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SELECT COMMITTEE ON A HEROIN REHABILITATION TRIAL

HOUSE OF ASSEMBLY, SOUTH AUSTRALIA

As to diseases make a habit of two things - to help, or at least, to do no harm. [Hippocrates, c 460-377 BC, *Epidemics*, bk 1, ch. 11]

Everything that emancipates the spirit without giving us control over ourselves is harmful. [Johan Wolfgang von Goethe, 1749-1832, *Proverbs in Prose*]

SUBMISSION

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1. INTRODUCTION

1.1 The Select Committee is being asked to consider the provision of 'injectable heroin as part of a program of rehabilitation' which 'retains into abstinence treatment drug misusers'. Two key questions are raised by this specific wording. Firstly, is the nature of the proposed trial clearly defined? That is to say, does a specific protocol for the trials exist, in which the steps towards abstinence are well defined and to be rigorously adhered to in the manner of a scientific, medical trial. Secondly, if no such protocol exists, does an alternative scenario consist of a maintenance program akin to the ACT heroin trials, which were clearly directed towards maintaining the heroin addict on specified daily doses of heroin with only a minimal, if any, emphasis on abstinence?

1.2 A trial based on the ACT heroin trials, has a goal that is quite different from one in which full rehabilitation and hence abstinence is the intention. The intention is not only crucial for the addict, but also for the community at large, as we will subsequently show. If reference is also made , by comparison, to the Swiss Trials, then it must be made clear that those trials were of the maintenance type.

1.3 The task of rehabilitating a heroin addict is acknowledged by all in the business, including the addict, to be extremely difficult. No-one would want to play down the arduous and traumatic nature of the process. There can be no doubt that withdrawal from heroin is so painful that it becomes the main objective of the addict to avoid, at all costs, even the beginnings of 'hanging out'. Because of this, both the addict and rehabilitation staff need to be committed to the task as a worthwhile objective before embarking on any program leading to abstinence. It is also true to say that when the early 'honeymoon period' prior to the onset of dependence is over, there comes a time when the addict 'wants their life back' as the reality of their addiction dawns and its

consequences become apparent. It is clear that most addicts eventually come to this point and want to get off heroin.

1.4 When the Swiss trials were proposed in 1991, the Swiss Federal Office of Public Health designated abstinence as its primary objective[1]. When methadone was introduced some 20 years ago, its purpose was to allow the addict to come down slowly until abstinence could be achieved. The aim of abstinence was commonly shared and considered a worthy and achievable goal. Now we have the Swiss 'heroin distribution projects' and 'methadone maintenance programs', both of which only very loosely, if at all, consider abstinence as a goal. It is almost as if embarking upon supply of the substance, heroin, which caused the actual addiction is acknowledging defeat. Furthermore, it is something we would never consider for an alcoholic or someone intent upon quitting smoking. There is therefore a view currently held by many that whilst abstinence is a noble goal, it is rarely achievable[2].

1.5 It was thought , and still is by many, to be abhorrent to maintain the addict in his addiction, especially since the very nature of the addictive process means that ever-increasing doses are required as the body accommodates to each new level of the drug. To support the notion of 'maintenance' on a set level of heroin indefinitely, is seen, particularly by addicts themselves, as denying the nature of the condition of dependence.[3]

1.6 If heroin trials were to occur in SA, the objective would need to be quite clear. Is the intention to provide strictly limited heroin prescription as an adjunct to treatment

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[1]Aeschbach, E (1999) On the Final Report of the "Programme for a Medical Prescription of Narcotics" in Switzerland. Analysis of the Scientific Value of the Evaluation. Downloaded from *Drugwatch* site.

[2]In a recent publication (*JAMA* 280(22):1936-1943) the National Institutes of Health Consensus Conference made the following statement, "Although a drug-free state represents the optimal treatment goal, research has demonstrated that this goal cannot be achieved or sustained by the majority of persons dependent on opiates. However, other laudable treatment goals including decreased drug use, reduced criminal activity and gainful employment can be achieved by most methadone maintenance treatment patients." Setting aside the fact that the achievement of these 'other laudable treatment goals' is in itself open to debate, a policy based on defeat is able to guarantee such defeat by removing abstinence as a real and primary goal. It is no wonder then that research shows that the majority of addicts cannot achieve abstinence.

[3]Addicts attest to the fact that once addiction has set in, more is always better, required and sought after. Personal communication with Drugaid Officer and ex-addict.

with a view to abstinence? Or is the intention the eventual widespread distribution of heroin to addicts to maintain them at a 'safe level' and hence hope to achieve some secondary harm-minimisation goals along the way? In any case, one would hope that neither would serve as an insidious foothold for the wider legalisation of drugs, with all their attendant direct harms.

1.7 Furthermore, the agenda of any group who would conduct the trials would need to be clearly ascertained. Since this proposal has aroused strong reactions from people at both ends of the spectrum, that is, those who would prohibit versus those who would legalise, the trials would need to be strictly monitored to assure that any philosophical bias does not influence the results or interpretation. It would be quite possible to start out by providing strictly limited prescription heroin and then slide into widespread 'maintenance' if the intention was in reality directed towards the latter, or if commitment to the rehabilitation of the addict was not paramount.

2 HEROIN TRIALS AND BIOETHICS

2.1 Heroin addicts are human beings with a chronic addiction to heroin. This means that any scientific medical trials involving heroin addicts are to be ethically evaluated in terms of experiments on human persons.

2.2 The Declaration of Helsinki of the World Medical Association reiterates the binding nature of the following principle taken from the Declaration of Geneva of the World Medical Association:

> The health of my patient will be my first consideration.[4]

2.3 Moreover, the International Code of Medical Ethics of the World Medical Association, also cited by the Declaration of Helsinki, declares that

[4] *Declaration of Helsinki*, World Medical Association, 1964, revised 1975, 1983, 1989, Introduction

> A physician shall act only in the patient's interest when providing care which might have the effect of weakening the physical and mental condition of the patient.[5]

2.4 The *Code of Ethics* of the Australian Medical Association in no way prescinds from the ethical requirements of the World Medical Association. Indeed, where clinical research is concerned, the physician is to

> Recognise that the well-being of the subjects takes precedence over the interests of science or society.[6]

2.5 Given that heroin addicts have a specified medical condition, any treatments trialed should be directed towards the optimal alleviation of that condition, namely abstinence. It would seem to be ethically unacceptable to treat a person's medical condition of addiction by maintaining that person as an addict, ie to see heroin addicts as 'incurables'. This amounts to a callous abandoning of persons to their addiction. This is particularly so when we have an opportunity to trial and further develop medical treatments clearly directed to abstinence.

2.6 Medical trials on heroin addicts which are carried out principally to serve the interests of science or society are ethically unacceptable. Thus, trials, whose efficacy will be assessed in part or in whole in relation to the reduction of property crime[7] or because "the war on drugs has been lost"[8] are unethical. Medical trials where heroin addicts are concerned are to be evaluated in terms of the alleviation of the addict's essential condition including his or her long-term health and well-being.

