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Prescribing Heroin for Addiction: Some Untapped Potentials and Unanswered Questions

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Abstract

The prescription of heroin to dependent users has been a distinctive feature of British drug policy for almost a century now, and in recent years the policy's evidence-base has grown significantly. However, whilst the evidence for heroin assisted treatment's effectiveness is strong it is somewhat limited by the clinical setting of the randomised control trial and thus leaves a number of important areas unexplored. This article investigates some of these through a sociological lens informed by both developments in regulatory theory and ethnographic research with a heroin-using population in North-West England. It is argued below that heroin prescription has currently 'untapped potential' as a means of regulating heroin markets, but also that it presents a number of 'unanswered questions' regarding heroin's socio-economic roles in marginalised communities and the importance of heroin-using identities.

Key Words

Drugs, Ethnography, Heroin Assisted Treatment, Identity, Moral Economy, Regulation

Introduction

The illicit use of heroin is bound up with a number of continued and pressing social problems in the UK at present, as it is in many other nations globally. According to the latest available data there are roughly 250,000-260,000 opiate users in England (Hay et al., 2014), with 155,054 of these receiving some form of structured treatment across 2012-13 (Lewis and Horgan, 2013: 17). As a group they are strongly associated with many of the most harmful aspects of drug use like the spread of blood-borne viruses and acquisitive crime, but they are also disproportionately affected by a number of social problems such as unemployment, poor health, low educational achievement and poverty (Pearson, 1987; Parker et al., 1988; Stevens, 2011). The current policy response to heroin – like other illicit drugs – is twofold; it involves the enforcement of the Misuse of Drugs Act 1971 by the criminal justice system, and the provision of various modalities of treatment/prevention through health agencies.

There remain however, certain ambiguities around the effectiveness of the UK's prohibition-based drug policy provisions (see MacCoun and Reuter, 2001; Seddon, 2010; Stevens, 2011), and recently the influential Home Affairs Select Committee recommended that alternatives to the current system be investigated further (HASC, 2012).¹ One of these was the clinical provision of pharmaceutical-grade diamorphine (heroin) to users with a view to ending their reliance upon illicitly sourced heroin: Heroin Assisted Treatment (HAT) as it is frequently termed. There have been trials of this technique in Germany, Spain and Canada, and it is an established component of drug treatment in the Netherlands and Switzerland. As a policy option, it has its roots in the 'British System' of heroin prescription born in the 1920s (see Strang and Gossop 2005a, 2005b).

There is a mounting evidence-base confirming HAT's beneficial qualities over and above other substitute prescribing techniques that is now global (Hartnoll et al., 1980; Perneger et al., 1998; van den Brink et al., 2003; March et al., 2006; Haasen et al., 2007; Oviedo-Joekes et al., 2009; see Strang et al., 2012 for an overview). It was in response to this – and particularly the UK-based Randomised Injectable Opiate Treatment Trial (RIOTT) (Strang et al., 2010) – that the Home Office issued invitations to tender for three injectable opiate treatment programmes in 2012.² Significantly though, this evidence has all been produced through strict clinical trials (usually in the form of randomised control trials) rendering it of questionable utility outside the clinical setting due to the analytic precision that is prerequisite of experimental methods. This is not to cast doubt upon the scientific rigour or validity of these trials, but rather to highlight the fact that they can be conclusive about their 'measures of measurable improvement', or their 'pre-selected primary outcomes', but unfortunately little else.

Thus there is a need to engage critically and theoretically with HAT; to assess it through a social scientific lens that can ask wider reaching questions than the 'cause and effect' clinical setting permits. The current lack of criminological analyses of HAT is surprising when its effectiveness over other methods of opioid substitution treatment and current policy relevance are considered. Whilst it is true that some of the conclusions reached below might apply to other methods of substitute prescribing (methadone or buprenorphine for example), these techniques are omitted from the present analysis to facilitate a tight focus on the potentials and pitfalls of HAT. Here HAT is investigated with a view to: (a) shedding light on an area of policy that appears set to expand in the near future; and (b), identifying any potential strengths and weaknesses within it which the clinical setting cannot/has not rendered clear.

