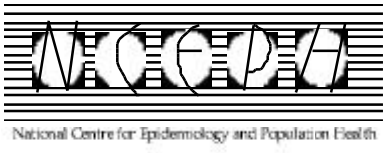
FEASIBILITY RESEARCH INTO THE CONTROLLED AVAILABILITY OF OPIOIDS

VOLUME 2
BACKGROUND PAPERS



IN COLLABORATION WITH

AUSTRALIAN
INSTITUTE OF
CRIMINOLOGY

Feasibility Research into the Controlled Availability of Opioids

Published by the National Centre for Epidemiology and Population Health
The Australian National University
Canberra, Australia

July 1991

ISBN 0 7315 1234 0 SET
0 7315 1235 9 VOLUME 1
0 7315 1236 7 VOLUME 2

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ACKNOWLEDGEMENTS

Useful information and comments were provided by:

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Valuable assistance and support were provided by NCEPH staff:

Kaye Devlin, Liz Foster, Rodney Malbon, Jenni Miller and Barbara Payne

1: ILLEGAL DRUG USE IN CANBERRA

Adele Stevens, Phyll Dance and Gabriele Bammer

This chapter covers general Canberra demographics, definitions, the types and patterns of illegal drugs use, drug prices, estimates of the number of heroin users and injecting drug users, trends in drug use in the ACT, drug treatment services, and the impact of illegal drug use on the community.

Setting Canberra in context

Canberra is the national capital of Australia with a population of approximately 260,000 people. It is situated in the Australian Capital Territory (ACT) and is adjacent to Queanbeyan, a city in New South Wales (NSW) which functions in part as a suburb of Canberra. The population of the region (ACT and Queanbeyan) was estimated at 273 300 at 30 June 1988 (Australian Bureau of Statistics 1988). Sydney, the largest city in Australia, is 300 kilometres away, a 3-4 hour drive. Canberra is located in the south east area of NSW, between the two major state capitals, Sydney and Melbourne. It serves as a regional health centre for the surrounding country areas of south east NSW.

Canberra is Australia's largest inland city. It is a planned city, designed in 1911 around five town centre districts, four of which are now substantially populated. The population has a younger age profile than Australia as a whole and there is a relatively high level of immigration. Nearly 20 percent of the adult population has a degree or diploma, and school retention rates are significantly higher than the national average. More than half the families are comprised of a couple with dependents, a larger proportion than nationally, although there is also a somewhat larger proportion of single parent families. Nearly half of all housing units are being purchased and 18 percent were owned outright in 1988. Unemployment is lower than elsewhere in Australia. More than half of the workforce is employed in the public sector, compared to less than a third nationally. The labourforce participation rate is relatively high and the Canberra community is seen as relatively affluent. In 1988 seventy-five percent of Canberrans rated walking in the neighbourhood at night as safe, 20 percent as unsafe and 4 percent as very unsafe. This information is taken from the 1988 Canberra Health Survey (ACT Community and Health Service, 1989).

Definitions

Drug users are commonly divided into dependent and non-dependent users. By dependent users, we mean people who are frequent, regular users of a drug. For heroin, this is most commonly daily use. Non-dependent or recreational users, however, are occasional, social and/or situational users.

The terminology to describe groups of illegal drug users has varied considerably over the years and in different countries. In the past dependent users were referred to as addicts, but this terminology was abandoned officially by the World Health Organisation in 1980 (Drew 1986; Edwards, Arif and Hodgson 1982), partly to deal with the problems associated with the disease model (see Appendix B) and the negative connotations which had become associated with the word addict.

Illegal drug users, like legal drug users, are not a homogeneous group of people (see also below). As Watson (1990) notes, "they come from a diversity of backgrounds and use drugs in a diverse number of ways". Rather than use the terms "dependent" and "non dependent", Watson describes users as either "career/full time users "or "recreational/casual users". Furthermore, she points out that the latter category consists of a variety of types of casual users:
- "first time users/new recruits"
- "one-off users"
- "opportunists" and
- "committed casual/recreational users".

In this report, we use the terms dependent and non-dependent as this is the most commonly accepted terminology at present in Australia. We would freely acknowledge, however, that this is not the only or the 'correct' way to describe categories of drug users.

Dependent users constitute the majority of clients of specialist drug treatment agencies. However, it is important to remember that they are a minority among both legal and illegal drug users (Hartnoll, Mitcheson, Lewis and Bryer 1985; Kosel and Adams 1986).

People's dependency status is not static. For example, dependent users can become abstinent, either with or without attending a treatment agency, and some may then return to non-dependent use. Dobinson and Poletti (1988), in their study of dependent heroin users who were also dealers, found that all but 26 percent of their sample had periods when they voluntarily abstained from drug use. This was apart from periods when they had been in treatment. Maddux and Desmond (1981), in a study of 10-20 year careers in opioid users in the United States, found that at any one time a proportion of the sample was either abstinent, in prison or in a treatment institution, or using daily or occasionally (occasional use could be as little as once a month). In the first 10 years, 36 to 43 percent of the sample were using daily, and in the second 10 years, 37 to 26 percent were using daily (Maddux and Desmond 1981:93). These two studies demonstrate some of the variability in use patterns among dependent users, an area which has had almost no study in Australia.

In any attempt to estimate the number of dependent and non-dependent illegal drug users, the fluid nature of dependency needs to be kept in mind.

Patterns of illegal drug use in Canberra - Qualitative data

We begin by offering a series of vignettes to describe the range of people who use illegal drugs, particularly heroin, in Canberra. The pictures are drawn from responses to the various surveys conducted as part of the feasibility study and from previous research conducted by one of us (PD).

Most people have only one image of illegal drug users, a stereotype which is only a small part of the whole picture and which is not realistic at all for many. That image is of alienated individuals with problematic lifestyles manifesting in a constellation of problems. Their daily routine is concentrated on running around trying to get drugs, raising money by prostitution or committing a range of crimes which often lead to imprisonment. Their lifestyle shows little regard for their own physical or mental health, and is characterised by unemployment and poor family and social relationships, including neglect of their children.

For some dependent users this image is a reality, although most commonly only some parts of it fit. For such people it is a "normal" lifestyle, one that they have grown up with and been socialised into. According to an ACT drug counsellor interviewed as part of the feasibility study many such people have

> "...forgotten a normal way of living...The people with problems have rarely spent time without one or another substance on their system...They tend to relapse quickly and dramatically. Should we legalise opiates we'll be removing a whole lifestyle for people, not a lifestyle we'd like but one they're used to. Some people [ie clients] say ‘I don't understand anything about life when I'm straight’ ".

This comment from an ex-user who responded to the survey conducted as part of the feasibility study gives a personal insight into the mind of a person on opioids:

> "When you're using or on methadone you don't think straight, everything you do has an air of insanity about it because you are insane - not thinking right."

Another respondent who called himself "an addict in recovery" commented:

> "I've found the majority of dependent users have horrendous childhoods relating to violence, sexual abuse, rejection, abandonment, unstable upbringing, dysfunctional families [and] emotional immaturity."

The importance of needle sharing was potently illustrated by a comment from a user who had had several previous habits and who was interviewed by Dance (1989):

> "When it comes down to it, whether you're hanging out or not, if there's powder there to be hit up and you don't have your own fit you're not just going to leave it there."

But this picture is only true of some users of opioids. Many others do manage to sustain a "normal" lifestyle and heroin use is only part, albeit an important part, of a routine which may include the same sorts of commitments as those of the rest of the community. Such a user was a survey respondent who identified himself as

"An old dependent user with an 18 year history of daily heroin use and a [career as a] Senior Officer Grade C-Aust. Public Service."

He was

> "...hopeful that people like me are not rated ineligible [for a trial] because they are not 'down and out' enough...Users who are in professional occupations and who go to [Treatment Centres] are not taken seriously simply because they have decent jobs and don't look or behave like your classic stereotypical junkie."

A woman using heroin three times a day interviewed by Dance (1990) was obviously coping well as a mother and was also working part time. This woman was spending an inheritance on heroin use and said that the good thing about heroin was

> "It makes me function."

These two cases are typical of regular heroin users who are, in many ways, in control of their lives.

As discussed above, dependence and use change over time for most people. A drug user interviewed by Dance in 1991 maintained:

> "There's a blending process between completely happy and enthusiastic drug user to junkies and there's nowhere you can draw a line."

Views differ on whether or not recreational users are dependent. The following is a survey response from a polydrug user who used heroin occasionally:

> "Even recreational users have a habit - it's a different sort of habit."

Another survey respondent wrote:

> "I am a recreational user (About 2-4 times per week). I tried to get on the Methadone Program [and was unsuccessful] because I do not have a bad enough drug problem, or withdrawal symptoms. The trial would be most helpful to people in my situation. I do not have a great drug problem but if I was to use heroin/opiates [on a trial basis] it would certainly make my life a lot easier and happier. I would eventually cut my dose down to a smaller amount and finally nothing at all."

The following statements were recorded by Dance (1989) and came from someone who at the time of interview said he was using heroin 2-3 times a month but had experienced

> "several habits in the past".

Recalling his earlier experiences of heroin use this respondent said

> "Heroin was the best. Heroin would give you a fantastic feeling right through your body and make you feel King of Canberra. You wouldn't be shy or nervous."

His later use was somewhat different and he graphically described his perception of heroin as

> "A blossom of problems"

going on to say

> "There's no such thing as a recreational user. Heroin is a subtle drug, once you start, it will never let you go."

Most non-dependent users interviewed by Dance in 1989, and who were for that research identified as recreational IVDUs (Intravenous Drug Users), and later identified by Dance and Mugford (1991) as "drug enthusiasts", did, however, see a very clear distinction between themselves and dependent users. The majority of those respondents had strong friendship networks, above average communication and intellectual skills (Dance 1991a), and were very far removed from the stereotypical image. A key member of that group who has been in the Canberra drug scene for about 15 years informs us that there are

> "Large numbers of people outside the group who share these characteristics and use drugs [often opioids] in a highly social context. They don't run into problems and they are not recognised in most models of drug use. It would not be difficult to expand [the findings from Dance's 1989 research] almost indefinitely...when they say we've got a drug problem they're overestimating the problem, but they're underestimating the number of people involved." (Anonymous personal communication, 1991.)

For those "drug enthusiasts" an important part of the drug use is the context in which it occurs. Drug use, including heroin use, is often associated with good times, parties and friends.

One inexperienced user described heroin as

> "...an OK drug if you use it right. Recreationally it's a right laugh. If you use it all the time it's no good." (Recorded by Dance:1989.)

One of the other respondents interviewed for that research described heroin as a drug which would help her think when she had a problem and another, a postgraduate student, said he used heroin to help him think more clearly and to aid his creative powers when he was writing.

Some who would like a place on a trial exhibit an altruism not usually attributed to users. One polydrug user who occasionally injects heroin, and who is HIV positive, said in our survey

> "The main target group for the trial should be dependent (users) if you're trying to minimise risk you do it for the people using most."

He later added that although he would apply for a place on a trial he would not be worried if he was unsuccessful because

> "[My] use of opiates is so low and other users need the trial option more than I."

Thus there is no such person as the typical opioid/heroin user. Levels of drug use vary widely as do the lifestyles accompanying that drug use. Many people who use opioids regularly, but not necessarily frequently, and perceive themselves to have problems would be willing to participate in a trial of controlled availability of opioids. Some of these are people who have not been considered eligible for inclusion in current treatment programs. There are others who would not, for a variety of reasons, be willing to take part in a trial. The reasons include low levels of use, a desire to remain anonymous and a view that a pursuit undertaken for pleasure should not be medicalised.

What illegal drugs are used in Canberra? - Quantitative data

Because of the illegal nature of drug use, the above question can never be fully answered. There are two prime sources of data which address these questions: the ACT Drug Indicators Project and a study of non-dependent drug users by Phyll Dance.

The ACT Drug Indicators Project collected data on drug use by people attending drug treatment and criminal justice agencies (Stevens, Wardlaw, Lee and Kieboom 1989). Poly-drug use was common among this group, with cannabis being the most frequently used illegal drug, followed by heroin, amphetamines, tranquillisers and then cocaine (Table 1). Bammer and co-workers, in a further analysis of poly-drug use based on 1988 and 1989 data from the Drug Indicators Project, found that 91 percent reported using more than one drug in the last 1-3 months, with 63 percent reporting use of 3 or more drugs. Heroin users took an average of 4 drugs; the middle 50 percent taking between 3 and 6 drugs, 25 percent taking 2 or less, and 25 percent taking 7 or more. Seventy-six percent of the heroin users also smoked cannabis, 50 percent took amphetamines, 46 percent benzodiazepines and 28 percent cocaine (Bammer, Freeman, Pittelow, Stevens and Wardlaw unpublished, 1991).

In the ACT Drug Indicators Project in 1988, over 65 percent of heroin users reported taking that drug on 4 or more days of the week (Stevens et al. 1989). Such frequent use would be expected in a treatment population.

Table 1: Reported Drugs on Admission or Arrest: Drug Type by Agency Type, January-December 1988

Drug Type		AGENCY TYPE Drug Treatment/ Corrective Services[+]	Police[++]	Total
Cannabis	(no.)	441	234	675
	(%)	77.9	78.3	78.0
Alcohol	(no.)	392	0	392
	(%)	69.3	0	45.3
Heroin	(no.)	310	40	350
	(%)	54.8	13.4	40.5
Amphetamines/other	(no.)	209	36	245
Stimulants[*]	(%)	36.9	12.0	28.3
Benzodiazepines and	(no.)	180	4	184
other tranquillisers	(%)	31.8	1.3	21.2
Cocaine	(no.)	71	3	74
	(%)	12.5	1.0	8.6
Methadone/other	(no.)	67	0	67
Opioids	(%)	11.8	0	7.7
Hallucinogens	(no.)	53	0	53
	(%)	9.4	0	6.1
Over the Counter Drugs	(no.)	39	0	39
and other Drugs[**]	(%)	6.9	0	4.5
Total Drug Reports[***]	(no.)	1762	317	2079
Persons Reported		566	299	865

[+]CDC, DRIC, Karralika, Toora, WHOS, Corrective Services (ACT and Queanbeyan), Queanbeyan Alcohol and Drug Service and ACT Community and Health Services Alcohol and Drug Service.

[++]Australian Federal Police (ACT) and NSW Police (Queanbeyan).

[*]Includes two cases of MDMA (Ecstasy).

[**]Includes inhalants, Kava, Polaramine, Magic Mushrooms, Medislim.

[***]Total drug reports exceed the number of persons reported because of drug treatment and welfare clients reporting multiple drug use, and arrests with multiple charges involving more than one drug for some individuals. Percentages are calculated on the number of persons reported.

Source: Stevens, Wardlaw, Lee and Kieboom 1989.

Amongst the heroin users in the ACT Drug Indicators study, over 96 percent were injecting the drug. Among amphetamines users, two-thirds reported injecting and over half of cocaine users reported injecting. Multiple modes of use were common among amphetamine and cocaine users (Table 2; Bammer et al., unpublished, 1991).

A description of non-dependent use in Canberra is found in Dance's study of 20 recreational injecting drug users (Dance 1991b). Poly-drug use was also common in this group with individuals reporting use of between 6 and 14 drugs (mean 8.5) in the previous year (including tobacco and alcohol). The most commonly used illegal drugs, in descending order, were marijuana, amphetamines, heroin,

"LSD[1]"mushrooms, barbiturates, and cocaine. Although this sample was recruited using a snowballing technique and the results cannot be used to generalise to other recreational users, it does provide an insight into the levels and patterns of use among some non-dependent users in Canberra.

Table 2: Mode of Drug Use Reported by Those Taking Each Drug

	% of Users*				
	Smoke	**Inject**	**Oral**	**Nasal**	**>1 Mode**
Heroin	5.4	96.4	0.3	3.6	4.7
Methadone	0.0	28.3	86.6	1.6	16.5
Other Opioids	12.5	59.4	40.6	0.0	12.5
Cocaine	3.9	56.4	2.2	54.1	14.9
Amphetamines	4.0	68.9	22.7	24.0	16.0
Other Stimulants	57.1	21.4	71.4	0.0	50.0
Cannabis	98.2	0.2	3.4	0.1	1.9
Hallucinogens	1.5	10.4	96.3	1.5	9.7
Barbiturates/OTC Drugs	1.9	8.7	97.1	1.0	8.7
Benzodiazepines	0.2	3.4	99.8	0.7	4.1
Other Tranquillisers	1.6	6.3	103.1	0.0+	10.9
Alcohol	0.1	0.4	99.5	0.0	0.0
Other Drugs	6.9	1.7	87.9	15.5	12.1

* May add to >100 because more than one mode used

\+ Recording error

Source: Bammer at al. 1991.

The frequency of heroin use ranged from 4 days per week to twice per month, and the number of intravenous administrations in one month ranged from 1 to 16 (mean 7). Heroin was also taken by nasal and rectal routes (Dance 1991b).

Tranquillisers obtained both legally and illegally are used by a third to a half of illegal drug users (Dance 1991b; Stevens et al. 1989). The high incidence of tranquilliser use among dependent users is often related to the lack of heroin (Watson M. 1991, personal communication). Some users who are unable to obtain sufficient heroin make do by using tranquillisers.

Although at the present time there are no general population surveys, either adult or adolescent, which would permit a description of illegal drug use in the ACT, by the end of 1991, data from the 1991 National Campaign Against Drug Abuse (NCADA) evaluation household survey and the ACT school survey will be available. Should a trial of controlled availability of opioids proceed, these data sets will be a valuable source of information. (In previous NCADA surveys the sample size in the ACT was too small to permit any statistical analysis which would describe the patterns of illegal drug use. In 1991, NCADA has overcome this problem by oversampling.)

[1]Pure LSD is rare in the ACT and these drugs are more accurately referred to as "trips". Tablets sold as LSD may contain a variety of hallucinogens and may, in addition, contain amphetamines (Anonymous 1991, personal communication).

Drug Prices

Heroin
The smallest amount of heroin that can be purchased in the ACT is a 'deal' for $50 which would be sufficient to provide one "hit" for an inexperienced user, or one who is non-dependent. For more experienced, or dependent, users $100 would be required to give the desired effect. A 'gram' of heroin costs between $350-400. (A street 'gram' is not necessarily a metric gram.)

Amphetamines
The cost of amphetamines varies between $70 and $100 per 'gram'. The best information available is that $50 would be needed for an experienced user to get a good 'buzz'.

Cocaine
There appears to be very little cocaine in the ACT, but users suggest that the price varies between $250 and $400 per 'gram'.

"LSD"
$15 - $20 per tablet.

Mushrooms (in season)
Free.

Cannabis
Leaf cannabis costs about $25 a 'stick' ('foil'); because they give a better effect heads are usually more expensive. A $25 'stick' of leaf cannabis would provide 4 or 5 big 'joints', or 20 cones for bongs. The price rises to $30 in the dry season over summer. Leaf cannabis can also be purchased as an 'ounce bag' with price depending on quality, usually $300 to $400; $450 to 500 in the dry season. Other forms of cannabis (hashish, oil or resin) are not generally available in the ACT.

Estimating the number of heroin users in the ACT

Direct estimates of the number of heroin users in a population can be made from survey data such as school surveys (for adolescents) or household surveys, although these are not without problems (Commonwealth Department of Health 1987; McDonald 1989). As indicated above, there are no data available in the ACT for direct estimates at the present time.

Hartnoll and co-workers (1985) describe a number of indirect estimation techniques: projections from deaths, capture-recapture, nomination techniques and combining estimates from the above into a best estimate.

Of these, only information about deaths is available in the ACT, but numbers are too small to provide reliable estimates.

In one particular setting in the United Kingdom, Hartnoll and co-workers (1985) calculated that for every person in treatment for heroin dependence, there were six to ten who were not in treatment. Further, they estimated that there were two to three non-dependent heroin users for each dependent user. This is commonly referred to as the 'treatment multiplier' method and has been used to estimate the number of heroin users in Australia by NCADA. The results were found to correspond well to those produced by other methods of estimation (Commonwealth Department of Community Services and Health, 1988).

We used the treatment multipliers on data collected by the ACT Drug Indicators Project[2]on the number of people in treatment in the ACT in 1988 and 1989. There were 381 people who reported heroin as a 'problem' (Bammer et al. 1991). Because the treatment multiplier was developed on annual admissions, we used half this number in our calculations[3]. This produces an estimate of between 1104 and 1900 dependent heroin users in the ACT region (i.e. ACT and Queanbeyan). The estimated number of non-dependent heroin users in the ACT region is between 2280 and 5700. The total number of heroin users is, therefore, between 3300 and 7600 people.

It needs to be noted that the treatment multipliers developed by Hartnoll and co-workers were based on UK data and no similar estimates have been developed from Australian data. The UK treatment multipliers, however, "are considered by some Australian experts to be, on face value, reasonable in the Australian context" (McDonald 1989). The experience of the officers of the ACT Drug Squad also suggests that these treatment multipliers are reasonable for dependent users (Foster E. and Drennan P. 1991, personal communication), i.e. of the dependent users known by the drug squad only a few are known to be in treatment.

The treatment multiplier method was criticised in the Cleeland Report (Parliamentary Joint Committee on the National Crime Authority, 1989) which also criticised other methods of estimation used by NCADA. The Cleeland Report favoured a method whereby the total number of heroin users in a population was based on the number of marijuana users aged between 15 and 30. They estimated that the number of heroin users was 4.5 percent of the number of marijuana users. Only 10 percent of these were estimated to be dependent users.

In the telephone survey of a random sample of the Canberra community conducted as part of this feasibility study (see Chapter 8: Attitudes to A Trial) 22 percent of people aged 18-30 had used marijuana in the last 12 months.

We assume that if those aged 15 to 18 had also been surveyed, the percentage of marijuana users would have been less and that if the survey had not been restricted to people who owned phones that it may have been more. Twenty percent may be a reasonable overall working figure. There are approximately 80,000 people in the ACT aged 15-30. Based on these figures, there are around 16,000 marijuana users and, using the estimation method from the Cleeland report, this suggests that there are around 720 heroin users (4.5%). Seventy-two (10%) would then be estimated to be dependent users.

From the ACT Drug Indicators data we know that 381 people citing heroin as their problem drug contacted drug treatment services in 1988 and 1989 and over the same time another 233 people who had used heroin but not cited it as a 'problem drug' also contacted the services.

The estimate of 72 dependent heroin users and 720 users in all may, therefore, be somewhat of an underestimation.

Another method of estimation that we have used is information from ACT key informants. It needs to be noted that the methods they used to arrive at their estimates are unknown.

In 1986, Keith Powell, Director of the Alcohol and Drug Service at the then Woden Valley Hospital, estimated that there were 1000 people dependent on heroin in the ACT. He believed that the number of regular users had risen steeply over the previous 5 years (Canberra Times April 27, 1986). In 1987, the coordinator of the ACT Health Authority's needle exchange program, Ms Sandy Spears, told an Authority meeting that the ACT had between 1000 and 6000 intravenous drug users (Canberra Times August 28, 1987). Recent data from the ACT Needle Exchange Program indicate that over a 1000 injecting drug users were using that service[4] (Watson 1990; Stevens et al. 1989). Whyte, Arachne and

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[2]In the ACT Drug Indicators Project data were collected on the number of individuals making contact with drug treatment services, as well as the number of admissions. On each notification, the individual's date of birth and three letters from their name were collected. This produced a unique identifier as well as maintaining anonymity.

[3] This would produce an under- rather than over-estimate.

[4]In an attempt to count the number of individuals using the ACT Needle Exchange Program since 1988, the service has been using a code system whereby people who are collecting their syringes use their own individual code at each attendance. By 1989, there were at least 1000 codes being used by clients of the service. Some individuals collect syringes for all the people in their household who are injecting drug users, so the code system

Watson (1987) report on a survey using a type of snowball method with peer surveyors, from which they estimated that there were 5000 to 7000 intravenous drug users in Canberra in 1986. The last three estimates include amphetamines and cocaine injectors as well as heroin users.

Hartnoll and co-workers (1985) stress that a best estimate, combining results from a number of estimation techniques, should be used. The figures from the ACT Drug Indicators Project with treatment multipliers and the figures from the key informants are reasonably similar but around 10 times greater than the figure based on the 'Cleeland calculation'.

Each method had obvious problems but it seems reasonable to suggest that in the ACT there are between:

70-2000 dependent users
600-6000 non-dependent users
700-8000 heroin users in total.

It seems quite possible that there may be around 1000 dependent users.

