Opinion

Bioethic Research Notes 11(1): March 1999

HEROIN TRIALS - NO EASY FIX

By Dr Gregory K Pike

> 'Oh! ho! ho! - you goo into the druggist's shop o'market-day, into Cambridge, and you'll see the little boxes, doozens and doozens, a'ready on the counter, and never a venman's wife goo by, but what calls in for her pennord o'elevation, to last her out the week. Oh! ho! ho! Well it keeps women-folk quiet it do; and it's mortal good agin the ago pains.'
> 'But what is it?'
> 'Opium, bor' alive, opium!'[1]

If England between 1820 and 1930 could be described as 'completely narcotised'[2], in years to come the latter part of the twentieth century may be remembered, amongst other things, for its even greater propensity for chemical panacea. We consume both licit and illicit drugs at prodigious rates, whether as balm for our ills or in quest of elevated awareness or some other altered consciousness. It is in search of this special state that some are attracted to opiates[3].
The sensations associated with opiate use were aptly described by Thomas De Quincey when, in 1821, he divulged his experiences to the public in an autobiography entitled 'Confessions of an English Opium-Eater':

> Here were the hopes which blossom in the paths of life, reconciled with the peace which is in the grave; motions of the intellect as unwearied as the heavens, yet for all anxieties a halcyon calm; a tranquillity that seemed no product of inertia, but as if resulting from mighty and equal antagonisms; infinite activities, infinite repose.[4]

As if in cruel antithesis to this magical phase, there could follow a hellish withdrawal.

> ....symptoms are manifested by severe cramps and aching muscles. The skin reaction resembles goose-flesh, hence the name 'cold turkey'. Excessive sweating, shivering and chills set in. Eyes water and a condition resembling sinusitis follows. Restlessness, anxiety, irritability are accompanied by a craving for the drug. Yawning and diarrhoea are common. Vomiting and convulsions and cardiovascular collapse....[5]

Around the turn of the last century, the interpretation of the addicted state changed from an understanding based upon 'a pathologically debilitated will' or what may be called a 'moral pathological model of addiction'[6] to an understanding of addiction as a pathological disease warranting medical treatment. Addiction to opiates has physical[7] and psychological components, and the preferred mode of dealing with the problem will depend on how the addiction is interpreted. For example, one view may prompt the 'just say no' approach, whilst the other may

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[1] Charles Kingsley, *Alton Locke* (reprint of 1850 edition, London: Cassell's, 1967), 124-125.
[2] Terry M. Parssinen, *Secret Passions, Secret Remedies. Narcotic Drugs in British Society 1820-1930.* Manchester University Press, Philadelphia, 1983, ix.
[3] The term 'opiates' includes morphine, heroin, codeine, pethidine, methadone, the raw product opium, and other related substances.
[4] Thomas De Quincey, *Confessions of an English Opium-Eater and other writings*. Ed. Aileen Ward (New York: Signet, 1966), 71.
[5] Moffitt et al., 1998, *Drug Precipice*. UNSW, Hyde Park Press, 50.
[6] Geoffrey Harding, *Opiate Addiction, Morality and Medicine*. *From moral illness to pathological disease*. St. Martin's Press, New York, 1988.
[7] Leshner, A.I., Addiction is a Brain Disease, and it Matters. *Science*, 3 October, 1997, 278: 45-47.

opt for a drug maintenance treatment such as methadone, or more topically heroin. One would hope that there is room in between for an approach which recognises both aspects of addiction. The notion that heroin addiction is a disease rests upon the fact that it displays symptoms and consequent physical defects in much the same way that alcoholism is considered a disease, by exhibiting clear pathology. That the disease is self-inflicted is not at issue. On this point it could be argued that the majority of diseases are self-inflicted and therefore avoidable by an act of the will, for example, sexually transmitted diseases, heart disease, lung cancer, reflux disease, and possibly many others. There are of course many diseases that befall us that no act of the will can prevent, such as genetic diseases or many infectious diseases.

The interpretation of heroin addiction as a disease does not absolve addicts from exerting their wills to enable or assist treatment, just as victims of lung cancer caused by tobacco need to quit smoking to aid their treatment, or alcoholics need to avoid drink to save their liver. And, for both alcoholism and opiate addiction,

> If addiction is a disease, then it is essential to keep the infectious agent away from the potential victim to the greatest extent possible.[8]

But it is the power of the mental straightjacket effected by heroin that makes opiate addiction so seemingly intractable.