To these ends the article opens with a brief overview of HAT in terms of its historical development and current trends. Following this the argument is made that HAT's potential as a form of market regulation is currently not recognised – that it has 'untapped potential' as a constitutive component of an alternative system of regulating heroin markets. However in the following section HAT is shown to have considerable obstacles preventing it achieving this potential. With recourse to some ethnographic fieldwork with heroin users in the North-West of England, these are demonstrated to be limited recognition of the socio-economic role of heroin in 'austerity Britain', and the nuances of what are termed below, 'real addict' subjectivities. Some cautious recommendations about the future of HAT are provided to close.

Heroin Assisted Treatment: Emergence, Evidence and Trends

By the early 1920s in Britain it was a punishable offence to be in possession of heroin without either a medical licence or a valid prescription. Whilst the UK's early heroin policy was control-based, it was never intended to restrict the medical practitioner from using this drug in their day-to-day practice. This was compounded by the conclusion of the Rolleston Committee in 1926 that prescription of morphine or heroin to addicts was 'sound medical practice' if other treatments had failed, or if it allowed them to live normal 'useful' lives. This was the basis of the 'British System' of heroin prescription. At its inception this system had little in the way of defining principles, specific practices, or clinical guidelines. This was largely because it did not need them at first; problematic heroin use was very rare in the UK at this time. In fact, David Downes once wrote that the pre-1960s British System 'has now been well and truly exposed as

little more than masterly inactivity in the face of what was an almost non-existent addiction problem' (1977: 89).

In the 1960s however prescription became cause for concern as heroin filtered out into the black market; the number of users known to the Home Office increased dramatically from ninety-four in 1960, to 2240 in 1968 (Seddon, 2007: 64). Tough new measures were introduced in the 1967 Dangerous Drugs Act requiring doctors to gain a licence from the Home Office to prescribe heroin. Following these (and then the introduction of methadone in the 1970s), 'British system' prescription rapidly declined. A 2002 survey revealed that only seventy of the UK's 272 eligible doctors currently held a licence to prescribe heroin, and of that number only forty-six actually use it. There were 448 patients prescribed heroin in the UK at this time (Metrebian et al., 2002: 1157).

Importantly at this point, the distinction between heroin prescription and HAT needs to be stressed. There is a dual incarnation of heroin prescription in the UK at present; there are roughly 400 'British System' users with long-term maintenance prescriptions, *and* new RIOTT – that is, HAT-receiving – prescribes (of which there were originally 43). Heroin prescription and HAT is *not* the same thing; British System prescription involves 'take home' doses of heroin, yet HAT involves two or three daily visits to a clinic where a single dose is administered under supervision. British system prescription is in terminal decline, while HAT looks set to expand.

This potential expansion is backed a growing evidence-base in support of HAT. Impressively, *all* clinical trials conducted to date have confirmed HAT's ability to reduce illicit heroin use more effectively than other forms of substitute prescribing. The conclusions reached by the RIOTT were that:

Treatment with supervised injectable heroin leads to significantly lower use of street heroin than does supervised injectable methadone or optimised oral methadone. UK Government proposals should be rolled out to support the positive response that can be achieved with heroin maintenance treatment for previously unresponsive chronic heroin addicts.

(Strang et al., 2010: 1885)

Moreover, the Swiss experience has, since 1991, seen the number of deaths from heroin overdose fall by c. 50 per cent and new HIV infections reduced by c. 65 per cent (Uchtenhagen, 2009: 35). Importantly as well, trials in Germany have recorded positive results for new and long-term users alike, casting doubt upon the belief that HAT should be used as an ‘end line’ treatment only (Haasen et al., 2010).

In summary, it is now well established that HAT is *the* most effective method of reducing ‘street’ heroin use. While HAT potentially undermines some aspects of the broader moves towards a more ‘recovery-orientated’ (i.e. abstinence-based) drug policy in the UK (see Duke, 2013) – the emphasis on users attaining ‘freedom’ from addictions for example – it is seemingly the case that the government are unusually willing to follow the available evidence and pursue the use of HAT further. In this respect it is crucial that this practice is investigated critically in terms of its wide-reaching potential outcomes, both positive and negative.

The Potentials and Pitfalls of HAT

What follows is divided into two subsections: the first is primarily theoretical and assesses the ‘untapped potentials’ of HAT as a possible alternative means of regulating low-level heroin markets, the second is primarily based upon the results of ethnographic fieldwork with a group of heroin users and is concerned with the ‘unanswered questions’ they present HAT. As such, a brief word on methods is required.