Trends in drug use

The lack of data referred to above also makes estimations of trends in drug use problematic. The ACT Drug Indicators Project, which was established to trial different methodologies for (among other things) estimating trends, and which was beginning to produce useful data, did not have its funding continued when the original project was completed. The Australian Federal Police have been collecting data since July 1987 which will allow analysis of drug arrests and seizures by drug type for the ACT (Foster E. 1991, personal communication); these data have not yet been published. Should a trial go ahead in the ACT this data base may be important for evaluating the trial.

The best estimates currently available are from key informants.

Dr. Keith Powell, physician to the methadone clinic, "guesstimates" that heroin use has risen slowly over the last decade in the ACT. Consequently, the ACT Methadone Clinic has steadily expanded the program to cope with the rising demand due to problem heroin use. Dr. Powell sees no evidence of a plateau in the demand. However, he notes that 40 percent of those entering the methadone maintenance program have been on the program previously (1991, personal communication).

Officers of the drug squad believe that there has been no significant rise or fall in heroin use in the ACT in the last 5 years. Generally they still see the same people; a few have died, a few have become abstinent and there are "a few new faces" (Drennan P. 1991, personal communication).

In recent months there have been reports in the ACT that there has been an increase in heroin users 'distilling' codeine to create an opioid called 'homebake'. This is supported by the survey conducted as part of this feasibility study (see Chapter 8: Attitudes to A Trial).

There is some evidence that amphetamine availability and use have increased in the ACT in recent years (Lee, Stevens and Wardlaw 1989; Drennan P. 1991, personal communication), with some young people taking amphetamines rather than heroin (Drennan P. 1991, personal communication).

When the availability of cannabis is restricted (as can occur seasonally or in response to enforcement activities) there is some evidence to suggest that there is an increase in amphetamine use as a 'cheap' and 'acceptable' substitute. Reports from both ACT drug treatment professionals and illicit drug users suggest that this has occurred intermittently in the ACT in recent years .

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of the Needle Exchange Program is a conservative measure of the number of individuals who obtain their syringes there.

Drug treatment in Canberra

A range of both government and non-government agencies in the ACT provide either treatment or support to illegal drug users. The principle agencies are listed in Table 3.

Table 3:Main ACT Agencies Providing Services to Drug Users 1991

Alcohol and Drug Service
- Hospital Unit
- Detoxification Centre
- Community Unit
- Treatment Referral Unit

ADD Inc.
- Crisis Detox Centre (CDC)
- Drug Referral and Information Centre (DRIC)
- Needle Exchange Program
- Halfway House
- ACTIV League

ADFACT
- Karralika Adult Therapeutic Community
- Karralika Family Therapeutic Community
- Halfway House for alcohol dependent males
- Halfway House for people leaving the therapeutic community
- Relapse Prevention and Intervention Program
- Drink Driving Prevention Program

TOORA
- Women's Addiction Recovery Service

Mancare Community Service

Government agencies

The Alcohol and Drug Service of the ACT Board of Health includes the following:

- a detoxification unit which caters for 10-13 people,
- a hospital unit which runs the only methadone program in the ACT and south east region of NSW, and
- an outpatient type of counselling service (run from both the Hospital and Community Units).

A variety of education and prevention programs are conducted by all 3 units (for a more detailed report of services, see ACT Board of Health [1991]).

In addition, the Alcohol and Drug Service administers the assessment panels for the Drugs of Dependence Act. The Act came into force in 1989 and provides for post-sentencing diversion into treatment for drug offenders. The Treatment Assessment Panels consist of both government and non-government personnel and represent both legal and drug treatment expertise. They provide professional assessment of drug dependence and treatment referral suitability to those people convicted of drug related offences in the ACT Law Courts.

Methadone
The methadone program in the ACT consists of both a reduction and a maintenance program. The size of the methadone program has increased steadily over the last 5 years, resulting in a doubling in the number of methadone maintenance places from 40 in 1986 to 85 in 1991 (Powell K. 1991, personal communication). In both NSW and Victoria, the number of methadone places has more than tripled over the last 5 years (Commonwealth Department of Community Services and Health 1990). In the ACT, there are 100 places on the methadone program, 85 of those places being presently allocated to the maintenance program. A year ago, there were 75 places on the maintenance program and 15 for the reduction program. Approximately 10 percent of the people on the ACT methadone program live in NSW, predominantly in Queanbeyan. There are no private methadone clinics in the ACT (as there are in NSW and Victoria).

There has been considerable pressure to increase the number of places on the ACT methadone program and the growth of the ACT program over the last 5 years is, in part, a response to that pressure. In August 1989, the Alcohol and Drug Service strongly recommended increasing the size of the program, with a proposal to create a two stream system of methadone maintenance; one with minimal supervision and the other with considerable support and supervision. Due to financial constraints, funding for this program was not approved (Powell K. 1991, personal communication).

At present there is a 2 month waiting period for entry to the methadone maintenance program, except for special cases such as women who are pregnant, and people who are HIV positive, sick with Hepatitis C or B (or a carrier of Hepatitis B) or suffering from another illness. People who test positive for Hepatitis C but who are not actively ill with the disease are not considered special cases. There is frequently a waiting period for entry into the reduction program but the waiting period is much shorter than for maintenance, a matter of some days or weeks for the reduction program.

Non-government agencies

The non-government sector consists of a variety of agencies, although the majority can be divided into two categories: those which are primarily drug treatment and those which primarily serve the youth sector.

There are two main drug treatment agencies: The Alcohol and Drug Foundation of the ACT (ADFACT) and ADD Inc. (Assisting Drug Dependence Incorporated). These agencies both run a number of services. The different type of services provided by ADFACT and ADD Inc. in part reflect their different philosophies.

ADFACT
ADFACT was established in 1975 with the following aims: "To enquire into, conduct research, make recommendations and implement programs for the prevention and treatment of alcoholism and other drug dependencies in the populations of the ACT." The "flagship" of ADFACT is the Karralika Therapeutic Community which began operations during 1978. The philosophy of Karralika is based on:

> "the Therapeutic Community approach towards rehabilitation. The basic concept used within the program is that dependence on chemical substances is not the main problem, but is a manifestation of deeper underlying difficulties. The program therefore aims to provide an environment that will not only assist people to give up their dependency on drugs, but also improve their personal and social skills.
> The Primary goal of the Therapeutic Community is to foster personal growth. Therefore, while there is an acknowledgement of the part certain social structures play in a person's drug taking behaviour, the problem is seen primarily as a 'People Problem'. People use drugs for a variety of reasons, but these have more to do with the pressures on the individual, and with their lack of life-coping skills, than with any hedonistic desire to 'get out of it'." (Alcohol and Drug Foundation of the ACT 1990).

ADFACT administers the Karralika Therapeutic Community which consists of two residential programs, an Adult Program and the Family Program. Adjunct programs are the Halfway house and the Relapse Prevention and Intervention Program (a non-residential program). Primary alcohol problems are serviced by the Halfway House for alcohol dependent men and by the Drink Driving Prevention Program.

ADD Inc
The ADD Inc philosophy is "that all people should be given the information, resources, assistance and opportunity to make their own decisions about their drug use and to be able to use (these) safely" (Watson 1991:357). ADD Inc. staff provide information and support but then, based on the above philosophy, they leave the decision to the client.

ADD Inc. administers the Drug Referral and Information Service (DRIC), a counselling service with "drop-in" facilities, the Crisis Detox Centre; a detoxification unit using non-drug natural methods; a Halfway House; the Needle Exchange Program; and the ACTIV League, an organisation of current and former injecting drug users which is affiliated with the national IV League.

Other
Other major drug treatment agencies in the ACT are the Women's Addiction Recovery Service (WARS) which is administered by Toora, a single women's refuge, and which, among other things, provides services for drug affected women and Mancare Community Service (operated by the Salvation Army) which runs a men's residential therapeutic community, principally with residents with alcohol problems.

There are a number of self help organisations in the drug field in ACT. For example, Alcoholics Anonymous, Al-Anon Family Groups, Drugs in the Family Support Group and Narcotics Anonymous all meet regularly. Narcotics Anonymous has nine meetings a week scheduled in Canberra.

A number of agencies provide support and services to drug users although that work may not be their primary focus. In the youth sector, Short Cuts provides information and advocacy for young people aged 12 - 25 years, the Open Family Foundation provides accommodation and information for young people at risk, and there are a number of youth refuges which are involved in drug counselling for their residents.

Other services which have indicated that they have clients who have problems associated with their drug use include the Winnuga Nimmityjah Clinic - Aboriginal Health Service; Ainslie Village, which provides accommodation for people on low incomes; Cura Casa, which provides short-term crisis accommodation; Thomas Cahill Cottage; and the psychiatric unit at Calvary Hospital. In addition, generalist health services, including some general practitioners, identify and treat patients with drug related problems, and a proportion of these patients will be referred to specialist drug treatment agencies.

The impact of illegal drug use on the Canberra community

Dependence causes a number of problems, both for the individual users and their families (and significant others), and for the community at large. Users can die (from heroin overdose and from overdoses caused by using dangerous combinations of drugs) or suffer from physical, mental or social problems as a result of their drug use. Physical problems may include abscesses and sores at injecting sites, septicaemia, malnutrition, dental problems and diseases such as Hepatitis B and C, and HIV.

Hepatitis B has been common among Canberra heroin users although at the present time there are few users actively ill with Hepatitis B or C. Two recent studies of clients of the ACT Methadone program showed that between 50 and 70 percent have had Hepatitis B (Powell K. 1991, personal communication). In other parts of Australia, the level of Hepatitis B among injecting drug users is over 80 percent (Bell, Batey, Farrell, Crew, Cunningham and Byth 1990; Wodak 1991).

Needle sharing has been common among injecting drug users in Canberra (Whyte, Arachne and Watson 1987; Jardine 1989) but appears to have decreased since the introduction of the Needle Exchange Program in the ACT in 1987 (Watson 1990). Nevertheless, needle sharing still occurs and

there is considerable concern regarding the development of HIV and AIDS among the intravenous drug using population in the ACT.

At the present time, the incidence of HIV resulting from intravenous drug use in the ACT appears to be low.

In June 1989, there were 6 people diagnosed as HIV antibody positive who were intravenous drug users. This represents only 6 percent of all individuals diagnosed as HIV antibody positive in the ACT (Jardine 1991). A similar proportion was found in all states except South Australia (Spooner 1991).

The proportion of injecting drug users who are HIV positive is also low. A 1989/90 study of injecting drug users in the Hospital Unit of the Alcohol and Drug Service found that only 2 percent were HIV positive (Powell K. 1991, personal communication).

There is some suggestion, however, that there may be under-reporting of HIV in the ACT. In the last few years it has become clear that there is no requirement to notify HIV positive cases to the health authorities. (AIDS *does* have to be notified.)

Two sources of current information are the STD/AIDS Clinic of the ACT Board of Health and People Living with AIDS. The STD/AIDS Clinic has 17 cases of people who have been, or are, injecting drug users and who are HIV positive. Three of these people are also bisexual/homosexual. People Living with AIDS, an AIDS support organisation in the ACT, has estimated that there may be up to 20 injecting drug users who are HIV positive (Anonymous, People Living with AIDS 1991, personal communication).

The normal social functioning of many dependent heroin users is impaired because their time and energy is devoted to obtaining drugs (the 'chaotic lifestyle'). This is detrimental to their mental and social well-being and the resultant problems also impact on their families and friends.

Crimes such as theft and assault have been associated with drug taking for some time (see e.g. Wardlaw 1978). Amongst dependent heroin users, the high cost of financing a daily habit means that users normally cannot support themselves by legitimate means and they must resort to dealing in drugs and possibly prostitution, fraud, property offences or armed robbery.

A criminal record is common among people in drug treatment in the ACT; three-quarters of the people seen by the drug treatment and corrective service agencies in the ACT region had a prior criminal record (Stevens et al. 1989). The two most common offences were 'drug offence' and 'break & enter, fraud and other theft'. Similarly, Deane (1988), in a 4 month study of the 161 individuals who appeared before the ACT Magistrates Court in 1987 on drug charges, found a high incidence of offences for 'break and enter, and other offences of dishonesty'. There were 538 charges for other than drug offences for the 4 month period and these made up 56 percent of all the charges in the 4 month period.

As was noted by the Parliamentary Joint Committee on the National Crime Authority, the Cleeland Committee, in its report 'Drugs, Crime and Society' (1989), the costs imposed on the community by drug related crime are substantial. Property crime not only harms individuals who are the victims but the costs are also passed on to the community at large through higher insurance premiums. Shop-lifting results in an increased price for merchandise. Householders and businesses bear the cost of increased security which they take up in an attempt to minimise the possibility of further losses.

Lastly, the costs of law enforcement and drug treatment agencies are significant and borne by the tax-payer. Collins and Lapsley (1991) have written a detailed estimate of the economic costs of drug use in Australia.

Conclusion

There is good evidence that illegal drug use, including heroin use, occurs in Canberra and is associated with significant health and social problems. There are no good data, however, on which to base estimates of the number of heroin users, but it is likely that in total there are more than 700 and less

than 8000 users, with between 70 and 2000 who are dependent. Based on their experience, the police, treatment providers and users estimate that the real number is close to the middle of these figures.

If we assume that there are about 1000 dependent users in Canberra, it seems likely that 600 or so might be attracted to and eligible for a trial.

These figures are clearly guesstimates. However they do provide a reasonable starting point for further careful work.

It should be noted that many drug takers in Canberra use a range of drugs and that amphetamines and cocaine (which are injected less frequently than amphetamines) are also commonly injected. A trial in which only heroin was provided would therefore impact only on part of the drug-using population at risk of HIV infection. Further if heroin users also commonly use other illegal drugs (and if they do so through choice rather than because heroin is not available) the potential beneficial effects being tested for in a trial may be muted.

Although there is some evidence of under-reporting, the rate of HIV infection among ACT injecting drug users currently appears to be relatively low. Despite the success of the Needle Exchange Program there is still some indication that needle sharing occurs.

In the ACT a range of treatment and support services are available to drug users and some services have expanded in the last five years. The methadone clinic, in particular, has doubled its number of clients, but there is still a significant waiting time for new clients.

This information has a number of implications for a trial of controlled availability of opioids:

- more work needs to be done to obtain a good estimate of the number of users who may be attracted to a trial
- amphetamines and cocaine, as well as heroin, are commonly injected
- vigilance is essential to prevent the spread of HIV in the drug-using community and also the Canberra community
- there is an unmet demand for places in treatment services.

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2: LITERATURE REVIEW: ARGUMENTS FOR AND AGAINST CHANGING THE AVAILABILITY OF OPIOIDS

Jennifer Rainforth

Introduction

A reappraisal of treatment approaches for injecting drug users is currently underway. This results from recent recognition of the particular risk of HIV infection faced by this group. There is a move away from abstinence-oriented treatment following acknowledgement of the need for intermediate treatment goals. The focus now is on harm minimisation and programs that aim to attract and retain a greater proportion of the injecting drug user population. The reappraisal has stimulated thinking and debate about the status of illegal drugs in our society and how changes in that status might help achieve the aim of harm minimisation.

The aim of this paper is to summarise the evidence presented in the literature that specifically addresses the issue of whether or not a trial of controlled opioid availability should go ahead. The issues of prohibition and legalisation are only touched on to the extent that they are relevant to this aim. It needs to be noted that the terms 'legalisation' and 'prohibition' are used to mean different things by different authors, although many are not specific about how they are using them. For example, the term 'legalisation' seems to be used by some to refer to free availability analagous to the availability of alcohol, however most seem to use it to refer to controlled availability.

The starting point for the literature reviewed here was a collection of papers provided by key individuals. The collection was augmented by obtaining papers and books referred to in these papers, in bibliographies on drug use, and in recent copies of relevant journals. A decision was made to limit the review to recent material as the nature of the debate has changed since the advent of HIV. Sources such as research by government appointed committees, Royal Commissions and other bodies are mostly covered elsewhere (see chapter 3: The Political Context).

Major points made either for or against the controlled availability of illicit drugs are summarised and grouped under headings to form this review. In order to remain as close as possible to the arguments as they were developed by the original authors, the style of presentation here is closer to that of an annotated bibliography than to a traditional review. Real debate in the literature has been limited as neither side has been specific about the changes proposed, so that there are only relatively few points on which protagonists from each side meet directly.

It should be noted that much of the material in this review is based on opinion and inference rather than empirical studies - heroin has not been legally available in Australia since 1954. Where time prohibited follow-up of supporting references the annotation '(references given)' is made. Evidence from overseas used to support proposals for changes to drug policy needs to be interpreted with caution: the Dutch experience is mainly with marijuana and methadone; the British experience with maintenance prescribing of opioids has been in a different social and legal context.

Within the limitations noted above, the case for increasing the controlled availability of opioids seems stronger than the case against. As pointed out elsewhere (see Chapter 4: Interest Groups and Social Controversies) this could be because those against have not felt the need to develop their arguments because the prospects for change seem so remote.

A major weakness in the argument to increase controlled availability is that although many authors argue for change, there is no agreement on precisely what should be done or even on a series of preferred options. As pointed out earlier, the term 'legalisation' is often used very loosely with no specification of exactly what programs or changes are being advocated or opposed. It should be noted, however, that some individuals have developed specific proposals for change; these are dealt with in Chapter 5 (Options for Structuring a Trial of Controlled Availability of Opioids).

Wodak (1990a) summarises the situation well when he says: 'There can be little doubt that...the diversity of opinion on the subject issuing from commentators of widely different backgrounds and views had made it all the more difficult to decide what are the important questions relating to the subject, let alone the important answers'.

The arguments, both for and against, are grouped under the following headings:
- prohibition as an effective policy
- HIV/AIDS
- costs and benefits of prohibition
- the need for change in drug policy
- myths and misconceptions
- the Dutch experience with marijuana
- the British experience of maintenance prescribing
- costs and benefits of legal availability of opioids, and
- the need for balance.

Prohibition as an effective policy

Prohibition of opioids has failed and should be changed

The Fitzgerald Report in 1989 stated that: 'Attempts to stamp out the illegal drug trade have failed all over the world and have consumed more and more resources. There is no benefit in blinkered thinking. The starting point must be an acceptance that illegal drugs are established in the community and that the prohibition has not worked. Orthodox policy is quite unable to enforce the law. Priorities must be established for the use of the [limited] available resources. One thing is certain: the conventional method of giving the job to the police, on top of all their responsibilities, has failed all over the world and a new approach is needed' (quoted in Robert Marks, 1990a).

Both Mugford (1989) and Chesher and Wodak (1990) claim that prohibition is clearly failing to achieve its main goal. Infractions are common, a substantial proportion of the community either sympathises with the infractions or finds them of little significance and, most importantly of all, increases in the level of enforcement effort are positively rather than negatively correlated with use.

Chesher (1990a) claims that prohibition has 'resulted in the creation of an illicit market for drugs'. Zaylor (1988) goes further and asserts that 'the consequences of criminalisation have led to heroin addiction'.

John Marks (1991) claims that: 'Empirically the prescribing of drugs, in a controlled fashion to drug users, worked in England between 1870 and 1960. Prohibition in the United States and in England since 1960 has coincided with an alarming rise in drug use, the rise being greater as more money is expended enforcing the prohibition.' [Note that the term 'prohibition' is used in a variety of contexts by different authors. In Britain heroin can be prescribed by licensed doctors.]

Chesher and Wodak (1990) claim that prohibition has effectively created a completely unregulated market for illegal substances. There is no control over quality or purity of product, no control over price, there are no dosage instructions and there is no information as to mode of use or of the hazards of drug use. They conclude that this means that the illicit drugs are much more hazardous than they need be.

Robert Marks (1990a) agrees, claiming that government regulation is preferable to the lawless laissez faire of the existing markets, in which the apparatus of the criminal justice system performs as some kind of de facto price-setting mechanism.

Wodak (1991b) claims that 'the war against drugs is doomed to fail' because 'they attempt to defy economic gravity'. He goes on to say that: 'There is surprising agreement among academic researchers concerning the ineffectiveness of strategies to reduce drug supply'. He concludes that the controlled availability of illicit drugs is a lesser evil than our current policies.

Mitchell (1990) argues that prohibition publicises obscure drugs and, with enthusiastic media support, generates new fashions in drug use. It fails to eradicate the importation or domestic production of

illicit drugs but 'perversely succeeds in shifting users to more potent forms of a drug or to more dangerous methods of ingestion'. He also contends that efforts to eliminate illicit drugs 'at the source' in Third World countries are futile, expensive and destructive.

Mitchell (1990) concludes that ending prohibition would 'destroy black markets, unclog prisons and courts, decriminalise millions of citizens, better protect youngsters and restore a good deal of tolerance and civility to society'.

Prohibition has not been a great success because it has not been implemented sufficiently rigorously

Friedman (1990) claims that 'prevention and treatment look like our best bets. Surely, neither has been tried to the extent necessary to assess its potential effectiveness?...The legalisation of drugs is a social experiment that we cannot afford to undertake. The benefits are elusive, the costs too high, and the public health risks in an already strained health care system are simply unacceptable.'

Kleiman (1987) states that either legalisation or a law enforcement crackdown would be an improvement over present policy. Weakly enforced prohibition increases specific risk without adequately reducing frequency of drug use. Legalisation of heroin could reduce the risk of HIV infection, but he feels that it would also increase the frequency of drug use, perhaps dramatically. Kleiman concludes that 'The combined effects of legalisation and increased consumption on crime, community life, the life chances of poor children, and public health and morals could be profound (for good or ill) and are not easily predicted. Legalisation for current addicts only - heroin maintenance - is similar to expanded methadone treatment in its promise and perils'. Rather than take these risks, Kleiman advises that the frequency of intravenous drug use could be adequately reduced by more effective law enforcement, particularly street level 'crack downs', and by increased availability of treatment programs.

Moore (1977) agrees that a weakly enforced prohibition may result in larger supplies and easier access to heroin than a tightly enforced regulatory scheme. However, he feels that the possibility of significant change to current prohibition policy is remote. Moore maintains that a well designed law enforcement strategy can achieve a subtle regulatory effect in spite of crude prohibition policy. He proposes a strategy for regulation of the distribution of heroin under current policy that focuses on law enforcement.

Batey (1991) states that 'not only are we not winning the war against drugs in Australia, we are actively losing the battle'. However he feels that arguments used to justify liberalising drug availability do not take into account all the facets of a complex situation. Batey argues that we are failing to win the battle for several reasons. 'Firstly, the ultimate objectives of the battle have not been agreed upon by all involved, and as a result, the resources for the battle have been inadequate and inappropriately allocated. Secondly, the acceptable rules for engagement have been altered during the battle, resulting in true chaos in the field!'

Society needs sanctions such as prohibition to regulate behaviour

Santamaria (1990) maintains that: 'Historical evidence and practical experience suggest the importance of sanctions in conditioning human behaviour. There is evidence that legal sanctions do deter people from using illicit drugs. In the 1988 survey in the USA of high school seniors in New Jersey, 70% said that the fear of legal penalties was a major reason for not using drugs'.

HIV/AIDS

The spread of HIV makes change to current drug policy imperative

Carballo and Rezza (1990) claim that injecting has become the primary route of drug use in many countries and a primary risk factor for the spread of HIV. For example, in Europe in 1989 approximately 27% of all reported AIDS cases were related to a history of drug injecting; in selected regions drug injecting accounted for as much as 50-60% of all cases of AIDS.

Brettle (1991) quotes studies which appear to show that continued injecting drug use may accelerate the development of AIDS in users infected with HIV. This is controversial as other groups have not found this increased risk. Nevertheless, Brettle concludes that: 'It is important to remember that

injection drug use itself is an immunostimulant which, in the context of HIV, is a disadvantage, and that opiates not only increase susceptibility for bacterial infections but also promote the growth of HIV in cell cultures' (references given).

Stimson (1990) states that a key issue in shaping recent drug policies is the choice that has been posed between two targets - the prevention of HIV transmission and the prevention of drug 'abuse'. He quotes the British Advisory Council on the Misuse of Drugs statement in 1988: 'We have no hesitation in concluding that the spread of HIV is a greater danger to individual and public health than drug misuse'.

Power (1990) reports on a study with Hartnoll in 1989 that indicated that drug users in contact with treatment agencies showed a reduction (at least in the short term) in demand for illicit heroin and a significant fall in criminal activity when compared with a group not in contact with drug agencies. The 'agency group' also showed a 'substantial decrease' in the frequency of injecting and sharing of injecting equipment. This suggests that drug users out of contact with services constitute a group associated with high risk behaviour. Programs need to be designed to attract and retain drug users not currently in treatment if the spread of HIV is to be curtailed.

