9. Conclusion and Policy Suggestions**

### **9.1. Introduction**

As documented in this research, it has been a long road to heroin maintenance. In Canada, proposals to study the effectiveness of heroin maintenance have been repeatedly made since the 1970s. Prior to this time, there were more general suggestions to experiment with narcotics distribution clinics and the 'British System'. As such, the NAOMI trial was a significant milestone in the history of maintenance treatment. After years of being rejected as too radical, an illegitimate or illegal treatment for addiction, and unneeded because methadone maintenance was already available, a study of the effectiveness of heroin maintenance was finally allowed to proceed in Canada. The introduction of the trial suggests, along with other trends such as the increased availability of methadone maintenance and approval of buprenorphine for maintenance treatment, that maintenance treatment has gained greater acceptance and maturity. It has reached a stage where it is moving beyond a single modality (methadone). It would appear innovation in this field is now feasible.

This chapter summarizes key findings presented throughout the dissertation. The social and political forces that had to come together to implement heroin maintenance are reviewed and the sustainability of heroin maintenance in Canada is discussed. This discussion is followed by an overview of the lessons learned from the history of heroin maintenance and how these lessons may be helpful for future initiatives and addiction treatment innovations. Finally, the chapter is closed with an exploration of potential policy options that would allow for the continued use of heroin maintenance in Canada.



## 9.2. Summary of Findings

This dissertation set out to explore how evidence, theories of addiction, ideology and political and social forces shape the treatment of addiction. An in-depth examination of the history and recent use of heroin maintenance was carried out for this purpose. As the above analysis indicates, the social, economic and political conditions of the period Garland (2001) refers to as late modernity (rather than those associated with the penal welfarism) allowed heroin maintenance to be used in Canada for the first time since the introduction of formal drug control. This situation may seem counterintuitive given some of the trends Garland suggests characterize crime control in late modernity, such as a decline of the rehabilitative ideal, increasingly political and populist policy environments, pervasive skepticism about the state's ability to control crime, and a return to highly punitive and expressive forms of justice. However, when one considers the treatment philosophy and understanding of addiction heroin maintenance is premised on alongside the basic tenants of welfarism this finding makes sense. Heroin maintenance is premised on a chronic disease model of addiction that assumes it is not possible for all individuals to overcome their dependence. In these instances, treatment becomes helping addicted individuals manage their addiction and reducing drug-related harms at a community or population level, rather than attempting to cure the condition. This approach to treatment is clearly premised on a risk management perspective. Managing the risk of addiction is somewhat at odds with welfarism which is premised on the idea that individuals and society can be reformed and rehabilitated and that it is the task of the state to carry out this reformed (Rose and Millar, 2010; Garland, 2001).

As was argued in Chapter Four, early efforts to implement a formal system of drug control in Canada, as elsewhere, were influenced by the social and moral reform movements that were active in the early years of the 20<sup>th</sup> Century. In an environment where the institutions of a welfare state were being established, the goals of welfarism became the goals of drug control. From its inception, drug control in Canada has been a policy of prohibition designed to eliminate both the non-medical use of drugs and the illicit drug trade. These goals clearly reflect the welfare state's approach of repression and reform. This approach was encouraged by international developments in drug

control and American pressure, as well as the Canadian medical profession's disinterest in addiction treatment.

The early experience of the UK with maintenance prescribing stands in contrast to what occurred in Canada. Unlike the Canadian medical profession, the British medical profession closely guarded their autonomy regarding the use of narcotic drugs, including the practice of maintenance prescribing. As a result, the British profession was actively involved in setting policy in drug control as it related to medical practice, alongside the Home Office. Conversely, drug policy in Canada, and the US, was almost exclusively guided by the federal drug administrations. This difference is the primary reason why a medical-penal model of control was adopted in the UK and maintenance prescribing was allowed, despite having very similar drug control legislation to Canada and the US.

In an environment of rising international interest in global drug control and moral and social reform, drug use and addiction were defined as a moral problem, a criminal model of drug control based on the ideal of achieving a drug free society was established, and maintenance prescribing was banned in Canada. The perspective that addiction is a moral shortcoming, or flows from a lack of will power, is simply not compatible with maintenance treatment. Under this perspective, drug use itself is considered a deviant act. As such, maintenance treatment is viewed as facilitating an addicted individual's vice and not a legitimate treatment. Similarly, maintenance treatment cannot be accommodated by a system of control that is premised on the ideal of achieving a drug free society.

Equally as important as inspiring an approach to drug control that is not compatible with heroin maintenance was how a moral perspective on drug use firmly situated drug users and traffickers in the category of 'other'. During the first half of the 20<sup>th</sup> Century, what is often termed as a 'drug fiend' ideology was advanced in Canada and the US by linking drug use to marginalized and disadvantaged groups in society (i.e., Asian immigrants, groups from low socioeconomic backgrounds who engaged in other forms of vice). This portrayal of drug users is an early example of what Garland refers to as the 'criminology of the other' or the perspective that criminals, or in this case

addicted individuals, are profoundly antisocial with few redeeming feature and little social value. This perspective was used to justify increasingly harsh and punitive responses to drug use, as well as banning maintenance prescribing and policing the prescribing practices of physicians. The need to save poor and disadvantaged groups through social and individual reform at the same time as repressing those that contributed to their corruption was a central goal of the early welfare state and clearly reflected in the 'drug fiend' ideology. In the UK, there was not as strong an association between minority groups and drug use than what was observed in Canada and the US. As a result, a moral perspective on drug use was significantly more muted than in North America and drug control interventions were limited. Heroin maintenance was allowed to continue.

This period in history is important to present-day discussions of why heroin maintenance was first used in the 1990s and 2000s for a number of reasons. To begin with, the legislative framework that was put in place at this time and was used to ban maintenance prescribing continues to exist today, albeit in a modified form. The existence of legislative framework means that any decision to use heroin maintenance has a legal and political dimension. It is not simply a matter of efficacy, need and funding. More generally, Canada's early ban on maintenance treatment has undoubtedly negatively impacted the availability as well as the degree of acceptance this treatment modality enjoys. Second, image of drug addicted individuals as the proverbial 'other' remains in late modernity. The drug fiend ideology, although modified and shaped to fit modern times, is still influential today and continues to be used to justify new repressive measures for responding to drug use. It also guides some of the opposition to heroin maintenance, some of which suggests that the health and wellbeing of heroin addicts is not worth the cost of the program or that it will not be possible to stabilize addicted individuals because they will demand progressively larger doses. Such arguments are clearly premised on the view that drug addicted individuals have little social value and are out of control.