The growing problems associated with illicit drug use have prompted many responses in recent years. One of these has been that the 'war on drugs' has been lost and therefore a new approach is needed.

The introduction of heroin trials in Switzerland in 1994-1996 almost paralleled in time the proposal in the ACT that Australia follow suit and conduct similar trials. As early as 1991 Gabrielle Bammer of the Australian National University began addressing the possibility of conducting Australian heroin trials, publishing a series of working papers with a thorough assessment of each and every aspect of the proposed trials. When it appeared that this work was approaching fruition the Prime Minister, John Howard, canned the idea with a strong commitment to the notion that the trials would send the wrong message to Australian youth. His efforts were directed against any 'normalisation' of drug use. That was in 1997. In 1998, the South Australian House of Assembly passed the following motion which had been moved by Liberal MP Martin Hamilton-Smith:

> That this House establish a select committee to investigate whether the Government should conduct a scientific, medical trial to determine if the provision of injectable heroin as part of a program of rehabilitation improves the community's ability to attract and retain into abstinence treatment drug misusers who are committing crimes, at risk of transmitting HIV or at risk of death or serious injury as a consequence of their abuse.[9]

To maximise the chances of a heroin trial going ahead, Hamilton-Smith realised that public support would only be forthcoming if heroin addiction touched home base. This is why considerable emphasis by proponents of the trial has been placed upon crime and the risk of disease transmission. These two evils are the concern of the whole electorate. The risk of serious death or injury to heroin addicts is likely to influence some, despite the callous attitude

[8] Terry M, Parssinen, *Secret Passions, Secret Remedies. Narcotic Drugs in British Society 1820-1930.* Manchester University Press, Philadelphia, 1983, 100.
[9] *Hansard*, Thursday 19 November, 1998: 313.

prevalent among many that 'they have brought this on themselves so they can stew in their own juices.'

The real difficulty for proponents of the trial is to convince others of the need to use the very substance which creates the addiction as a 'treatment'. This amounts to maintaining the addict in his addiction for certain trade-offs to benefit the community at large while at the same time attempting to improve the addict's lifestyle. Around the turn of the century, despite heated dispute, a consensus began to emerge about a theory of addiction. Writers were in agreement on the major issues, one of which was that

> .....substitution of drugs such as cocaine, cannabis indica, or even heroin - which had been variously recommended in the last three decades of the nineteenth century - was a terrible mistake.[10]

This 'terrible mistake' was an attractive proposition to some, given the tenacity of addiction and the failure of much of the treatment effort. Indeed it is much the same today when we see so much effort thrown at a problem which not only refuses to go away, but escalates.

During the Opium Wars of the last century the Emperor of China repeatedly pleaded with the British to halt the smuggling of opium into his country by British merchants. He was well aware of the harm opium smoking was doing to his nation. However, British representatives in China urged the Emperor to legalise the trade, highlighting the vast revenue to be raised for both sides by the subsequent increase in use. The Emperor remained resolute.

> It is true, I cannot prevent the introduction of the flowing poison; gain-seeking and corrupt men will for profit and sensuality defeat my wishes, but nothing will induce me to derive a revenue from the vice and misery of my people.[11]

The Emperor recognised the damage to his society by the pervasive use of opium and refused to become complicit in what he saw as a social evil. He was refusing to accept that opium use should be allowed to become normalised into everyday Chinese life. It was too harmful and was tantamount to consigning to the grip of addiction even greater numbers of his population than were already affected.

In our day there is a particular approach to the problem of illicit drug use which accepts that drugs are in use, makes little attempt to diminish use, and becomes complicit in assisting users. That approach is called 'harm minimisation' or 'harm reduction'. *By side-stepping the primary harm of the mind-altering illicit drugs themselves, it instead focuses on the secondary harms and seeks to reduce their impact.* In one sense it could be described as a form of 'if you can't beat 'em, join 'em.' Hence, a harm minimisation policy endorses needle exchange (in reality, free needles), safe injecting rooms, methadone or heroin maintenance, and educating safe, 'responsible' drug use. By its very nature harm minimisation has few distinct boundaries and some proponents go so far as to advocate the legalisation of currently illicit drugs.[12] It is claimed that such an approach would do away with drug-related crime, reduce drug-related deaths, and limit drug-related health problems. However, if in the process a rapid expansion in the number of drug users occurred, any of the gains in these areas may be rapidly outstripped by primary drug-induced harm.

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[10] Terry M, Parssinen, *Secret Passions, Secret Remedies. Narcotic Drugs in British Society 1820-1930.* Manchester University Press, Philadelphia, 1983: 96,97.