2.7 Standard arguments used to justify maintenance programmes are based on an unarticulated commitment to a particular form or forms of the moral philosophy known

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[5] *Ibid.*

[6] *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)

[7] Assuming there is a clearly understood causal relation between heroin use and property crime. At the moment such evidence is not available.

[8] This highly problematic claim is often the starting point for arguments directed towards heroin legalisation, cf Introduction to the *Beyond Prohibition Report of the Redfern Legal centre Drug Law Reform Project*, September 1996

variously as consequentialism or utilitarianism. This theory is based upon JS Mill's observation that human beings strive to be happy by seeking pleasure and avoiding pain. Peter Singer, for instance, says:

> Consequentialists start not with moral rules but with goals. They assess actions by the extent to which they further these goals. The best-known, though not the only, consequentialist theory is utilitarianism. The classical utilitarian regards an action as right if it produces as much or more of an increase in the happiness of all affected by it than any other alternative action.[9]

2.8 From a public policy point of view (as well as from the individual's point of view when making a moral choice) such utilitarian calculations would not be possible unless

a) one can objectively identify pleasures and pains (ie, if all consequences of heroin use are identifiable in the pleasure/pain calculus for all individuals affected by it), and

b) that such calculations can actually be made.

Even if one could identify all the pleasures and pains of all individuals affected by heroin addiction (an impossible task), the fact is that the calculation cannot be made because we have no scales by which pleasure and pains can be commensurated. This attempt to commensurate the incommensurable (such as adding the weight of the page to the number of words on the page and dividing that figure by the area of the page) is incoherent.

2.9 The experimental treatment offered to heroin addicts must be of a kind which is good in itself. This cannot be evaluated in terms of consequences alone, although consequences are obviously important. It is not permissible to harm a patient to achieve a good outcome for society. There must also be a good means used with the intention to assist the patient's return to good health. Addiction is harmful to the patient. To maintain the patient in a state of addiction is to do harm

[9] Peter Singer. *Practical Ethics.* Cambridge: Cambridge University Press, 1979, 3

2.10 This latter point is even more clearly obvious when one considers what is to become of the experimental subjects at the end of the experiment. Subjects have been maintained on heroin. The experiment is declared to have been a failure. What then is to become of the subjects? Are they to be abandoned? Or is it the case that the real object of heroin maintenance trials is the permanent legalisation of heroin?

2.11 Ethically acceptable trials where heroin addiction is concerned must be directed to abstinence as an achievable goal. Everyone wants to see a reduction in crime, heroin deaths, and disease. Even if all these goals could be met by heroin maintenance programmes one would be achieving social goods at the expense of the lives of heroin addicts. It is never permissible to do evil to achieve good. The fundamental principle of medicine, Primum Non Nocere (above all do no harm)[10], is contravened by heroin maintenance trials and programmes. It treats heroin addicts as disposables, as lives beyond recovery. Yet the medical model requires patients to be treated for themselves, that is that treatments should be oriented first and foremost to the good of the patient. Where heroin addiction is concerned, if we can be more successful in helping addicts become abstainers, then the other goals (assuming they are directly affected by heroin abuse) would also be met. Fewer people with heroin addiction will mean fewer crimes caused by heroin use (if that is indeed the case), fewer heroin deaths, and better overall standards of health.

2.12 It is notionally ethically possible for prescription heroin to be used as a first stage in a detoxification leading to abstinence maintenance trial. In this case heroin would be used in decreasing amounts to bring the patient to a point where detoxification can safely be carried out. However, there are alternatives to using heroin in this first stage.[11] The ethical advantages of using alternatives are that

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[10] Cf *International Ethical Guidelines for Biomedical Research Involving Human Subjects 1993* [CIOMS in collaboration with the World Health Organisation]; Principle 2 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]; §46.111(a) of the *DHHS Regulations for the Protection of Human Subjects (45 CFR 46)* [US, June 18, 1991]; No. 4 of the *Nuremberg Code 1947*

[11] Eg Instead of heroin, MS contin and capinol may be used for three days. There are other possibilities as well, cf 7.3 below.

- no message is being sent to the community that heroin has been, in any way, legalised,
- there will be no expansion of limited legal heroin to a broader maintenance programme, and
- the trial begins by breaking all connections between the addict and the heroin sub-culture.

2.13 In making ethical judgments it may turn out that there are two or more possible choices each of which, in itself, is morally permissible. That is, each of the possible moral choices involves an act which is morally good or at least morally neutral, the means themselves are not immoral, the act is directed to a good end, and the good which is to be achieved outweighs any foreseen but undesired bad effects. How then does one choose? At this point a prudential judgment is made. A prudential judgment is oriented towards making a moral choice which avoids or minimises further undesired consequences.

2.14 The considerations set out in 2.12 above are, in our view, very important side-effects of the legal provision of heroin to addicts. If it is the case that there exist other remedies to prepare the heroin addict for detoxification then those remedies should be explored and, all other things being equal, preferred as a matter of prudence.

2.15 Within any particular experimental trial other bioethical issues will arise. Gaughwin and Ryan (Department of Public Health, University of Adelaide) correctly point out that there "is an important ethical discussion yet to be had about the extent to which we should introduce new elective procedures which require anaesthesia". Moreover, they say, the fact that there is

> the risk - perhaps increased risk - of death from heroin overdose (as a consequence of reduced opiate tolerance) that can accompany poor compliance with naltrexone means that there is a great responsibility to inform patients being treated with naltrexone about that specific risk. There is also an urgent ethical responsibility to decide whether that risk is too

> great for some or all participants, and thus to act to reduce or eliminate the risk even if that means stopping or modifying trials and treatments.[12]

The clear indications here are for the provision of such backup counselling and facilities as is needed at least to monitor and encourage naltrexone compliance.

2.16 Even more importantly Gaughwin and Ryan draw attention to what they rightly describe as the "often neglected dimension of public health ethics". This point is especially relevant given the hasty way in which the Parliament has gone about its business in this Select Committee. The failure of the Parliament to set a fair and reasonable time line in which considered submissions could be made from the public, not to speak of the even more unreasonable expectation that such a short time line could be met over the Christmas/New Year break, gives the impression that the public's interests are not to be treated seriously. The problems associated with heroin addiction are far too important to be left to the pre-prepared positions of establishment groups and special interest lobbies. It is worth quoting Gaughwin and Ryan *in extenso*:

> Trials which are publicly funded have special ethical obligations to ensure, as far as possible, that the questions being asked, and the design and evaluation of trials, are in the public's best interest - that is, what a public given the chance to deliberate adequately about the issue would choose. Because there are no standards for deliberation about public health issues such as heroin addiction, proposals for trials may be approved or denied at the discretion of those who hold the relevant power. Thus, the ACT heroin trial was halted by the Prime Minister and Cabinet, while State governments, such as the South Australian government, announced trials of rapid opiate detoxification *without comprehensive consultation and deliberation with the public, heroin addicts or the clinicians who treat them.* ... If there has not been meaningful public deliberation about proposals, we believe their proponents can not claim that they are ethical trials in a public sense.[13] [emphasis added]

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[12] Gaughwin MD, Ryan P. Heroin addiction: the science and ethics of the new treatment pluralism. *Medical Journal of Australia* 1999; 170:129

[13] *Ibid.*

The point is clear. Public consultation needs to precede any publicly funded trials. And short term inquiries by a Select Committee, mostly held over the Christmas/New Year holiday, hardly qualifies.