Third, the first years of formal drug control established a tradition of international involvement that has had both a positive and negative impact on the use of heroin maintenance. On the one hand, countries considering the use of heroin maintenance

have come under significant pressure from the WHO and the US not to adopt this treatment. Conversely, it has contributed to an international community of practice where there is significant information sharing in the field of addiction treatment and harm reduction. Lastly, the ideals of the social and moral reform movements of the early 20<sup>th</sup> century continue to influence drug control today. The goal of a drug free society and a moral model of addiction are reflected in many drug control current policies and practices and can have a very real impact on decisions to use or reject heroin maintenance. For example, the Canadian Health Minister's recent decision to change the regulations of Health Canada's Special Access program so it can no longer be used to provide addicted individual's access to heroin clearly reflects these ideals. Although drug control, like crime control, has diversified, became bifurcated, and can no longer be said to be guided by unifying, heterogeneous model of control, it can be argued that model of control established the first half of the 20<sup>th</sup> Century continues to provide the primary rationale behind Canada's response to drug problems.

The legacy of the first half of the 20<sup>th</sup> Century on the availability of heroin maintenance has been a limiting influence whereas the events that occurred mid-century set the stage for the changes that occurred in the late 1980s and 1990s. These events eventually allowed for the introduction of heroin maintenance. As discussed in Chapter Five, the social, political and economic changes that occurred post-WWII led to significant changes in the field of drug control. Similar to the trend Garland (2001) noted in the larger field of crime control, rates of drug use increased rapidly and have remained high. This rise in drug use, combined with the liberalization of social values that was occurring at the time, inspired widespread criticisms of prohibition and the introduction of treatment services. Widespread criticism of prohibition can be viewed as an extension of Garland's more general observation that penal welfarism was increasingly seen as a failed approach to crime control from the mid-1970s onwards. This trend was accompanied by growing skepticism that neither the criminal justice system nor the state in general could effectively control or eliminate crime, or in this case illicit drug use. The equivalent trend can also be observed in drug control where prohibition is increasingly seen as a failure policy and the idea that drug use can be repressed through enforcement alone has largely been abandoned.

With the introduction of treatment services, an increasing diversity of actors became involved in the field of drug control, from provincial and municipal officials to physicians and other health care professionals. The involvement of these actors shifted the focus of drug control from almost exclusively an activity of the criminal justice system to one that also included health (and educational) interventions. Later, high rates of drug use encouraged questions regarding the effectiveness of traditional addiction treatment models, advances in understanding of addiction, and the introduction of methadone maintenance. The involvement of a greater variety of experts and professionals and questions about the effectiveness of abstinence-based treatment models set the stage for later preventative partnerships created through the implementation of harm reduction initiatives, such as heroin maintenance, that were designed to reduce the risk of drug use and prevent drug-related harms.

In *The Culture of Control*, Garland (2001) argues that the criticism of a penal-welfarism that were made in the mid-20<sup>th</sup> Century, combined with increased crime rates and social change, resulted in a significant and unexpected change in crime control in late modernity. The result is a bifurcated and expanded approach to crime control that involves both state and non-state actors and is no longer guided by a common set of values or knowledge base. The recent experimentation with heroin maintenance in Canada and Europe can be viewed as a reflection of a similar change in the field of drug control. For instance, it was argued in this dissertation that heroin maintenance only became available outside the UK after persistently high rates of drug use and a perpetual sense of crisis in this field led to increased skepticism about the ability of law enforcement and abstinence-based treatments to address drug-related problems or eliminate drug use altogether. This skepticism, combined with a heightened sense of urgency created by the HIV/AIDS epidemic and problems with open drug scenes, encouraged the adoption of harm reduction and a risk management perspective. These forces were critical to the introduction of heroin maintenance.

Garland (2001) also argues that the changes to crime control that occurred in late modernity have devalued the role of experts and professionals. He suggests that criminal justice policy has become more politicized, populist and, at times, more reactionary. The introduction of heroin maintenance does not really reflect this trend and

in some regards suggests an opposite pattern of events. To begin with, heroin maintenance was introduced through a series of clinical trials and research studies with the express purpose of determining its efficacy, safety and cost effectiveness. The use of clinical trials does not suggest a reactionary, politicised or populist approach but a cautious and rational response to the very real problems associated with illicit drug use. It has the hallmark of the calm application of an evidenced-based approach to addiction treatment. The emphasis on evidence is not to say the decision to use heroin maintenance did not become a political issue. It clearly did in all countries considered here, with the possible exception of the UK. This history is perhaps a reminder that not all policies and practices implemented in highly political settings or in response to a pressing crisis are ill thought out, reactionary or punitive.

Moreover, it is argued in Chapter Eight, that experts and professionals played a key role in the introduction of heroin maintenance, as advocates and policy advisors. For instance, the NAOMI trial was not a government sponsored initiative. It was designed, planned and initiated by a group of private clinicians and academics. The possible exception to the key role of professional advocacy is the UK where the idea to run a heroin maintenance trial came from the British government. Considering Garland's work, the involvement of experts could simply be attributed to the continuation of a penal-welfare model of control where the opinions and perspectives of experts and professionals play a central role in crime control policy. This explanation seems unlikely given the incongruity between welfarism and heroin maintenance, as mentioned previously. A more plausible explanation is that public health professionals have come to replace criminal justice professionals as the primary experts in addressing drug-related harms, particularly health consequences of drug use. This development can be viewed as an extension of the process of defining down minor drug offences and the creation of preventative partnerships to deal with harms related to illicit drug use, which has moved addiction further into the domain of medical or public health controls. In this regard, the transfer of expert authority is not akin to the organizational/professional power struggles observed in the early and even mid-20<sup>th</sup> Century. Rather, the transfer of expert authority is perhaps more aptly viewed as criminal justice actors voluntarily relinquishing the role. This line of reasoning can offer some explanation for why police have generally been supportive of heroin maintenance. Such support is particularly

strong at a local level where police are spending their resources to address drug related harms and therefore have the most interest in defining down minor drug crimes and pushing responsibility for these harms to another professional group such as physicians or public health service providers.