Wodak (1991a) supports this by quoting several reports from the US and Europe that indicate that injecting drug users undergoing drug treatment have a lower rate of HIV infection and a lower prevalence of risk behaviours than those not in treatment. He argues that it is important that the proportion of injecting drug users in treatment is rapidly increased by expanding the capacity of treatment services and making them more attractive to the target population (also Nicolosi et al., 1991).

Wodak (1990a) claims that current drug policies result in high prices and low purity of street drugs which almost guarantee that street drugs are injected and not consumed by other means that place the user at less risk from contracting HIV (e.g. smoking the drugs). He also feels that the illegal status of opioid use makes it difficult to change HIV risk-related behaviour by education and other means.

Similar arguments are made by Kaplan (1983) who adds that injection, for instance, is rare in those Asian countries where opioids are inexpensive and easily available. However, Kaplan feels that this argument is oversimplified: culture often determines the method of drug administration and many users now include injection as a part of their lifestyle.

Drew and Taylor (1988) point out that 'reliance on attacking drug use through attempting to reduce demand for drugs and to control the supply of drugs has not contained the spread of AIDS, whereas a concentration on reducing harm through minimising needle sharing considerably slows the spread of AIDS.' Evidence provided for this assertion includes the relatively high HIV seropositivity rate in Edinburgh compared to the rest of the UK that has been associated with policy activity to curb drug use (including restricting the sale of syringes and needles) and medical opposition to maintenance prescribing. In other areas of the UK, where police activity is less intensive and substitute prescribing is more actively practised, there is a much lower level of HIV infection. In the USA, the seropositivity rate is 60% amongst an estimated 200,000 intravenous drug users in New York City, despite an unrelenting attack on drug use (for example, sterile syringes and needles are not freely available) (references given).

Methadone programs and HIV

Hall et al. (1991) provide a comprehensive review of the current research literature on the efficacy of methadone maintenance. The evidence includes the results of three randomised control trials in different cultural contexts (New York, Hong Kong and Sweden). They conclude that methadone maintenance is an effective form of treatment for opioid dependence, particularly for those programs that follow the Dole and Nyswander model, that is, relatively high doses of methadone in the context of a comprehensive treatment program with maintenance rather than abstinence as a treatment goal. Efficacy was judged in terms of the impact of methadone maintenance on illicit drug use and on criminal acts. The efficacy of programs which depart from this model - by reducing methadone dose, eliminating ancillary services or by imposing abstinence as a treatment goal - is much less certain. (Hall and co-workers warn that the same is likely to be true for the newer harm minimisation programs which reduce the therapeutic demands on methadone clients in the interests of preventing equipment sharing and the transmission of HIV.)

Ward et al. (1991) also survey the available literature and conclude that being in methadone treatment 'has been associated with lower rates of HIV infection for intravenous drug users (IDUs) than not being in treatment in cities where the incidence of infection is quite high. Evidence also suggests that methadone treatment is effective at reducing injecting drug use and needle sharing. Successful methadone programs retain their patients in treatment, have higher maintenance dosages, have low staff turnover, and develop close, long-term relationships with their patients. Patients who drop out of methadone treatment have been found to have higher levels of HIV risk-taking behaviour than those who remain in treatment. Attracting HIV positive IDUs into methadone treatment is also important. Low threshold methadone programs may be a way of widening the appeal of methadone treatment, thereby reaching members of the injecting drug using population who would not otherwise consider treatment as an option'.

There have been no controlled clinical trials and no large prospective studies of methadone maintenance in Australia. Australian research on methadone maintenance consists of a small number of observational studies which describe patient populations and report outcomes, usually without any comparison group. For example, Foy et al. (1989b) report a prospective study of 47 clients who stayed in treatment for at least two weeks in a methadone program in Newcastle. The authors concluded that, as only 14% of the clients became abstinent as a result of the treatment, methadone maintenance was not particularly successful. These results, however, were affected by a high drop-out rate (70%) as a result of the punitive policy adopted towards illicit drug use.

A study by Lewis and Chesher (1990) of 346 clients on methadone maintenance in Sydney during 1986-1987 indicated that illicit heroin use continued among a substantial number of clients, although others showed a reduction in use. The results showed that 51% of all clients were 'heavy' users whose urine samples indicated that they accounted for 90% of the illicit drug use (Note that 'heavy' use was defined as use of heroin once or twice a week). About half of the clients monitored during this period had used very little or no heroin.

Hall et al. (1991) quote Australian studies which provide evidence that time spent in methadone programs is associated with a reduction in opioid use; that methadone dosage is an important predictor of retention in treatment; and that programs which use low doses of methadone and are punitive in dealing with illicit drug use have high treatment drop-out rates (references given).

Hall et al. (1991) conclude that 'Australian studies provide suggestive support for the overseas evidence with regard to the efficacy of methadone. Although considered by themselves they do not provide compelling evidence, when taken together with the American research, they suggest that Australian methadone treatment reduces illicit opiate use. There is a clear need for good quality prospective Australian studies to provide more definitive evidence of the efficacy of methadone maintenance in Australia'.

The evidence seems to indicate that methadone maintenance can be effective treatment for clients who persist with the program. It seems however that many drug users are either not attracted to or drop out of methadone programs. A study by Dobinson and Ward (1984) of 225 NSW prison property offenders, for example, found that 47.4% had had no experience of any form of treatment. Only 12 out of the 41 users who had undergone treatment had completed it. The main reason given for drop out of treatment was general dislike of the program offered.

The British Advisory Council on the Misuse of drugs (ACMD) proposed in 1988 that much greater attention should be paid by drug services to improving the extent of contact with the wider drug using population rather than concentrating on those with a clear resolve to become drug free in the short term. It is estimated that at the most only a fifth of drug users are in contact with treatment agencies at any given time. Strang and Farrell (1989) assert that prior to seeking help, drug users had spent a mean of nine years using drugs and four years injecting, and at time of presentation most were injecting.

The sharing of injecting equipment, rather than opioid use per se, is a factor in the spread of HIV

Pilotto and Navin (1990) point out that HIV is spread by sharing of injecting equipment and not by heroin itself. They claim that users still persist in sharing injecting equipment when free syringes are available. Pilotto and Navin argue that the habit of sharing would be 'unlikely to change in the face of free heroin'. However, John Marks provides evidence that drug users in the Mersey region, where

heroin maintenance is available, have one third the needle sharing rate of their counterparts in the rest of the UK (personal communication, 1991).

Hawks (1990) points out that the present illegality of heroin use has not precluded the free and ready distribution of needles and syringes. He asserts that for the legal availability of heroin to be justified on the grounds that it will reduce the risk of HIV infection, it needs to be demonstrated that the risk of HIV infection would be reduced further than is already the case with existing programs.

Similarly Loxley (1990) argues that legalising currently illegal drugs will not necessarily prevent sharing of injecting equipment and hence the spread of AIDS. She states: 'Unless legalisation involves the open sale of drugs, which few people advocate, experimental and recreational users may not benefit: yet these users, whose drug use is often unplanned and spontaneous, may be the most likely to share needles'. Loxley also quotes data collected in the Multi-Centre Australian National AIDS and Injecting Drug Use Study that indicate that most users are concerned about the risk of sharing injecting equipment and have altered their behaviour accordingly. She does not feel that the legalisation of opioids is an appropriate option.

The legal availability of opioids may increase the risk of HIV infection

Hawks (1990) argues that if heroin were made legally available together with other drugs capable of injection, there would be an increase in the level of intoxication to be found in certain sub-groups, with a consequent increase in the level of unsafe, unprotected sexual behaviour which itself contributes to the risk of HIV infection.

Hawks (1990) also argues that the legal availability of heroin would result in an increased number of needles and syringes requiring disposal, which would in itself constitute an increased risk of HIV infection.

Costs and benefits of prohibition

There are high costs associated with the illegal status of opioids

There are many costs borne by the whole community that are not a necessary corollary of drug use and that could be sharply reduced by alternative policies. These costs include legal problems such as street crime; corruption; court delays and trial costs; illegal super profits that spur selling; and the creation of court records for otherwise non-criminal persons. Health problems include those caused by impurities in the drugs (and exacerbated by self-neglect and malnutrition as a result of the high cost of the drugs); overdoses as a result of impurities in drugs; sharing of injecting equipment and effects on children born to dependent mothers. Opportunity costs include the high cost of enforcement; lost revenues; lost foreign exchange; and the loss of the ability to use heroin in the treatment of chronic pain (Baume, 1989; Chesher, 1990a; Chesher and Wodak, 1990; Kaplan, 1983; Robert Marks, 1990b; Robert Marks, 1991; Mathews, 1991; Mugford, 1989; Zaylor, 1988).

Engelsman (1989) maintains that repressive law enforcement influences the nature and magnitude of the health and social problems of drug users. He claims that this can lead to misinterpretation of the nature and extent of harmfulness of illicit drugs because it is based on clinically described dependence problems and not on drug use experience outside the system. These secondary problems should be distinguished from the direct primary effects of drug dependency, yet sometimes overshadow them.

Robert Marks (1991) argues that it is the illicit nature of the black market supply of the drug which imposes the very high costs on society and on the users themselves (also Chesher and Wodak, 1990). He estimates a cost to society of $320 million for 1987-88 for the resources diverted from other law enforcement work to attempt to enforce the drug laws. He claims that with a policy of regulation of drug use rather than the current ineffective prohibition most of these costs would disappear.

Collins and Lapsley (1991) define the economic costs of drug dependence as 'the value of the net resources which in a given year are unavailable to the community for consumption or investment purposes as a result of the effects of past and present drug abuse, plus the intangible costs imposed by this abuse'. They estimate the economic costs to Australia in 1988 of dependence on illicit drugs to have been $1441 million.

Loxley (1990) makes the point that the criminal nature of drug use contributes to the reluctance of users to make contact with health workers and needle exchanges. This increases the risk of transmission of HIV through shared injecting equipment.

Engelsman (1989) claims that most young people are not deterred by the threat of punishment or the health hazards associated with drug use. Present drug education efforts do not keep young people from using drugs. On the contrary, many drug users need and want attention. Some young people are attracted by the exciting and glamorous lifestyle of a deviant person. Engelsman feels that the current social and legal situation can thus reinforce drug dependency.

Young people are very sensitive to the double moral standards surrounding drug use. Engelsman (1989) points out that many more people die from the adverse effects of smoking tobacco and drinking alcohol than from illicit drug dependency. Yet society condones legal drug use while reacting with fear and anger to illicit drug use (also Chesher, 1990a).

Mitchell (1990) argues that drug law enforcement in America relies on informants, entrapment and undercover agents and creates a warlike atmosphere conducive to the abuse of human rights. He claims that current drug laws ignore American constitutional guarantees of legal equality and are elitist and undemocratic because they minimise voter input and reject citizen autonomy while granting unjustified drug control monopolies to police and physicians. The mass demand for prohibited drugs creates an extensive black market that feeds organised crime, increases violence, destroys respect for the law, corrupts enforcement, aids tax evasion, glamorises crime and wastes police resources (also Kaplan, 1983).

Mugford and O'Malley (1991) argue that 'the fact that some drugs are legal, and others not, reflects not the wise separation by state officials of the harmful from the harmless, but rather the historically contingent separation of drugs to reflect the interests of power of some groups over others.' They conclude that 'it may be productive to think of demand for drugs as a normal...part of a modern society...A progressive and realistic policy would be to require that the drug commodities, the ownership and conditions of their production, sale, distribution etc., be subject to state regulation rather than abandoned to the highest licit or illicit bidder.'

Legal availability of opioids would adversely affect the whole community

Friedman (1990) claims that because all illicit drugs impair normal cognitive or motor behaviour, the increased availability of drugs will lead to increased accident rates and decreased productivity.

In contrast, Capelhorn (1990) concludes from an extensive review of experiments on opioid users that the chronic administration of opioids caused 'little or no impairment' in intellectual or psychomotor functioning.

Friedman (1990) extrapolates from the huge health costs associated with tobacco and alcohol to predict a huge increase in health costs associated with increased availability of heroin (also Lidz et al., 1975).

Wodak (1990a) counters this by claiming that the vast majority of deaths related to illicit drug use resulted from accidental overdose, which is often due to the uncertainty of the dose of street drugs as a result of their illegal status. He feels that even if the legal availability of opioids did result in an increase in consumption, an increase in morbidity and mortality would not necessarily follow. Wodak points out that neither the legal provision of intravenous morphine in USA in the early 1900s nor the legal provision of intravenous heroin, cocaine or amphetamine in the UK have been criticised on the grounds of increased mortality (references given).

Hawks (1990) argues that there has been no costing of the expense of providing heroin to those presently dependent on it, let alone to any others who may start to use it. Nor have the financial implications of providing rehabilitation to an increased number of users been estimated. The costs associated with regulating the availability of other drugs which would need to be legalised as well have also not been considered.

Kaplan (1983) argues that legal availability of heroin would make dependence on the drug longer-lasting and more difficult to cure. 'Even in our areas of relatively high heroin use, a major reason why

many addicts give up the drug - either temporarily or permanently - is the unavailability of heroin at a price they can afford.' He concludes that 'it is unlikely that free availability would further lower the remission and cure rates for addicts'.

There would be complex legal issues to be resolved if opioids were to be legally available

There is legal precedent overseas for placing some legal blame for accidents involving alcohol on bartenders or party hosts. Friedman (1990) asks who would be legally liable in the case of accidents involving clients under the influence of heroin that had been provided legally. [It is debatable whether this kind of server liability could be argued successfully in Australia.]

Young people would be at risk if opioids were legally available

Friedman (1990) points out that we do not have a way to protect young people from drugs, especially in a situation where legal availability has made the drugs more easily accessible.

Some commentators counter this by asking how could opioids be more easily accessible to young people than they are now - for example, Wodak (1990a). In addition, many schools now have drug abuse prevention programs which involve psychological inoculation and pressure resistance skills or which focus on personal and social skills training (Department of Health and Human Services, 1984).

The need for change in drug policy

Change is urgently needed as most current drug treatments are unsuccessful in attracting and retaining drug users

Drew and Taylor (1988) point out that a new approach is needed to attract intravenous drug users (IDUs) to use drug treatment services; in general, only 10% to 20% of IDUs contact treatment agencies (British figures; reference given). They maintain that IDUs are unlikely to make contact if they are going to be pressured to give up drug use, as is the case with most current treatment programs. Those unwilling or unable to face the idea of abstinence remain beyond the reach of the health care system, have no alternatives, become further isolated and degraded and are more likely to be at risk of HIV infection (Engelsman, 1989).

Martin (1990), for example, reports that over 80% of problem drug users in one London health district were not in contact with any drug treatment service. She feels that reaching this group must be the priority of the district's drug services.

Gossop et al. (1987) document a high level of relapse (or at least episodic drug use) in drug users who have been involved in abstinence oriented treatment programs.

Many respected authorities in Australia are calling for changes to drug policy

According to the National Campaign Against Drug Abuse (NCADA) Task Force on Evaluation (1988), there is a growing body of professional and public opinion in Australia that the time is right for a review of policy regarding the legal status of some presently illicit drugs. Such a view was put to the NCADA Task Force on Evaluation in a number of the key informant interviews, in the State Forums, and in public submissions. The argument for change relates directly to harm minimisation: the harm predicted to public health because of the spread of HIV; the harm and cost to society caused by the illicit drug market; and the harm to the individual drug user deriving from the illegal status of the drug. The report concludes that there are public health, economic and social considerations which support a reconsideration of the total prohibition of illicit drugs.

The NSW Bar Association in its 1989 submission to the Parliamentary Joint Committee on the National Crime Authority recommended that illicit drugs should be provided to 'selected drug users through regulated clinics following careful assessment of individuals with assistance provided in treatment programmes' (quoted in Robert Marks, 1990a).

Community attitudes towards opioid use are changing

Wodak (1990b) claims that public opinion polls in Australia in 1987 and 1988 have reflected 'a more sceptical attitude to the efficacy of law enforcement and supported a more positive attitude to drug policy reform as a necessary response to the threat of AIDS'.

Robert Marks (1990b) provides evidence that community attitudes towards heroin users are changing in Australia. A survey carried out in 1988 by Irving Saulwick and Associates found that 35% of the 1,000 registered voters polled would support the supply of free heroin under supervision to registered users. Support was greatest (41%) among the 18 to 24 year olds and least (25%) among the 55+ age group.

We cannot predict what would happen if changes in drug policy were made

Much of the relevant data on the effects of legalising heroin again in Australia will only be available as a result of engaging in the experiment. Hawks (1990) sees this as one of the reasons for recommending caution in concluding that the present system needs to be abandoned (also Saunders, 1990), although he admits that the present system is inadequate. Hawks argues that 'moving from illegality to legality in the case of heroin, however fraught, may be easier than again seeking to reverse this process'. He goes on to state that those who have advocated legalisation of heroin have yet to provide sufficient evidence that it would benefit the community.

Kaplan (1983) agrees, stating that: 'one would have to be an incurable optimist to believe that heroin could be made freely available without a considerable degree of social dislocation'.

Wodak (1990a) points out the symmetry of this argument; it is also true that the possible benefits of the existing policy of prohibition are equally difficult to determine.

Myths and misconceptions

There are many myths and misconceptions about opioids and their use

Robert Marks (1990b) and Strang (1990) both claim that when properly administered in known quantities and known dosages, heroin is of very low toxicity and causes no long-term deterioration, psychological or physical (also Kaplan, 1983; see also Appendix A).

The 1989 Report by the Parliamentary Joint Committee on the National Crime Authority (the Cleeland Report) accepts the results of recent research which has revealed that much of the conventional wisdom about heroin is mythical: friends rather than 'pushers' are the initiators for many young people who begin using illicit drugs; dependence is not inevitable; those who do develop dependent use of heroin can and do voluntarily cease heroin use; and heroin users either stop using after relatively brief periods of dependence or continue for some years until voluntarily 'maturing out' between the ages of 35 and 45 (quoted in Robert Marks, 1990a).

Robert Marks (1990c) quotes research on US servicemen who had used heroin in Vietnam. Those who had injected in Vietnam were almost four times as likely to use it on their return to the US; 75% of those who had injected before Vietnam continued to use the drug on their return. Twenty five percent of those who had first injected in Vietnam continued to use the drug on their return. Robert Marks concludes that there are high rates of heroin use without dependence and it is likely that most users do not become dependent.

However, the fact that 25% of those first injecting in Vietnam continued to use the drug on their return to America could be taken as evidence of a high carry over effect rather than as evidence of the improbability of addiction occurring. Canaris (1991) quotes a figure of seven percent of Vietnam veterans still dependent on heroin 12 months after their return to the United States. (It is not stated what proportion of these had used heroin before going to Vietnam.) Canaris, however, feels that this highlights 'the existence of vulnerable groups in our society and the impact of environmental factors such as availability of a drug or the social milieu on the outcome of physiological dependence'. He concludes that 'Any decision to legalize hitherto illegal substances should surely consider the likely impact on our growing pool of the alienated and marginalized'.

A survey of one illicit heroin distribution network conducted in Victoria in April 1981 by the wholesale heroin dealers themselves revealed a high proportion of casual heroin users. There were 450 'full-time' users in the network, but over the four week period of the survey there were almost 4200 casual users who bought, on average, two caps per week (quoted in Robert Marks, 1990a). These 'casual' users represent the majority, do not generally present for treatment and are not deemed to have a 'drug problem'.

The Dutch experience with marijuana

Many commentators refer to the Dutch experience although it is not directly relevant to the debate about changing the availability of opioids. However the Dutch concept of 'normalisation' as applied to marijuana use is relevant and this section is included to give some idea of what is involved. It is not intended to be a comprehensive account of the Dutch system.

The Dutch government is moving towards 'normalising' the drug problem: that is, reducing the stigma of dependence and helping users to function better in society. Normalisation seems to have produced a context where the user more resembles an unemployed Dutch citizen than a monster endangering society. It is seen as a pragmatic compromise between an intensified war on drugs and legalisation (Engelsman, 1989; Grund, 1989).

The Dutch Amended Opium Act (1976) draws the distinction between 'drugs presenting unacceptable risks', such as 'opiates', cocaine, LSD and amphetamines on the one hand and 'hemp products', such as hashish and marijuana, on the other. The penalties for possession of marijuana have been reduced and penalties for large scale dealing have been increased. Priorities in the investigation and prosecution of drug offences have also changed (Engelsman, 1989; Trebach, 1990).

This situation has resulted in the sale of limited quantities of hashish and marijuana in youth centres and coffee shops in the Netherlands. The aim has been to separate the markets in which soft drugs and hard drugs circulate. The Dutch Ministry of Justice claims that this policy succeeds in keeping the sale of hashish out of the ambit of 'hard' crime as much as possible, and also prevents young people from going underground. Engelsman (1989) claims that the policy of normalisation in the Netherlands has not produced higher crime rates than in many other European countries [figures given] (also Trebach, 1990).

Despite this ready availability, Trebach (1990) claims that the prevalence of cannabis use in the Netherlands is less than in comparable countries. This suggests that the policy of de facto legalisation of cannabis has not produced a large increase in drug use; however, it is not possible to say whether this low rate can be directly attributed to Dutch drug policy. The assertion has been made that the use of marijuana by Dutch youth has in fact dropped since the 1970s (also Van de Wijngaart, 1989; Cohen, 1990).

Wardlaw (1991) quotes studies that estimate that the Dutch drug treatment system has contact with 70-80% of the dependent user population, as compared with an estimated 10-15% in the United States. Cohen (1990) believes this to be a reflection of the broad range of assistance programs offered to users. For example, in the case of methadone maintenance, the programs available range from strict ones monitored by urine analysis to more flexible, low-threshold programs. He believes that within this range of treatment options, many clients find the program to suit their needs (also Buning, 1988).

Criticism of the Dutch model raised by van de Wijngaart (1989) includes its lack of rehabilitation and socialisation perspectives and the concern that it is increasingly motivated by a desire for public order (also Grund, 1989).

Although medically prescribed methadone is widely available in Holland, Engelsman (1989) asserts that increasing numbers of users are asking for detoxification and drug free treatment. He claims that in Amsterdam this number doubled between 1981 and 1986. He concludes that an increasing number of users want to give up altogether and that for them legalised heroin may not be the answer.

Van de Wijngaart (1989) argues that a weak feature of the Dutch system that could be applied to the legalised supply of heroin is the reported experience of many users that they are chained to a system more interested in controlling them than in helping them.

Dorn (1989) claims that there is criticism of Dutch cannabis retail sales by law enforcement agencies from other countries who argue that Dutch provision of a 'safe haven' for cannabis suppliers disrupts the overall network of control. Dorn also criticises other aspects of the 'Dutch system' as presented by Engelsman (1989). He argues that there is an overestimation of the power of education and states that: 'A nostalgic taking up of 1970s American-derived drug education programmes, characterising drug experimenters as lacking in social competence and skills seems incompatible with the broader normalisation thesis'. He also feels that the comparison between Dutch crime rates and those in other European countries is meaningless. Finally Dorn argues that increasing penalties for drug suppliers by the Dutch as well as other countries has created a violent, professional, criminal organisation that is difficult to deal with and far outweighs the advantages of 'normalisation' of cannabis. He maintains that the way to contain drug markets is to develop more focussed strategies of law enforcement that increase deterrence by increasing the chances of apprehension and capture, instead of decreasing them.

Engelsman (1989) quotes an Amsterdam city government proposal in 1977 to extend Dutch drug policy to include experimenting with medicalised heroin for users. However, the proposal was rejected by the national government for political reasons. There was no political support for the legalisation of illicit drugs in the Netherlands in 1989 as the government did not want to find itself isolated and wanted to fulfil its obligations to international drug conventions.

The British experience of maintenance prescribing

Background to the 'British System'

Strang (1989) has summarised the main features of the 'British System'; his article forms the basis for this account. He points out that there is in fact no central co-ordinated policy or system in Britain; rather the doctor in charge of each clinic has the responsibility to develop treatment programs in accordance with professional experience and the needs of clients.

Britain became a signatory to the International Opium Convention in The Hague in 1912. This was an international agreement to confine the use of 'opiates' and cocaine to medical use. The First Dangerous Drugs Act in Britain was passed in 1920. In 1926 the Rolleston Committee published a report establishing the right of medical practitioners to prescribe regular supplies of 'opiates' to treat certain patients. Patients eligible for prescriptions were those who wanted to undergo supervised withdrawal; those whose use of the drug could not be safely discontinued because of the severity of the withdrawal symptoms produced; and those who could not lead a normal life unless a certain minimum drug dose was available. Opioid dependence thus became the domain of medical practice. Most users had become dependent through the prescription of opioids in the course of medical treatment or through availability as a result of their profession (eg, doctors, nurses and dentists).