Methods

The latter sections of this article utilise the findings of an ethnographic exploration of heroin in austerity Britain conducted across 2012-13. The research was based on a housing estate in North-West England that I call ‘the Range’. Whilst there are limits to the amount of data/sources that can be included here without compromising the participants’ anonymity, their home town has a population of just over 30,000 and the local county council claim the sub-ward within which the Range is located to rank inside the top ten per cent most deprived areas in England by four measures of deprivation: ‘educations, skills and training’; ‘employment deprivation’; ‘income deprivation’; and ‘crime deprivation’. For the latter two of these it ranks inside the top two per cent most deprived nationally. In short, this is an area that has above average levels of many measures of social exclusion.

A total of seventeen people from this locale were recruited via a snowballing technique to participate in this research. Six of them were female the rest male, the youngest was twenty-three and the eldest in her early seventies. All of them (except a 72 year old woman) were regular and current heroin users with almost all using other drugs too (crack cocaine most frequently). The main method of data collection

employed was participant observation due to the group's initial aversion towards being recorded, however in-depth interviews were conducted towards the end of the fieldwork with three of the project's five 'core' participants. Whilst in the field I was always open about my reasons for being present, but sometimes only when asked. I did however prepare and carry a detailed participant information sheet.

To collect data I visited the participants' homes and 'hang outs', and I accompanied them on their various excursions around the town: on 'official' visits to places like the doctors surgery, needle exchanges and the job centre, and on their heroin-related 'missions' too (typically shoplifting and/or buying drugs). I carried a pen and notebook with me at all times, using them as and when it was appropriate to do so; at the end of every day a detailed set of field notes was compiled and shorthand quotations typed up. All data were securely stored and protected digitally, following the guidance of Aldridge et al. (2010).

In summary, whilst it has its inherent limitations, the observation-based methodology used here has been argued by some to be *the* most reliable way to research this particular population due to the frequent disparities between what they *say* they do, and what they *actually* do (Bourgois, 1998). It is recognised that there are many methodological issues inherent in a project such as this, yet space precludes their detailed analysis here. The methodologically-interested reader is directed towards Wakeman (2014a) which provides a detailed autoethnographic account of this research.

The Untapped Potentials: HAT as Market Regulation

Before venturing into the ethnographic data, it is possible to make a strong theoretical case for HAT as having the 'untapped potential' to regulate heroin markets. As noted

above, HAT-style prescription is clinically managed in that it requires users to attend dispensing and consumption facilities to receive and administer their heroin. Relocating heroin use to the clinical setting like this has many advantages, however the main one is that it relieves users of their reliance upon ‘black market’ heroin. It is here that a key manifestation of HAT’s untapped potential can be identified – it has the capacity to reduce the harms of this black market.

This is the case because heroin, like all drugs, is produced, sold and consumed in *market systems*. And, it is in these markets that the majority of the drug’s harmful qualities are located. The current regulatory arrangements that heroin is subjected to cultivate a market that is at the same time hazardous to users’ health, violent, and criminogenic. They also play a significant role in the reproduction of heroin use’s exclusionary properties. These are not *just* consequences of the use of this drug, but consequences of the way in which it is regulated. The key point here is prohibitive drug policies constitute (in that they create) a criminal market space: thus, an alternative system of regulation could constitute an alternative market space.

This has been noted in the emerging works of scholars attempting to integrate aspects of ‘regulatory theory’ (see Braithwaite, 2008) with drug policy (e.g. Ritter, 2010; Seddon, 2010, 2013; Wakeman, 2014b). One of the main advantages that these works sought to highlight is the ability of a regulatory conceptualisation to ‘broaden the field’. They contend that when it comes to regulating markets, the law is not the only effective method. That is, asking questions of drug policy and drug markets requires thinking beyond the traditional domain of the law. Rather, this is a problem of the overall system of regulation first and foremost.

To clarify the above, whilst UK drug policy remains influenced by *both* criminal justice and public health concerns, drug market regulation is a strictly criminal justice-based affair. However, there is a need to think in a more nuanced way about the options available to regulate this market. Shearing's (1993) 'constitutive conception' of regulation reiterates this point:

It insists that any move to re-regulation ['re-' as he refers to a post-deregulation world] should take a much broader view of regulation than the control conception permits. In taking this view it insists that regulatory space as a whole should be made the subject of regulatory policy. In so doing it decentres the state as a source of regulation and points to the role that can be played by a whole host of regulatory schemes.