### **9.3. Sustainability of Heroin Maintenance in Canada**

This dissertation has demonstrated that a complex array of social and political forces needed to align for the NAOMI trial to be carried out in Canada. Now that it has been a number of years since NAOMI finished and the SALOME trial is nearing completion, the sustainability of heroin maintenance in Canada is a topical consideration. Some of the conditions that facilitated the introduction of the NAOMI trial still exist today but others have changed. These changes have generally not made the drug policy environment more compatible with heroin maintenance. Canada appears to be going through a period where the federal government is advancing drug control policies that align with what Garland (2001) refers to as punitive segregation. However, this changing situation does not necessarily mean heroin maintenance will be abandoned in Canada. As Garland argues, crime control in late modernity has become increasingly bifurcated and it is quite feasible for both punitive segregation and preventative partnerships to coexist, or for heroin maintenance to be used at a time when mandatory minimum sentences are implemented for drug offences. Moreover, the experience of European countries included in this research suggests that the precise set of forces that facilitated initial research into heroin maintenance are not always the same as the conditions that allowed it to become a permanent treatment option. Some forces were more influential in initiating heroin maintenance and less so in making it a routine treatment and vice versa. The following discussion considers what is needed for heroin maintenance to be a sustainable treatment option and whether these conditions exist in Canada.

As discussed in Chapter Six, there are some basic conceptual and system factors that need to exist for heroin maintenance to be considered. These factors are important to both the introduction and sustainability of heroin maintenance. At a conceptual level there needs to be some acceptance of a chronic disease model of

addiction and recognition of treatment goals other than abstinence, or a trend towards risk management in addiction treatment. This understanding of addiction and its treatment must have some influence on drug policy. In this regard, it is necessary for the drug control system to include treatment. It is also helpful if it has adopted a risk management perspective and includes harm reduction services and public health goals. For example, the approach adopted by the European countries considered in this research clearly endorses a disease model of addiction and views treatment, and heroin maintenance specifically, as an avenue for preventing drug-related harms, including criminal behaviour. In comparison, the US has not advanced as far in incorporating a risk management perspective in their approach to drug control (at least at the federal level). As a result, their predominant approach remains one that can be characterized as a penal welfare model of control or a policy of punitive segregation rather than the bifurcated approach Garland highlights.

In Canada, when the NAOMI trial was implemented there was a trend toward a more bifurcated approach to drug control, including the adoption of a risk management perspective. However, the drug policy environment has changed with the election of a conservative federal government. As discussed in Chapter Six and Eight, this government has endorsed a crime control model of drug control, eliminated harm reduction from the National Anti-drug Strategy and recently indicated they do not support treatment services that do not have abstinence as their end goal, indicating a move away from a risk management approach. Clearly, this government's approach to drug control is strongly situated in a moral perspective on drug use and addiction, which is not a perspective that is compatible with heroin maintenance and more compatible with punitive segregation. Similar to the trend Garland (2001) noted in crime control, this government's approach also reflects an increasingly politicized drug policy environment where the perspectives of experts and professionals are devalued and excluded from the policy making process and the political agenda of politicians are favoured. Favouring political agendas over the expertise of professionals is not a situation conducive to heroin maintenance and stands in contrast to the cautious, evidence informed approach that allowed initial experiments with this treatment. Moreover, removing harm reduction from the National Anti-drug Strategy and devaluing the role of public health experts can have the effect of damaging or terminating preventative



partnerships that were established to respond to drug related harms in the 1990s and 2000s.

That being said, over the years, drug control has become much more nuanced than simply a policy of prohibition enforced by the criminal justice system. As Garland suggests, crime control, as is the case with drug control, is no longer guided by a unifying model or shared set of values and common knowledge base. It is, therefore, unlikely that the recent revival of a hard line approach to drug problems will initiate a return to a purely criminal model of drug control. Although clear trends can be observed throughout history from repressive policies to more liberal policies and back again, the 'pendulum' never ends up in the exact same position. Outside of this oscillation there is an underlying trend towards a more diverse approach to drug control that arguably supports different strategies for exercising control, some of which do not include the criminal justice system. For instance, in the 1960s and early 1970s a more liberal approach to drug use was adopted and addiction treatment, including methadone maintenance, was implemented and expanded. This approach was also accompanied by improvements in understanding of addiction and greater acceptance of a chronic disease model of addiction. When there was a trend back towards a more hardline approach to drug control in the late 1970s and 1980s there were efforts to curtail methadone maintenance and to introduce involuntary treatment. However, methadone maintenance was not banned and treatment continued to play a role in the country's response to drug addiction.

Likewise, now that harm reduction philosophy has been introduced and interventions implemented it is unlikely they will be entirely excluded from the drug control landscape again, even in the face of a federal government that opposes harm reduction. The government may roll back harm reduction but not eliminate it entirely. For instance, the conservative government has attacked Vancouver's supervised injection site and seems to oppose heroin maintenance but, to date, they have not called into question more established harm reduction initiatives such as needle exchanges and methadone maintenance. Indeed, when questioning the practice of heroin maintenance they point to methadone maintenance as an available and effective treatment (Health Canada, October 3, 2013), missing the incongruity of endorsing one form of

maintenance treatment as a critique of another form. The experience of Switzerland, Germany and the Netherlands all illustrate how heroin maintenance can be continued even under more conservative national governments. In each of these countries, the election of a conservative government slowed the process of making heroin maintenance a routine treatment option but these countries were all ultimately successful in achieving this outcome.