3. HARMS RELATED TO HEROIN USE

3.1 There are considerable harms associated with heroin use, as there are with legal drugs such as tobacco and alcohol[14]. The harms caused by heroin misuse may be divided into four categories. First, there is direct physical harm done to the user as a consequence of the pharmacological action of heroin itself, including:

- constipation
- depression of breathing
- reduced sex drive
- red watery eyes
- chronic runny nose
- death due to overdose

Secondly, there is the psychological harm of addiction:

- the pursuit of heroin to the exclusion of the normal pleasures of life
- withdrawal symptoms ('hanging out')

The psychological harm effectuates a vice-like grip on the addict so that heroin occupies the absolute centre of attention to the exclusion of other pursuits.

[14] To gain a perspective on the impact of all drugs, licit and illicit, the causes of death for the year 1990 reveal the following: 6605 deaths attributed to alcohol, 18110 to tobacco, 457 to opiates, 28 to barbiturates and 313 to other drugs (*Australian Government Drugs Online* website).

Thirdly, indirect harm is done to the user and includes:

- poor general health
- poor living conditions
- poor employment prospects
- involvement in criminal activity
- prostitution
- risk of infection with HIV, HCV or bacterial endocarditis due to needle-sharing.

Fourthly, harm is done to the wider community in terms of:

- criminal activity
- the spread of infectious diseases
- relationship conflicts with family and friends

3.2 There is a perception that these harms are measurable and well-defined, and in particular that the harms done to society are well understood. The motion before the Select Committee focuses upon three aspects of harm, namely crime, HIV transmission, and risk of death or serious injury. It is a most attractive proposition that the provision of injectable heroin to addicts will reduce the overall harms, both to addicts and to the rest of society. Crime will be reduced, addicts will no longer overdose, and HIV will be contained. However, such a notion presupposes that the harms are indeed measurable and that one harm can be traded off against another. For example, if there are substantial cost savings to society to be made by providing legal heroin to the addict, is it acceptable to maintain the addict in a state of dependency, as if this is somehow either 'not an evil' or at worst a 'lesser evil'? The intention to maintain an addict in his addiction with this sort of trade-off raises serious ethical questions, including the

sacrificing of the addict to protect the rest of society[15]. As it turns out, there are other ways of addressing both issues ethically (refer section 7, An Alternative Approach).

3.3 Surrounding the issue of heroin abuse, several key assumptions consistently emerge.

- We know the number of deaths caused by heroin overdose, and that a pure, controlled supply of heroin will deal with the problem.
- The war on drugs has been lost, and therefore a radical new approach is needed.
- We know the relationship between crime and heroin use, and that crime will decrease if heroin addicts no longer need to feed their habit.
- HIV and HCV transmission will be reduced by 'harm reduction' measures such as controlled heroin supply.

Each of these assumptions is contestable.

OVERDOSE DEATHS

3.4 The most tragic consequence of drug abuse is when life is lost. There can be no doubt that the pain experienced flows out into the community by way of family and friends. To fully understand what actually happens when someone dies from a drug overdose, one needs to look very closely at the details of the events surrounding the death, including all factors leading up to the moment of overdose. What causes the death is not always simply a dose of heroin which is too high for that individual. Often

[15] Cf Section 2 above

other drugs are present, and the cause of death cannot readily be attributed to heroin alone[16].

3.5 Statistics on heroin-related deaths vary considerably depending on the way in which the cause of death is classified. The widely quoted figures[17] for South Australia for 1997, 1996 and 1995 are 34, 32 and 38, respectively. However, the figures provided by the Research Centre for Injury Studies, Flinders University, using international E-codes are 8,10 and 8 for the years 1996, 1995 and 1994, respectively.[18] Such a significant discrepancy may be attributable to the data-gathering process. For example, if a death is recorded as a heroin overdose death by using the criterion that heroin is present in the bloodstream, then the contribution to the death by heroin itself may be small if the concentration is small. As Police Commissioner Malcolm Hyde has said about his own reference to 'heroin related deaths within South Australia, his reference "does not confirm heroin as a cause of death in every case but rather a factor which was present."[19] The cause of death is, then, very much open to interpretation. As a consequence of this, it is very difficult to be certain of a baseline which may be used reliably when assessing the impact of the proposed heroin trial upon the number of heroin-related deaths. Furthermore, a pure, legal supply of heroin will not preclude addicts from supplementing their doses with street heroin or other drugs in an uncontrolled setting, and doing themselves harm, possibly to the point of bringing about death.

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[16] Catherine McGregor, Robert Ali, Shane Darke, Katrina Hall and Paul Christie. Evaluation of a targeted intervention to reduce the prevalence of overdose amongst heroin users in Adelaide, Australia. Paper presented at the 1997 Australian Professional Society on Alcohol and other Drugs Conference. This study reported 71 heroin-related overdose deaths in SA for 1994-96 (approximately 24 per year). 2 or more drug types were detected in 73% of the cases. Benzodiazapines were detected in 41% of cases, codeine in 40%, alcohol in 39%, cannabis in 20%, antidepressants in 8% and amphetamines in 5%.

[17] Martin. Hamilton-Smith, MP, *Hansard*, Thursday 19th Nov 1998, 313. Democrats leader, Hon Mike Elliott, MLC, commenting to *The Advertiser*, Wednesday 4th Nov, 1998. In comments to *The Advertiser*, 19th September 1998, SA Police commissioner Mr Malcolm Hyde was reported as stating that the number of overdose deaths due to illicit drugs in 1996 was just 12, whilst the number for 1998 was 'expected to top 40'.

[18]Obtained from Malinda Steenkamp, Associate Lecturer, Research Centre for Injury Studies, School of Medicine, Flinders University of South Australia.

[19] Malcolm A Hyde. Commissioner of Police. South Australia, personal communication. 4 February 1999

3.6 The popular catchcry preceding demand for drug law reform is that we have lost the war on drugs[20]. This failure to win the 'war on drugs' is, it is said, proved by the fact that people still continue to abuse illicit drugs, that there appear to be more 'drug-related' deaths[21], and that more drugs appear to be available involving more criminal elements. This is then used as a point of departure for radical reform, usually in terms of drug legalisation. Taken at face value, exactly the same argument could be applied to other matters such as breaking and entering, rape, speeding, theft, fraud, drink driving or any other number of social problems for which laws are in place, and which continue to be a burden to society. We do not consider it necessary to legalise these practices, which are harmful, simply because with some of them the problem continues to grow. Even in the case of serious damage to health caused by smoking and excessive alcohol consumption, which are legal practices, we would not dream of slackening our resolve to keep affirming that such damage can be averted by a reduction in use.