Many (mainly American) authors have praised the effectiveness of the 'British System' because there were relatively few dependent users. However, many others now believe that the system worked because there were so few dependent users rather than the small numbers constituting evidence that the system was a success (Strang, 1989).

The 1960s saw the rise of a very different kind of drug user; mainly young men in London, obtaining drugs from a small number of private doctors. Strang (1989) feels that the system was actually contributing to the spread of the drug problem by making supplies so easily available. Drug dependence came to be seen as a socially infectious condition that needed treatment. The Second Brain Report in 1965 resulted in the restriction of heroin prescription to licensed doctors; the setting up of special drug dependency clinics; and the introduction of a notification system for dependent users.

The first drug dependency clinics were set up in 1968 with the dual aims of providing medical care and controlled withdrawal for users, and control over the spread of heroin use.

Strang (1989) reports that: 'One thousand three hundred and six addicts were notified in 1968 - the first year of operation of both the new clinics and the Addicts Index. Most were dependent on heroin and

were living in the London area. Fifteen special drug clinics were established in the London area, which between them saw 79% of the notified opioid addicts in England and Wales in 1968. Frequently, the doctor working in the clinic would initially prescribe heroin and/ or cocaine at doses similar to those previously prescribed by the private doctors. Thereafter the average daily dose of prescribed heroin fell steadily over the next few years and there was also a gradual introduction of injectable and oral methadone as substitute opiate drugs which might be prescribed alone or in combination with the heroin. Cocaine was initially prescribed in injectable form by the drug clinics, but this ceased abruptly and almost entirely in late 1968 following a voluntary agreement between the clinic doctors'.

Strang (1989) states that a short-lived experiment into the possible provision of injectable amphetamines 'was largely a record of therapeutic failure' (references given). 'By the end of 1968, a voluntary agreement had been reached between the Department of Health, the Drug Clinics and the manufacturers of methylamphetamine ampoules, so that the drug was withdrawn from supply to retail chemists; thus it was in effect only available through the drug clinics who chose not to prescribe.'

By the mid 1970s disillusionment had set in. There was evidence of a large population of injecting drug users who remained out of contact with the clinics. Instead of being motivated to withdraw, substantial numbers of the users who did attend the clinics became institutionalised. Fixing rooms which had been available in clinics disappeared. Studies were published which indicated that maintenance prescribing did not stabilise users: there was evidence of substantial criminal activity and supplementation with illicit heroin (Ashton, 1981). However, it must be noted that by this time most clinics were only offering oral methadone to new clients; existing clients were still able to receive injectable drugs. A medically administered heroin maintenance program had changed into a methadone treatment program (Robert Marks, 1990b).

According to Fazey (1989) this change in policy did not come about as a result of rigorous evaluation of maintenance programs. 'There is no tradition, in the U.K. at least, of evaluation of treatments. Research has always been done on the effects of particular drugs and their effectiveness in bringing about physical changes and controlling disease, but not evaluations which look at other variables ... It is only in the past four years that service evaluation has been instituted.'

Fazey (1989) goes on to say that '[c]hanges in [British] policy have been brought about by professional protectionism, concern for service deliverers and pitches for the moral high ground but have not been enlightened by knowledge of the effect of service delivery ... By the late 1970s a de facto change of policy had come about. A group within the medical establishment, and psychiatry in particular, seized the moral high ground and declared unilaterally that drug addicts should not be given drugs. They redefined the nature of addiction (saying that it was an illness which could be cured) and they therefore redefined the nature of what treatment was appropriate - detoxification - the "curing' of the drug addict. It is a classic case of moral entrepreneurial behavour ... made possible because of the small numbers involved. By hounding the private doctors they also managed to maintain hegemony over what was "correct" policy'.

A study conducted at one of the London clinics (Hartnoll et al., 1980; more fully reported in the next section) randomly assigned 96 heroin users to either injectable heroin or oral methadone maintenance. It was found that provision of injectable heroin maintained the status quo, with the majority of users continuing to inject regularly and to supplement to some extent from illicit sources. Provision of oral methadone either resulted in a higher abstinence rate or a greater dependence on illicit drugs for those who continued to inject. Significantly, the drop out rate from oral methadone treatment was much greater (71%) compared with the heroin group (26%) at 12 months. Hartnoll et al. concluded that the results did not indicate a clear overall superiority of either approach; it depended on the priorities assigned to the various outcomes.

The 1980s saw changes in the perception of the drug problem in Britain. Drug users were seen as a heterogeneous group with a range of problems, many of which required non-medical intervention. Most clinics had adopted a short-term abstinence oriented approach. Private doctors had again emerged as a force in drug prescribing, often in competition with their clinic counterparts.

Stimson (1987) claims that there is probably now little that uniquely distinguishes the British approach from that of other countries. There has been a major trend away from a medico-centric approach to a

more diffuse response. Clinics are less central than in previous years: notifications of new dependent users from clinics in 1984 made up only 30% of the total, the rest came from doctors in general practice (55%) and from prisons (15%).

The focus in Britain is now on a community-based response to drug problems: the existing specialist services are seen as a last resort for problems that cannot be dealt with elsewhere, and to provide training and support for generalist services. The aim is to deal with drug problems at the community/generalist level organised around Drug Advisory Committees or Community Drug Teams (Stimson,1987).

Concerns about HIV transmission have accelerated these changes. They have also brought about some radical policy shifts or even reversals; maintenance of drug users with long-term prescriptions of opioids has become a more acceptable option, prescribing of injectable opioids has been at least considered and needle-exchange schemes have been introduced (Edwards,1989).

A criticism of British specialist drug services is that they concentrate most of their attention on those actively seeking treatment and may have neglected the others. Strang (1990) feels that the advent of HIV necessitates a serious reconsideration of this policy so that a greater proportion of illicit drug users are drawn towards contact with health services.

Some have argued that the British clinics were an experiment that failed, but many observers feel that it was not an experiment but part of a continuous evolution in dealing with a demand for drug use that was growing and which was not appropriate for legal controls alone (Robert Marks, 1990a).

Evaluations of British programs

Evaluation of a controlled trial: injectable heroin versus oral methadone

Researchers at the Drug Dependency Clinic at University College Hospital, London, undertook a study from 1972 to 1976 of 96 dependent users seeking a heroin prescription. Users were randomly allocated into two groups - one prescribed injectable heroin (HM) and the other oral methadone (OM) (Mitcheson and Hartnoll, 1990; Hartnoll et al., 1980).

Criteria for participation in the trial were that patients had to be aged between 18 and 35 years; resident in London; not psychotic; had a history of regular 'opiate' use, including daily injection of heroin for at least three months which qualified them for heroin maintenance; and persistence in asking for heroin maintenance and in rejecting alternative treatments. Prescriptions were mailed to a retail pharmacy where special arrangements (unspecified) are made for the drugs to be dispensed daily.

All clients were followed up for a period of 12 months by a social psychologist or his assistant, both of whom operated as independent research field-workers. The majority of interviews and other contacts took place away from the clinic in clients homes, in cafes and bars, on the streets and at various centres of drug exchange and dealing.

Hartnoll et al. (1980) found that the prescription of heroin maintained the status quo, with the majority continuing to inject heroin regularly and also supplementing from other sources. There was a continuing intermediate level of involvement with the drug subculture and of criminal activity.

Refusal to prescribe heroin while offering oral methadone constituted a more confrontational response and resulted in a higher abstinence rate, but also greater dependence on illegal sources of drugs for those who continued to inject. It also resulted in a significantly greater drop-out from regular treatment.

Refusal to prescribe heroin also tends to be associated with a higher conviction rate. During the year of the trial 50% of HM and 70% of OM were convicted of a crime (the difference approaching statistical significance). There was no difference between the groups in terms of their consumption of non-opioid drugs, employment or health.

At the completion of the one year trial period, treatments were altered by agreement between patient and physician. Informal follow-up suggested that subsequent provision of injectable drugs to OM

patients rarely improved their situation if they had continued to use illegal drugs and lead a 'chaotic lifestyle'. Some HM were persuaded to convert to OM. Thus, given a subsequent policy of restricting injectable drugs, the comparative state of the two groups was not noticeably different at the end of a follow-up period varying from a further 18 months to four years. Hartnoll et al. conclude that a policy of allowing maintenance with injectable drugs for a limited period of time does not have adverse consequences on the long-term status of the patients. The ultimate outcome depends more on the patient's personal resources for coping than it does on the effect of treatment.

Hartnoll et al. (1980) warn that the results of this trial may not be relevant to other contexts or other countries - dependent users in London believe that they are entitled to a maintenance prescription of injectable drugs (heroin or methadone) if they can satisfy a physician that they are dependent.

The long-term implication of the OM approach is that although it is more therapeutic in terms of discouraging continued drug use, it also leaves a group of heavily drug-involved people outside clinical control. This prospect might be considered undesirable to society, both because of the criminal activities of this group and because they form the basis of a potentially expanding illicit drug subculture.

Hartnoll et al. (1980) feel that the results do not provide strong evidence that entirely justifies continuing the policy of maintaining dependent users with injectable drugs. The differences between the two groups, while significant, are not startling. Whichever treatment is given, there are obvious casualties. There is a conflict between a policy that would maximise the numbers who achieve abstinence and a policy that would maintain greater surveillance over a higher number of drug users and ameliorate their total preoccupation with illicit drug use and criminal activity.

The authors consider that it might be appropriate both on humanitarian grounds and to reduce the social cost of 'addiction' to provide maintenance on injectable drugs just to that group of dependent users from socially and personally disadvantaged backgrounds who had a poor prognosis when refused heroin, even if they continued to use some other drugs. However, they point out that allocation of patients to separate treatments raises major ethical and political problems.

Hartnoll et al. (1980) also felt that many of their clients would not have approached the clinic had there been the much higher degree of control envisaged in proposals that include on-the-premises administration, participation in counselling and training and relatively quick transfer to oral medication.

A study of users on maintenance prescriptions

Strang et al. (1990) report on a study of 26 users who had received long-term opioid prescriptions from a British private sector doctor and who had subsequently had to attend the Maudsley drug dependence unit in Britain. Their ages ranged from 24 to 43 years, and 16 were aged over 30 years. Six of the clients were women. One client had received methadone ampoules only; 23 had received both methadone ampoules and methadone syrup; and two had received only oral preparations of methadone.

The results indicated that these maintained users were not, as had been claimed, stable, non-criminal, and in regular employment. One third reported continued use of black market heroin, other opioids or amphetamines. Ten clients had received convictions, mostly for drug-related offences such as possession or burglary to sustain drug use, and two had outstanding offences related to drug use. All of these had occurred during the period of maintenance prescribing. Despite their on-going intravenous drug use, these clients reported a low level of high-risk behaviours with regard to possible HIV infection, and their levels of intercurrent infection appeared low. It is not clear whether this is a cause or a consequence of their special treatment status.

After six months of outpatient treatment involving decreasing doses of methadone, about half of the clients moved to a private clinic where there was not the same pressure to reduce the extent or duration of their injecting behaviour.

The results of this study are equivocal with some outcome measures showing an improvement, but not others. It needs to be noted that this is a small sample.

Evaluations of programs in the Mersey Region

The current UK government's Department of Health delegates control of health services in England and Wales to 15 Regional Health Authorities. There are several District Health Authorities within each region. The Mersey Regional Health Authority, for example, covers the counties of Merseyside and Cheshire (Newcombe, 1989). Each District Health Authority has a consultant psychiatrist who is responsible for prescribing heroin. GPs have the power to prescribe oral and injectable methadone, as well as codeine and morphine. Only specially licensed GPs, who work at Drug Dependence Units, can prescribe heroin under the direction of the consultant psychiatrist. The type of prescribing therefore varies widely across Health Authorities and can vary markedly across time as consultant psychiatrists change or change their prescribing policies. Overall, only a small number of psychiatrists in the UK prescribe heroin, amphetamines and cocaine. Clinics in the Mersey region probably prescribe to more people per head of population than elsewhere in the UK.

Evaluation of the Liverpool Drug Dependency Unit

The evaluation discussed below is for the Liverpool Drug Dependency Unit for the years 1985-1987. At that time John Marks was on secondment from Widnes as consultant psychiatrist. At that time also the Liverpool Drug Dependency Unit had a catchment area of Liverpool, South Sefton and Southport and Formby health districts. The information is taken from Anonymous (1988) and Fazey (no date). Marks suggests that in some ways this period was atypical and the Unit had not settled into a Marks/Parry model (Marks, personal communication, 1991; see also Chapter 5: Options for Structuring a Trial of Controlled Availability of Opioids for discussion of the Marks/Parry model).

Background

Increasing concern about the level of drug use in Liverpool in 1983 and 1984 led to funding being made available for an out-patient drug clinic in 1985. The funding given was just under £550,000 for three years, less than half that applied for. The exact nature of the treatment offered was left up to the clinic director, who initially set the centre up as a maintenance clinic rather than a detoxification clinic.

Client groups

It was originally envisaged that the clinic would provide treatment and rehabilitation to a wide range of drug users, including solvent users. However, staff shortages and the desire not to have young solvent users mixing with older established dependent users meant that in practice the clinic mainly dealt with people who had a serious heroin problem.

Overwhelmingly the clients came from areas which had the greatest economic disadvantage. The average age was 23, with a ratio of three males to every female client. One third of all clients were parents. Clients were mainly unemployed - 84.7% were out of work at the time they first came to the clinic. Some 6.7% were in part-time work and 8.1% in full-time work. Thirty-five percent of patients had never had a job. The client population was a highly criminal one: thirty percent had cases pending when they first came and twenty percent were on probation. Only eighteen percent had no previous criminal convictions. (Further data are provided.)

Staffing

It was originally estimated that there would be at least 1,000 clients per year and that staffing should consist of a consultant, clinical assistant, seven nurses, two social workers, a clinical psychologist, administrative support staff and assistance from the Probation Service (two days a week).

The actual number of new clients in the first two years of operation was 1019; staffing levels never reached the recommended number. Many posts took months to fill and chronic overloading of staff led to a high rate of staff turnover. A security officer was appointed in November 1985.

Goals of the clinic

1. To return the client to a drug-free lifestyle.
2. To wean the dependent user from heroin to methadone.
3. To change the mode of administration from intravenous use to oral use.
4. To stabilise the client's drug consumption if the client is unable to decrease it.
5. To decrease the amount of drug the client receives, providing that this does not conflict with goals 9-12 below.

6. To improve the physical health of the client.
7. To improve the mental health of the client.
8. To inhibit the spread of hepatitis B and HIV.
9. To stabilise the lifestyle and family relationships of the client.
10. To decrease the amount of blackmarket drugs being bought.
11. To decrease the level of criminal activity of the client.
12. To increase employment prospects of the client.
13. To reduce the level of drug abuse in the catchment area of the clinic.

Program details

Each new client was seen by a doctor and nurse team. A full history was taken along with urinalysis. Most clients were seen on a monthly basis.

Treatment options included: no medication; a withdrawal regime; maintenance oral methadone or maintenance intravenous methadone or heroin. Referral to an in-patient detoxification unit at Winwick Hospital was another option. Drugs were dispensed via a prescription to be filled by the local pharmacist.

Urine testing was used initially to confirm that the new client had been taking drugs, but was used thereafter as a tool to help in the counselling and monitoring of the client, and, at times, as a positive measure of achievement in being drug free.

A needle exchange program started in January 1987 and, although open to anyone who wanted to come, was in effect used mainly by the patients at the clinic. The scheme has not been extensively used; there were a high proportion of clients who only used the service once.

Results

a. Treatment outcomes

Of the 1019 patients for whom data were obtained, eleven and a half percent (N=116) did not receive any medication and four percent (N=40) were immediately admitted to hospital. Some 58.9% (N=596) were put on a detoxification regime. Only 17.5% were on an oral methadone maintenance regime and 6.2% on an intravenous prescription (0.5% of these were prescribed heroin). Combining these categories, 74% of clients were either given no medication or were on a detoxification regime. The average time of treatment was six months. (These results would seem to contradict the assertion that the clinic was using a maintenance model of treatment; Marks, personal communication 1991, agreed with this and suggested that the period was somewhat atypical.)

After six weeks over half (50.8%) the clients were not in receipt of a prescription. Almost twenty percent were undergoing a detoxification program. Twenty-three percent had decreased their level of drug use after six weeks. Forty-two clients did not return to the clinic after receiving continuing prescriptions for oral methadone (31) or intravenous drugs (11 - although six of these later returned to the clinic on a maintenance regime and two later completed a detoxification program.).

Sixty percent of the clients over the two years of the evaluation were no longer in treatment when the data were recorded (November 1986 - February 1987). It is not known what happened to the majority and cannot be assumed that they are all drug free. However, eighteen percent had completed the detoxification program and had not returned, four and a half percent were known to be in prison and four percent were sent to hospital.

Seventy-two percent of all patients who received a prescription also started a detoxification or withdrawal program at least once. Fifty-two percent of all clients had dropped out of treatment at least once. Thus although three quarters of all patients had been drug free at some time, many returned to drug taking and many to the the clinic.

Only 0.5% of clients were given a prescription for heroin when they first came to the clinic, although 98.1% of patients had been using this drug. Only one intravenous user became drug free. The reluctance to give intravenous drugs except in those cases where the client demonstrates a persistent, determined and chronic use of intravenous drugs means that it is likely to be a long time before these clients can be changed to oral methadone. Thirty percent admitted to buying heroin on the black market to "top up" their treatment.

b. Health outcomes

Clients, particularly intravenous drug users, seemed to undergo a significant improvement in their physical health when they were prescribed intravenous drugs and given clean needles. This improvement was judged from records of weight gain and the annual review sheets. Fifty-four percent increased their weight and there was in all a net average gain of 2.8 kg in one year.

The questionnaire used to measure mental health (the Goldberg General Health Questionnaire) did not yield any significant results and was felt to be unreliable with this client group.

Six clients out of the 23 tested were positive for the Hepatitis B virus; none of the 15 tested for HIV were positive.

c. Crime outcomes

Most clients (four fifths) had criminal convictions, with sixty percent having convictions prior to drug use. Convictions during the previous year of treatment were incurred by over one quarter of clients. Over three quarters of those who did not have a conviction in the past year had previous convictions. By contrast, sixty percent of those who had dropped out of treatment and returned, admitted to committing some sort of crime.

d. Employment outcomes

Nearly one quarter of those who were in the clinic after one year were in employment, but mostly part-time (19%). If voluntary work and education were included, 40.8% had employment.

e. Client views

When asked what they realistically would like to be prescribed, many clients wanted a small increase in the amount of drug given. Out of 164 responses, 14 clients wanted injectable drugs and said that they were still injecting street heroin. Another nine said that they injected but did not expect a prescription. Overall, 14% were still injecting but were not prescribed injectable drugs.

Over 85% of patients said that they were either satisfied or very satisfied with the service. Most clients put forward the re-establishment of an ordered way of life and being able to "get off the streets" and out of crime as the best things about the clinic.

The worst things about the clinic identified by clients were the waiting time, travelling time and concerns about being identified as an dependent user. Wrongly made out prescriptions also seemed to be a constant source of minor irritation.

When asked what they would do if they could not come to the clinic, 48% said that they would be back on the streets, 24% said committing crimes and only one percent would seek help from their GP or another clinic.

The report strongly recommended that clients' views are systematically sought every two years, and that the results be fed back to staff to help with program improvement and to give them much needed positive feedback.

f. Cost of the service

The cost of the service was high, but to bring pressure to reduce the cost would, in effect, be bringing pressure to change the type of treatment which is thought appropriate to dependent users. By far the most expensive of the treatments were for the intravenous drug users, where costs per client per year averaged just under £1,000. These people were also the most difficult to treat because they were the most persistent drug users. To treat dependent users by a maintenance regime thus resulted in a continually rising drugs bill. However, compared to the costs of other treatments, such as those used to treat cancer and HIV/AIDS, the cost per client per year was small. These costs would seem minimal compared to the costs that would be incurred if the drug treatment were not available - such as costs for treating hepatitis and HIV/AIDS and the cost of crime. If the client was actually taken into account, the service was a necessary and "literally life saving" one (Fazey, no date, p.132). (Marks, personal communication, 1991 has added that the cost was high because EEC regulations meant that expensive ampoules rather than sterile blister packs or 'jacks' and sterile water had to be used. This has increased the cost from about one half-penny for a 'jack' to one pound for an ampoule. The cost was

also high because of the high dispensing fees and the frequency with which drugs need to be dispensed.)

This is one of the most carefully described evaluations available, but the results are still equivocal. An important reason for this is that the study is a program evaluation, there is no comparison group, instead it relies on retrospective data to compare clients with themselves over time. Further the outcomes could not be rigorously measured. In addition very few of the clients were prescribed heroin.

Evaluation of syringe and condom use by drug users in the Mersey Region

Background

Fazey (1990) conducted a survey of the syringe and condom use of 140 clients from four drug dependency units (clinics) in the Mersey Region in Britain. The aim was to establish a baseline as to the degree of risky behaviour with respect to HIV infection shown by this group. The original intention had been to compare dependent users in treatment with a group not in treatment, however there were not the resources to undertake a survey of the latter group.

According to the Home Office, the area in which these clinics operate (the Merseyside police force area) has more drug addicts per million population (1,184) than any other area in Britain.

All four clinics have prescription of intravenous drugs as a treatment option. The total client population of the four clinics at the time of the study was 476. The treatment emphasis for these clinics was on detoxification or stabilisation on methadone syrup. Injectable drugs were prescribed to 56 clients, who were mainly older drug users.

One clinic (the Widnes clinic) prescribed intravenous drugs to 50% of its clients; the other clinics averaged 2, 9 and 15% intravenous prescriptions. The Widnes clinic had been established longer than the other three clinics and had a higher proportion of older clients. Unfortunately the numbers involved were too small to make significant comparisons with the other clinics.

Client population

Of the 140 clients in the study, all but 25 had received prescriptions for 6 months or more. Thirty people were being prescribed injectable drugs.

Clients from three of the clinics came from the poorest and most deprived areas of the region. The average age was 25 with a range from 16 to 46. Males comprised 80% of the sample group.

The first drug injected by the sample group was listed as heroin (69%), amphetamine (22%) or temazepam (4%; used as a heroin substitute when the Liverpool Drug Dependency Clinic had a long waiting listand prescriptions for intravenous drugs were hard to obtain).

The overwhelming majority of those who injected, regardless of whether they received a prescription or not, have partners who also inject, most of whom are in treatment.

Seventy percent of the sample had been to prison. While in prison 70% had used drugs, with 20% using drugs intravenously. Not all of those who used drugs intravenously while in prison had a history of injecting drugs before confinement, nor did they necessarily continue injecting drugs when released.

It is interesting to note that 21 people had had prescriptions for intravenous drugs drastically reduced or cut off while attending another clinic. For 17 clients this change had been against their will. All were now in receipt of prescriptions for intravenous drugs at levels equal to or greater than before.

Results and discussion

a. Use of illicit drugs

Only 11% of the sample said that they never 'topped up' with illicit drugs. Eighteen percent said that they used illicit drugs every day; 28% used once or twice a week; 8% once a week or at weekends; and 35% less often. Most of those who were injecting illicit drugs daily had asked to be prescribed injectable drugs and had been refused.

Those prescribed injectable drugs 'topped up' more frequently than those not prescribed injectable drugs. Cannabis was the illicit drug most frequently used (78%), followed by heroin (67%). Of those who used illicit drugs intravenously, 70% used heroin and 36% used amphetamines.

Only three people (out of the sample of 140) admitted to giving away, swapping or selling some of their prescription drugs.

b. Sharing of injecting equipment

Some sharing of injecting equipment does occur, mainly among those in the group not prescribed injectable drugs. Five people had used someone else's equipment in the past month; 8 had passed equipment on to others. Two of those who had passed on equipment were receiving prescriptions for injectable drugs; none of this group used equipment that had been used by others.

Fazey found that sharing of injecting equipment was more likely amongst those who wanted a prescription for intravenous drugs but who were not currently receiving one or amongst those who claimed that they needed more of the drug than they were currently being prescribed. She cites other studies that also show that drug users in treatment tend not to share needles, but that a small group persistently do so.

Fazey recommends that clinic staff identify and monitor clients who are using illict drugs intravenously, that they reassess their prescriptions and persuade them to use the needle exchange without fear of penalty.

