

# SIMON FRASER UNIVERSITY

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Dr. Dan Small  
PHS Community Services Society  
20 West Hastings Street  
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Dear Dr. Small:

I am writing in response to your request that I supply an expert opinion regarding the successes in other jurisdictions of heroin maintenance programs for addicts and the need for similar facilities in the Vancouver area. First, allow me to state my qualifications for offering such an opinion. I have been involved, since the 1970's, at Simon Fraser University, in teaching and research regarding the effects of psychoactive drugs. I was a founding board member of both the Drug Policy Foundation in Washington, D.C. and the Canadian Foundation for Drug Policy in Ottawa. I served for four years as contributing editor of *The International Journal on Drug Policy* and I have testified on several occasions as an invited witness before committees of the Canadian Parliament dealing with scientific and policy issues with respect to psychoactive drug use. I have testified numerous times as an expert witness in both Canadian and American courts, and before regulatory bodies such as the B.C. Labour Relations Board, regarding psychoactive drugs, their effects, and effective regulatory and remediation policies.

For several years, I was one of the invited faculty at the Summer Institute on Drugs, Crime and Justice at Imperial College of the University of London. This annual institute was a "think tank" devoted to finding workable and humane alternatives to the War on Drugs. The psychiatrist Dr. John Marks, of the Merseyside Health Authority in Liverpool, co-founder of the world's first comprehensive "harm reduction" program for dealing with urban substance abuse problems, was a fellow lecturer in that summer institute, as were several of his colleagues. Even then, as the institute's director Dr. Arnold Trebach opined after seeing the Merseyside data, it was obvious from the Liverpool experience that "this is a job for the surgeon general, not the attorney general." Of course, the fact that the Merseyside program had the strong endorsement and participation of the local police administration as well as officers on the street was instrumental to its success. Comparison of data from Liverpool and from the close-by and demographically and economically similar city of Manchester (which opted to continue with a strict criminal

justice approach to drug-related problems) points to the clear superiority of the harm reduction measures instituted by Dr. Marks and his group. Based on the successes of these methods in the Merseyside region, and the long experience of British physicians, who for many decades before then had been permitted to prescribe opiates, including heroin, for addicts, it has been accepted by experts worldwide that heroin maintenance of addicts is just another tool that could be used effectively as part of a system of maintenance and treatment options that are well integrated with comprehensive medical, psychological, and social services programs and law enforcement.

Specific historical and ethnic considerations in North America have led to the demonization of heroin in the public mind, making it difficult, politically, for the public, the media, and lawmakers to accept it as just another of several possible options for opiate maintenance of dependent users. As I have travelled the world, attending conferences and visiting treatment facilities, my foreign colleagues have always been mystified as to why these prejudices against heroin should persist in North America, even among many trained professionals who should know better. As far back as 1926, after an exhaustive review, the respected Rolleston Committee (the U.K. Departmental Committee on Morphine and Heroin Addiction) recognized that “the infinitely prolonged administration of morphine or heroin [might] be necessary [for] those [patients] who are capable of leading a useful and normal life as long as they take a certain quantity, usually small, of their drug of choice but not otherwise.” Respecting the recommendations of the committee’s chair, Sir Humphrey Rolleston, the president of the Royal College of Physicians, the British government opted not make such prescription illegal in the UK, as some were demanding at the time. Viewing developments since Rolleston’s report, Canada’s highly regarded LeDain royal commission, in 1973, voiced its conclusion that heroin maintenance should be implemented on an experimental basis because, even then, there was reason to expect that such programs would be able to recruit users who had not been attracted by existing treatment modalities and that they would improve retention and efficacy, while reducing the costs to users and society at large. Since LeDain’s wise advice, supporting evidence has continued to mount.

It should be recalled that heroin (diacetyl morphine) is turned back into morphine by enzymes in the brain before it can stimulate receptors in the brain’s endorphin (endogenous morphine-like) system. Despite this, the differences in absorbability make it preferable to other opiates in some instances. All other drugs currently used for maintenance of heroin addicts ultimately exert their pharmacological effects on the same endorphin system in the brain, so there is no reason why prescription heroin should not be an option in maintenance programs. If some addicts seem to accept it more readily and function better as a result, I see no pharmacological reason why heroin should not be one of the maintenance choices available. Individual differences among addicts mean that one size does not fit all. More, rather than fewer, maintenance options should be available, since it is well established in the scientific literature that pharmaceutically pure opiates pose remarkably little in the way of health risks for maintained users—who, it has been shown repeatedly, can lead more normal, less harmful, lives as a result. In 2005, comprehensive review of the literature on heroin prescription maintenance for dependent users was published by the influential Australian addiction treatment expert, Dr. Alex Wodak. His review, published in the

journal *Expert Opinion on Drug Safety*, concludes, “On present evidence, [heroin prescription] is feasible and safe with limited, but increasing, evidence of safety and effectiveness.” Dr. Wodak emphasized the lack of serious negative consequences stemming from the heroin prescription programs that he reviewed and recommended that access to such programs be expanded.