(Shearing, 1993: 72-73)

Thus, the regulatory 'space' of heroin markets would be best addressed through an array of agents and apparatuses, not *just* the application of the criminal law. In this sense HAT has a potentially significant role to play as one 'scheme', or *constituent*, of an alternative system of regulation.

The goal from a regulatory perspective is to provide a framework that can shape the whole system rather than just address certain problematic components of it. It is arguably the case that HAT, if used on an advanced scale, would enact a change in the dynamics of this whole market space. Drug markets operate along conventional lines of supply and demand (MacCoun and Reuter, 2001; Paoli et al., 2009). While HAT would not reduce demand *per se* (a large-scale roll-out may actually increase it somewhat),

what it *will* do is reduce the share of market controlled by the harm-laden illicit sector. If high-quality pharmaceutical-grade heroin is easily available then users are unlikely to opt for an inferior product sold in dangerous market spaces. However, and this crucially important point is revisited below, such a contention rests upon heroin users making this seemingly ‘rational’ choice (Becker and Murphy, 1988). HAT is predicated upon a compliant ‘addict subjectivity’ which – as demonstrated in the next section – complicates its extended use somewhat.

In the event of an extended HAT roll out though, it would be unlikely that illicit heroin-dealing operations could compete with the quality of pharmaceutical-grade produce, and as such (and provided that the leakage of licit heroin into black markets can be restrained to the same degree it presently is) they would be edged out of business (Killias and Aebi, 2000; Buxton, et al., 2008). It is of course possible that some might survive on the market share of users ineligible for prescriptions.³ Yet it is debatable as to whether or not this would be a significant proportion given the fact that the numbers of new and younger heroin users (the group most likely to be ineligible for prescriptions) are in long-term decline. Crucially, the only section of the UK’s heroin-using population *not* declining in number is the ‘35-64’ age group (Hay et al., 2014: 15), suggesting that the largest consumer-base in this market is the long-term user group – the very group HAT is proven to be so effective for.

It must be asserted that this is *not* a system whereby heroin becomes legal and criminal justice-based operations against markets cease. Rather, they would be complemented through the introduction of another form of regulation that has the power to constitute the market as less harmful – that is, a regulatory framework that can encourage and facilitate positive outcomes at the same time as reducing negative ones.

While health outcomes almost always feature in drug policy debates (see Haden, 2004), HAT has the capacity to enact effects over and above these in areas like employment and housing.⁴ While data supporting the criminal justice potentials of HAT are unfortunately in short supply, in their account of the RIOTT's secondary outcomes Metrebian et al. (2014) claim a statistically significant reduction in treatment group offending. Similarly, Uchtenhagen (2009) recounts a notable reduction in 'drug-related delinquency' in Swiss cities following the introduction of HAT, but likewise notes the absence of robust data to support this. However, HAT's potential impact on criminal justice outcomes is very real.

In summary, there is currently 'untapped potential' in HAT to not only restrain negative behaviours, but also engender positive ones too. Employment, educational uptake, better health care practices, reduced offending rates and improved social functioning are all pertinent examples (Killias and Aebi, 2000; Metrebian et al., 2014). However, whilst there are considerable potentials to be found in HAT as an alternative technique of market regulation, there are a number of significant barriers that will be likely to preclude their full realisation. It is to these that this article now turns.

The Unanswered Questions: HAT, Moral Economics and 'Real Addict' Subjectivities

Despite the potentials of HAT there remain a number of 'unanswered questions' surrounding it, and these frequently reside in issues of *desirability*. For example, of the 1969 patients attending Swiss HAT clinics between 1994 and 2001, 60 per cent left to pursue alternative modalities of treatment (residential rehabilitation or methadone prescription for example) and once they had left, only nine per cent returned (Rehm et

al., 2001: 1418-19). Also of interest here is the fact that there are *no* waiting lists for HAT in either Switzerland or the Netherlands (Strang et al., 2012). Whilst this could be interpreted in a number of ways, it is emblematic of a pertinent question here – namely, is HAT reaching everyone who needs it and working well for most of them, or is there something about it that users find undesirable? Leaning towards the latter – and with recourse to the ethnographic data described above – it is held here that HAT’s apparent lack of desirability resides in the complexities of heroin’s cultural economic roles in marginalised communities, and the ways in which *being* a heroin addict can constitute a meaningful identity.