[11] '*England and the Opium Trade'*, 'Society for the Suppression of the Opium Trade' pamphlet, Dyer Brothers, London, 1880, 6.

[12] see for example: *Beyond Prohibition*, Redfern Legal Centre, 1998, Website (*http://www.rlc.org.au*). Also Dr John Ellard, *The Advertiser*, 5th November, 1990, 3.

The introduction of 'harm reduction' measures into Australia in the 1980s certainly appears to have done little to kerb increasing drug use, and could be argued to be the cause of increased drug use by the not-too-subtle implication that responsible use is acceptable. It is fascinating that after fourteen years of harm minimisation, amidst an escalating drug problem, that the blame is laid on prohibition. It is false reasoning, having used small increments to induce change, to blame the remaining unchanged measures for the worsening predicament, and then suggest that more of the same is needed. Rather, it is possible that 'harm reduction' has exacerbated aggregate harm, most of which is difficult to measure and therefore left out of the equation.

A recent article in *The Weekend Australian*[13] reiterates the overworked phrase that the 'War on Drugs' has been lost, and that a new approach is needed; in this case, legalisation, with a proposal for licensing like that applied to tobacco and alcohol. Almost the entire article is taken up with creating an excessively depressing picture of the drug problem. The reason for doing this is clear. Change is most likely if the problem can be shown to be resilient to our most extensive efforts. A sense of defeat is needed. This is a powerful tool to dishearten anyone who may have become convinced that to protect the community from being extensively mind-altered by harmful drugs we need collective agreement upon prohibition of some kind.

It will become apparent that one of the strongest emphases of the legalisation movement is to play down the harmfulness of illicit drugs, or attempt to compare the harm with licit drugs such as alcohol and tobacco. Clearly, both of these create extensive harm. It is argued that illicit drug-related harm is small by comparison, and that there is, therefore, no reason to ban one and not the other. The weakness in this argument lies in the fact that by acknowledging direct and indirect harm in legal drugs, which attract high use rates, legalising other drugs with similar or greater harm can only add to overall harm, not lessen it. To argue that legalisation does not encourage use is ludicrous. Would we really be happy with usage figures for heroin, cocaine, ecstasy, LSD or amphetamines around the 30% mark that exist for tobacco?[14]

What has all this got to do with heroin trials which purport to be a form of treatment for a select group of heroin addicts? In the current debate some have expressed bewilderment at the negative reaction to the trials, emphasizing that heroin maintenance would only serve a very limited number of addicts and would represent one small component of a raft of treatment measures. However, many people recognise that, in reality, not only may the trials be part of a larger agenda, but treatment of a heroin addict with heroin fundamentally questions our understanding of disease and medical treatment.

What many people have not realised is that methadone[15] maintenance treatment is already operating in exactly the same way as heroin trials. Typically, methadone is provided on a long-term basis to addicts with little if any view to abstinence. The disturbing feature of methadone prescription is the entirely different perspective provided by the 'drug establishment' compared with the addicts. The former describe methadone maintenance treatment as

> ....the best supported and accepted form of maintenance treatment for opioid dependence.[16]

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[13] *The Weekend Australian*, March 6-7, 1999, 6.

[14] *Australian Government Drugs Online*, Website.

[15] Methadone acts in a similar way to heroin by activating the same receptors in the brain. It does not produce the 'rush' that heroin does, but lasts about four times longer and hence can be taken once daily to allay cravings. Like heroin it is highly addictive, and it is acknowledged that withdrawal from methadone is much more difficult than from heroin.

[16] Ward *et al*. Role of maintenance treatment in opioid dependence. *The Lancet*, 1999, 353: 221-26.

The latter are less enthusiastic. On the street,

> methadone has earned the reputation of being a hellish substance that wreaks havoc on your body and mind.[17]

Furthermore, many previously hidden problems are coming to light about the methadone program, not the least of which is its diversion to the street to create a methadone 'grey market.'[18]

Maintaining a heroin addict in an addicted state by the long-term supply of either heroin or methadone is in effect seeing the addict as 'incurable.' It is ethically unacceptable to conduct a scientific, medical trial where the primary purpose is to achieve secondary gains for society, rather than what is of foremost benefit to the addict. The Code of Ethics of the Australian Medical Association constrains the physician to:

> Recognise that the well-being of the subjects takes precedence over the interests of science or society.[19]

In light of the fact that addiction is harmful to the patient, it is clearly apparent that the fundamental principle of medicine, *Primum Non Nocere* (above all do no harm), is contravened by heroin maintenance trials.[20]

Much has been made of the Swiss heroin trials with respect to gains in social circumstances. However, a closer analysis of the trials shows that, not only were they poorly conducted scientifically, but the social benefits were shared, albeit to a lesser extent, by the 'control' group who received no heroin.[21] Perhaps it was the sense that someone actually cared enough to do something that was the most significant factor in rehabilitation. In other words, could a programme of counselling and support coupled with other features have achieved the same gains?