In prison, some people used drugs and occasionally injected them even though this was not their normal habit. There was a high rate of sharing of equipment due to the scarcity of syringes. Under these circumstances, the risk of transmission of HIV is high.

c. Condom use

Sixty five percent of the sample had either never used a condom or used one only occasionally. This figure rises to 90% if the responses of those who only used a condom 'sometimes' are included. Whereas many users are adopting safer injecting equipment practices, they are not using safer sexual practices (Fazey cites other studies that have also found this result.)

d. Literacy

One of the striking and unexpected results of the study was the extent of illiteracy or near illiteracy among clients. Many could not fill in the survey questionnaire without help. This finding has implications for education programs for this group, which tend to consist of leaflets and information brochures. The group was also found to have little understanding of what was happening to their bodies in the medical/biological sense. Fazey suggests that videos on safe injecting practices may be needed in waiting rooms or even that home visits and one-to one counselling might be necessary to educate this group.

e. Perceived risk of HIV/AIDS

The study found that among this group the perceived risk of becoming HIV positive was very low.

A change in attitude, and therefore behaviour, in this group is difficult so long as they do not perceive themselves to be at risk of HIV infection. Fazey felt that, for this sample group, educational programs needed to be devised that did not rely on printed material. She also felt that the clinic staff may need training to undertake more effective sexual counselling.

Conclusions

Fazey concluded that a clinic policy to significantly reduce the amount of intravenous drugs prescribed to clients over a short period of time, or to bring them off intravenous drugs against their will, was 'conspicuously unsuccessful'. She points out that it is unknown how many ex-clients continue to use intravenous drugs because they do not believe that the clinics will help them in the way that they want to be helped.

No conclusive results can be obtained from this study due to the low numbers involved and the lack of a comparison group. However, there are some trends which are also supported by other studies. The extent of sharing of injecting equipment in the sample group (who were all under treatment at one of

the four clinics) was low, but so was condom use and the perception of risk of contracting HIV. New ways of getting information across to drug users need to be considered. The sharing of injecting equipment that did occur was mostly among those who were not in receipt of a prescription for intravenous drugs but who would like such a prescription or who wished their prescription to be increased. This seems to indicate that more flexible prescribing practices that involve some client input need to be considered for this group.

Evaluation of other programs in the Mersey region

In 1987 the Liverpool drug squad was asked to examine all arrested drug takers for evidence of clinic prescribed drugs (John Marks, 1991). Hundreds were detained weekly and the survey continued for 6 months. Not a single person was found in possession of clinic drugs to which they were not authorised. In addition, Marks cites an estimation by Marjot that the minimum consumption of illegal heroin per year in the UK is 5,000 kg . Prescribed heroin and methadone total 50 kg per year, so even if all of it leaked to the black market, a far greater problem remains with illicit heroin.

John Marks (1991) also provides some statistics from evaluation of the Widnes Drug Dependency Clinic in the Mersey region. The Widnes Clinic has been offering maintenance opioid management to drug users for many years. (Details of the Marks/Parry model followed by the Widnes Clinic are given in Chapter 5: Options for Structuring a Trial of Controlled Availability of Opioids; The English System.)

John Marks (1991) cites Fazey as finding that of the Widnes cohort 20 (22%, 1989) are now drug free and have lower criminal records than would have been expected, and are physically healthier.

'It is estimated by the local police and Home Office co-ordinators that the Widnes clinic takes £5,000 per 100,000 population per week out of the black market' (Marks, 1991, p.7).

Marks (personal communication, 1991) also says the statistics show a 15-fold reduction in crime (from 6.88 criminal convictions/person/year in the 12 months before maintenance to 0.44 in the 12 months after registration at the clinic); a 12-fold reduction in incidence (15.83 per 100,000 new notifications per annum in Widnes compared to 207.6 per 100,000 in Bootle in 1985 before a clinic opened there); zero HIV (the rate is 20% in many other UK cities, 30% in Dublin and 70% in Edinburgh) and zero drug-related deaths (without maintenance clinics the rate is 10-20%).

General conclusions from evaluations of programs in the Mersey region

Fazey (1989), a researcher with extensive experience in the evaluation of drug treatment programs in Britain, has firm conclusions to make on the subject of what works in the treatment of drug dependency. 'In short, what works for drug addicts is giving them what they want, in quantities which keep them from withdrawing, for as long as they believe that they need it. It works in the sense that they stay alive, do not spread HIV, lead more stable lives, do not commit as much crime, are less a burden to the state. In essence giving drugs to drug addicts is considerably of benefit not only to the addict but the whole of society as well. One fact must be clearly established - heroin is cheap and methadone very cheap. In England [in 1987] the average cost of drugs prescribed to patients at the Liverpool clinic on oral methadone was $275 per year, and for intravenous heroin or methadone, just under $1,700 per year.'

'If the only goal of treatment is to be drug free, by definition, giving drugs to addicts does not achieve this ... If treatment goals are widened to include goals relating to the patient's health, the stability of their home life and lifestyle and reduced criminal activity, then maintenance works in varying degrees with all who need it except for a very small proportion. Criminal activity is not eliminated, but is considerably reduced ... Detoxification for those who want maintenance only works in a small proportion of cases. The evidence here comes from those who have been through numerous detoxification regimes, but who are still addicted' (Fazey, 1989).

Maintenance prescribing is an important strategy in harm reduction

John Marks (1985) summarises the arguments for the prescription of illegal drugs as: the user will maintain the condition anyway; a stable supply benefits the user and provides pure, clean drugs; doctors should help society combat illegal drug use; if alcohol were prohibited, it would be more humane to prescribe a daily dram of whisky than to see someone sell their last possessions for

methylated spirits; there are still insufficient, properly-controlled clinics; and the contrast between England and the USA of 1920-1960 suggests that maintenance doses are an effective means of control.

Maintenance prescribing does not work

According to Kaplan (1983), maintenance prescribing has one major and intractable disadvantage: 'Those addicts who pick up their supply of low-cost heroin will have a strong incentive to resell at least part of their supply, and the more they sell, the more closely will the maintenance system then approximate free availability'. Kaplan goes on to point out that diversion of heroin from a prescription maintenance system would be much more difficult for police to contain than our present illegal distribution system. He expresses concern that prescription maintenance may create a wholly new and large class of regular sellers who will make heroin more accessible as well as cheaper than it is now.

Kaplan (1983) also points out that: 'Anyone interested in limiting governmental power over the individual should worry about programs which will keep sizeable numbers of citizens dependent upon the goodwill of officialdom to avoid withdrawal and being deprived of their supply of an addicting drug'.

Again, Kaplan (1983) argues that heroin maintenance would 'be very likely to lure away from methadone even those who could, in fact, adjust to that more convenient and therapeutic drug.

Madden (1987) summarises criticism of British maintenance prescribing: 'The technique was felt to continue indefinitely the dependence problems of its recipients, inhibited the unfolding of alternative therapies, treatment facilities and research, and had not forestalled an expansion of the drug market'. He feels more encouraged by the range and flexibility of the rehabilitative measures that are now available in Britain.

However, John Marks (1987) argues that it is prohibitionist policy that has created a black market demand, not maintenance prescribing. If maintenance prescribing had been responsible for the expansion of the black market, then he claims that there should have been a fall in the notification rate for dependent users when maintenance was largely ended in the 1970s. Marks also makes the point that maintenance prescribing is not treatment: 'maintenance continues the addiction, but keeps patients in contact with staff, health care and sound advice pending the patient's consent to treatment'.

Krivanek (1988) claims that the whole maintenance concept is 'based on some very dubious assumptions. One is that its existence would make a difference in the demand for illicit drugs...the only real question is how much drug will be diverted from the low-priced [market] to the high-priced one...Neither does maintenance necessarily eliminate demand for illicit heroin by addicts actually in these programs...A second faulty assumption is that given a choice, all addicts would enter a maintenance program...entry into any form of treatment amounts to an admission that one can no longer cope with the habit...Treatment threatens the addict's perception of being in control and normal...A third assumption is that only addicts would seek to enter maintenance. In fact, there are considerable incentives for non-addict users and even non-users to enter...A final assumption is that addicts entering maintenance want to be cured, and that maintenance can do this. Without a doubt, addicts want the maintenance drug. Whether they also want treatment is another matter'. Krivanek also doubts that the offer of methadone maintenance can be used to 'hook' users into treatment, when their drugs give them their most immediate and gratifying solution to their problems. She concludes that the most effective way to control heroin use may be to encourage the development of informal social controls.

John Marks (1985) summarises (and argues against) the main arguments against the prescription of illegal drugs as: it maintains the condition of dependence; it is a public health exercise to protect people from the black market; it is not a doctor's job to control the illicit use of drugs; barbiturates and alcohol are not prescribed because they are damaging, so why prescribe opiates?; the illegal use of drugs is not curbed by prescription; users traffic and supplement their prescriptions; and the efficacy of maintenance doses is not proven.

Users are not interested in legally available opioids

Burr (1986) maintains that the assumptions that users ought to be supplied with what they want and that they would prefer pharmaceutical heroin (PH) to illicitly manufactured heroin (IMH) are false. He claims that a substantial proportion of British users actually prefer the experience gained from IMH.

Many long-term users also cut their opioids with other drugs, such as cocaine, Ritalin, Diconal and barbiturates. Burr adds: 'cheap PH would mean that addicts could sustain their drug use on the blackmarket for a much longer period than they were able to do nowadays...An IMH market is to be preferred because the relatively high cost of regular daily IMH use means that drug users will come to treatment centres much earlier'.

Heroin should be one of the opioids made legally available

Lidz et al. (1975) use the results of the British system to argue that there are advantages in a control system that reflects and embodies a medical approach. The stability of such an approach depends on the availability of the treatment drugs to compete with street drugs. They conclude that: 'This argues strongly for the inclusion of heroin as one treatment option'.

Costs and benefits of legal availability of opioids

Legal availability of opioids would not result in a great increase in use

The Dutch experience has been that the legal availability of marijuana has not been followed by a huge increase in use. This evidence has been used by authors such as Wodak (1990a) to indicate that the legal availability of opioids would not inevitably increase the use of these drugs either.

Robert Marks (1990b) argues that easier access to heroin will not result in a proportionate growth in heavy users. He claims that the distribution of the drug-using behaviour of most psychoactive substances is usually skewed towards light use and this seems to be so for heroin. Marks concludes that a relaxation of prohibition would result in more users, but proportionally fewer heavy users.

For Lidz et al. (1975), the British experience provides evidence that heroin use is not just a function of ease of availability. With an essentially open and cheap supply for most of this century, the increase in use in Britain came only when the type of demand changed in the middle of the 1960s. At this time, drugs began to be seen as agents of pleasure and heightened experience rather than as a consequence of medical treatment.

Lidz et al. (1975) maintain that what seems like a good deal to an already dependent user may not look like such a good deal to the young person considering whether or not to become an user. A large proportion of American users were attracted to the use of heroin because of the lifestyle associated with it. Clinic dependence would not have the same attractiveness. They estimate that the most likely effect of clinic availability of heroin would not be a dramatic increase or decrease in use, but a tendency to stabilise both the numbers of heroin users and the demand for heroin use. They also point out that an increasingly medical image of dependence may change the characteristics of heroin users.

The work of John Marks (1991) in drug clinics in Britain also provides evidence that the availability of opioid maintenance does not result in the spread of illicit drug use. The rate of recovery (defined as being drug free) of users who had received prescriptions for opioids from one clinic was no different from users who had not been prescribed drugs; however, the death rate was significantly lower than might have been expected (0 compared to an expected 16 deaths). The crime rate was also lower than might have been expected. Marks concludes: 'Maintenance is simplistically misperceived as 'treatment', but in fact merely continues addiction, but there is no evidence showing it prolongs addiction: nothing does: there is a spontaneous remission rate of, at most, 5% per annum regardless of what you do...If the remission rate is spontaneous and impervious to external agency, medical intervention should try and ensure healthy survival until the ten years has elapsed.'

Wodak (1990a) makes the point that it may be prohibition policies which increase the availability of a drug by encouraging a pyramidal retail network. The legal availability of opioids would not then be expected to result in an increase in use, and may even decrease it.

Chesher (1990b) argues that the behaviour of destructive drug use is found in a defined sub-section of the community. He cites references that indicate that those who use drugs destructively have a background of personal and social problems. Therefore he claims that an increase in availability of an illicit drug would not be accompanied by an equivalent increase in those who use it destructively.

Legally available opioids will result in a great increase in users

Hawks (1990) claims that legalised heroin would need to be provided free or at greatly subsidised prices if the black market was to be undercut. This would remove many of the present disincentives to heroin use. As a consequence, Hawks feels that we will need 'to entertain and fund the possibility that a significant number of users will use for life'. He also asks what are the implications of making heroin legally available for the rehabilitation of those wishing to reduce their dependence. Would there ever be any incentive to give up if heroin was legally available?

Hawks (1990) expresses concern about the criteria by which people would be eligible for legalised heroin. He feels that criteria related to the intensity of drug use or the level of safety used have the potential to become incentives for people to adopt these dangerous practices.

According to Hawks (1990), one consequence of making heroin more readily available would be an increased number of 'recreational' users, not all of whom would necessarily inject safely. He feels that this number may then exceed the present number who share injecting equipment. Hawks points out that we do not know what the effect of legalisation would be on recreational users. He concludes: 'Why should we be entertaining so hazardous an experiment when other countries with more experience of the legal prescription of heroin are not moving in this direction?' (also Santamaria,1990).

Foy et al. (1989a) endorse this view and cite their experience in the Hunter Valley in Australia where: 'we have seen a disturbing variability in intravenous drug abuse, and an apparent over-all increase in its prevalence in spite of the availability of a legal narcotic agent in the form of methadone'.

Pilotto and Navin (1990) also claim that ready access to heroin, coupled with lessened risks due to the availability of clean syringes, will enable the 'pusher' to develop new markets. A potential user may see heroin as a suitable and safe option and the incidence of heroin use will greatly increase. They suggest that the legalisation of heroin can be seen as a politically expedient act rather than a genuine attempt to solve the drug problem.

Friedman (1990) claims that there was an increase in heroin use following the legalisation of heroin in the UK, and that this is a sound predictive model of the effects of legalisation on the public consumption of drugs in Australia. (Many authors would not agree that heroin has been legalised in the UK.)

Kaplan (1983) warns that 'the very act of making heroin legally accessible might change the cultural message we convey about the dangers of the drug and indicate to many that it may be safe enough to try'. He goes on the say that legal availability may also accustom the population to moderate users, thus eroding the belief that heroin use leads to dependence and serious health and social problems.

All injectable drugs would need to be made available

Hawkes (1990) argues against treating heroin 'on its own'. Even if heroin could be legally supplied without a substantial black market developing to supply those denied it, he asks what would prevent a black market developing for other substances some of which, like cocaine and amphetamines, are already injected? (also Santamaria,1990).

Legal availability of opioids would not result in more crime, and may even reduce it

Robert Marks (1990a) asserts that the controlled supply of heroin of known purity and strength would eliminate the motivation for drug-related corruption in law enforcement agencies and that low prices would eliminate the wherewithal for this corruption.

Robert Marks (1990c) also claims that the tendency for a drug 'habit' to cause the user to embark on a criminal career has been exaggerated. Nevertheless, he acknowledges that it would probably be incorrect to assert that a reduction in the price of heroin to a small fraction of its street price would entirely eliminate the crime now committed by drug users, some of whom would undoubtedly have become criminals anyway.

Engelsman (1989) feels that the legal availability of illicit drugs could lead to a lower crime rate.

Wodak (1990a) agrees that at least the extent of property crime is likely to be reduced if illicit drugs become legally available. Part of his evidence for this is the claim that 'the weight of expert opinion' is in favour of a reduction in criminality following admission of users to methadone programs.

Dobinson and Ward (1984), in a survey of 225 NSW prison property offenders, found evidence for a strong economic link between heroin use and income-generating property crime. For 78.2% of heroin users, property crime was a major source of income; 89.7% of users saw their drug habit as the reason for committing crime. Dobinson and Ward concluded that if the price of heroin decreased then so would property crime.

Chesher (1990a) states that: 'Drug related crime and corruption is primarily associated with the drug as a commodity on the illicit market and not to the pharmacological effects of the drug. It is a consequence of prohibition. Crime is however not the sole domain of drugs, and reform of the drug laws will not eradicate crime and corruption. It will however, make drugs a much less attractive business for investment'.

Legal availability of opioids would increase crime

If heroin were legalised in Australia and not in surrounding countries, Pilotto and Navin (1990) express the concern that 'criminal elements' may set up bases in Australia from which to export heroin overseas. In addition, drug users from overseas might be attracted to Australia.

Unless drugs are to be given away free, users will still need money to buy them. In addition, many users were criminals before they started using drugs. Friedman (1990) uses both these arguments to claim that legal availability of heroin will not result in the decrease in the crime rate that is predicted by others. Saunders (1990) agrees, claiming that: 'it is unrealistic to expect a massive reduction in criminal activity if heroin, amphetamines and the like are legalised'. On the contrary, both these commentators predict an increase in crime if opioids are available legally.

Legal availability of opioids would not affect the black market

Unless heroin were to be made available to everyone who requested it and at whatever dose demanded, Hawks (1990) finds it hard to see how the present black market would be significantly undercut (also Friedman,1990; Santamaria,1990), although he agrees that it would be undercut to some degree.

Hawks (1990) goes on to point out that even if by some means heroin could be legally prescribed without a substantial black market developing to supply those denied it, there would still be a black market for other illegal drugs, some of which, like cocaine and amphetamines, are already injected.

Loxley (1990) claims that: 'it is unlikely that any system other than the most libertarian model of legalization will significantly reduce a black market in drugs'.

The need for balance

We need to find a balance between prohibition and a free market for opioids

John Marks (1985, 1990, 1991) argues for a 'happy medium' when looking at the availability of heroin. Prohibition 'peddles use' and results in a black market and gangsterism; a free market 'promotes use' and results in epidemic intoxication. He claims that 'controlled availability', such as rationing, produces controlled use. He concludes that ultimately drugs will only be controlled by culture - the 'social climate' - as shown in the Dutch situation with cannabis. O'Malley and Mugford (in press) concur with this opinion and add that it is also important to 'normalise the user not the use'.

Stephen Mugford (1991) argues that we have to bring illicit drugs 'in from the cold' without going so far as to give them 'a warm spot on the hearth rug'. That means creating conditions in which users will be accepted (if not praised) rather than condemned. In that way he feels that we may expect user groups to help the general regulation, and hence limitation, of use.

The policy of controlled availability is unbalanced

Edwards (1989) raises the question as to whether drug policy dominated by concerns about HIV will lead to an imbalance in the overall response, and points out the danger that clinical skills and experience will be discounted or forgotten.

We need to treat the cause not the symptoms

O'Malley and Mugford (in press) conclude that: 'it seems improbable that either treatment or education will significantly reduce...what we call "demand-in-general" for drugs and drug related experiences. This conclusion is based upon the premise that since "demand-in-general" arises from deep seated forces in the society and is not merely a result either of personal deficiency or of incorrect information, approaches that deal with the symptoms of demand cannot remove its cause.'

Farrell and Strang (1990) argue that: 'there is evidence of a search for simple solutions to what are complicated problems. The danger is that this...will interfere with the development of the necessary multi-faceted response'. They go on to say that: 'rather than debating the legalisation of drugs we need to widen the debate to discuss the mix between enforcement and demand reduction strategies'. (However, no specific strategies or policies are put forward.)

Hawks (1991) argues that the concept of a 'war against drugs' is an erroneous way of thinking about the problems associated with drugs. He goes on to say: 'If we are going to have a war or an offensive let us "attack" the reasons for problematic drug use. Let us direct our energies to addressing those conditions which breed a disillusionment with the future and a sense of hopelessness about the present, conditions which make the temporary intoxication afforded by drugs a preferred alternative to unclouded consciousness. Let us seek to reverse those conditions of poverty, of family dislocation and of long-term unemployment which render young people vulnerable to the enticements of a dependence on using and dealing in drugs'.

Conclusion

There is a broad consensus of opinion in the literature that:
a) prohibition as it is currently enforced is not effective;
b) heroin should not be freely available; and
c) changes are urgently needed to prevent the spread of HIV infection, in particular amongst intravenous drug users and the general community.

There is no consensus, however, on what form changes should take. The consequent debate between strengthened enforcement of prohibition or increased regulated availability of opioids has been characterised by a lack of evidence and an absence of specific detailed proposals. The case for increasing the controlled availability of opioids, including heroin, seems to be the stronger of the two.

There are indications, but no conclusive proof, that making heroin and other injectable opioids available in a controlled manner would have beneficial outcomes for users and the general community. A trial such as that proposed would be an important rigorous test of these claims.

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3: THE POLITICAL CONTEXT

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This paper examines the political context of a trial which would make opioids available in Canberra in a controlled manner. Clearly there are a number of aspects of the current Australian political scene which have to be taken into account in assessing the political context of such a trial. At the minimum an analysis has to be made of the Federal, State and Territory political conjunctures. As well however, a number of levels of politics are relevant to the trial (party platforms, the positions of key individual politicians, government reports and so on). Since issues relating to opioids, and the availability of opioids most often arise in discussions of heroin dependence, the arguments of this paper will tend to focus on statements which consider heroin, heroin dependence, and ways of responding to heroin dependence.

With these complexities in mind, this paper is broken into a number of sections: **Section 1** examines the "party political" context of a trial. Both Federal and State/Territory levels are considered. An analysis is made of the platform positions of the major parties (including their lack of policies on drug use), and statements of leading party representatives which have touched on the issues around opioids. **Section 2** discusses a selection of Committee Reports, Royal Commissions, and inquiries into drug use in Australia since the 1971 report of the Senate Select Committee on Drug Trafficking and Drug Abuse. In particular, constructions of the "drug problem", drug users, and reasons for not changing the legal status of drugs are examined. **Section 3** considers the history of the National Campaign Against Drug Abuse (NCADA), and the relationship of a trial to this campaign. **Section 4** considers the Cleeland report of 1989, and the way that the Parliamentary Joint Committee on the National Crime Authority (NCA) dealt with proposals to change the legal status of drugs. **Section 5** concludes the paper by examining the exclusion of arguments for the controlled provision of opioids from the political arena, and by analysing the repetitions which can be found in Australian conceptualisations of drug use.

Assessing the political context of such a trial is complex, for reasons which will become clear. Throughout this report there is a concern with the objective constraints and facilitating factors which would affect a trial, and the less certain sea of possibilities which a trial would have to navigate. In a sense the political context of any action is made up of all the actual arguments, and all the possible arguments, that can be articulated about it. At a very basic level the political feasibility of making opioids available in a controlled manner, depends on whether it is possible for people to argue that opioids should be available in a controlled manner.

Section 1: Political parties and opioids

The nature of Australian political parties creates an obvious difficulty for this section. Each party has different procedures for formulating policy, and each party distinguishes party and parliamentary policy in different ways, and relates them to each other in different ways. Policy thus resides in a number of sources, from the statements of the parliamentary leaders, to resolutions carried by party conferences. These sources have a significance that is specific to the different parties. The argument in this section moves from parties with the most clearly defined policies to those which are least clear.

Platforms and party politics

Australian Democrats

Of all the political parties, the position of the Australian Democrats most strongly argues for a change in the legal status of opioids. While the aims of official Democrats policy are not exceptional (they

include the objectives of reducing and ultimately arresting "drug abuse", and the elimination of the illicit supply of drugs), the policy items which the party has endorsed are way beyond the official positions of the other major parties. Items 13, 14 and 15 of the Democrats' policy paper *Drugs: Abuse and Reform* read this way:

> The use of heroin in the treatment of patients with terminal illnesses is supported where such use, to relieve suffering, is in accordance with qualified medical opinion.
> The use of heroin or physeptone (Methadone) in the treatment of opioid addiction is supported where strict medical supervision is ensured and government controls met.
> We support the nationwide establishment of facilities to provide self-identified addicts of injectable drugs with these drugs under supervision, recognising that such programmes would reduce the spread of the HIV (AIDS) virus, reduce crime and bring addicts into contact with counselling and treatment services.
> (Australian Democrats 1990)

This is a policy document of the National Secretariat of the Australian Democrats, and given that this party formulates its policies via a national census of all of its members, there is a strong chance that Democrats' political representatives would support a trial which made opioids more available (even without the policy being formally binding on the Senators). However, as noted below, the position of individual Senators does differ from the party on a number of points.