Moreover, outside of the federal political environment, advances continue to be made in understanding of addiction. Through these advances, a chronic disease model of addiction is becoming increasingly popular. This popularity has also advanced medical ownership of addiction. For instance, the BC Medical Association has recently officially endorsed the view that addiction is a chronic disease and should be treated as such (BC Medical Association, 2009). Because of this underlying evolution in drug control and understanding of addiction outside of time-limited trends towards more repressive or liberal models of control, heroin maintenance continues to be at least conceptually feasible, even in the face of the federal government's endorsement of a criminal justice model of drug control.

Additionally, this regression to a more hard line approach to drug control seems to be somewhat limited to the federal government. A bifurcated approach continues to exist in the sense that although the federal government has adopted an approach of punitive segregation, preventative partnerships continue to exist at a provincial and local level. In British Columbia, both the provincial and Vancouver municipal governments continue to support harm reduction initiatives. For instance, the provincial health officer spoke out against the recent change to the Special Access Program that prevents restricted drugs from being provided through the program and in support of the continued use of heroin maintenance (Wherry, October 3, 2013). Likewise, Vancouver Coastal Health continues to fund Vancouver's supervised injection site despite clear federal opposition to this facility (Vancouver Coastal Health, n.d.). More formally, both the City of Vancouver and the provincial government have policies that endorse harm reduction (City of Vancouver, April 30, 2012; BC Centre for Disease Control, 2013 & 2011). Perhaps the continued controversy over heroin maintenance is indicative of a growing divide between the federal and provincial or local perspectives on how best to

respond to the problem of addiction, though it also may simply reflect the reality that the current federal government has particularly extreme views within this realm. In Canada, it is the federal government's responsibility to enforce the country's drug laws and the provinces responsibility to deliver health care services. It is not surprising then that at the federal level there is more support for a criminal justice approach to addiction and a public health or medical approach enjoys more support provincially. However, even in the face of federal resistance to heroin maintenance, the experience of the Netherlands and Germany provides an example of the influence local support and advocacy can have on national drug policies. Support from municipal governments and the public was critical to the adoption of heroin maintenance as a routine treatment in both of these countries.

History has shown that greater involvement of provincial governments has led to critical advances in the field of addiction treatment. For instance, the federal government has historically advocated that provincial governments take responsibility for addiction treatment, as a health care service. When the provinces began to accept this responsibility addiction treatment began to play a role in drug control and methadone maintenance treatment was introduced. Likewise, when authority to regulate methadone maintenance was divested to the provinces the availability of this treatment expanded significantly in BC. Over time, provincial and, to a lesser extent, municipal governments have taken on a greater role in drug control through funding and delivering addiction services to extent now that they are vocally opposing decisions made by the federal government to curtail harm reduction initiatives. They are beginning to complain that through these actions the federal government is infringing on their jurisdiction over the delivery of health care services. As the experience of Germany and the Netherlands has shown, support for the continued use of heroin maintenance from local governments and communities can go a long way in persuading even conservative federal governments to adopt heroin maintenance. It seems likely that support of provincial and municipal governments will also be central to the sustainability of heroin maintenance in Canada.

However, the current federal political environment in Canada is different from the political environment in Switzerland, Germany and the Netherlands, where they have made heroin maintenance a routine treatment. It can be characterized as more socially

conservative and its current drug policy more ideologically driven. In comparison, the political environment in Switzerland, Germany and the Netherlands is better characterized as a neoliberal environment where pragmatism and evidence have more influence over drug policy, at least regarding addiction treatment, than moralism. As discussed in Chapter Eight, heroin maintenance is most likely to be introduced in a liberal political environment but it can continue to be used in a neoliberal environment. In this environment its crime prevention and cost effectiveness potential is crucial. The experience of the UK provides the best example of this. Although UK had adopted what was described by interview participants as ‘an American style war on drugs’, the RIOTT trial and heroin maintenance were advanced by the government because of its crime prevention potential. However, the crime prevention and cost saving potential do not hold as much sway in a socially conservative political environment, as can be seen with Australia’s experience of having to abandon its plans for a heroin trial after the election of a conservative government. As Garland suggests, sometimes the neoliberal ideals of cost effectiveness and risk management are abandoned in favour of punitive segregation, no matter the cost of a return to more repressive policies. Disregarding neoliberal ideals often occurs when there is a strong link to the proverbial ‘other’. This link to the ‘other’ has a strong history in drug control and it is not surprising that countries continue to revert to justifying repressive policies on grounds that they are necessary to control drug users and traffickers.

This finding does not bode well for the sustainability of heroin maintenance in Canada. The Canadian government still must approve any further clinical trials and provide a section 56 exemption to import heroin. For heroin to be used outside of a research setting they would have to approve it as a medicinal product and amend the *Controlled Drug and Substance Act*, similar to what was done in Switzerland, Germany and the Netherlands when they made heroin maintenance a routine treatment option. It seems unlikely that the current federal government would do either of these things, but particularly not amend *the Controlled Drug and Substances Act*. Such an amendment would require the government to support a bill designed to make these changes in the House of Commons, which is counter to their political agenda on crime control. In this situation, the only option may be a constitutional challenge to the *Controlled Drug and Substances Act* in an attempt to force the federal government to make heroin

maintenance legal in Canada. A change of federal government may also, however, produce changes in maintenance treatment policies.

Clearly, the current political environment presents a challenge to the continued use of heroin maintenance. Even so, there are also a number of developments that support its continued use. For instance, the growing body of evidence on the effectiveness of heroin maintenance will be difficult for any government who professes to have evidence-based policies to ignore. This evidence will also likely be instrumental in the legal challenge against the government's change to the Special Access Program. It is also helpful for discounting criticism from within the addiction treatment field that suggests it is not needed because methadone is available or because the full benefit of methadone maintenance has yet to be realized. Likewise, the fact that a number of European countries now offer heroin maintenance as routine treatment option will support efforts to have heroin maintenance continue to be available in Canada. The combined strength of evidence and the fact that other jurisdictions have adopted the treatment are critical for supporting physicians and other professionals who advocate for this treatment to continue to be available. It is difficult to argue with clinicians and experts in the field of addiction who are suggesting an intervention that is supported by a series of clinical trials and used in a number of other countries. Given this difficulty, expert advocacy, evidence and international developments may have a greater role to play in the sustainability of heroin maintenance than they had in its introduction.