Is it ethically acceptable to use heroin as part of *any* programme of treatment? There appears to be no reason *per se* why heroin could not be used in the first stage of treatment to detoxify patients by successive reductions in dose until abstinence is achieved. However, considering that there are other issues involved where the supply of prescription heroin is concerned, and that other treatment options for this first stage detoxification are available, a prudential judgement would lean towards complete avoidance of prescription heroin.

These other issues include the message sent to the community by any step towards heroin legalisation, expansion of limited heroin supply into broader maintenance, and breaching Australia's international commitments to UN conventions on drugs, as well as the perception by the international community that Australia has 'gone soft on drugs.'

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[17] Ann Bressington, *Ethical and Moral Issues to be Considered Regarding the Supply of Prescription Heroin to Opiate Dependent Persons*. Drugaid of South Australia Ltd., 1998, unpublished report, 2.

[18] Milton Luger, *Youth need Heroes, not Heroin*, in *Legalising Drugs. Deliverance or Deception?* Ed. by J F Martins and J B Saunders. Warrane College, University of New South Wales, 1991, 46.

[19] *AMA Code of Ethics*, (Barton, ACT: Australian Medical Association 1 February 1996), 1.4 (c); cf also Principle 2 (1) of the *Recommendation No R (90) 3 of the Committee of Ministers to Member States Concerning Medical Research on Human Beings 1990* (adopted by the Council of Europe on February 6, 1990)

[20] A more detailed description of ethical issues related to heroin trials can be found in: J I Fleming and G K Pike, *Submission to The Select Committee on a Heroin Rehabilitation Trial*, Southern Cross Bioethics Institute, February 1999, 4 -10, as yet unpublished.

[21] Perneger *et al*., Randomised trial of heroin maintenance programme for addicts who fail in conventional drug treatments. *British Medical Journal*, 4 July 1998, 317:13-18.

There is a further advantage to the addict of avoiding any form of prescription heroin. By making a clean break with the addictive agent at the moment treatment begins, there is a cathartic rift with heroin and the culture that surrounds its use.[22] This process is recognised to be important in the treatment of alcoholism where cutting back is considered to be ineffective.

If heroin trials are not approved, what alternatives can be offered to addicts? There are many possibilities for rehabilitation, each with varying success rates. For a programme to be effective, the individual needs of each addict must be considered as well as the nuances of dependency. Since so much of the emphasis in Australia has centred on methadone maintenance therapy, and the 'drug establishment' is firmly committed to the expansion of such programmes[23], it will require a radical shift to move to alternatives.

Some of the more promising methods involve rapid and ultra-rapid detoxification followed by regular use of the drug naltrexone to assist relapse prevention. Drug therapy such as this can only be a part of the process. Following detoxification, one of the biggest problems experienced by addicts is what to do with the spare time once occupied by extensive efforts to gain and use heroin. In this regard, any attempts at relapse prevention will be fruitless unless this issue is addressed adequately, by offering gainful employment alongside dedicated counselling.

Keeping users out of the criminal system has been addressed by the introduction of 'drug courts', which offer rehabilitation as an option to jail for the offender. Given that drug use in prisons is recognised to be a significant problem, it is highly desirable to direct non-violent drug offenders elsewhere.

In summary, we might return to opium, the source of our most effective pain control. The poppy has provided merciful relief for many, but has become a source of agony for countless others. The search for healing has been a central concern of humankind through the ages, as has the search for ways to expand our consciousness and extend our minds. Some drugs provide an avenue to pursue such mind expansion. However, this goal can be achieved by other means, which although less instant and perhaps more arduous, are at the same time more enduring, have fewer undesired side-effects, and may finally lead to greater enrichment of the whole of life.

[22] The process of injecting heroin involves a phenomenon called 'needle fixation', an important part of the addiction that needs to be broken if abstinence is to be achieved.

[23] Dr Robert Ali, Director, Drug and Alcohol Services Council, South Australia, *personal communication.*