3.7 By its very nature, any legalising of currently illicit drugs must lead to an escalation of use.[22] Whether the issue is handguns in America or opium in China (where an

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[20] For example, amongst many others, comments by the NSW Police Commissioner Peter Ryan, *The Australian*, January 11th 1999, and cf footnote 8 above.

[21] A highly problematic notion as we have already argued in 3.4 and 3.5 above.

[22] If we take the decriminalisation of cannabis in SA as a gauge, we will find significant discrepancies in reporting about whether cannabis use in SA has increased. On the one hand we find that the number of offences for possession and use following partial decriminalisation in April 1987 has dramatically increased (5,657 in 1985/86, 6,231 in 1987/88 to a peak of 17,425 in 1993/94; *Annual Report of the Commissioner of Police*, and Ali et al., 1998, The Social Impacts of the Cannabis Expiation Notice Scheme in South Australia, National Drug Strategy Committee), whilst on the other hand we find that an analysis of the National Campaign Against Drug Abuse (NCADA) household surveys indicates a moderate increase in South Australia compared with the rest of Australia (Donnelly et al., The effects of partial decriminalisation on cannabis use in South Australia, 1985 to 1993, *Aust. J. Public Health* 19(3): 281-287, 1995). The adjusted prevalence rate in SA for ever having tried cannabis rose from 26 to 38 percent between 1988 and 1993. It is notable, however that the adjusted rate of weekly cannabis use increased from 3 % in 1988 to 7% in 1991. The authors are quick to dismiss the notion that decriminalisation has contributed to this increase, citing similar increases in the ACT and Tasmania. It has however, been suggested that South Australia has become the supply state for the rest of the country (Phil Warrick, SA Police Drug Task Force, personal communication) and that part of the increase in other states may be attributable to laws in SA allowing the user to cultivate 10 plants 'for personal use', which has a street value in excess of $20,000 per crop interstate. Owning 10 plants carries a fine of $150 in SA. We note that SA law is in the process of change to reduce the number of plants to 3.

(footnote continued)

estimated 1 in 3 of the population were addicted[23]), wider availability, even of dangerous items or practices, attracts more adherents. Whether the 'war on drugs' is being won or lost ought not to be a criterion for the full or partial legalisation of heroin and other presently illegal substances.

CRIME REDUCTION

3.8 The most pervasive notion regarding heroin abuse is that by supplying heroin to users, they will no longer participate in crime and the community at large will be safer. The media has supplied a regular diet of articles to fuel this notion[24], but the fact remains that the relationship between heroin users and crime is not the subject of definitive studies. Much of the surveying utilises self-reporting by addicts, which is a questionable source of hard data, or alternatively is anecdotal. The fact that many prison inmates are heroin users does not provide conclusive evidence that heroin use is a predictor for crime.

3.9 Heroin-related crime can mean several different things:

- crime committed for the purpose of raising funds to purchase heroin.
- crime committed whilst under the influence of heroin and as a result of taking the drug.
- crimes committed by those criminals who happen also to be heroin users, because there is significant overlap in the two cultures.

3.10 If it were true that crime in the first category did genuinely and unequivocally exist, then we first need to ask to what extent can crime be attributable to heroin, and

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The large increase in cannabis offences has been attributed to a 'net-widening' effect because 'more operational police are available for this work, and the work involved in issuing a CEN will be much less than that required under a prohibition model' (Ali et al, 1998). This implies a change in police practice for which there is no evidence. In reality, police may be *less* likely to issue a CEN for the following reason. The cannabis expiation notice (CEN) scheme in SA was intended to achieve a reduction in court cases. As it turns out the huge increase in CENs compared with offences under the old system has resulted in an *increase* in court cases due to a 55% default rate on payment of fines. At least in this respect the CEN scheme has backfired, and if, in addition, cannabis usage has indeed increased, the scheme has a lot to answer for.

[23] Moffit et al., *1998 Drug Precipice*, UNSW, Hyde Park Press, 71.

second, if heroin were supplied to addicts, and they were involved in crime of this type, would they stop committing such crime? In answer to the first question, the extent is not clearly known, and neither is the type of crime. Indeed, Australia suffers from poor data collection in this area.

> ....A systematised approach to the ongoing monitoring of illegal drug use and its link to offending and recidivism in this country has been lacking ... Law enforcement agencies have for many years wrestled with the dilemma of drugs and crime, yet we still have no coordinated national programs for police to utilise when forming strategic plans to combat this problem.[25]

There is, therefore, no basis for the conclusion that crime of a particular type is carried out by heroin users to feed their habit. Furthermore, 'while heroin is viewed as the big evil on the streets, it is cannabis, the drug with a more benign image, that is linked with more crime'[26].

3.11 As to whether heroin addicts will no longer participate in crime of the first type (assuming for the moment that they are involved) when supplied maintenance heroin, it must be acknowledged that users will most likely 'top up' their legal dose with street heroin or other drugs for which funds will still be required. The nature of addiction is that more is always better. Subjects on methadone maintenance who were questioned about their criminal activity before and during a methadone program indicated that they were less involved in crime whilst on the programme[27]. However, subjects are hardly likely to risk their supply of methadone by stating that the methadone program has done nothing to dispense with their criminal behaviour.

3.12 Crime committed whilst under the influence of heroin and as a result of the action of the drug itself is even less clear. However, inasmuch as heroin or any other psychoactive drug interferes with normal mental processes, it is conceivable that

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[24] *The Advertiser* 20th May 1996, 3; 4th November 1998, 19; 9th October 1998, 23.

[25] Toni Makkai, Research Analyst, Australian Institute of Criminology, personal communication, 4 February 1999

[26] Justine Ferrari, *The Australian*, 10th December, 1998.

[27] Alisen W Brooks et al., "Reduction In The Costs Of Crime Following Entry Into Methadone Maintenance". report in preparation for publication. 1999

aberrant criminal or even violent desperate behaviour could result from the pharmacological action of the drug.. Lucy Sullivan has made the following analogy with alcohol.

> Would it be logical to lower the cost of alcohol in order to reduce the incidence of crimes of assault, on the grounds, perhaps, that drinkers are made angry by running out of money to buy more drinks[28]?

With this in mind, any process which makes heroin more available and leads to the recruitment of more users would be expected to increase this sort of crime.

3.13 With regard to the current proposal for heroin trials, if such a measure in any way contributed to the perception by certain members of the community, eg impressionable teenagers, that the 'powers that be' were prepared to give heroin to addicts and hence it can't be that bad after all, then some may be recruited into trying the drug and inadvertently be led into addiction. It is quite possible that the vulnerable in the community would take their perception at face value and not be aware of the complexities of the problem. One cannot underestimate the signal sent to the young by the authorities.