The level of expert advocacy needed to support the continued use of heroin maintenance may not be forthcoming because some of the pressure to address drug related harms has been eased now that HIV/AIDS and overdose deaths have been brought somewhat under control. Moreover, changing patterns of drug use may also shift the focus of addiction experts as well as governments to different interventions. For instance, in Switzerland, interview participants indicated that heroin maintenance and illicit drug control in general were not on their government's political agenda and this slowed the process of making a permanent change to their drug control legislation to allow heroin maintenance. That being said, all the European countries considered here made heroin maintenance a routine treatment option after problems with HIV/AIDS and open drug scenes had subsided. The experience of these countries suggests that

although a crisis was critical to introducing heroin maintenance in some countries it may not be necessary for it to be adopted as a routine treatment option. Instead, the strength of evidence supporting the intervention and support from communities or cities where the programs operated was central to heroin maintenance being adopted as a routine treatment.

Moreover, similar to what Garland (2001) observed in the larger field of crime control, there is a perpetual sense of crisis surround drug use and pessimism about the criminal justice systems ability to address drug problems which acts to keep drug use in the public eye and on political agendas. This combined sense of crisis and skepticism facilitated the introduction of heroin maintenance and may continue to support its future use. The risk in this regard is that public health or medical responses to drug problems may also become the focus of such skepticism. If such skepticism arises, heroin maintenance could be abandoned in favour of a novel initiative if it becomes viewed as unsuccessful at addressing community or population level drug related harms, or is perceived to not meet the neoliberal demand for cost effectiveness.

The sustainability of heroin maintenance treatment may also depend on the outcome of the SALOME trial. If Dilaudid is found to be equally or more effective than heroin maintenance then it seems likely there will be little appetite for pursuing heroin maintenance, at least in the short-term. As the critical literature on harm reduction suggests, greater involvement of public health professionals has defined harm reduction as a value neutral approach. From this perspective, the value of an intervention is judged on its outcomes and ability to reduce risks. According to this line of reasoning, if Dilaudid and heroin are equally effective there is no reason to pursue heroin maintenance. Efforts may be directed at the politically easier task of having Dilaudid approved for maintenance treatment rather than trying to revise the drug laws so heroin maintenance could be used outside of a research setting.

Clearly, moving heroin maintenance beyond clinical research trials will be an uphill struggle in an environment of competing approaches to responding to drug problems. Methadone maintenance provides a good example of the time and effort required for maintenance treatment to be accepted and become widely available. For

instance, the history of methadone maintenance is peppered with examples of top down efforts to restrict and control the use of this treatment from both federal and provincial governments. Even in Switzerland and the Netherlands where there was significant support for heroin maintenance it took over 10 years for heroin maintenance to become a routine treatment option on a permanent basis. It is also unlikely that the initiative to make heroin maintenance a routine treatment option would originate with the federal government. Rather, local support from municipal or provincial governments and organizations and expert advocacy are a necessary driving force behind such a change. Moreover, some crisis in the drug field may be necessary to create enough urgency for the federal government to act and make the necessary changes to the drug laws and fund such programs. Alternatively, court challenges or a change in the political environment could also facilitate the continued use of heroin maintenance as there is evidence and the experience of other countries that support the permanent adoption of heroin maintenance.

#### **9.4. Lessons for Future Initiatives and Treatment Innovations**

An ideal situation is for new initiatives and innovations in the field of addiction treatment to be evaluated on their effectiveness and ability to meet unaddressed needs in the drug using population or their communities. As the history of heroin maintenance has demonstrated, decisions on addiction treatment are often not based on evidence of effectiveness and need, or these considerations are only one among many. Politics and morality are a significant force in the field of drug control and addiction treatment is not protected from these forces (Strang, Babor, Coultins, Fischer, Foxcroft and Humphreys, 2012). Moreover, Garland's (2001) observation that criminal justice policy has become increasingly politicized is equally as applicable to drug control as the larger field of crime control. Given this environment, the first lesson the history of heroin maintenance can offer is to acknowledge the role of politics and realize it will likely be necessary to 'join the game' for a treatment initiative or innovation to be adopted. This suggestion is not meant to be crass or to suggest evidence on effectiveness or the needs of drug using populations have no role in decisions on how to respond to addiction problems. They

do. However, evidence and the needs of drug using populations may be politicized themselves and there are other factors at play which influence whether a treatment intervention is adopted. As Berridge (2009) suggests, “Results such as those from the NAOMI trial matter, but they do not operate in a vacuum” (p. 821).

Because of the highly politicised nature of drug control and addiction treatment, messaging around a proposed intervention is of particular importance. In Canada and elsewhere, experimentation with heroin maintenance was rejected until it was presented as an extremely limited intervention for the most marginalized, treatment-resistant users. The message that it would benefit the larger society through crime prevention and preventing the spread of communicable diseases and that it was cost effective was also important. This type of messaging suggests situating an intervention within a currently popular risk management perspective is helpful. As Garland suggests, there is no unifying approach to crime control (or drug control) in late modernity so although the current federal government has become more socially conservative, neoliberal goals and objectives (such as crime prevention, cost effectiveness, and risk management) continue to hold significant appeal to other decision makers.

Another lesson for controversial treatment interventions that can be gleaned from the experience of heroin maintenance is that messaging should appeal to multiple stakeholders (i.e., governments, care providers, police and the public) and it should lessen the political risk of adopting the intervention. Appealing to multiple stakeholders can often be done by emphasizing how it is helpful beyond simply meeting the needs of drug using populations and waylaying concerns that it will encourage drug use, particularly in youth. These messages are particularly important for harm reduction initiatives. This type of careful messaging is essentially doing precisely what the critical literature on harm reduction suggests is the problem with the harm reduction movement becoming a more mainstream approach (Roe, 2005, Smith, 2012). Namely, it is making initiatives that seemingly undermine the goals of prohibition more compatible with prohibition rather than offering a critique of it. However, given the unlikelihood that prohibition will be abandoned in any of the countries considered here in the near future, this may be the best available option. Although the failure to critique prohibition and mitigating some of the harm it creates promotes its continuation, it is possible to achieve



system level reforms through incremental change, even if this approach is very time consuming. The Netherlands is an example of a country where public health goals and initiatives are beginning to take precedence over simply repressing drug use.