As part of my teaching and research efforts, I keep a close watch on developments around the world regarding attempts to shift efforts to alleviate drug problems from the legal sphere to the medical, psychological, and social services sectors. I have also visited personally many of the municipalities in which this has been tried and I can state unequivocally that these jurisdictions, by all the usual markers of success, have fared far better than those who have persisted in the failed criminal justice approach. The role of harm reduction measures as part of a comprehensive approach to problems of substance abuse is well documented in the peer-reviewed scientific literature. Heroin maintenance has proven itself an effective arm of those efforts, as British Columbia’s Chief Officer of Medical Health, Dr. Perry Kendall, has asserted on numerous occasions.

Just as methadone maintenance for heroin addicts was attacked on ideological grounds, despite clear evidence of its utility in reducing the health and social costs caused by criminalizing non-medical drug use, attempts to extend maintenance options to heroin itself have been attacked by those who are ignorant of, or distort for their own political purposes, the results of several trials in a number of countries. The Netherlands, Switzerland, Germany and Spain have all mounted successful trials with heroin maintenance for addicts. Not only have the results been positive with respect to drastically reduced overdose death rates, lessened transmission of HIV and hepatitis C, and reduced involvement of participants with black market drugs, there has also been evidence of reduced criminal activity and improved employment statistics among previously unemployable substance users. Moreover, a reduction in homelessness rates has been seen among the street addict population. It should be noted that these sorts of results were achieved in Switzerland in spite the fact that, in order to obtain permission to mount their initial experimental heroin maintenance trials, the Swiss health authorities had to agree to admit only the most “hopeless” cases; i.e., those whose health, psychological status, history of criminal involvement, poverty, failure in previous programs, etc., made them most unpromising candidates for rehabilitation. Despite the salutary outcomes of the experimental heroin maintenance trials in Switzerland, opponents of the program still managed to put the proposal to continue these interventions on a nation-wide referendum ballot. The beneficial effects on health and crime statistics and improvements in the safety, livability, and esthetics of some of Europe’s most blighted urban areas were so obvious to the average citizen following implementation of the trials, that the referendum to terminate the program was voted down by the electorate by a two to one margin.

Some may argue that if the results from Europe are so clear, there is little need to “re-invent the wheel” with more trials in Vancouver. The answer to this is that, while the results in Holland, Spain, and Switzerland were strongly positive, and in my opinion will be borne out in the B.C. trends as well, there are unique aspects of Vancouver’s history, culture, and drug scene that make

it worthwhile to further investigate the details of how best to administer such a program here, before embarking on a wholesale change of policy and procedure. However, I am quite confident that the results already obtained in other jurisdictions are sufficient to support adoption of such a program here. I expect that heroin maintenance, if made available in British Columbia, would prove, as it has in Europe, to be an effective and humane option for those addicts who cannot function without the drug, and for whom there is ample scientific data to suggest they could lead productive, non-criminal lives with legal, affordable supplies of their drug of choice.

Experience has shown that many users, initially enticed to enter maintenance programs only by the availability of clean, modestly-priced drugs, often develop a trust and rapport with the facility staff that leads to utilization of other health and counselling services as well. It is often the case that, in this supportive environment, maintained users who would have vehemently rejected abstinence at the outset, become more willing to consider the prospect. Facilities that also offer help in becoming abstinent when the maintained user decides he or she is ready, eventually do see many of them succeed. Obviously, this should be encouraged. But, as Sir Humphrey Rolleston and many others who have studied the issue have concluded, even for those who must stay on maintenance indefinitely, the payback for them and for society at large, in terms of improved health, crime, and employment statistics, and the livability of our cities' core, is an affordable and ethical price to pay. There are no panaceas for societies' drug-related ills, only what Arnold Trebach calls "second-order solutions," ones that will help turn a disaster back into a problem. Heroin maintenance has proven that it can be one arm of the solution. Not only will the users be much better off than at present if affordable, non-judgemental ways of administering heroin maintenance can be implemented in Vancouver and elsewhere in Canada, we in the rest of the community will reap the benefits as well.

Sincerely,

A handwritten signature in black ink, appearing to read 'Barry L. Beyerstein', with a stylized flourish extending to the right.

Barry L. Beyerstein, Ph.D.  
Professor of Biological Psychology