3.14 The overlap between the drug culture and the culture of crime is complex. For example:

> One of the common misconceptions of the connection between drugs and crime is that crime is caused by drugs. But crime holds an attraction of its own for young people and is often part of their risk-taking behaviour rather than the result.[29]

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[28] Lucy Sullivan, "Could legalising drugs lead to more crime?" *News Weekly*, April 20, 1996, 4.

[29] Dr. Copeland, National Drug and Alcohol Research Centre (NDARC), quoted by Justine Ferrari, *The Australian*, 10th December, 1998.

Moreover, a study of 767 patients seeking methadone treatment in Sydney's western suburbs showed quite clearly that heroin users were involved in crime before they began using heroin[30].

> The relation between illicit drug abuse and crime is not simply the economic necessity for drug users to steal to support their habits.[31]

Perhaps a more realistic interpretation is that there are common precursors for criminal behaviour and partaking in the drug culture.[32] It is naive to consider that the provision of heroin to addicts will sever the connection, and that addicts will no longer be criminally active.[33] Any theoretical gains in crime reduction made by allaying the need for addicts to raise funds by criminal activity could easily be outstripped if more addicts were recruited by a softening resolve on the part of the State to maintain legal disapproval of the non-medical use of heroin.

3.15 In early January 1999 Southern Cross Bioethics Institute put a series of questions to the Office of Crime Statistics (Attorney-General's Department). The reply was received too late (2 February 1999) to be incorporated into the argumentation in this submission. However, the general thrust of the answers to those questions supports the argument we have so far advanced in 3.8 - 3.14 above. Of particular interest is the fact that robbery offences in South Australia have declined between 1993 and 1997 "with the 1997 figure of 1,167 12.5% lower than that recorded in 1996 and the lowest figure since 1990". Although there was a significant increase in armed robberies (both with firearms and other weapons) between 1996 and 1997, nevertheless "the 1997 figures for

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[30] Bell et al., Heroin users seeking methadone treatment. *The Medical Journal of Australia* 152, April 2, 1990. In this article, subjects self-reported their criminal activity and conviction records were cross-checked. The subjects under-reported by 50%. Considering that users were prepared to be untruthful about conviction records, which they would be aware could be easily checked, it is hardly likely they would be truthful about crime for which they held no conviction.

[31] *Ibid.*

[32] Dobinson, I. and Ward, P., *Drugs and Crime*. Sydney: NSW Bureau of Crime Statistics and Research, 1985.

[33] For the heroin addict, aspects of the culture surrounding their use become habit-forming in a manner similar in seductiveness but less potent than the heroin addiction itself. One of the problems encountered in rehabilitation is what to do with all the spare time that was once occupied by activities coupled to the addiction, such as relationships, crime, street culture, various rituals and so on. A complete refocussing is required.

robbery with firearm are still 20.3% lower than those recorded ... in 1987, while those for *robbery with other weapon* are 8.4% lower than those recorded ... in 1991".[34]

While it is clear that "there is a connection between drug use and crime ... there is considerable uncertainty about the nature and extent of this relationship." Such results of studies as are available "only suggest an association between drugs and crime and not a causal link."[35]

We believe that we are completely justified in saying that we do not have sufficient base-line data which would enable us to compare future increases or decreases in particular crime in relation to drug use in general and heroin use in particular. Moreover, any drug trials held now would be held in the context of currently decreasing amounts of the crimes of robbery, break and enter, and shop theft in South Australia.[36]

The full text of the answers to our questions may be found in Appendix A.

HIV AND HCV TRANSMISSION

3.16 The spread of HIV and HCV in injecting drug users has been addressed in part by the provision of needles to addicts through so-called Needle Exchange Programs. The success of these programs is zealously proclaimed by some[37] and seriously doubted by others[38]. Certainly there are incongruities in a law which allows the provision of legal needles to addicts who can then be apprehended and convicted of heroin use. In any

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[34] Jayne Marshall, Office of Crime Statistics, "Drug Use and Crime - Responses to questions from Dr J Fleming". 2 February 199, 2

[35] *Ibid.*, 1

[36] *Ibid.*, 2

[37] Hurley et al., Effectiveness of needle-exchange programs for prevention of HIV infection. *The Lancet* 349, June 21, 1997, 1797-1800.

[38] Lucy Sullivan, Free Needles and HIV Transmission in Australia. *Drugwatch website*, 1998. An important principle at work is the expansion of so-called harm minimisation measures once the initial step has been taken. For example, the introduction of needle exchanges has been followed by proposals for safe injecting rooms, and now injectable heroin. With each step taken down this particular road the next step seems only logical, necessary and more easily argued. However, do we know where we are going, and can we be sure that those pushing each particular stage do not have a wider scheme in mind?

case, it is hard to see how a heroin distribution program can do better where street consumption and polydrug use still abound.

4. OVERSEAS EXPERIENCE

THE SWISS TRIALS

4.1 The alleged success of the Swiss Heroin Trials has been used as the justification for the implementation of similar programs throughout the world. Recently Australia jumped on the bandwagon with proposals for similar trials in the ACT. Whereas the Swiss trials started out with a view towards abstinence, the ACT trials were initiated under no such pretence and from the word go, were committed to heroin maintenance. At the very least this was in recognition of the reality of what the Swiss trials had inevitably become. Although the Swiss Federal Office of Public Health has enthusiastically expounded the success of its heroin trials, there are serious doubts concerning both the validity of the data itself and the process by which results have emerged.

> By euphorically and uncritically announcing success for the projects in the public media, even before the evaluation was completed, the proponents and evaluators have lost credibility[39].

The International Narcotics Control Board of the United Nations feels similarly:

> The Board regrets that, before the evaluation by WHO of the outcome of the Swiss experiment, pressure groups and some politicians are already promoting the expansion of such programmes in Switzerland and their proliferation in other countries[40].

[39] Ernst Aeschbach, The scientific value of the evaluation of the Swiss heroin distribution projects. *Drug Watch World News* 1(2):3, 1997.

[40] *Report of the International Narcotics Control Board 1997*, 367, February 1998.

4.2 One of the cohorts from the trial became the subject of a publication in the *British Medical Journal*. To our knowledge, nowhere else does any report of the trials appear in a peer-reviewed journal. In this article, the authors come to the following conclusion:

> A heroin maintenance programme is a feasible and clinically effective treatment for heroin users who fail in conventional drug treatment programmes[41].

Closer scrutiny of this paper yields an alternative conclusion.