The ACT division of the Democrats has also made a submission to the feasibility study. The gist of this submission in regard to this paper is that,

> The Australian Democrats (ACT) support making opiate drugs available in a legal and controlled manner for a trial period in the ACT.
> (Australian Democrats, ACT Division, 1991)

Clearly the Australian Democrats could be expected to be supportive of a trial, if it was to go ahead.

Liberal Party

By contrast, the positions of the Liberal Party of Australia would not be so favourable to a trial which would change the availability of opioids. At the Federal level, the Liberals (and the National Party) have prepared a number of policy documents. Three of these documents are particularly relevant to this feasibility study: the Health Policy; the Law and Justice Policy; and the AIDS policy. The issue of the legal status of drugs emerges in the Liberals' discussion of AIDS policy. The party supports education programs directed towards injecting drug users, and,

> A Liberal and National Party Government will also support the various State and Territory administered needle and syringe exchange programs, including supporting the repeal of legislation which impedes the needle and syringe exchange strategy. (Liberal and National Parties, 1989)

But,

> The Liberal and National Parties do not support the legalisation or decriminalisation of heroin or any other narcotic in the fight against HIV and AIDS. (Liberal and National Parties, 1989)

The reader will have noticed that this policy explicitly deals only with *legalisation* and *decriminalisation*, which are only two of many possible options for a trial that makes opioids available in a controlled manner. The policy positions of the Liberal party, as formulated in these party documents, are not binding on its parliamentary representatives (though they do give a good indication of the likely response of the mainstream of the party).

The ACT division of the Liberal Party has also prepared a number of policy documents which were adopted at a policy convention held by the party on the 1st of June 1991. Two of these documents - the Health Policy and the Police and Justice Policy - are particularly relevant to a trial which would make opioids available in a controlled manner. The Police and Justice Policy calls for the "fight against illegal drugs" to be given a high priority (Liberal Party, ACT Division, 1991a). This does not mean that the party simply endorses a straight prohibitionist response to illicit drug use. The document also argues that drug users should be rehabilitated, while traffickers should be "subject to the full force

of the law" (Liberal Party, ACT Division, 1991a). It supports the NCADA approach to drugs, which is examined more fully below. The policy document on Health gives even more emphasis to law enforcement.

> Liberal policy in general favours freedom of choice and personal responsibility for one's decision, but recognises that choices must not be made in ignorance, that some vulnerable individuals need protection, and that the community should not be excessively burdened by the responsibility of protecting individuals from self harm, or the consequences of individuals choosing to harm themselves.
> An ACT Liberal Government will:
> *Discourage substance abuse through public education;
> *Retain and extend tobacco and alcohol advertising restrictions;
> *Increase efforts to restrict the supply of harmful and illegal drugs, to the extent possible under international law;
> *Support blood tests for cannabis where it is suspected to be a factor in a serious motor vehicle accident;
> *Not decriminalise the personal use of cannabis;
> *Review the penalties applying to the possession and supply of drugs of dependence specified in the Drugs of Dependence Act 1989 to ensure they remain up-to-date in fulfilling a deterrent objective.
> (Liberal Party, ACT Division, 1991b)

Though opioids are not mentioned specifically, this policy position is a comprehensive response to perceived problems with drug use.

Australian Labor Party

The Australian Labor Party is more complex, because policies formulated through the state and federal conferences are formally binding on the political representatives of the party. At the federal level, the policy of the party, as formulated in resolutions from the Federal Conference, does not contain references to the legal status of heroin, or options for the care of opioid dependent individuals. These policies are very general statements of the intention of the National Branch in relation to health services. However, Labor is a strongly federal body in its organisation, and most of the party's policies actually reside at the state level. Here the situation is very interesting.

There are a number of policy positions at the state level of the Labor Party. In the Victorian State Branch, the Civil Rights and Law Reform Policy, as endorsed by the Victorian State Conference in October 1985, had this to say about laws on drug use.

> "Victimless crimes", including consensual sexual offences, drug using and vagrancy, to be abolished. (ALP, Victorian Branch, 1985)

The Health and Welfare policy of the Victorian ALP calls for the "de-criminalisation of drug addiction" (ALP, Victorian Branch, 1991). The policy of the NSW Labor party, as contained in the document *Building a Drug Free Society - Labor's Strategy on Illegal Drugs* (ALP, NSW Branch, 1991), is diametrically opposed to the Victorian Party policy.

> The Labor Party opposes the legalisation or decriminalisation of currently illegal drugs.
> Criminal sanctions and price continue to provide an important disincentive to hard drug usage. Illegality sends a clear message to potential drug users and suppliers - drug usage is simply unacceptable. (ALP, NSW Branch, 1991, 3)

In contrast again, the ACT branch of the Labor party says this in its Platform under the title *Drug Offences.*

> In general, persons using illegal drugs or possessing them for personal use should be dealt with other than by the imposition of criminal sanctions.

> Penalties for trafficking in illegal drugs should remain high and should include the forfeiture of assets acquired through drug trafficking.
> Possession and use of cannabis for personal purposes should not be a punishable offence.
> Rehabilitation programmes and facilities should be provided and should be used as the primary sentencing option for drug addicts facing prosecution.
> (ALP, ACT Branch, 1989, 60)

This position falls somewhere between the Victorian and NSW positions. Clearly the more time spent researching the Labor Party's position on currently illegal drugs, the greater the number of positions that will emerge.

Implications for a trial

A number of things are worth noting about these formal party positions. Within the two major parties (the Labor and Liberal parties) there is a diversity of positions and policies that have been arrived at by a diversity of means. In general the written platforms of the parties, or policy documents which have an equivalent status to platforms, do not consider the complete range of options for the provision of opioids in a controlled manner to users. At times they do take up the issue of legalisation, or decriminalisation,[5] of drugs in general and heroin. As we have seen, on this issue the Liberal party is generally against legalisation or decriminalisation, while the Labor party can fall either way. The Labor party it should be noted is usually more concerned with marijuana or drugs in general, than it is with opioids in particular. These issues of course do not necessarily touch a trial which would make opioids available in a controlled manner. So in two senses the platform positions of the major parties do not collide with such a trial; first a trial would not necessarily involve legalisation or decriminalisation; and second the platforms do not specifically address all of the issues around opioids, and dependence on opioid drugs. Such lack of consideration would be, at this level of politics, a major facilitating factor for a trial. The Democrats are, it seems, unique in even formally recognising this issue, let alone recommending the provision of heroin as a course of action. However, the scene does change when the positions of the political representatives of the parties are considered.

Party representatives

It is also interesting to examine the statements of representatives of the parties. Both parliamentary and non-parliamentary representatives are considered here, and it should be noted that it is necessary to distinguish ministers/shadow ministers, and backbenchers when we discuss the parliamentary representatives of the major parties. At this level the position of the parties is more diverse. The position of Democrat Senators is considered first. The section then analyses backbench and non-political representatives of the major parties, and ACT politicians. Finally statements by federal ministers and shadow ministers are examined.

Democrat Senators

Within the Democrats some Senators prevaricate on the issue (worrying about what would happen if heroin or other opioids were more freely available, and about whether a change in policy really would change the practices of users, and the involvement of organised crime in drugs), while some are prepared to run hard on changing the present situation. Mike Elliot, a Democrat from the South Australian Legislative Council has said this in a position paper.

> Creating a Government-controlled monopoly in narcotics has often been seen as an alternative to prohibition. The notion has support from all sides of politics in Australia. The creation of a controlled market, protected by the maintenance of the present high penalties for importation, would aim to remove drug users from the criminal process. (Elliot nd)

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[5]Here we can only assume that the authors of these documents use legalisation to refer to a situation where a drug is freely available, with no *criminal* sanctions on its possession, use and retailing, while decriminalisation involves a nominal fine for possession and use, or the legality of possession (in small quantities) and use.

Elliot believes that the criminal law system does not deal with drug use in an appropriate manner, and that;

> Legalising presently illicit drugs will... remove the main harms those drugs are causing in society. (Elliot nd)

Backbench and non-political representatives of major parties

Elliot's estimation that legalisation has support from all sides of politics in Australia is, like a lot of political calculations, both true and false. Certainly there are a number of individual politicians and activists in both of the major parties who are advocating some change in the present policy of prohibition.

Peter Baume was active in the parliamentary Liberal party for many years trying to change the prohibitionist policies adopted by that party. For example, in 1989, in a statement prepared for the Alcohol and Drug Foundation (now ACADA), Australia, Senator Baume (as he then was) said:

> The crisis of drug policy failure today is so severe that we have to decide which goals we wish to pursue. Continuation of the model of prohibition and punishment will continue to fail and will make inevitable worse corruption of important communal institutions. We have the opportunity to turn aside from present failed policy - let us at least consider and assess the legalisation alternative. (Baume 1989a)

Recently as well, John Gorton has come out in support of some change.

> I think the only way to improve the situation is if we take the money out of it that people make by selling it. That means getting the drugs sold, presumably, by the government or some government instrumentality, at a price you could easily sell it for. (Gorton 1990, 11)

Of course Gorton was not speaking as a parliamentary representative of the Liberal Party in making this statement. But the statement does indicate that a change in the present prohibitionist policy could be accommodated within that party. The present Premier of NSW, Nick Greiner, when leader of the opposition in 1984, is quoted as saying:

> If we can bring these drug-addicted people away from having to commit crime to get the money to pay their pusher - that would mean a drop in crime. If we can wean them off the drugs in a controlled system then we are winning. If the demand is not there, the drug bosses have no one to supply. (quoted by Wodak 1990, 76)

Such a "controlled system" could clearly encompass the controlled availability of opioids.

In relation to the Labor party, statements in support of changes in prohibition from parliamentary representatives are harder to find (perhaps because the success or failure of prohibition has become an issue while the Labor has been in government). Clearly however, given the diversity of opinions in the platforms of the Labor party, it would not be unreasonable to expect that some support could be forthcoming for a trial which made opioids available in a controlled manner. Groups which operate internally to Labor have discussed the costs and benefits of prohibition. In the document *Reforming Victoria's Cannabis Law*s (1986) the Drug Law Reform and Drug Dependency Task Force of the Victorian ALP recommended a move to a system of "partial prohibition" for cannabis. Though opioids were not considered, this document (which was later adopted by the State Conference), along with the party platforms examined above, indicates that it is possible for Labor to question the value of prohibition.

ACT politics

In the ACT Michael Moore, an independent member of the ACT Legislative Assembly, and chair of the Assembly's Select Committee on the HIV, Illegal Drugs and Prostitution has been prepared to publicly canvas changing the availability of opioids, and more specifically heroin.

> The "war on drugs" method used in the USA hasn't been successful. The "reduction of harm" principle has proved thus far to be a suitable alternative response to the drug problem; an

> examination of the use of opiates ... could provide benefits not only to the ACT but to the wider Australian community. (Moore, pers. comm., 1991)

The "reduction of harm principle" will be examined more fully below. It is a crucial switch point for arguments about opioids, and the availability of opioids (as noted above). Moore's stand on opioids has received cautious, though not specifically negative, responses from other members of the Select Committee. To quote a Canberra Time article on this topic, Woods (Labor) has said that he was open to all options which would reduce the harm of illegal drugs, and Nolan (Liberal) has said that she had strong reservations about opioids (Canberra Times, March 26th, 1991).

Federal Ministers and Shadow Ministers

The pendulum does, of course, swing the other way. When we move to Federal ministers and shadow ministers a different position emerges. On issues relating to the National Campaign Against Drug Abuse, and responses to HIV, ministers and shadow ministers responsible for these areas share a similar position. In fact officially there is a high degree of bipartisanship between ministers and shadow ministers on these issues, and on the appropriate responses to drug problems. This bipartisanship does not include changing the availability of opioids, though it is a complex phenomenon. In 1990, Neil Brown said this in a speech to Parliament on behalf of Andrew Peacock, the Shadow Attorney General.

> Many suggestions have been made to address the whole drugs problem. One of these is to legislate for the legalisation of illicit drugs. I, for one, would not advocate such an approach, but it is worth observing that in fact this view has been expressed by some people - indeed, some fairly close to the Government on occasions. However, I was pleased to see that in October last year the Minister for Justice and Consumer Affairs, Senator Tate, flatly rejected any such approach that legalisation was the solution to the drug problem. Indeed, to his credit, the Minister for Justice has said - and I am sure that the Attorney-General would say too - that under no circumstances should governments consider the licensed marketing of drugs such as heroin or cocaine.
>
> Conflicting views have been expressed and one need not take this any further, except to say that there is conflict of opinion about this subject and we hope that, through debate, we can work it all out one day. But what we would suggest should be common ground at the end of the day is that there must be at least an area that places emphasis on proper prosecution steps, penal steps and the enforcement of them, if one is ever going to have any hope of making inroads on this major problem. (Brown 1990, 3)

Brown ended up supporting the government bill he was speaking to, and thus perpetuating the shared approach to drugs and crime.

It is evident though that this extract also flags differences between the government and the opposition on this issue. So the consensus on drugs and crime between the government and the opposition is itself a complex phenomenon. What is vital for this paper however is that at the official level, there is a gloss of consensus. That gloss is not ephemeral. It is a real constraint on a project which is considering the controlled provision of opioids. Michael Tate in fact had this to say about drug users.

> Quite clearly it would be utterly inappropriate to treat the young and gullible victims who haunt our inner cities as criminals, to impose some penalty on their already wretched state, and to stigmatise them as criminal, in a way which left them socially marked for life, as short as that might be. Society should, however, be able to compulsory require them to submit to a regime of treatment and rehabilitation, by way of an order based on their commission of a statutory offence. (Tate 1989, 2)

This statement about users may, or may not, go beyond what Neil Brown would regard as a reasonable position. Importantly though, it is combined with a rejection of legalisation. In relation to government sponsored campaigns against alcohol and tobacco,

> ... it would be contradictory and defeatist to allow the marketing, whether by government agencies or licensed entrepreneurs, of a further range of drugs such as heroin or cocaine. (Tate 1989, 4)

The position of ALP parliamentary representatives on drug law reform, and the options which might reasonably be said to be available for the treatment of drug problems will be examined further in the section which deals with NCADA (section 3).

Implications for a Trial

Therefore, in what ministers and shadow ministers have said in official statements, there is indeed a formal consensus that the legal status of opioids, and the availability of opioids should not be changed. But it must be noted that this consensus equates changing the availability of opioids with legalisation or decriminalisation, and that those two policies do not exhaust the range of options available to a trial which would make opioids available in a controlled manner. The positions of ministers and shadow ministers also does not exhaust the range of views within the major political parties, and certainly does not include the position of the Australian Democrats. The present political climate does not therefore preclude a trial which would make opioids more available in a controlled manner. Perhaps the most important reason for this is that this debate has not considered all of the ways in which society can respond to the drug "problem" (the limitations of the existing discussion of drugs in Australian society will be taken up below).

Non-government politics

The policy position of the Australian Council of Alcohol and other Drug Associations (ACADA) is examined in this section. ACADA is not a political party. But it does present the positions of non-government organisations concerned with drugs at a national level. As the only national organised voice of the non-government sector in drug treatment/rehabilitation/prevention/research ACADA has considerable significance. Its policy on heroin, adopted in 1989 relates to present government policies in interesting ways.

> The objective of the policy is the minimisation of harm associated with heroin use. The policy is divided into three sections each of which deals with a harm minimisation strategy in a particular area, the areas are HIV Prevention, Education and Treatment. (Australian Council of Alcohol and other Drug Associations, 1989)

Under the heading of HIV prevention, the document states that ACADA advocates;

> ... that heroin user/addicts be diverted from gaols where possible to rehabilitation and treatment. (Australian Council of Alcohol and other Drug Associations, 1989)

and,

> ... the decriminalisation of the possession of threshold amounts of heroin. (Threshold is defined here as 2.0 grams of pure heroin). (Australian Council of Alcohol and other Drug Associations, 1989)

The significance of this articulation of harm minimisation and advocating change in the legal status of heroin will become clear below. In the present political environment this is a significant connection. It should be noted though that the various organisations which ACADA represents hold a greater range of views then the ones formally adopted by ACADA.

Section 2: Reports and inquiries into drugs

Since 1971 there have been at least 10 major reports which have dealt with drugs, drug use, and ways of ameliorating the effects of drug use. While such a number of reports, arising from Royal Commissions, Committees of Inquiry, and Parliamentary Committees, might be thought to indicate some degree of controversy in the area, in fact here as well there is a good deal of consensus on the nature of the problem, and the appropriate ways of dealing with the problem. Repetitively asking the same questions, and producing the same answers is, in relation to this study, as interesting as any controversy. What this section will do is tease out the different lines of argument which make up the shared approach of recent inquiries into drug use. This consensus is a complex thing, and it does not

inevitably exclude consideration of the new ways in which opioids could be made available. This section will examine: the report of the *Senate Select Committee on Drug Trafficking and Drug Abuse* (the Marriott report of 1971), the report of the *Senate Standing Committee on Health and Welfare* (the Baume report of 1977), the report of the South Australian *Royal Commission into the Non-Medical Use of Drugs* (the Sackville report of 1979), the report of the *Australian Royal Commission of Inquiry into Drugs* (the Williams report of 1979), and two NSW reports of the 1980s into treatment options for opiate dependence (the Rankin report of 1981, and the Kerr report of 1985). The report of the *Parliamentary Joint Committee on the National Crime Authority* (the Cleeland report of 1989) will be dealt with in a separate section (section 4). A number of more peripheral reports were not considered: the progress report from the *Joint Committee of the Legislative Council and Legislative Assembly upon Drugs in NSW* (the Durick report of 1978), the report of *NSW Royal Commission into Drug Trafficking* (the Woodward report of 1979), the report of the *Royal Commission of Inquiry into Drug Trafficking* (the Stewart report of 1983), and the report of the *Royal Commission on the Activities of the Federated Ship Painters and Dockers Union* (the Costigan report of 1984).

Marriott (1971)

In 1971, as Neal Blewett puts it, the "first of the modern inquiries" was produced (Blewett 1987, 4). This was a report of the Senate Select Committee on Drug Trafficking and Drug Abuse (the Marriott report), and Blewett sees its recommendations as "the genesis of most elements in the current National Campaign" (i.e. NCADA; Blewett 1987, 5). The general orientation of this report is to see harmful drug use as a "people problem, not a drug problem". Indeed the report starts in this way:

> The evidence is clear that drug abuse in Australia is mainly a problem within the individual and therefore greater emphasis should be placed on the treatment of an illness rather than punishment for crime. (Senate Select Committee 1971, 3)

It should be noted that this Committee also recognised that alcohol and tobacco are drugs, and that they are the major source of drug problems in Australia, though it did not consider them in its report. While the report construes harmful drug use as a "sickness", it does not see the causes of drug abuse as being wholly medical or individual. Indeed the Committee lists a number of social and individual factors which combine to contribute to "drug abuse":

> lack of awareness of the dangers of drugs;
> the affluent society;
> the stresses of modern life;
> the personality factor;
> the living environment; and
> advertising and the news media.
> (Senate Select Committee 1971, 40-41)

The Committee also produced a series of distinctions which are vital to Australia's responses to perceived drug problems. The Committee clearly constructed a hierarchy between the drug trafficker, the drug pusher, the drug peddler, and drug users (peddlers may also be users, while pushers are less likely to be so involved) (Senate Select Committee 1971, 11). The existence of experimenters was also recognised (Senate Select Committee 1971, 11). For the authors of the report, the relationship between these types of people is vital.

> The abuser becomes enslaved by his habit to the extent of requiring constant and increasing dosages to obtain an equal effect to his original dose. This then provides the trafficker with a regular market. (Senate Select Committee 1971, 26)

The principal recommendations of the Committee call for more education and treatment, better coordination of law enforcement efforts, more research into drug "abuse" and the creation of better statistics, and legislation which emphasises a humanitarian approach to users, while providing for penalties which will be "sufficiently severe to deter the drug trafficker and drug pusher" (Senate Select Committee 1971, 80). Apart from a recommendation which calls for the destruction of existing stocks

of heroin,[6] the drug problem is seen to be a problem with illicit drugs generally, and the recommendations apply to all drugs.

Baume (1977)

In 1975 the Senate Standing Committee on Health and Welfare produced a report on the actions following from the report by the Senate Select Committee. This new report assessed progress since the 1971 report, and repeated the conclusions of the earlier report. In 1977 the Senate Standing Committee on Social Welfare produced *Drug Problems in Australia - an Intoxicated Society?* (the Baume report). This report again saw alcohol and tobacco as the major source of drug problems, and importantly, considered these drugs in the body of its report, and in its recommendations. Again a national strategy for drug use was called for, and interestingly, the Committee defined the goals of such a strategy in terms of harm minimisation.

> Total elimination of drug abuse is unlikely, but government action can contain the problems and limit their adverse effects. (Senate Standing Committee 1977, 20)

Drug use was seen as a social and medical problem by this Committee.

> Drug abuse is primarily a social/medical, not a legal, problem, though such abuse may have important legal consequences and aspects. Drug abuse occurs in the context of other social problems and the strategy must take cognisance of such problems. Interventions which do not alleviate these social problems can at best achieve only partial success. (Senate Standing Committee 1977, 22)

Apart from a series of recommendations on alcohol, tobacco, analgesics and cannabis, the Committee generally recommended that research on drug use be increased, that efforts be made to improve statistics on drug use, and that more education about drugs be provided. Heroin was only considered by the Committee in relation to cannabis, and the need to differentiate between the two drugs in law.

> The Committee recommends: That the Commonwealth and the States enact cannabis legislation which recognises the significant differences between opiate narcotics and cannabis in their health effects and in the criminal impact on users and the community. (Senate Select Committee 1977, 164)

The Committee (with dissenting opinions) suggested that cannabis possession for personal use be decriminalised (Senate Select Committee 1977, 165). It is also worth noting that the Committee did not regard drug use as simply deviance, because drug use in fact corresponded to some of the "basic mor? s of our society" (Senate Standing Committee 1977, 13), and that the Committee felt itself obliged to note the poor standard of public debate about drug use.

> Unless the standard of debate improves appreciably, we shall not even begin properly to comprehend the problem, let alone move toward its alleviation. (Senate Standing Committee 1977, 13)

Though it was a continuation of the approaches adopted in previous inquiries, obviously this report was controversial in many ways. Peter Baume's assessment of the government's response to this report, and to his campaigning on this report is interesting.

> The Prime Minister of the day, rather than come out and say I was a fink, did something cleverer. He appointed a learned conservative Judge to head up a Royal Commission into Drugs

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[6] In 1971, heroin was still available for use on prescription in Victoria.

> In Australia the importation of this drug was banned in 1953 after consultations between the Commonwealth Department of Health and Australian medical organisations. As there is no production of heroin in Australia the Committee was astonished to learn that it is still available for use on prescription in Victoria where substantial stocks are still held. (Senate Select Committee 1971, 76)

The Committee recommended so as to "rectify" this situation.

> with terms of reference which virtually made inevitable that the learned Judge would bring out a report which said we need more social control, heavier penalties, more enforcement authorities, and don't change the laws. (Baume 1989b, 54-55)

In fact the Liberal government of the day did not respond to the Baume report for two and a half years. This response was actually tabled after the government's response to the Williams Royal Commission, and declined to deal with Baume's recommendations about illegal drugs on the grounds that such matters had already been dealt with in the response to the Williams report of 1979! Before examining the Williams Royal Commission we will consider the Sackville Report of 1979.

Sackville (1979)

In parallel with the Baume report the South Australian *Royal Commission into the Non-Medical Use of Drugs* (Sackville 1979) located the causes of drug use in the general attitudes of the community as a whole, and saw that the problems of drug use involve licit and illicit drugs. This report also endorsed the objective of harm reduction, not elimination.