The Moral Economy of Heroin The anthropologist Philippe Bourgois (1998; Bourgois and Schonberg, 2009) has described the practices of sharing heroin among homeless heroin users in California as a ‘moral economy of heroin’. He went on to note that this economy of sharing was critical to the everyday survival of this group. A similar system exists on the Range, and here too heroin’s significance transcends its ‘use value’. It has become a core component in a moral system of exchange and reciprocation that extends into virtually all spheres of social life. In fact, it could be argued that this micro economy of exchange *is* social life for these users. In this group almost all social interaction becomes embedded within this moral economic order, as the following excerpt from my field notes illustrates.

This morning I find myself sat alone in a dark flat waiting for Ryan (a long-term heroin user in his early forties) to return from buying heroin. It’s colder in here than it is outside; it’s January and he’s had no gas or electric for days! A knock at the

door introduces Alan to the day (long-term heroin user, late-thirties). He's visibly agitated and it doesn't take me long to work out that Ryan's getting the heroin for him. He rummages round in his pocket and pulls out a chocolate bar. He hands it over to me and lets me know he brought it here for me specifically. I doubt this is true; he didn't know I was here. I thank him anyway. Ryan arrives back in stereotypically animated fashion and Alan jumps up to give him the cigarette he's been smoking as a greeting (he literally places it between his lips). Ryan drops two bags of heroin and a two 'rocks' of crack cocaine on the table, 'two-and-two' as they call it.

Alan snatches it up and loudly asserts that he will be sharing it all with Ryan: "I told you didn't I?" he beams excitedly. "You know it with me lad, you know I look after you". Ryan registers his gratitude but then checks quietly that being 'sorted out' like this won't prevent Alan from "doing 'that thing' for me until tomorrow too?" By 'that thing' I later learn he meant borrowing five pounds to get some electricity. Alan assures him it's still ok and so begins the process of cooking up a speedball (a mix of heroin and crack in one hit). A brief argument then ensues over the water, whether .70 or .80ml went in the cooker? This is important as it decides how much goes in each needle for injecting. Whilst this is taking place Alan again makes it known that he's a 'reliable' user, that when he says he'll get money for drugs, he always comes through. Ryan reciprocates: "Yeah I know mate, but you do too isn't it? He knows I'll be looking after him tomorrow Ste, don't you Al?" Alan confirms this with a bang of fists, followed by a second one shortly after in recognition that their injections are ready.

Alan injects in his groin and thus he's done within seconds. Ryan however isn't prepared to do this and his process is slightly more drawn out. Alan steps up to do it for him – he actually insists. He 'gets him' in his foot after failed attempts in both arms and hands. He then insists (equally as forcefully) upon cleaning the injection site with a sterile wipe he has in his pocket, he finishes up by carefully putting a plaster on it. He again asserts how good a person he is to have around whilst deliberately and loudly looking for his chocolate bar. I remind him he gave it me and he feigns recollection; he knew this all along. He falls back into his seat and looks in my direction: "Give us a smoke then lad?"

The above shows the extent to which the moral economy of heroin edges out into the daily lives and practices of these users. Both typically spend between ten and fifty pounds on heroin daily. Today Alan has money and he took care of things, but tomorrow Ryan will.

In a sense then heroin's moral economy is a straightforward system of exchange that enables people to maintain their drug use over and above their financial means. However this is a shallow reading of a complex, multi-faceted phenomenon in a constant state of flux. For example, the above extract shows that Ryan went to 'score' the drugs. On an estate like this – in a town rather than a large city – an 'open market' (see May et al., 2005) is rare; one needs to be known and approved of by dealers to purchase drugs. Alan was unable to see this particular dealer, yet Ryan was. Use of a 'service' like this requires a payment into the moral economic order, a small amount of heroin typically. Similarly, Alan was able to inject Ryan when he could not do so himself. The ability to always find a vein in heroin using circles is a highly privileged

one. This is why Alan made sure it was noted through the extended ‘cleaning’ procedure. The money loan too is bound up within this order. Alan’s assurance that he will get his money back comes today in the form of his ‘sorting out’ Ryan and the moral economy-based responsibilities it engenders. It is the loan’s security, neither would risk letting down such an important trading partner as the other; to do so would jeopardise their ability to acquire heroin the following day. Finally, Alan giving me the chocolate bar permitted him to ask for the cigarette (as well as obliged me to give it him).