Research and evidence can be used to support messaging around a controversial treatment intervention such as heroin maintenance. The highly politicized nature of drug control and addiction treatment often necessitates a strong evidence base for controversial interventions to even be considered or to move beyond initial experimentation, if they do not fit with the agenda of the government of the day. When there is little opposition to an intervention there is often limited need to justify it being adopted. However, when an intervention is controversial or opposed on ideological grounds, as is the case with heroin maintenance, it is often evidence of its effectiveness and the need for the intervention that can eventually overcome ideology. Research evidence can expose faulty logic and false assumptions. For instance, a common rationale for opposing heroin maintenance that has persisted throughout its history was the belief that addicted individuals would have an insatiable demand for heroin. It was believed that it would never be possible to find a stable dose and patients would continue to demand larger and larger amounts of the drug. Recent clinical trials have proven this false and have shown participants quickly reached an optimal, stable dose (Strang et al., 2012). Overcoming ideology may not happen at an individual level (it is difficult to persuade an individual of the value of an intervention when they are ideologically opposed to it) but it can happen at a community or systems level. Strong evidence of the effectiveness, safety and efficiency of an intervention can change attitudes and perspectives on a particular intervention. However, this often takes time. Key players in the field of addiction treatment and the public may be slow to absorb evidence into their perspectives on a particular problem and what they view as an acceptable intervention. It may take even more time for evidence to move an intervention from the controversial to the routine.

Not only is it imperative that messaging around heroin maintenance and other controversial interventions be carefully crafted and backed up by evidence but who delivers that message is also important. Having experts (i.e., academics, physicians, or other professionals working in the field of addiction treatment or drug control) speaking

to the scope of the problem an intervention is designed to address and its value is necessary to lend credibility to messaging around a particular intervention. However, experts advocating for an intervention alone can, at times, be dismissed. They can be written off as elitist, radical or even self-serving. This is particularly true in environments where the opinion and role of experts and professionals are devalued as Garland suggests is the case with crime control in late modernity. Endorsement from larger professional organizations can mitigate some of these characterizations. For instance, the American and Canadian Medical Associations' endorsement of methadone maintenance were instrumental in the acceptance and spread of this treatment. The ideal situation is to have expert advocacy combined with endorsement of professional organizations as well as strong local support for the intervention, including support from drug user groups. This combination of support for an intervention is difficult for governments to ignore or discount by questioning its legitimacy.

The recent history of heroin maintenance in Canada and Europe suggests that achieving this level of support was crucial to the implementation of the clinical trials but takes considerable time and effort. For instance, the heroin maintenance clinics established in Canada, Germany and the Netherlands worked extensively with the communities where the clinics were located to address concerns about having them in their neighbourhood and generate support for the clinics. They set up processes for gathering ongoing community feedback and monitoring complaints. Receiving endorsement from local police was important to getting community support for the clinics. The time and resources needed to achieve this level of support should be considered when planning new or controversial addiction interventions. Achieving local community, public and municipal support for harm reduction initiatives, such as heroin maintenance, essentially involves convincing these groups that it is, at least in part, their responsibility to protect themselves and their communities from drug-related harms. In the words of O'Malley (2009), they need to become convinced to be prudential citizens. Preventative partnerships can only be formed when actors outside of the criminal justice system take on responsibility for preventing crime, or in this case the risks associated with drug use. Opposition from community groups, the police or other addiction service providers has the potential of delaying or derailing efforts to implement new treatment programs or clinical trials. Widespread local support for heroin maintenance tended to

be more forthcoming in cities struggling to highly visible drug problems. Having up-to-date knowledge of drug use patterns and trends and being aware of the needs of local communities can increase the chances of success of any new addiction intervention.

## **9.5. Future Directions and Policy Suggestions**

An overarching theme of this research is how politically contentious an issue heroin maintenance has been throughout its history and how key turning points in the history of maintenance treatment were driven by drug-related crises. As such, Canada's approach to maintenance treatment can be described as reactive and curtailed by ideology. This situation has undoubtedly undermined the impact maintenance treatment has had on individuals as well as its broader utility in addressing opioid addiction problems in Canada. Individuals have been impacted by limited availability of treatment space or, when the treatment is available, less than optimal treatment models and restrictive rules (Reist, 2010; Fischer, 2002). This situation in turn has contributed to Canada's large untreated opioid user population. For instance, in a study of untreated injection drug users in five major Canadian cities, Fischer et al. (2005) reported that existing opioid treatment resources were insufficient to meet the needs of their study population, both in terms of the availability of services and their structures and practices. The participants in this study had high rates of HIV and Hepatitis C, physical and mental health conditions, were frequent users of emergency rooms, and were often involved in with the criminal justice system. This finding suggests the failure to provide adequate treatment resources to this group has significant individual, social and economic consequences. Better treatment coverage for opioid addicted individuals is possible. In Switzerland, Germany and the Netherlands a large majority of their heroin addicted population is in treatment, most often some form of maintenance treatment.

In a review of the effectiveness of various drug policies Strang, et al., (2012), suggest that maintenance treatment is an effective strategy for improving what they term the 'public good', which includes improving public health, reducing crime and improving the quality of life for families and communities. To use the language of Garland (2001) and the critical literature on harm reduction, maintenance treatment is an effective risk management strategy. Because the treatment can be linked to population level

outcomes and reduced drug-related risks in communities, it is well suited to a policy environment dominated by neoliberalism, as observed in Europe. However, in order to achieve the full benefit from maintenance treatment in Canada it will be necessary to move beyond politics and crisis-driven policies to a pragmatic approach, similar the approach adopted in the European countries considered in this research. Such an approach would be based on evidence of the efficacy and cost effectiveness of maintenance treatment, as well as the needs of drug using populations and their communities. A number of things can be done to move in this direction.