> It follows above all from what we have said that it is neither desirable nor feasible for the Government of South Australia to pursue a policy of *eliminating* the non-medical use of drugs. The broad policy objective, underlying official controls in this State, should be concerned with the harmful aspects of drug use and drug-related behaviour. *In our view, then, the objective of social policy should be to minimise the harmful consequences of the non-medical use of drugs.* (Royal Commission into the Non-medical Use of Drugs 1979, 25; original emphasis)

The report noted that harm may flow from drug use either by the effect of drug use on the community, or the individual. Importantly, the report questioned the model of drug users as "dope fiends" which was current in mythologies about drug use (Royal Commission into the Non-medical Use of Drugs 1979, 5), and differentiated between different types of drug use (experimental, social or recreational, circumstantial, intensified, compulsive). A number of influences were recognised as affecting drug use and these were summarised as "drug factors, person factors and social factors" (Royal Commission into the Non-medical Use of Drugs 1979, 41).[7]

This Commission rigourously separated its consideration of different drugs (while of course noting the phenomenon of polydrug use). Again in parallel with earlier reports the major recommendations concerned education, treatment and legal controls (whilst also recommending that more research be done). It should be noted that the Commission did distance itself from this structuring of its recommendations:

> ... a strong case can be made for the proposition that education is the now third major social agency from which a simple cure-all for the drug problem is being sought - the law and medicine having already had their turn. (Royal Commission into the Non-medical Use of Drugs 1978, 71)

Different types of drugs were considered separately in this report, and it appears that for the first time heroin dependence was the subject of specific recommendations. Opioid maintenance was discussed, and while heroin and morphine were considered, methadone was preferred because its effects are longer lasting. The report argued that the short action of heroin and morphine creates difficulties because the dependent user would either have to attend a clinic three or four times a day, or multiple doses would have to be provided, which creates a risk of diversion (Royal Commission into the Non-medical Use of Drugs 1979, 180-181). This does not mean that heroin and morphine could not be used for opioid maintenance. It merely means that the Commission considered that methadone was generally a more apt opioid. In some circumstances the Commission anticipated that heroin might

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[7] Interestingly, in supporting documents the Commission recognised that the "pleasure" of using drugs may be an important factor in people's decision to use drugs (Royal Commission into the Non-medical Use of Drugs 1978, 41).

have a limited use in the "treatment of addiction". Later in the report under its consideration of legal controls, the Commission discussed the legalisation of heroin.

> Theoretically the illicit market might be eliminated if heroin were provided lawfully to everyone who desired it, but such a policy would be unthinkable, even if it were feasible in the light of Australia's international treaty obligations, simply because such a policy would actively encourage wider use of the drug and rapidly lead to an increased incidence of addiction. (Royal Commission into the Non-medical Use of Drugs 1979, 313)

The Commission did argue that the total prohibition on heroin should be reconsidered if it is shown that heroin has therapeutic advantages over its competitors as an analgesic. If heroin does have advantages, it should be reclassified and,

> If this were done, we envisage that heroin could be used in the treatment of addiction, but only in very rare cases and under the closest supervision. In our view these steps will help to "demystify" heroin and challenge its magical reputation. (Royal Commission into the Non-medical Use of Drugs 1979, 315)

In these arguments, and in its treatment of marijuana (the Commission recommended that some offences relating to marijuana should be changed) the South Australian Royal Commission into the Non-Medical Use of Drugs is an interesting mix of continuities and discontinuities with earlier reports.

Williams (1979)

In 1979 the *Australian Royal Commission of Inquiry into Drugs* handed down its report. In common with the earlier reports, a number of reasons were noted for drug use, and a number of reasons were also noted for the progression from experimental to regular use (Australian Royal Commission of Inquiry into Drugs 1980, A115ff). The Commission recognised that it is a misconception to see drug use as a recent problem, or to see drug use as confined to a specific section of society, or to see drug use as only concerning illegal drugs (Australian Royal Commission of Inquiry into Drugs 1980, D3). However the Commission did not conclude from these arguments that the legal status of presently illegal drugs should be changed. The Commission did not recommend that the present policies of prohibition should be changed to undercut organised crime.

> Rather, the Commission believes that it is necessary to tighten the existing controls so that legal drugs, which at the moment offer ample scope for choice, are less abused. (Australian Royal Commission of Inquiry into Drugs 1980, D11)

The Commission argued that since drug use is substantially influenced by availability,

> It is therefore essential to increase law enforcement efforts to limit the availability of those drugs of dependence which are prohibited, such as cannabis and heroin, and to police restrictions on drugs which are legal but subject to controls... (Australian Royal Commission of Inquiry into Drugs 1980, D11)

The Commission advocated that Australia should continue with its present "criminal/medical" model of dealing with illegal drug abuse (Australian Royal Commission of Inquiry into Drugs 1980, D12). A three pronged approach to the drug problem was proposed; law enforcement, treatment and education (Australian Royal Commission of Inquiry into Drugs 1980, D13). The Commission noted that this did not differ "from the main thrust of the conclusions" (Australian Royal Commission of Inquiry into Drugs 1980, D14) of the Senate Select Committee report in 1971. Given that nearly a decade had passed since the earlier report, this observation throws up some problems.

> If the Commission is proposing a policy that is not novel the question that inevitably must be answered is why it has not worked before. The answer is that it has not really been tried. (Australian Royal Commission of Inquiry into Drugs 1980, D14)

In relation to this problem the Commission recommended more coordination (including uniform legislation) and better information. In all a national strategy is needed.

Heroin maintenance was considered by this Commission as was the use of heroin for analgesic purposes (Australian Royal Commission of Inquiry into Drugs 1980, C32, C177-C199). However methadone was found to be preferable for maintenance.

> It does appear, however, that if maintenance by an opiate is to be used, there are significant drawbacks in using heroin or morphine for this purpose *compared with using methadone.* (Australian Royal Commission of Inquiry into Drugs 1980, C199; my emphasis)

Like the Sackville report, the Williams report considered it possible that heroin could be used for the "treatment or maintenance of addiction". Again the report preferred methadone for similar reasons to the Sackville report. Unlike the Sackville report, the use of heroin for treatment or maintenance was explicitly recommended against. While it was a possibility, it was not desirable for this commission.

> Heroin should not be used for maintaining drug dependent persons in the course of their treatment. (Australian Royal Commission of Inquiry into Drugs 1980, C200)

We saw above that the Sackville report envisaged a very limited use of heroin in the "treatment of addiction" if it could be shown that heroin has other medical uses (Royal Commission into the Non-medical use of Drugs 1979, 315). However the Williams report considered that heroin might prove to have some other medical uses. In all though, the Commission argued that no action should be taken to relax legal controls on heroin until it can be demonstrated that it has unique analgesic properties, and that diversion can be effectively controlled (Australian Royal Commission of Inquiry into Drugs 1980, C200).

In responding to the Williams report in March 1980 the government of the day foreshadowed future developments in Federal Government Policy.

> The moment is therefore propitious for a joint and co-ordinated effort by all governments. The opportunity should not be lost. With a common resolve, I am optimistic that we can achieve progress against the public health problems that drug abuse has presented us with, and against the predators, both inside and outside Australian, who seek to exploit the weaknesses of some Australians for profit. (MacKellar 1980, 868)

The Williams report of 1979 did not, however, end even federal government inquiries into drugs and drug use. As we have noted, the Stewart report of 1983, the Costigan report of 1984, and the Cleeland report of 1989 were to follow. However at this point we will consider two reports which examine the provision of services to heroin dependent individuals in NSW. The Cleeland report of 1989 will be considered in a separate section below. That report will be considered independently because its arguments have special significance for a feasibility study of making opioids available in a controlled manner.

Rankin and Kerr

The report of the New South Wales *Committee of Inquiry into the legal provision of heroin and other possible methods of diminishing crime associated with the supply and use of heroin* (Rankin 1981), and the report of the *Committee of Review into Drug and Alcohol Services in New South Wales* (Kerr 1985) are important for this study. They are somewhat outside the self contained history of inquiries into drug use we have been outlining, but because they specifically consider the controlled provision of heroin for dependent users, it is important that they are analysed.

The Rankin Committee was asked by the then Premier of NSW, Neville Wran, to report on treatment options for heroin dependent individuals. The NSW government was interested in breaking the connection between dependent heroin users and organised trafficking, and the UK's treatment of heroin dependent individuals was held to be an important example for the inquiry. Reflecting these concerns, the terms of reference of the inquiry were (in part):

> Can the legal provision of heroin or other drugs of dependence to heroin-dependent individuals decrease the incentive for criminals to become (or remain) involved in heroin trafficking?
> Can the legal provision of heroin or other drugs of dependence to heroin-dependent individuals decrease the likelihood of their becoming (or remaining) involved in criminal activity?

> Would the legal provision of heroin or other drugs of dependence to heroin-dependent individuals yield legitimate benefits in areas other than crime, or produce any undesirable results? (Committee of Inquiry into the Legal Provision of Heroin 1981, 1-2)

The committee was also asked to report on the difficulties facing a program which provided heroin to individuals (international obligations, diversion etc.) and other possible measures. In general, the Committee repeated the constructions of drug use adopted by previous reports, arguing that drug use must be seen as a result of personal, pharmacological and environmental factors (Committee of Inquiry into the Legal Provision of Heroin 1981, 15). The Committee used Sackville's classification of drug users, and produced a taxonomy of heroin users. Heroin users can, for this Committee, be classified as: drug dabblers, joy poppers (recreational users), hustlers, conformists, addicts, drug dependents, maturing-out users, and burnt-out users (Committee of Inquiry into the Legal Provision of Heroin 1981, 17-18).

The Rankin Committee considered a number of approaches to providing heroin in a controlled manner:

> 1. long term heroin maintenance for residual addicts.
> 2. short term heroin maintenance for all addicts
> 3. long term heroin maintenance for all addicts
> 4. heroin legally available to all who ask for it (Committee of Inquiry into the Legal Provision of Heroin 1981, 31-33)

Each option had its advantages and disadvantages for the Committee. The first two proposals would not eliminate the black market in heroin, and so they don't meet all of the criteria the Committee had before it. The arguments against the last two options are interesting. In relation to the third option, though the committee thought that substantial numbers of people would be attracted to it, and that this would reduce street crime to a base line level and effect the black market, it added:

> However, it is commonly believed (and experience has shown) that, where one source of black market income is partly stopped up, the organisers quickly develop some alternative source. It seems highly likely that any decrease in the heroin black market would find its compensation in increased trafficking in other drugs of dependence. (Committee of Inquiry into the Legal Provision of Heroin 1981, 32)

In relation to the fourth option (free availability), this would eliminate the black market,

> However, the social cost would be enormous. Heroin is one of the strongest reinforcers of repetitive behaviour known, and the addict becomes lost to the drug to the extent where he is unable to evaluate or control his own actions, unable to judge or choose or live any sort of rationally determined life. And though proponents of the addict's right to choose his own destiny consider that drug-taking is a victimless crime, heroin-addiction has many victims - the addicts themselves, their spouses, children, families, friends and society at large.
>
> As a consequence, the unlimited availability of licit heroin would seem wholly unacceptable to the Australian community and to the international community. All of our witnesses were agreed that availability creates demand - indeed, that is the chief factor in demand. (Committee of Inquiry into the Legal Provision of Heroin 1981, 33)

Thus only free availability was seen to limit the involvement of professional criminals in heroin trafficking, and that was unacceptable because of its social costs (and the fact that trading in other drugs would probably increase). The Committee felt that methadone was a more appropriate drug for opioid maintenance for most clients. However the Committee did consider that heroin maintenance may be appropriate for

> ... the comparatively small group of hard-core dependents who, after repeated attempts at seeking improvement through methadone-maintenance and other forms of treatment, remain firmly addicted to heroin...(Committee of Inquiry into the Legal Provision of Heroin 1981, 34)

Thus the Committee recommended that research be undertaken into the value of narrow maintenance program such as this, where the objective of the maintenance would be:

> ... to improve the general health and quality of life of such individuals, and decrease their criminal involvement. (Committee of Inquiry into the Legal Provision of Heroin 1981, 34)

The clients of such a program would be the "burnt-out" users who are at one extreme end of the Rankin report's taxonomy of heroin users. The Committee found that the British experience did not lend support to arguments that heroin should be administered to dependent users, and recommended that, with the exception above, heroin not be made available to opioid dependent individuals (Committee of Inquiry into the Legal Provision of Heroin 1981, 35). Not unexpectedly, among other proposals the Committee also recommended that government policy should be care, not punishment, orientated, that it should be placed in the context of broader perspectives on substance "abuse" generally, that more research into drug dependence should be done, and that more coordination should occur (Committee of Inquiry into the Legal Provision of Heroin 1981, 36).

In 1985 a Committee of Review into Drug and Alcohol Services in New South Wales (the Kerr committee) handed down its final report. As part of that report the provision of heroin to heroin dependent individuals, and to patients for analgesic purposes was considered. On the first question, this Committee did not differ from the Rankin report submitted four years earlier. It recommended that heroin maintenance not be adopted as a treatment option (Committee of Review into Drug and Alcohol Services in New South Wales 1985, 129). Interestingly this Committee repeated, exactly, the words of the Rankin report (Committee of Inquiry into the Legal Provision of Heroin 1981, 33) used to dismiss the notion that heroin should be freely available (see Committee of Review into Drug and Alcohol Services in New South Wales 1985, 128). This second Committee did however recommend that heroin be considered in the treatment of patients for analgesic purposes.[8]

Conclusion

What is interesting about all of these reports is not their differences, though those differences are important in some respects, but their similarities. It is possible to say that since 1971 there has been a working consensus in Australian commissions of inquiry on drug matters. All the reports ask similar questions, and come up with similar answers. This repetition tells us something about the possibilities in Australia for making opioids available in a controlled manner.

In general, all of the reports construe drug use as a result of a myriad of factors. In other words, drug use is something that is determined by social, pharmacological, and psychological factors. It is not the result of free choice (though the people who use drugs are not necessarily "sick" or "deviant"). The reports also work with taxonomies of drug users, and drug dealers of varying degrees of elaboration. These classifications clearly relate to the constructions of drug use as "determined phenomena" because they identify individuals with varying levels of control over their lives. They also usually identify a group (traffickers/pushers) who might be said to control the lives of others. Thus these taxonomies are used to differentiate the real targets of the criminal law. As well all of the Committees either consider legal and illegal drugs together, or say that drugs in general should be considered. At the level of their recommendations, all of the reports rely on a three pronged approach which includes education, treatment and law enforcement. This will presumably either stop individuals taking up drug use, or help get them off drug use. Again, these three approaches are related to the reports' constructions of drug use as determined phenomena. The objective of all of these approaches, thus construed, is the reform of individuals. If individuals are manipulated by external factors, or factors beyond their control, so that drug use is attractive to them, then clearly they can be manipulated in the opposite way. The reports also always conclude that more research is needed. In affirming the relevance of the three prongs of government drugs policy, the reports find some sort of place for law enforcement. The precise role of law enforcement does however differ between the reports. In the "left wing" reports, the law enforcement option is restricted to traffickers of drugs, and the decriminalisation of cannabis is raised as a possibility. In the "right wing" (for instance the Williams report of 1980) the law is to be tightened for all drugs. All of the federal reports argue for a national

[8] It should also be noted that a dissenting recommendation advocating a national movement towards "decriminalisation of heroin" was produced by a member of this Committee (Committee of Review into Drug and Alcohol Services in New South Wales 1985, 368)

coordinated approach to the drug problem. And at least since the Baume report of 1977, the reports have argued for "harm minimisation" rather than the elimination of drug use.

These continuities clearly lead to the NCADA (as Neal Blewett recognises, Blewett 1987), and we will move to considering NCADA in the next section. What should also be said about this working consensus is that it does not completely exclude some sort of controlled availability of opioids. Clearly an approach which simply maintained heroin dependent individuals on heroin, without trying to treat them or educate them or rehabilitate them (or enforce laws on them) falls outside of the approaches recommended by these inquiries and commissions. Such an approach would not address the social/psychological/medical determinations of drug use. It is also true that the inquiries which have considered heroin maintenance for heroin dependent individuals have recommended against it. However these recommendations are not necessarily connected to all of what is agreed on in the reports. In fact the reports have a number of levels of argumentation in them. The arguments which are used against heroin maintenance have a slightly different hue to arguments in the reports which lead to general principles which should be followed by drug amelioration programs. Other lines of argument in these reports are compatible with making opioids available in a controlled manner. For instance, making opioids available in a controlled manner is compatible with the principle of "harm minimisation". This will be examine more fully below.

The question of opioid availability is a rather recent phenomenon in these reports. It is not considered individually, as a separate issue, until the Sackville report of 1979. This is of course not to say that making opioids available in a controlled manner was unheard of until 1979. Rather, the government inquiries have not separated this issue out from more general questions about the desirability of treatment approaches until that report. As we have noted, the drug report industry has its own particular, self-contained, history. Ever since opioids have been considered as a separate issue, the desirability of using heroin for maintenance has been discussed. All of the reports which discuss heroin maintenance, in whatever form, have rejected it. At best some tentative recommendations for more research on a limited scheme for "hard core" users is considered (e.g., the Rankin report of 1981). However this is not as constraining as it first seems for a trial which would make opioids available in a controlled manner. It is necessary to carefully examine the status of the arguments about opioid availability.

Here the major issue for the reports is whether heroin or methadone should be used to maintain or treat heroin dependent drug users. Generally, methadone is preferred for the maintenance or treatment of opioid dependent drug users. This does not mean that heroin is considered to be utterly inappropriate for maintenance or treatment. Rather, methadone is preferred on the balance of costs and benefits. There are three main reasons which are used to dismiss the option of using heroin to maintain or treat heroin dependence (these arguments have some relevance to all proposals which would make opioids available in a controlled way). First, methadone is said to be a more effective drug for maintenance; it lasts longer, it can be taken orally, it can be diluted with orange juice to discourage intravenous use, and so on. Second, wider heroin availability was said to encourage wider heroin use, and that would lead to more dependent heroin users. Third, wider heroin availability will not decrease organised crime (if that is one of its objectives) because organised crime will simply move on to the next drug.

What is evident about these two arguments is that they are not technical or scientific or medical arguments, but *political* arguments.[9] They are calculations of possible effects, and desirable states of affairs done in the context of imperfect knowledge of such effects and affairs, where there is no immediate prospect of a technical solution to this imperfection. For example, none of the reports advance more than anecdotal evidence that an increase in availability will increase heroin dependence, or that an increase in availability will mean that organised crime will move on to new drugs. Organised crime is understood as a creature with a force of its own which will simply move on to other illegalities, not as a response to existent unmet demand. But no evidence is advanced to support this proposition. Given the arguments of the reports work in this way, people who want to argue against the reports can simply take an opposing view. For instance, it may be the case that all of the people who are going to be dependent on heroin are already dependent on heroin, so increasing the availability of heroin will not increase heroin dependence.

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[9]With regard to the first argument, the effects of methadone are based on evidence, but the comparison with heroin is not. The second argument rests on an analogy with alcohol, which is disputed by some.

More importantly, the political calculations contained in the reports' arguments against increasing heroin availability involve value judgements about two crucial issues. First, these calculations involve value judgements about people who use heroin, and who are dependent on heroin. Their lives are said to be meaningless, and thus the government cannot risk increasing their number. This is a judgement about the "proper", "desirable" life a person should have. Second, and this point is closely related to the first point, these calculations involve judgements on what a "good society" is like. Implicitly the reports compare a society where some people use illicit heroin at a great cost to themselves, and a large cost to the community, to a society where (possibly) more people use legal heroin at less (direct) cost to themselves, and less cost to the community. In a simple sense, the reports prefer the first society. This is reflected in the language of the reports. As we noted above, the Rankin report characterises a heroin dependent individual as an "addict" who,

> ... becomes lost to the drug to the extent where he [sic] is unable to evaluate or control his [sic] own actions, unable to judge or choose or live any sort of rationally determined life. (Committee of Inquiry into the Legal Provision of Heroin 1981, 33)

Such judgements are the nodal points of arguments against changing the availability of heroin. By extension they could also be applied to any proposal which canvassed making opioids, of whatever sort, available, even in a controlled manner.

This characterisation of the political nature of the arguments in the reports is not meant to denigrate the reports, or the arguments of the reports. In such reports there is inevitably some political calculation involved. What must be recognised however is that this implication of political calculations in the arguments of the reports means that their conclusions are tied to those calculations. Because the calculations involve selective pictures of society, and the people in it, the arguments of the reports are inevitably selective themselves. The reports produce particular pictures of what society is like, and what it should be like, which inevitably means that they ignore or suppress other options. It also means that the arguments are not written in stone. These calculations were done in specific circumstances. They are not immutable. Clearly a whole series of factors have been excluded from these calculations. Society's sense of what is possible, what the balance of factors is like, and what is desirable is changing in the light of HIV, and the continued failure of prohibition. These themes will be taken up again when we consider the Cleeland report in section 4.

Section 3: National Campaign Against Drug Abuse

First mooted towards the end of 1984 by the Prime Minister, and launched at a special Premiers Conference in April 1985, NCADA is the major recent initiative in ameliorating drug problems in Australia. Its objectives and principles are also a clear continuation of the approaches canvassed in government reports from 1971 to the present day. The central aim of NCADA is to "minimise the harmful effects of drugs on Australian society" (Department of Health 1985, 2).

> Its ambition is thus moderate and circumscribed. No utopian claims to eliminate drugs, or drugs abuse, or remove entirely the harmful effects of drugs, merely to "minimise" the effects of the abuse of drugs on a society permeated by drugs. (Blewett 1987, 2)

As Neal Blewett also recognises, this strategy, which is in opposition to the elimination of drug use or total prohibition, can be traced back at least as far as the Baume report of 1977.[10]

> The aims of the National Campaign, the final strategies adopted, and the programs implemented thus far, all rest on a number of principles which are common to, or consistent with, the reports of the Senate Committees referred to previously, and to the major recommendations of the Williams and Sackville Royal Commissions. (Blewett 1987, 9)

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[10] It is interesting to note that Blewett also assesses the standard of community debate in the same terms as Baume, quoting that report where the poor standard of debate is noted (Blewett 1987, 6), and that a later review of NCADA notes the continuity again, drawing attention to the fact that the past reports usually called for control of the abuse of legal drugs as well as illegal drugs, and the need for a coordinated approach and more research and statistics.

What are these principles? NCADA is based on the premises that: a national approach is essential; existing institutional and community structures should be strengthened; a comprehensive approach to drug use and drug problems is essential;[11] reliable data for monitoring programs and new approaches to evaluation are needed; the emphasis should be on demand reduction, though this should be interrelated with supply control; and the campaign must have a degree of permanency (Department of Health 1985, 3). NCADA also embodies the traditional three pronged approach of treatment/rehabilitation, education, and controls/enforcement (Department of Health 1985, 4).

Clearly, at least initially, the relationship of a trial of making opioids available in a controlled manner to NCADA is similar to the relationship of that trial to previous inquiries, commissions and such like. Some sort of controlled availability could formally come under the banner of harm minimisation. However, in the context of the launch of NCADA, harm minimisation was translated into measures which revolved around supply and demand reduction. This meant that controlled availability was not actively considered. On the launch of NCADA, harm minimisation was interpreted in this way:

> The aim is to minimise the harmful effects of drugs on Australian society, through:
> * promoting greater awareness and participation by the Australian community in confronting the problems of drug abuse;
> * achieving conditions and promoting attitudes whereby the use of illegal drugs is less attractive and a more responsible attitude exists towards those drugs and substances which are both legal and readily available;
> * improving both the quantity and quality of services provided for the casualties of drug abuse;
> * directing firm and effective law enforcement efforts at combating drug trafficking with particular attention to those who control, direct and finance such activities;
> * supporting international efforts to control the production and distribution of illegal drugs; and
> * seeking to maintain, as far as possible, a common approach throughout Australia to the control of drug use and abuse.
> (Department of Health 1985, 2)

This is a particular implementation of the principle of harm minimisation. Controlled availability does not necessarily fit well with the streams of education, treatment, and enforcement, as they have been interpreted in this context. However in 1988 NCADA was reviewed, and early in the resulting report it was noted that;

> The emergence of AIDS as a major public health issue, in Australia as overseas, and the role of unsafe drug injecting practice in the spread of the AIDS virus, is perhaps the single most important change of recent years in the context of drug policy. (NCADA Task-force on Evaluation 1988, 7)

In fact HIV infection put the legal status of drugs, especially heroin, onto the agenda. The report of the task-force on evaluation also notes that,

> The argument in favour of a change in the legal status of illegal drugs, including heroin, marijuana, cocaine, the amphetamines and the analogues, relates directly to the harm minimisation aim of NCADA. (NCADA Task-force on Evaluation 1988, 115)

Three points are noted on this topic; harm to public health because of the spread of HIV infection; harm and cost to society because of the illicit drug market; and harm to the individual user because of the legal status of the drugs. Like previous reports this task-force weighs the likely benefits of a change in the legal status of drugs against the

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[11] This principle originally directed that particular attention should be paid to illegal drugs. After an evaluation of NCADA (Report of the NCADA Task-force on Evaluation, 1988) the Ministerial Council on Drugs Strategy (MCDS) resolved that legal and illegal drugs which cause the most harm be targeted (NCADA, monograph No. 12, 1989, 13-14).