This system of exchange is fluid and porous – it involves money, food, electricity, services and more. Yet crucially, heroin is its core commodity and this is precisely why it stands as a barrier to HAT; relocating heroin into the clinical setting removes the user from a harmful illicit market yes, but also from the cultural-economic order that surrounds it, which actually brings many social and economic benefits to users such as these. In HAT there is no sharing, there is no ‘getting’ each other.⁵ This may be overcome by the instrumental benefit of having heroin available, but it would mean both Ryan and Alan’s key ‘skills’ – which enable them to both survive their socio-economic situations *and* provide them with some form of meaningful social interaction at the same time – are rendered obsolete. Ryan’s abilities to get heroin and quickly sell stolen goods means there is always someone in his company. People who are obliged to help him with heroin, but also lend him five pounds to keep his heating on. If his heroin were provided for him at a clinic, his role in this moral economic order – and the vital social/economic benefits it brings – would be lost.

Importantly though, it must be stressed that the moral economy of heroin is not static. It is fluid in its operation its boundaries are easily permeated. This is significant as it means that while the system does provide a means by which these users can better

maintain their heroin habits and survive their socio-economic circumstances, it could also facilitate change too. There is a pertinent link here with the criminological theories of desistance from crime (e.g. Laub and Sampson, 2001; Maruna, 2001) which postulate that changes in social contexts can act as catalysts for change. This is certainly true in the case of drug users (see Frisher and Becket-Wilson, 2006; Cloud and Granfield, 2008) and as such, the moral economy of heroin should not be understood as a rigid barrier to change across the spectrum of heroin users.

The above considered, the crux of the matter remains as such: HAT is predicated upon the resituating of heroin from its current *social* context into an alternative *clinical* one. This relieves heroin and its associated practices/activities of their socio-economic significance to users, and renders participation in the moral economy of heroin practically impossible. Where this occurs in tandem with the ever-advancing intrusion of neoliberal capitalism's exclusionary processes – which have resulted in an almost complete erosion of meaningful social systems in locations like the Range (Stiegler, 2011, 2013; Winlow and Hall, 2013) – it will become a significant hindrance to any extension of HAT. It is vital that the emergence and importance of heroin's moral economic order be situated in this context; it is a meaningful response to structural and cultural marginalisation. Remove these users from this cultural-economic system and the harsh truth of the matter is this: very little of a 'social' remains.

Real Addict Subjectivities It is not just the instrumental features of heroin use that have the potential to inhibit the effectiveness of HAT; this drug and its use have symbolic significance for identity too. In locations like the Range 'heroin addict' can become a meaningful identity when these are not easily available. That is, to be what

the participants in this study frequently termed a ‘real addict’ is to be something/someone in an environment where the possibilities for status are limited. For these people a heroin-using identity becomes meaningful, and then crucially, their resultant self-concepts (or *subjectivities*) likewise become potentially incongruent with those required by HAT. Succinctly put, the ‘real addict’ is strong and resourceful; s/he is a transgressive survivor of circumstance. The real addict is capable of looking after one’s self, and sufficiently skilled to meet the day-to-day challenges of maintaining a heroin habit, at times s/he actually enjoys doing so too. The user in HAT however, is a patient. This is *not* how these users understand themselves, and this is why HAT may not appeal to them.⁶

The kernel of the issue is this: while some claim significant proportions of heroin users want to get off drugs completely (e.g. McKeganey et al., 2004; Gordon et al., 2008), this is not true of many others. Issues of sample bias are perhaps resonant here, but it must be recognised that some users do *not* want any sort of ‘treatment’, they do *not* want to be abstinent and that in fact, they hold their ‘addict’ identities in considerable regard (see Preble and Casey, 1969; Pearson, 1987). By way of an example, the following brief excerpt of data is useful. It covers a conversation I had with ‘Baily’, a well-known and ‘respected’ (read: ‘feared’) heroin and crack user aged 30. I’m with him today after Ryan and I met him and his partner Sarah out shoplifting.