One avenue for moving towards an evidence and needs-based approach to maintenance treatment would be to extend the current system that is used to regulate methadone and buprenorphine maintenance to heroin maintenance. In the future, this regulation system could also be extended to other forms of maintenance treatment that are safe and effective as established through scientific research (e.g., Dilaudid, injectable methadone). To some degree extending the regulatory system for methadone to heroin maintenance has been done in Switzerland, the Netherlands and Germany where specialized clinics and associated physicians are provided with a special license to run a heroin maintenance clinic similar to what is done with methadone maintenance providers, only this license is not given to individual physicians as can be done with methadone. The choice of available maintenance treatment options should also consider the needs of the user population. For instance, prescription opioid abuse is common in many Canadian cities (Fisher et al., 2005; Canadian Centre on Substance Abuse, 2013) but it is unclear if heroin, methadone or buprenorphine maintenance treatment is the best choice for these users or if the effectiveness of additional medications needs to be explored. Having a variety of medications approved for maintenance treatment would allow physicians more discretion to use their clinical judgement in determining the most appropriate treatment for their clients. Providing the most appropriate treatment possible can optimize treatment outcomes. Greater choice in available treatment options can also motivate previously untreated users to seek treatment and encourage them to remain in care longer, as there would be more flexibility to ensure they received the care best suited to their needs (Arria & McLellan, 2012).

Greater choice in available treatment options and user autonomy in deciding what treatment works best for them aligns with the currently popular risk management perspective. As discussed in the proceeding chapters, risk management (and harm reduction as form of risk management) results in the increased responsabilization of drug users by situating responsibility for mitigating or avoiding risk with the users themselves. Drug users are not only responsible for reducing harms to themselves but also to their communities. Authors writing in the critical literature on harm reduction often view this responsabilization as negative or an avenue for social exclusion, punishment or blame. However, Pat O'Malley (2008) suggests the opposite is the case. Making individuals responsible for reducing drug related harms makes them more empowered. Providing addicted individuals with more options for managing their addiction, in this case through offering a more diverse selection of maintenance treatment services, will empower them by giving them greater control over their treatment.

The federal government divested authority to regulate methadone maintenance treatment to the provinces in 1996, who in turn gave this responsibility to their Colleges of Physicians and Surgeons. If this model was followed for heroin maintenance, provincial Colleges of Physicians and Surgeons would be responsible for developing guidelines for heroin maintenance, including eligibility criteria, dosing, options for take home doses, required support services, treatment facility specifications and so on. They would also be given responsible for monitoring compliance with those guidelines and approving physicians, or potentially clinics, to prescribe heroin for maintenance treatment. This model would have the effect of strengthening medical ownership of addiction, on more than simply a conceptual level, and move drug control further from the exclusive purview of the criminal justice system and the federal drug administration. Situating this authority with the medical profession rather than the federal or provincial bureaucracy makes sense on a number of levels. It is appropriate given the ongoing advancements in understanding of addiction as a chronic disease. It also makes sense, considering physicians will have an integral role to play in any maintenance treatment program as the profession authorized to prescribe drugs. On a more practical level such a system is an ideal model of oversight. It is a highly clinical undertaking in terms of reviewing clinical research, developing guidelines for dosing, induction, tapering doses and so on, and monitoring compliance with guidelines.

Provincial (and potentially federal) governments would continue to retain some control over heroin maintenance as program funders. Program funding often comes with requirements that certain conditions be met for funding to be initiated and continued. They would also have an important role to play in ensuring the demand for heroin maintenance treatment was met by providing adequate resources for this service. Moreover, local health authorities would likely be tasked with service delivery (as well as potentially making funding decisions), as it is unlikely any College of Physicians and Surgeons would allow private physicians to deliver heroin maintenance treatment. Evidence supporting the safety and effectiveness of heroin maintenance has only been established in highly controlled clinics where clients are required to administer the drug onsite and have access to additional supports (Strang et al., 2012). This treatment model is beyond the resources of private physicians. Moreover, given the controversial nature of heroin maintenance and its status as a new treatment option, it is likely that at least initially provincial governments would want to retain considerable control over such programs.

Before heroin maintenance could be regulated under the same system as methadone and buprenorphine, it would be necessary for heroin to be approved for the treatment of addiction by Health Canada's Therapeutic Products Directorate. This requirement is a major stumbling block for the feasibility of heroin maintenance. Although the approval of a drug for a particular treatment is meant to be based on scientific evidence of its effectiveness and safety, the recent move by the Minister of Health to prevent heroin, or other restricted drugs, to be prescribed in the treatment of addiction under Health Canada's Special Access Program suggests that decisions of the Therapeutic Products Directorate are not free from political interference. This interference is evidence that Garland's argument that criminal justice policy has become more political and less likely to rely on input from professionals and experts is also applicable to drug control policy. Ideally, the body responsible for approving new drugs would be arm's length from government rather than within a government ministry. An arm's length agency would help prevent political interference such as that observed in the case of the Special Access Program.

Barring a substantial restructuring of how Health Canada approves drugs for medical use, it seems unlikely that heroin will be approved for maintenance treatment in the near future. A less controversial alternative would be to follow the early experience with methadone maintenance and allow heroin maintenance to continue to be available under the auspices of research studies. This approach would require greater initiative on the part of provincial governments and health authorities. Given the federal government's strong statement against heroin maintenance when revising the regulations of Health Canada's Special Access Program (to prevent this program from being used to maintain addicts on heroin), it seems almost certain now that the federal government will not provide further funding for heroin maintenance research regardless of the results of the SALOME trial (e.g., even if the trial finds heroin maintenance is more effective than Dilaudid maintenance). As such, funding such research would fall to provincial governments. Moreover, in the current environment it may be difficult to obtain a section 56 exemption for further research into heroin maintenance. Similar to the fight to keep Vancouver's safe injection site open, it may be necessary to pursue court action to force the government's hand in granting section 56 exemptions to allow further research to be undertaken. The legal challenge from the supervised injection site provides a precedent for this type of court action. Similar to what was done with the supervised injection site, it could be argued that the federal government is infringing on provincial jurisdiction by not allowing heroin maintenance, which is clearly a health care service.