4.3 The study assigned subjects to one of two groups. The experimental group (n=27) received injectable heroin three times daily in addition to oral opiates (methadone or morphine sulphate). Furthermore, they received benzodiazepine substitution treatment if addicted to benzodiazepines. In addition, they received psychological counselling, HIV prevention counselling, social and legal support services and somatic primary care. The so-called 'control' group (n=24) did not receive any drug treatment or any of the support services and were assigned to a six month waiting list. During that six months most of the 'control' group enrolled for separate methadone or detoxification programmes, but duration of stay was not monitored. At the end of the six month period both groups were assessed.

4.4 The differences between the two groups were by no means outstanding. Comparing the two groups, there were 'no benefits in terms of work, housing situation, somatic health status, and the use of other drugs'[42]. There were significant self-reported reductions in illegal income, drug expenses, and criminal activity in the experimental group, but not in the 'control' group. In addition, improvements were evident in social functioning, emotional and mental health, but notably also in the 'control' group, but to a lesser and not statistically significant extent. It is possible that the provision of additional services to the experimental group were indeed the key contributor to positive outcomes. The authors made the following observation.

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

> We cannot exclude that the benefits of our heroin maintenance programme were entirely attributable to these additional services[43].

At the end of the six month period, when the 'control' group were offered entry into the heroin maintenance programme, only 9 out of the 24 subjects enrolled, the remaining 15 giving as their main reasons not to continue, "a satisfactory personal situation and a desire to stop injecting drugs."[44]

4.5 In total, the Swiss trials involved 800 addicts over a 3 year period (1994-1996). As noted earlier, one of the primary goals of the trials was abstinence. By this measure, the trials have been an abysmal failure, yielding an abstinence rate of just 5.2%[45]. Alongside the claimed success rates of established drug rehabilitation programs or more recent treatments such as rapid detoxification with naltrexone, the Swiss trials lag far behind[46].

GREAT BRITAIN

4.6 In 1925 legal heroin supply was introduced in the UK whereby medical practitioners could prescribe the drug to addicts. What has become known as the 'British System' worked to a degree between 1930 and 1960 while the number of addicts was small (400 total). Through the 1960s and 1970s the system became unmanageable as heroin abuse escalated until by 1985 there were an estimated 80,000 heroin addicts in Britain. The last trial was a pilot programme which began in Merseyside in the late 1980s and supplied heroin to addicts; however it was closed down in 1994 by the Home Office which was clearly disenchanted with the results and

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[42] *Ibid.*, 13

[43] *Ibid.*, 17

[44] *Ibid.*, 16

[45] Ernst Aeschbach, Heroin Distribution in Switzerland. *Analysis of the Scientific Value of the Evaluation*. Schweizer Arzte gegen Drogen, 1998.

[46] Moffit et al., *Drug Precipice*, UNSW Press, Sydney, 1998, 50.

cost of its operation. Dr John Strang, head of the Drug Dependence Clinical Research and Treatment Unit at the Maudsley Hospital in London has said:

> merely supplying drugs and injecting equipment is unlikely in itself to bring about an adequate and durable change in behaviour[47]

Dr Strang went on to advocate the use of goals, including abstinence.

SWEDEN

4.7 By international standards Sweden has a restrictive drug policy. This was not always the case. In 1965, when nearly 20% of all those arrested for criminal acts were illegal intravenous drug users, a 'legal prescription experiment' began in response to intense lobbying and a massive campaign for legalisation.[48] By 1967 it was abandoned due to irresponsible prescribing and deaths from the legally prescribed drugs. At the collapse of the trial, frequency of intravenous drug abuse had climbed by nearly 40%, arrests had doubled, and frequency of use amongst adolescents had increased from 3.6% to 33%[49]. From that point on, Sweden adopted a policy which embraced a strong emphasis on 'a close interaction between preventative measures, control policy by means of law enforcement and the treatment of drug users'[50]. It is primarily a preventative strategy. As a result, Sweden now has one of the best records in terms of low drug use and level of experimentation amongst school students[51].

HOLLAND

4.8 The Dutch government has adopted a policy which attempts to separate the so-called soft drug market from the hard drug market. Cannabis is openly sold in public

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[47] Quoted by Santamaria, J. *Heroin Trials*. unpublished, 1998.

[48] Malouf, J., *Legal Heroin Supply*. unpublished, 1998.

[49] *Ibid.*

[50] Gun Hellsvik, The value of a restrictive drug policy. *Drug Watch World News*. 1(1):1, 1997

[51] A Preventative Strategy. Swedish Drug Policy in the 1990s. The Swedish National Institute for Public Health 1998:21, 12-15.

venues whereas laws regarding harder drugs have been toughened. The lenient attitude to cannabis is touted as the reason for the apparently low numbers of drug-related deaths in Holland[52]. However, given the restrictive nature of laws related to heroin use, which is responsible for most drug-related deaths, it is hard to see the logic of attributing the cause to lax cannabis laws. Furthermore, as we have already seen, statistics on drug-related deaths are not always straightforward.

4.9 It has been claimed that the open sale of cannabis in The Netherlands has not led to an explosion of use[53]. However, this is not borne out by the evidence. Surveys of marijuana use amongst Dutch youth show a dramatic increase from less than 5% in 1984 to well over 30% in 1996 for 16-17 year olds. For 18-20 year olds the rate has risen from 15% to 44%[54]. Furthermore, from 1991-1993 there was a 49% rise in registered cannabis addicts[55].

5. COSTS

FINANCIAL COSTS OF HEROIN TRIALS

5.1 Whether the model is a limited heroin prescription programme with a clear abstinence goal, or a heroin maintenance program, the financial costs need to be considered. Certainly a strictly limited regime of heroin prescription would minimise costs, but any expansion into maintenance must be considered a distinct possibility, especially given the Swiss experience.

5.2 The costs for the ACT heroin trials can be used as a guide to the costs of a similar program in SA.

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[52] Democrats leader, Hon Mike Elliott, MLC, commenting to *The Advertiser*, Wednesday 4th Nov, 1998.

[53] Democrats leader, Hon Mike Elliott, MLC, *Hansard*, Wednesday 4 November 1998,113.

[54] MacCoun, R. & Reuter, P. Interpreting Dutch cannabis policy: reasoning by analogy in the legalisation debate. *Science*, October 3, 1997, 278(5335):47-52.

[55] Dutch National Committee on Drug Prevention. Cited from *Drug Watch World News* 1(1):4, 1997.

Preparatory Costs 1991-1994 $560,000

Proposed Pilot 1 Cost $822,000 (40 persons, 7.75 months)

Proposed Pilot 2 Cost $1.5m (250 persons, 10.25 months)*

Total $2,882,000

* Translates to $585 per person per month.

The proposal for the ACT trial included 3,000 addicts over 2 years. This translates to $42m in total when the cost per month of $585 is used.[56] SA has an estimated 5,000 dependent users[57]. The cost to SA for just 2 years, if a program expanded out to include all 5,000 addicts, comes to $70m. Considering that there are an estimated additional 15,000 non-dependent heroin users in SA[58], and that by its very addictive nature heroin recruits more dependent users, a blow-out in costs would not be entirely unexpected. The figures we have quoted do not include the cost of the heroin itself, which is acknowledged to be 'relatively high'.