I don’t mind admitting that this bloke scares me a bit. He’s happy enough now, but I don’t want to be about when that crack runs out. He’s talkative at the minute so I pry a little about his criminality and drug use, I ask if he didn’t take drugs would he still

have done that this morning with the DVD players [a couple of hours previously he had stolen two from a supermarket]?

“Well yeah and no, it’s like, obviously it’s the drugs ‘cus that’s what I need the money for right now isn’t it? But, it’s not *just* that, it’s like, it’s just what I do lad, it’s who I am you know? I was lifting stuff before I ever took drugs – I grew up in homes [care homes] and that, and we never had fuck all. The thing was, we knew we was never going to get fuck all either unless we took it...”

I don’t want to risk provoking him by disagreeing, so I make some sort of agreeable response about this being ‘him’ and ‘his life’. He seems to appreciate this and even makes a joke about it not being a “bad life”, the only downside being that ‘they’ “throw me in jail now and again”. I ask what, if anything, might calm him down, drug treatment maybe?

“Treatment for what? This [motions towards the needle he’s now got in his hand with a look of disbelief/annoyance on his face]? This [meaning drugs] is the same as the crime; it’s what I do, who I am, and everyone knows that. I don’t need no ‘treatment’ to get off this you know, tell him bab [he motions to Sarah who nods a barely coherent reply in my direction], tell him what I’m like. I do my thing ‘cus I want to, but if I want off it then I’m off it, that’s that.”

This neatly demonstrates Baily’s identity as a ‘transgressive subject’ (Hayward and Young, 2004). He is aggressive and active in his heroin use, he pursues ‘heroin addict’

as a meaningful identity in of itself. He has constructed an identity around his abilities as an addict and his criminal prowess; he told me of his many criminal exploits and the ways in which he ‘did what had to be done’ to get heroin. Whilst he insisted he could come off it at any time (to be seen to maintain control is crucial to him), he was equally adamant that he would not ‘rattle’ (experience withdrawal) for ‘no one’. On one occasion he even assured me, chillingly, that if this meant he had to “go snatch a handbag, then I’m going to go snatch a handbag!”. Whilst some of this was no doubt bravado, it would be foolish to dismiss it all as such. When he describes himself as a ‘real addict’, he does so by situating this identity at the very core of who he is.

Like the moral economy the real addict subjectivity is both varied and fluid, yet its core processes remain constant. Alan for example is not as aggressive in his approach to maintaining his habit as Baily, but this too is important here. Alan takes a more passive approach through his ‘trading’ with Ryan (as outlined above): he is certainly not averse to breaking the law, but understands himself as a survivor of circumstance before a prolific criminal. The following brief recounting of our introduction is indicative of this:

As soon as he [Alan] walks in I can tell he’s unsure of me, but he’s not hostile. He sits down and makes some small talk; he asks how long I’ve been over here and where I’m from, but when I tell him something shocking follows. He tells me he used to live there too, but moved away after his young daughter was kidnapped and murdered. I’m literally blown away by this and don’t know how to respond. The thing is, he’s not the first person to ‘introduce’ himself with a painful disclosure like this. These stories are thrown in as a means of both justifying their present

conditions (and drug addiction) and of identity assertion – ‘look how hard I’ve had it yet, I’m still here doing what I do’. It’s like Ryan always says, “no matter what, I’m a survivor I am”.

Within a matter of weeks from commencing fieldwork I had been told of two cases of sexual assault, the murder of a child, the recent death of a close friend, and an incurable health condition. These examples were not evoked out of self-pity; they were used specifically to demonstrate a level of resistance to misfortune/social setting.

Importantly again, it should be noted that there is congruence here with desistance theory and that the above can also be considered catalysts for change in some circumstances – this is certainly true of the painful events described here (Maruna and Roy, 2007). However, the fact remains that the subjectivities displayed by the heroin users on the Range – be they active criminal or resistant survivor – are simply incongruent with that required for the successful expansion of HAT which, as described above, is more akin to that of ‘patient’ than anything else. The ‘real addict subjectivity’ is one of survival and agentic capacity to transcend social circumstances, yet HAT would critically reduce this prized transcendent capacity. The core of this issue is this: the compliant subjectivity identified above as being crucial to HAT’s success is not always evident among some sections of the heroin-using community. The subjectivities witnessed here are resistant, transgressive and in some instances committed to being a heroin user. This incongruence must be accounted for if HAT is to ever achieve its full potential.