Assuming these barriers could be overcome, making heroin maintenance available through research studies would have the effect of strengthening the existing body of evidence regarding heroin maintenance by refining what is the most efficient, effective, and safe model for delivering this treatment. Similar to what happened with methadone maintenance, building up this body of evidence would be important to the future viability of heroin maintenance. As argued in earlier chapters, one reason why methadone maintenance continued to be available in the face of federal and sometimes provincial government skepticism of this treatment was the solid body of evidence establishing it as the most effective intervention for opioid addiction available. A similarly strong body of evidence supporting heroin maintenance that speaks to its value as a risk management strategy for individuals as well as communities and populations will be

necessary for this treatment to remain available in a drug control policy environment that continues to be driven by politics, ideology and moral perspectives on addiction.



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## **Appendix A. Archival Sources**

### **British Columbia Provincial Archives**

- GR-0119 – BC Department of Health Services and Hospital Insurance 1944-1961
- GR-0120 - BC Department of Health Services and Hospital Insurance - 1960-1965
- GR-0133 – Mental Health Branch Executive Records – 1936-1972
- GR-0363 – Community Resource Board Records – 1973-1977
- GR-0365 – Social Welfare Department Executive Records – 1958, 1963-69
- GR-0678 – Department of Health Executive Records – 1946-1976
- GR-0941 – BC Ministry of Human Resources Vancouver Resources Board - 1973-1977
- GR-2570 – BC Inspector of Hospitals - 1937-1956
- GR-2588 – Ministry of Health Executive Records – 1977-1981
- GR-2649 – Ministry of Health Executive Records 1963-1979
- GR-2662 – Ministry of Health – Dr. Foulkes Papers – 1946-1974
- GR-2670 – Ministry of Health Consultation Division Records – 1955-1978
- GR-2689 – Alcohol and Drug Commission – 1972-1977
- GR-2698 – Department of Health Services and Hospital Insurance – 1946-1978
- GR-2921 - Vancouver Resource Boards Records – 1953-1975
- GR-3000 – BC Attorney General Criminal Justice Branch – 1966-1980
- MS-0677 – Frederick Longstaff Papers – 1848-1961
- MS-1605 – Hugh Wesley Dobson Papers – 1912-1951
- MS-2120 – Dave Barrett Papers – MLA – 1972-1983

### **Simon Fraser University Archives**

John Howard Society Papers

### **National Archives of Canada**

- RG 29 - Bureau of Dangerous Drugs – Narcotics Control Division Files – Narcotics.
- RG 29 - Mental Health Division Files
- MG 28 – Alcoholism and Drug Addiction

## **British Library Archives**

BS 18/350 - Home office Department of Health and Social Security - The Amphetamines and Lysergic Acid Diethylamide (LSD) – Report by the Advisory Committee on Drug Dependence

BS 17/164 (1960; 1961; 1965) Ministry of Health / Department of Health for Scotland - Drug Addiction – Report of the Interdepartmental Committee

BS 17/72 – Ministry of Health – Departmental Committee on Morphine and Heroin Addiction Report (1926)

## **National Archives of the United Kingdom**

HO 45/25413 Dangerous Drugs and Poisons: Doctors who are addicts, 1921-1952

MH 71/108 – Committee on Drug Addiction: Meetings 1 to 24 – November 1924

MH 71/109 – Committee on Drug Addiction: Meetings 25 to 54 – December 1924 to February 1925

MH 71/110 – Committee on Drug Addiction: Meeting 55 to 90 – March to June 1925

MH 150/368 – Dispensing of drugs to drug addicts: precautions against misuse of prescriptions: Future arrangements 01/01/1967 – 01/12/1974

MH 154/367 – Drug Dependence: Rehabilitation and aftercare for drug addicts; Subcommittee Reports and Recommendations – 1967-1971 (Report by the Rehabilitation Sub-Committee on Drug Dependence)

## **Appendix B. Interview Instrument**

### **Participant information:**

1. Interview number:
2. Date:
3. Country:
4. Professional position and program affiliation:
5. Length of time involved in addictions/illicit drug field

### **Background:**

6. Please briefly describe the nature of the drug problem and the character of the user population in your country (e.g. type of use, age of users, etc.).
7. Please briefly describe your government's approach to drug use/addiction (policies) as you see it.
8. Could you provide an overview of the treatment services that are currently available in your country and some of the problems or shortcomings of these services?
9. Drawing on your involvement in the addictions field, how would you characterize current political or social attitudes towards illicit drug treatment in your country? To harm reduction?

### **Heroin Maintenance Treatment:**

10. Can you provide a brief description of the heroin maintenance program in your country?
11. Were you involved in the initial implementation of your country's heroin maintenance programs? In what capacity?
  - a) If yes, what were some of the practical, legal, or political challenges or hurdles the program initially faced?
  - b) If no, are you aware of any practical, legal, or political challenges or hurdles the program initially faced?
12. In your experience, what are some of the challenges facing your country's heroin maintenance program in its day-to-day operations?
13. In your opinion, will heroin maintenance continue to be offered as a treatment option given the current political and social environment in your country? Why or why not?
  - a) If yes, do you believe it will become entrenched as a common treatment option? Will its availability be expanded? Why or why not?

### **Stimulant Maintenance Treatment:**

14. In your opinion, is there a need to develop alternative forms of maintenance treatment, such as stimulant maintenance, to address the needs of addicts who do not use opiates? Why or why not?
15. On a practical level or in terms of day-to-day operations, do you think stimulant maintenance is a viable treatment option? Why or why not?
16. Given the current political and social environment in your country, is stimulant maintenance a viable treatment option? Why or why not?
17. If a stimulant maintenance treatment program was going to be established in your country what are some of the political or legal challenges or hurdles the program would face?
18. If a stimulant maintenance treatment program was going to be developed in your country what would you recommend in terms of the following?
  - a) Type of drug to be prescribed (a substitute drug or initial drug of choice) and the properties of a substitute drug if this is what you would recommend.
  - b) Target population and the profile of users who would likely be successful in the treatment.
  - c) Supervised use or a take-home prescription.