LITIGATION

5.3 Personal and financial damage caused by the use of illicit drugs must currently be shouldered by the individual user. But were heroin to became legally manufactured and sold, the playing field would change dramatically. Manufacturers, sellers, those giving advice including government agencies, would have a legal duty to the subjects of such a trial. The strict laws concerning product liability may apply to the trials. Heroin by its very nature is a dangerous product. This may expose the government and those involved in the trials to liability for deaths and injuries caused by the heroin. A good analogy is the recent multi-billion dollar payouts by US tobacco companies for the deaths and injuries caused by smoking. Other dangers faced by the government include

[56] Malouf, J., *Legal Heroin Supply*. appendix, unpublished, 1998

[57] Mr. Hamilton-Smith, Hansard, Thursday 19th Nov 1998, 313.

[58] *Ibid.*

the possibility of wrongful death actions by aggrieved family members for the death of loved ones under the program. Given the potential for harm associated with heroin use, the stakes could be quite high.

ORGANISED CRIME AND THE BLACK MARKET

5.4 One of the tenets of the legalisation lobby is that organised crime and the black market will fade away as the control of drug supply changes hands. However, organised crime

> .....is versatile and rapidly adapts to challenges and changes.....it is also expert in infiltrating legitimate business, which it then monopolises by organised crime methods.[59]

It is noteworthy that these words come from Athol Moffitt, retired judge and former NSW Supreme Court Judge who was the first Royal Commissioner in Australia to inquire into organised crime in the US and into its infiltration into Australia.

5.5 Steps towards decriminalisation of drugs may actually be encouraged by the black market.

> If merely the use of a particular drug or drugs, such as cannabis and heroin, and even of drugs on a wider scale, were decriminalised, so sale and supply remains illegal, the undeniable and inevitable increase in use would have to be met by the illegal black market.[60]

Even if full legalisation occurred, it is a common characteristic of any situation where supply is controlled, that a black market develops, even for example a black market in food during rationing in World War II. Whether elements within organised crime actually promote legalisation is not known.

> Whether or not organised crime, its fellow travellers or benefactors contribute to the enormous amount of finance required for world-wide

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[59] Moffitt et al., 1998 *Drug Precipice*, UNSW, Hyde Park Press, 103-104.

[60] *Ibid.,* 104. Compare the scenario outlined in this quote with the current situation regarding decriminalisation of cannabis use in SA.

> permissive movements is carefully concealed. It may well be that these movements are only the unwitting tools of organised crime and its black markets.[61]

6. MEDICAL MODEL OR CRIMINAL SANCTIONS?

6.1 It is frequently asserted, invariably without argument, that heroin addiction is a medical issue and not a legal issue, that we should treat the problem of heroin addiction medically and progressively withdraw or minimise the involvement of the criminal law. In effect, this is an argument for the legalisation of heroin and other currently illicit drugs of dependence. It wants us to accept an either/or approach to the problems associated with heroin abuse. This is too simplistic a basis for sensible law reform and the treatment of heroin abuse. It assumes that something appearing in one compartment of life cannot recur in another.

6.2 It simply does not follow that the existence in some persons of a medical condition should exclude criminal sanctions against behaviours related to that condition. Indeed the law continues to encourage the sick (including the mentally ill) not to engage in behaviours which society judges will threaten the common good as well as exacerbate their own sickness.

6.3 The justification and rationale of the practice of justice has been expressed in a variety of different ways. For example, Fitzgerald says simply:

> the general aim of the criminal law is to discourage and prevent certain types of conduct, and this aim is pursued by the prohibition of the conduct in question, together with the assignment of a punishment for disregard of the prohibition.[62]

This view is one that assigns an educative role to the criminal law, and it has a respected ancestry in criminology.

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[61] *Ibid*., 125.

[62] *Criminal Law and Punishment* (1962), 1

6.4 Another approach is to use the criminal law as an instrument of "retributive justice". Under this model, the punishment is an end in itself. The true position probably lies between these two views. The Wolfenden Report contains a challenging formulation

> . . . of the function of the criminal law so far as it concerns the subjects of this enquiry. In this field, its function, as we see it, is to preserve "public order and decency", to protect the citizen from what is "offensive or injurious," and to provide sufficient safeguards against exploitation and corruption of others, particularly those who are specially vulnerable because they are young, weak in body or mind, inexperienced, or in a state of special physical, official or economic dependence …[63]

6.5 One example of the way in which society combines compassionate medical treatment with certain legal restraints is persons living with HIV/AIDS, hepatitis B, hepatitis C, and those with more than one of these conditions. Clearly society treats HIV/AIDS as a medical issue providing the best medical and social treatments (eg counselling and other forms of social support) available. But HIV/AIDS is also a public health issue. The South Australian *Public Environmental Health Act 1993* was amended in 1993, in line with the recommendations of the Legal Working Party Report, to provide "quite stringent safe-guards to prevent the spread of infectious disease."

> In section 33 of the Act, the Health Commission is granted authority to make application for a quarantine order. This can be applied where a person with a controlled notifiable disease, including HIV, AIDS, hepatitis B and hepatitis C, does not take all measures to prevent transmission of the infection to others. ... For a person infected with a controlled notifiable disease, who knowingly exposes others to that infection, there is a maximum penalty of seven years imprisonment or $30 000 fine under section 36 of the Act.[64]

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[63] Home Office, Scottish Home Department "Report of the Committee on Homosexual Offences and Prostitution, 1957, 9-10

[64] Parliament of South Australia. "HIV/AIDS - Hepatitis B Inquiry (Part II): The Rights of Infected and Non-Infected Persons". *Tenth Report of the Social Development Committee*. April 1997, 27-28

There are similar provisions in the law in most jurisdictions in Australia.[65] On one view, this is a Millsian account of human conduct: it embodies the 'harm to others' principle which many hold to be a sensible yardstick in liberal democracies to judge whether (and if so, to what extent) a person should be restrained from acting or be compelled to act.

6.6 Further, there may be civil liability in the transmission of HIV/AIDS and other controlled notifiable diseases. Civil liability would lie under the torts of assault and battery, as well as in negligence, on the basis that " ... an assent to bodily contact under a mistake as to its harmful or offensive character ought not to be treated as genuine consent, if the mistake is known and concealed by the defendant."[66]

> Indeed, the least unauthorised touching constitutes a battery; in relation to negligence, once a duty to disclose 'relevant information' is established, the failure to do so will likely result in a claim in negligence.[67]

Thus it is clear that a person with HIV/AIDS (or hepatitis B or hepatitis C) can be treated medically as a medical condition while at the same time be subject to certain constraints in personal lifestyle which would be subject to both civil and criminal law. There is no sensible case being argued that the civil consequences of one's actions should be excused simply on account of one's medical condition. The only plausible analogy, the case of diminished responsibility in the situation of murder or manslaughter, does not translate across into the present context since diminished responsibility in legal terms seeks to ameliorate the criminal effects of an accused's act(s) because the mental condition of an accused throws doubt on whether the accused appreciated the criminal nature of his or her act(s).