In summary then, whilst it is true that there are important pragmatic issues surrounding the ethics and costs of HAT that are also pertinent here, these are not nearly

as pressing as the very real possibility that HAT's target population does not and will not find this treatment an attractive option. Despite the fact that the respective authors and research teams did not set out to focus upon such issues, the evidence-base for HAT is still crucially guilty of neglecting both heroin's role in the construction and maintenance of individually meaningful identities, and the importance of heroin's moral economic order in the marginalised communities of austerity Britain.

Conclusions

In terms of drawing out some conclusions from the above, it has been demonstrated that HAT has the realistic potential to address some of the harms associated with heroin use, but that it also has a number of barriers likely to preclude the realisation of said potentials. Regarding the former, the ability of HAT to act as one constitutive component of an alternative system of drug market regulation should not be downplayed. Within HAT there remains considerable 'untapped potential' to achieve progressive outcomes such as reductions in harmful drug use and criminality, as well as increases in positive outcomes like health experience and social functioning. Importantly, heroin's current prohibitive regulatory arrangements have proven to be unable to achieve reductions/increases such as these. In this respect, an increased roll out of HAT has to be considered worthy of further investigation.

Yet the above also demonstrated some of the difficulties any potential increase in HAT provisions will encounter. Importantly here, these issues were shown to exist beyond the epistemic reach of the randomized control trial. While positive outcomes are surely realisable through HAT, the issue of heroin's multiple roles in marginalised

groups remains to be accounted for. Users like Ryan and Alan gain multiple benefits from their participation in heroin's moral economy, and these are frequently important to their economic survival. As such, a treatment technique that relieves them of these benefits appears destined to have limited desirability. Likewise, the incongruence between the real addict subjectivity with its resistant, transgressive edge and that of the patient-like rational chooser required by HAT is also a significant issue that requires further attention to properly resolve.

In conclusion, it would appear that the future use of HAT in the UK is all but assured and its extension (backed by considerable 'gold standard' evidence) is more than plausible. This considered, the key task of policy makers and treatment providers involved in HAT provision will need to be as such: to maximise the treatment's reach through increasing its desirability in the eyes of its target population. In this respect, a pan-European approach to HAT (whereby the Swiss/Dutch models are mirrored in the UK) becomes problematic, despite the initial successes of the RIOTT which adopted a similar approach. To achieve its inherent potentials HAT will need to be attuned culturally to the contours of heroin use in 'austerity Britain'; it will need to be rolled out extensively so as to enact a significant effect upon the market, but in such a way that does not deter individuals for whom heroin use itself remains a meaningful activity. In this sense then, HAT's future is perhaps far more complex than it initially appears – it should now become a key concern for practitioners, policy makers, and academics with an interest in the drug treatment field. HAT is far too complex to be confined to the randomised control trial.

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Notes

1. It is perhaps noteworthy that similar recommendations regarding drug policy were made by the HASC a decade ago and largely ignored. However in the case of UK HAT specifically, the successes of the RIOTT has made this less likely to occur again.
2. These clinics are currently operating in London, Darlington and Brighton, tenure was initially commissioned until 2015.
3. Here questions become resonant surrounding who would (and who would not) be eligible to receive HAT – the exact parameters of a future system are certainly important, and as such would require more attention than space permits here.
4. In the Swiss programme across 2005-2010, between 14 and 21 per cent of new entries were in employment, however after a year in HAT 42 per cent were (re)integrated into labour markets. Similarly, approximately 24 per cent entered

treatment without secure living arrangements, yet after one year this was just 4 per cent (Strang et al., 2012: 109).

5. There is in fact virtually no social interaction at all. Users inject in individual booths and are encouraged to leave promptly after their supervision period is over (see MacCoun and Reuter, 2011).
6. When a conference presentation I was writing on this paper was mentioned to one participant in the field, he laughed off prescribed heroin as an addiction treatment as potentially the ‘stupidest idea’ he had ever heard.

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