6.7 So also where heroin addiction is concerned, there is no contradiction in treating the addiction as a medical problem while at the same time constraining addicts from

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[65] *HIV/AIDS And Your Rights*. Australian Federation of AIDS Organisations. 1998. 5th edition, 28

[66] John Fleming. *The Law of Torts, 9th Edition*. Sydney: LBC Services 1998, 89

[67] Warwick Neville, personal communication, 2 February 1999

behaviour which not only worsens their own condition but which represents a threat to the health and well-being of the society as a whole. *In fact there is a duty on politicians to protect members of the public against such abuses.* The legalisation of heroin, even for restricted medical purposes (as referred to in section 2.12 above),

- sends a message to the community that the use of heroin for non-medical purposes is tolerable to society,

- implicitly sends a message that any person's conduct intended to secure the financial resources to gain heroin if that person is not part of a legalised heroin programme is justifiable (ie, the end justifies the means),

- creates or fuels the impression that there is an unfair distribution of resources in favour of those addicts selected for a programme and away from those not included for whatever reason,

- will almost certainly be used to support broader maintenance programmes which cannot be in the best interests of anyone, and

- dangerously suggests to current non-users that heroin can somehow be safely used 'recreationally'.

6.8 Addicts can be encouraged into treatment programmes which are directed towards abstinence. Indeed such an option may be put to an heroin addict convicted of a criminal offence alongside other more punitive options. In those circumstances an addict may well opt for an opportunity to be free of his or her addiction.

6.9 Thus in the treatment of heroin abuse there are roles for both the criminal law and for medical treatment, roles which may well be seen as complimentary as far as the common good is concerned.

7. AN ALTERNATIVE APPROACH

7.1 The way in which the medical problem of heroin addiction is to be dealt with must firstly recognise the basic rights of the addict to the same degree of medical care afforded the rest of the community. Whether the nature of a condition is self-inflicted or not cannot be used as a criterion for determining the extent of treatment. By the same token, treatment options need to recognise all the nuances of dependency, including the behavioural aspects which may thwart an effective treatment regime.

7.2 Those nuances which are evident in an addict's experience include:

- Users often experience a 'honeymoon' period before the onset of dependence, in which heroin is the best thing that has happened to them since sliced bread. Many of their problems fade into insignificance and aspects of the new lifestyle seem exciting and far less drab than reality.
- Once dependency becomes the new reality, the focus of attention shifts to avoiding, at all costs, withdrawal or 'hanging out'. Furthermore, the desire to regain the 'same old feelings' leads to the use of increasing doses of heroin to 'get on the nod'.
- When heroin is not available, other drugs such as benzodiazepines, amphetamines or cannabis , to name a few, will be used.
- The culture surrounding heroin use is an essential element of the addiction. Wheeling and dealing, danger, street level relationships, crime, personal habits and so on form a fabric of existence surrounding the drug itself.
- It is important to recognise the phenomenon of 'needle fixation', whereby the addict becomes fixated on the importance of the process of injecting. Rehabilitation programs need to address this reality and the part played by 'needle fixation' in breaking the addiction.
- There comes a time when an addict wants to 'get my life back'. This desire to become drug-free is pervasive, and such a hope is directed at abstinence.
- The interests of the 'drug establishment' do not necessarily coincide with the interests of addicts or the wider community, especially with respect to the legalisation of hard drugs.
- Methadone programs are not acceptable to many, if not most, addicts. On the street, "methadone has earned the reputation of being a hellish

> substance that wreaks havoc on your body and mind."[68] Withdrawal from methadone is more arduous than from heroin and for many has become a 'legal addiction'. Furthermore, "97% of people on the methadone program still use heroin on a regular basis."[69]

7.3 Consequently, alternative programs for rehabilitation are required, which are ethically sound and are acceptable to dependent users. There are several promising treatment options available that do not involve the ethical problems associated with maintenance-based treatments[70]. These include the use of other opiates as part of a detoxification protocol, including buprenorphine, levo-alpha-acetylmethadol, tincture of opium, codeine linctus, MS contin, capinol, and doloxene. Furthermore, follow up using naltrexone[71] and intensive counselling and social support structures are required to minimise the relapse rate.

7.4 It is acknowledged that short term relapses occur as part of the quest for long term results. Various strategies may be useful in dealing with short term relapse, not the least of which is a strong commitment to counselling and on-going support services. The message sent to the addict by such a commitment may indeed, of itself, be highly therapeutic.

7.5 Given the number of alternatives for treatment, there appears to be no requirement for injectable heroin. An argument based upon the addition of prescription heroin to the range of possible treatment measures, even in a limited abstinence-oriented trial, ignores the wider issues. The most significant of these are the ramifications for Australia consequent to contravening international treaties, the message sent to the

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[68] 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.

[69] *Ibid.*

[70] It is questionable whether the word treatment can fairly be applied to a maintenance-based program where addiction is maintained for other trade-offs in lifestyle for the user or society at large. Treatment implies therapeutic intent to remedy the condition itself for the direct benefit of the patient. A maintenance program, whether methadone or heroin, does not address the primary symptoms, concentrating instead on secondary or even tertiary symptoms (see 3.1 above), which might be permissible if the patient was objectively shown to be 'incurable'.

[71] There has been much publicity surrounding this opiate antagonist, particularly with respect to so-called rapid and ultra-rapid detoxification. Subsequently, trials are currently under way or proposed for NSW, SA and Victoria (see *Briefing Notes*, Vol. 7, October 1997, 8.). In addition, naltrexone may be useful for relapse prevention.

young and vulnerable, and the potential slide into heroin maintenance or even wider legalisation.

8. RECOMMENDATIONS

1. That heroin not be provided for maintenance trials.

2. That heroin not be legally provided as part of a detoxification regime.

3. That government funded trials be conducted both by the public sector (DASC) and the private sector (we suggest Australian Drug Treatment and Rehabilitation Programme Inc.) to test the efficacy of programmes dedicated to detoxification followed by sustaining in abstinence.

4. That such detoxification/abstinence trial programmes be supported by:

    a) counselling before, during, and after detoxification and as an integral part of the entire protocol of the trial

    b) provision of opioid drugs other than heroin and methadone to minimise the amount of heroin present in the body prior to rapid detoxification

    c) the use of naltrexone to aid relapse prevention

5. Review the use of methadone as a maintenance therapy with special reference to the views of addicts.

6. Review the current detoxification procedures.

7. Appoint independent bioethical scrutiny of all new government funded drug trials in both the private and public sectors.

8. Appoint an independent committee to review the bioethical implications and justifications for harm minimisation strategies in dealing with drug addiction.

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** The views expressed are our own and not necessarily those of our respective institutions.*

APPENDIX A

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APPENDIX B

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