> ... possible costs of such a change in terms of expanded use of these substances and the consequent health and social problems. (NCADA Task-force on Evaluation 1988, 116)

But significantly, this still involves a rethinking of the notion of harm minimisation. In its recommendations the task-force on evaluation argued that MCDS should;

> note the increased level of interest in the impact on society of the legal status of drugs;
> develop a mechanism to bring together for its use evidence and arguments about this impact;
> monitor the continuing development of this debate, including the enquiries being conducted by the Parliamentary Joint Committee on the National Crime Authority; and
> develop explicit mechanisms to ensure that the information derived from these various initiatives is used in the on-going development of policies on the legal status of particular drugs in Australia. (NCADA Task-force on Evaluation 1988, 176).

After receiving and considering the evaluation report, MCDS noted

> the increased level of interest in the impact on society of the legal status of drugs;
> the enquiry being conducted by the Parliamentary Joint Committee on the National Crime Authority; and
> the need to review the committee's report when it become available. (NCADA, monograph No. 12, 1989, 16)

To this date MCDS is still considering the Cleeland report.

A trial which would make opioids available to users in a controlled manner is thus positioned ambiguously in relation to NCADA. On the one hand it falls outside of the established framework for dealing with drugs which NCADA has inherited from previous government reports and inquiries. This framework involves the use of either treatment, education, or law enforcement (or a combination of these approaches) to manipulate individuals so that their use of drugs is minimised or stopped. Such a trial is not itself necessarily treatment, education, or enforcement, in these terms. Though of course, more generally, these approaches could be part of such a trial. Making opioids available in a controlled manner thus does not fit easily with the deeper assumptions which generate the three pronged approach of governments to drugs. Making opioids available does not by itself grapple with the causes of drug use, either by negating those causes (treatment/education) or changing the situation so that drug use does not occur (deterrence through enforcement, supply reduction). It ameliorates the social and individual problems of drug use in an entirely different way. In other very important respects such a trial is compatible with NCADA. Making opioids available is thinkable within the objective of harm minimisation, as it has evolved. Simply put, the classic argument of people who would like to increase the controlled availability of opioids is that such a strategy would minimise the harm consequent upon drug use. If every proposed response to opioid dependence was assessed only in relation to the objective of harm minimisation, a trial which would make opioids available in a controlled manner would be politically feasible.

Section 4: The parliamentary joint committee on the National Crime Authority

The political context of a trial which would make opioids available in a controlled manner in Canberra is complex. A trial would clearly be beyond what *has been* thought and stated in mainstream politics (with the exception of the Democrats), but that does not mean that it is beyond what *can* be thought in mainstream politics. Responses to the "drug problem" in Australia since 1971 are made up of a complex web of arguments. Such a trial is a possible extension of some of what has been already argued and accepted.

It has been noted a number of times that the dominant interpretation of drug use in Australian politics is that something (no one is quite sure what) determines that individuals use drugs. Thus these individuals may or may not be sick, but what is constant is the fact that their use of drugs is not the result of free choice. It is produced by the working of deeper social or psychological factors. In a sense the recommendations of the inquiries and so on that have examined drug use flow from these

assumptions. Education, treatment, and enforcement, as they have been conceived, are ways of coming to grips with the social or psychological determinants of drug use. Clearly a trial which does not try to educate or enforce or treat, in the terms in which these three prongs are at present construed, does not jell with the dominant interpretation of the origins of drug use. However there are other elements of the consensus on drug use, and these other aspects create the space for those who would want to argue that opioids should be made available in a controlled manner to opioid users.

Primarily the objective of harm minimisation can be pointed to, and the fact that this objective can formally accommodate a trial like the one this feasibility study is investigating. The structure of the political arguments that have been used to reject proposals to make heroin available in a controlled manner in Australia is also important. Here the Cleeland report, and responses to that report, are vital to this paper.

The report

In one sense the Cleeland report is a break from the history of government concern with the drug problem since 1971. This 1989 report clearly says that prohibition has been a failure, and attempts to gauge the costs of the prohibitionist approach.

> Having observed that it is universally conceded that the present policy of prohibition is ineffective, in that it cannot stop the illegal drugs being supplied to those Australians who seek them, the Committee has attempted an assessment of the costs which that policy imposes on the Australian community. (Parliamentary Joint Committee on the NCA 1989, 75)

The costs of prohibition include: direct costs to the government of policing, the courts and gaols; the raising of prices which attracts business; drug related crime; the criminal milieu which is created; corruption; health costs; adulteration of supplies; stigmatisation of users; civil liberties violations; hypocrisy; and benefits foregone (Parliamentary Joint Committee on the NCA 1989, 75-88).

To some extent this change in perspective is attributable to the (comparatively) recent rise of economistic ways of examining social issues. The committee is clearly motivated, in part, by direct considerations of the economic costs of present policies, and by the notion that social policies can be assessed in terms of economic costs and benefits (which is a more indirect influence on the arguments of the Cleeland report). This aspect of the Cleeland committee's report ties to other recent assessments of Australia's "drug problem" (see Collins and Lapsley 1991; Marks 1990). Along with the advent of awareness of the risks of HIV infection (noted above in the analysis of the report of the NCADA Taskforce on Evaluation 1988), this change in the political scene leads to a reconsideration of present drug policies. Interestingly, it should also be noted that the risks associated with the HIV virus can be construed in economic terms (see Parliamentary Joint Committee on the NCA 1989, 84; Collins and Lapsely 1991, 75).

The Cleeland committee considered a diversity of alternatives to Australia's present policies, which ranged from increasing penalties, to arrangements which would increase the availability of drugs such as de facto decriminalisation, decriminalisation, the prescription of drugs like heroin, licensing of users, and a regulated market for presently illegal drugs that would resemble the markets for alcohol (Parliamentary Joint Committee on the NCA 1989, 93-115). Not surprisingly the committee found that there are arguments for and against each option. The arrangements which would change the status of presently illegal drugs all imply a break with the existent three pronged attack of the government on drug use. However such changes are compatible with other elements of NCADA.

> It is clear from the thrust of the campaign that at the official level harm minimisation means reducing the use of drugs, both by demand reduction (through education, treatment and rehabilitation) and by supply reduction (through law enforcement). An alternative interpretation, based on an acceptance of certain levels of drug use in Australian society, would emphasise the need to minimise the harm which users may do to themselves as a result of their drug use. Such an interpretation implies rather different policies to those being pursued at present. It would suggest, for example, that the policy should put primary emphasis on safe use, rather than on deterring use, and that the supply of the illegal drugs

> should be regulated by the government in some way rather than being left outside the law in the hands of criminals. It would certainly imply that use and possession should not be criminal offences as they are at present. (Parliamentary Joint Committee on the NCA 1989, 91)

However, the radicalism of this reinterpretation of harm reduction is only indirectly reflected in the recommendations of the Cleeland report. Apart from recommending that more information be gathered (again), and that advertising of alcohol and tobacco be banned (Parliamentary Joint Committee on the NCA 1989, xv-xvi), the committee recommended that movement away from prohibition be debated.

> Recommendation: The Committee recommends that the Federal and State Governments and the community at large give earnest consideration to the options by which governments might impose more controls on the sale and marketing of the presently illegal drugs. (Parliamentary Joint Committee on the NCA 1989, xvi and 124)

While that recommendation does not mention problems with prohibitionist approaches as such, it should be read in conjunction with the supporting text of the report.

> Should these latest initiatives fail to make any significant inroads on the market then it would be appropriate to consider some relaxation of the present prohibitions as an alternative policy. (Parliamentary Joint Committee on the NCA 1989, 123)

It is also interesting to note the way in which the committee balanced arguments for and against proposals which would make heroin more freely available.

> Each option involves trade-offs between costs and benefits. The present policy raises prices and restricts access, thus making it more risky and difficult for both new and existing users to obtain drugs. It deters new users and may push existing users into treatment and rehabilitation programmes. At the same time it imposes an enormous cost on the users themselves - through damage to their health and now the threat of the spread of AIDS through sharing needles - and on society at large through drug-related street crime, corruption and the direct costs of law enforcement. At the other end of the spectrum making the presently illegal drugs available subject to government regulation would eliminate many of the social costs although not necessarily diminishing the health problems of addicts or improving their employment prospects. At the same time, however, it could lead to a dramatic increase in the use of the drugs and almost certainly to an increase in addiction. (Parliamentary Joint Committee on the NCA 1989, 116)

This is a clear statement of the *political* choices which face policy makers in drug and alcohol services. Of all of the committees we have examined, the Cleeland inquiry into the NCA is the closest to taking the extra step that would result in a recommendation that the legal status of opioids be changed. It does not do this for essentially political reasons: such a step could not be carried on a multi-party committee; and perhaps more importantly, the world that would result from such a change (or rather the picture of the world the committee works with) was judged to be less desirable that the present situation.

The Cleeland report also shows us something else. It is possible to think about change at the present moment. This reconceptualisation is not completely outside of the history of political and governmental discussion of problems of drug use. But it is still a large step to take. In responding to the Cleeland report, the Labor government at the time decided to refer the principal recommendation of the Report (the recommendation which urged the government and the community to consider different ways of controlling presently illegal drugs) to the MCDS. This was done, officially, because drugs policy in Australia is the responsibility of Federal, State and Territory governments. In the context of NCADA, and because of the need for intergovernmental cooperation, it was thought appropriate that

an intergovernmental body examine the report. MCDS of course coordinates and oversights NCADA. Even in doing this, perhaps to keep the official gloss of consensus we noted above in examining the statements of ministers and shadow ministers, the Attorney-General felt that he had to distance himself from the report.

> I should make it clear that the Government, in referring these matters to the Ministerial Council, and in recognising the seriousness of the current drugs debate, in no way necessarily accepts the Committee's conclusion that Australia has a drug policy of prohibition that has failed. Nor does the Government necessarily accept the need for any changes to current drug laws. It is that case, simply put, that the Government does not wish to pre-empt the outcome of the proposed Ministerial Council consideration of this matter. (Duffy 1989, 6)

As we noted above, MCDS is still considering the Cleeland report at this point in time.

Submissions to the report

The official text of the report by the Parliamentary Joint Committee on the National Crime Authority does not exhaust what that committee can tell us about a trial which would make opioids available in a controlled manner. Particularly because there is some disjuncture between the arguments of the report, and the recommendations of the report, it is interesting to examine the transcripts of submissions to the Parliamentary Joint Committee on the National Crime Authority. They reveal some possible explanations of the gap between the Cleeland report's arguments and its recommendations.

The majority of the submissions to the committee which are publicly available argue for a change in the present policies of prohibition. Especially in relation to heroin, it is argued that controls other than the criminal law should be used. Given the diversity of submissions to the committee it is impossible to succinctly summarise the arguments for changing the availability of heroin, though generally it can be said that the submissions argue that a move away from prohibition, while having its own problems, would be a lesser of two evils. The committee, in its questioning of the authors of these submissions, takes these arguments seriously. However a number of related issues worry the committee throughout its public hearings. In the transcripts, we can find repetitive questions on a number of topics. Four often repeated questions are particularly relevant for the feasibility study.

First, the committee was worried that an increase in availability would lead to an increase in use, and thus an increase in dependency.

> Mr MacKellar - One of the points that I am trying to sort out in my mind is whether, if it was open slather or carte blanche, we would get an accelerating percentage of users throughout the community or not, or whether there is a basic element within any society which has addictive propensities and we will not get too much more than that. There is some evidence to suggest that that may be the case and therefore we are wasting our time and money, and corrupting society in a fairly spectacular way, if we continue the way we have been going so far. That is the very difficult question to evaluate. (Parliamentary Joint Committee on the NCA, Official Hansard Report 1989, 85)

A second related question which worried the committee is whether changing the availability or legal status of opioids (and here again the committee was particularly concerned with heroin) would in fact change the "lifestyle" of opioid dependent individuals.

> Chairman - What about the hard-core group? Some of the evidence suggests to me that the hard-core users may not take advantage of the free, medically pure heroin because it is the subculture which is the attractive part of their lifestyle and which is indirectly heroin related. They would not come out of the woodwork. We would still have the same needle sharing, the same subculture, the same criminality, no matter what we did. Is there any evidence to support that view? (Parliamentary Joint

> Committee on the NCA, Official Hansard Report 1989, 1169-1170)

This question really has a couple of parts. Would users be attracted to "bureaucratic" heroin (Parliamentary Joint Committee on he NCA, Official Hansard Report 1989, 1464)? Would more freely available heroin change dangerous practices, like needle sharing?

The third question which the committee mulled over is the possible effect of changing the status of heroin on organised crime. The fourth, related question, concerns the spectre of "crack".

> Senator Macklin - Is it not the situation that you are suggesting that you would move one drug out of the illegal group and put it into the legal group, which already has a couple of quite lethal drugs in it? There are 20,000 Australians dying from using those two legal drugs every year. They would then have three legal drugs to kill themselves with. Would the attractiveness not be still to the illegal drugs? In other words, would one not perceive a growth? Seemingly, at least as we have heard from a lot of people who have come before us, it is not totally the effect of the drug that is being sought but also the lifestyle, the illegality, the adventure and all of the other things that go along with that living on a slightly faster track. So we might be pushing people out of what you describe as a possibly a benign drug, if it were pure and properly administered, into stuff that we know certainly is not, such as crack. (Parliamentary Joint Committee on the NCA, Official Hansard Report 1989, 1127-1128)

The committee also perceived that in legalising heroin, it might be necessary as well to legalise drugs like amphetamines, crack, cocaine, and the drug analogues (some of which do, it is thought, have harmful effects).

Despite the rather colourful language of the quotations above, the committee wanted to see these questions as technical questions. That is, they would like scientific, value free, answers to be produced on these questions (in a sense the committee's first question is: will the number of dependent users *really* go up, and by *exactly* how much if we legalise heroin?). Of course this perspective leads to the eventual call for more research, because nobody can definitively answer these questions at present. However at times the committee also recognised that these questions involve political calculations. We have noted above that the committee is aware of the political choices which face it, and society. In questioning a witness who had argued strongly for no change to the present approach the committee had this to say:

> Mr MacKellar - Given that it is true, you have to weigh that against the current situation in terms of total community cost. Is it worse to have a few more addicted or a lot more addicted than in the situation that we have at the present time where the very basis of our society's organisation is being threatened by the massive effects of the huge profits that are available to illegal drug organisers and suppliers? As far as I am aware, we have never had a situation like this in Australia or in many other Western countries, except for a while in America with Prohibition, where the profits were so great that organised crime not only became established but became extraordinarily lucrative and started to undermine the entire basis of society - the legislature, the judiciary, the police, the whole lot. Are your lesser number of addicts worth that extraordinary attack against society? (Parliamentary Joint Committee on the NCA, Official Hansard Report 1989, 1241-1242)

The questions which concern the committee here revolve around what a "good society" would look like.

These arguments give us a sense of the nature of the political calculations which prevented the report as a whole recommending change in the present status of opioids (heroin in particular). They tell us a little about why the committee did not take the extra step from the recognition that prohibition was not working, to the advocacy of change in the way society responds to drug dependent people. In terms of

the arguments of the report on opioid availability, these questions are the crucial issues which lead the committee *not* to recommend increasing the availability of opioid drugs. What we can see by bringing out these statements from the text of the committee's inquiries is that these questions are to a large degree political calculations. They centre on what the "good society" looks like (trading off more heroin dependent people and less social problems for less heroin dependent people and more problems) and value judgements about the nature of people who are dependent on heroin (they "choose" a "junkie lifestyle", and get pleasure from that "lifestyle"). These political calculations are essentially the same as the ones which previous reports had used to argue against making heroin available in a controlled manner. The Cleeland inquiry works with a set of value judgments which closely parallel the judgements of most government reports since the Marriott report of 1971.

Though the Cleeland report is the most questioning report from the Australian drug report industry, its arguments stop at a similar point to other reports from that industry. The political calculations in the report are similar to the other reports we examined above. While the Cleeland report indicates that society's perception of "drug problems" is changing, it also illustrates the strength and persistence of the value judgements about people who use drugs, and what a "good society" looks like which previous reports contained. Despite their "radicalism", the arguments of the Cleeland report contain the same gaps, absences and blocks which previous arguments on drug use contain.

Section 5: Conclusion

The political context of a trial which would make opioids available in a controlled manner is made up of a range of phenomena, some of which are definite and known, and some of which are indistinct. Paradoxically, the features of the political context which are most often thought of as objective are extremely uncertain. All that we can be clear about are features of the political context which concern the way drugs and drug use are thought about. Chief among the uncertain objective factors that will determine the feasibility of a trial which would make opioids available in a controlled manner is the ACT party political context. At the moment the electoral system of the ACT does not seem to deliver stable majority governments. The two largest parties, the ALP and the Liberals, do not have the numbers to form governments in their own right. Rather they must rely on shifting alliances, or at least accommodations, with a number of "independent" groups. To this unpredictability must be added the fact that, at the time of writing this report, an election for the Legislative Assembly of the ACT is due in the near future. These uncertainties are not necessarily a constraint on the trial. Indeed it is not even clear whether the lack of certainty in the ACT political conjuncture is a constraint on a trial, or something which might facilitate a trial. It is in a real sense imponderable.

This report will end with two other paradoxes. At least these paradoxes are not imponderable. First, there is the paradox that while a series of lengthy reports have been produced over the last 20 years in Australia on drugs, and drug dependency, there is no substantive controversy in the area. The reports are highly repetitive. The second paradox is that while there are a range of official reports and inquiries into drug use, there has been little debate on the topic in the public domain, and even less debate in the narrower party political domain. In a sense the upshot of both of these paradoxes is that every new report on the drug problem calls for informed public debate, and more research. But what accounts for the repetitive reports, and the exclusion of arguments on opioid availability from the political arena?

We will deal with the second paradox first. At one level, the exclusion of consideration of making opioids available from political debate is perfectly obvious. There is no percentage in the issue for any of the major parties. They do not have to take a position on the availability of opioids, so they do not do so, probably correctly calculating that there are more dangers than benefits to be had from opening such a debate. As we have seen as well, at the level of ministers and shadow ministers there is a formal consensus on NCADA. Though this consensus glosses over some real differences, by and large NCADA is seen as a success, and so there is no need to tinker with its operation. Though a trial which made opioids available in a controlled manner could be accommodated within the principles and objectives of NCADA, the perceived success of the present operation of NCADA limits debate on drugs policy. Ironically, this lack of debate is also, in a sense a facilitating factor, in that nobody has taken a position against such a trial. However there is more to this picture than this. As we have also seen, in the Australian Democrats, and in both of the other major parties, there are at least some

platform positions, and individual activists, which argue for a change in the legal availability of presently illicit drugs. Why have these positions not percolated up into ministerial politics?

The explanation here is also relevant to the second paradox. Why have we had so many reports which have basically said the same thing? Why do we need to repeat the same recommendations every three to five years? As we have noted, at least some of our reports from the Australian Drug Inquiry Industry recognise the repetitions of their trade. We can start to find an explanation for these repetitions by examining the detail of the arguments of these reports. Throughout this paper it has been emphasised that these reports are made up of a number of complex arguments. These arguments do not all have the same status (some are statistical analyses of drug use, some are medical arguments about the pharmacology of drugs, some are political calculations and so on). And these arguments do not necessarily mesh together in a simple coherent way. However, to grossly simplify the texts of the reports, we can say that there are two major *lines* of argument in the reports: One line of argument follows from the assumption that drug use is a *determined phenomenon*. People are caused to use drugs by either individual, psychological, pharmacological or social factors (or of course a combination of these). This assumption produces the typology of drug users that is so popular with government reports, and this typology in turn generates a three pronged policy response to drug use. All of the reports rely, to varying degrees, on education, treatment, and law enforcement. The typology of drug users identifies the targets of these policy streams (treatment for "helpless addicts", law enforcement for traffickers, and education for occasional users or people who are likely to experiment with drugs). All of these policy responses, as they are conceived by the reports, construe their objectives as the manipulation of individuals. In short they want to alter the way that people who use drugs behave, and that objective ultimately ties these policies to the initial assumption that drug use is determined by factors that are outside of the control of individuals.

The second line of argument in the drugs reports is slightly, but significantly, different. This line of argument is of course the argument that government policies should try to *minimise the harm* accruing from drug use, not try to eliminate or prohibit drug use. The harm that results from drug use can concern both "society" and the individual drug user. These two lines of argument are not necessarily opposed. They can happily coexist. For instance, the departments who administer NCADA clearly see the goals of demand limitation and supply reduction (which lead to the three prongs of law enforcement, education and treatment) as being continuous with the overall objective of harm minimisation. However, as the Cleeland report demonstrates, they can also lead in different directions. We noted above the Cleeland committee's radical interpretation of "harm minimisation" which lead to consideration of government regulation of the supply of drugs (Parliamentary Joint Committee on the NCA 1989, 91). This is not to say that the Cleeland report's arguments on harm minimisation necessarily contradict the goals of NCADA. What is important is the recognition that they are different lines of argument.

The first line of argument produces the repetitions of the drug report industry. Given that it is believed that drug use is determined by factors that are outside of the control of individuals who use drugs, then the only answer that we can give to the perceived "drug problem" is that we should try to change the balance of determining factors. If these policies fail, then the only answer that can be given to their failure, while we still believe that drug use is a determined phenomenon, is that we must try harder. The Williams report of 1979 illustrates this logic. As we noted above, that commission recognises that previous reports had produced very similar conclusions. However the commission staves off the problems that this observation gives rise to by arguing that the recommendations of previous inquiries had not really been tried, or implemented (Australian Royal Commission of Inquiry into Drugs 1980, D14). Law enforcement, education, and treatment must be the answers to the failure of law enforcement, education and treatment.

Arguments on the determination of drug use have some dominance in the political arena. This is not to say that arguments about harm minimisation are excluded from the political arena. Obviously, as our analysis of NCADA shows, they are present in contemporary political discourse. However, their place in the political scene is defined by arguments about the determination of drug use. This dominance accounts for the exclusion of arguments for making opioids available in a controlled manner from the political scene. While arguing that opioids should be made available in a controlled manner can be brought under the rubric of "harm minimisation", because harm minimisation is construed in relation to the determination of drug use, arguments on the availability of opioids tend to be left to one side. Government reports illustrate this logic. The vital discursive link here is the political calculations

about drug users and the "good society" which we have been noting throughout this paper. These calculations, which depend on value judgements, seem to fit naturally with arguments about the social determination of drug use. What is meant by this is that, while these political calculations do not follow *automatically* from the theory that drug use is a determined phenomenon, they do sit comfortably with it: If drug use is determined by factors that are outside of the control of individuals, then fears that people will still adopt "junkie lifestyles" even with the provision of "free heroin" are well founded. It may be that some people are "destined" to partake of a "junkie lifestyle". Equally, if drug use is a determined phenomenon, then it is not unreasonable to fear an increase in use if opioids are more available. Such connections could be argued against. But that is not the role of this paper. Our task is to assess the way in which arguments have in fact been made. At this level what we can see is that the political calculations which are finally brought to bear on proposals to increase the availability of opioids (especially heroin), connect to assumptions about the social, medical and psychological determinations of drug use. This accounts for the repetitions of these calculations, and ultimately for the exclusion of considerations of the availability of opioids from the political arena. Given that assumptions about the determinations of drug use are widely shared, it is natural that political debate will end at a reaffirmation of the three traditional prongs of enforcement, education and treatment.

As the Cleeland report and the first evaluation of NCADA indicate, society's perception of drugs, the "drug problem" and even strategies for dealing with drug problems is changing. This change is uneven. It is not all in the one direction, or attributable to the one cause. But it is present. What appears to be happening is that the hierarchy between the lines of argument on drugs is changing. Two features of the current political scene are particularly important here. First, the risk associated with HIV is leading to consideration of how safe drug use can be ensured. This implies a move away from attempting to prohibit or eliminate drug use. Second, the importance of economics, and economistic conceptions of social problems, is leading to a consideration of the economic costs of attempting to prohibit drug use. Both of these features of the Australian political scene can lead directly to proposals to make opioids more available (and they can of course be combined into one argument). But perhaps more importantly they contribute to a political context where harm minimisation is the dominant argument on drug use. This creates space for those who would want to argue that the availability of opioids should be changed. In a sense it is forming a new political context, made up of new arguments, and new possible arguments.

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4: INTEREST GROUPS AND SOCIAL CONTROVERSIES

Brian Martin

It requires only a brief investigation of debates over drugs to conclude that there is much more to the issue than logical arguments. In order to understand the debates better, it is useful to introduce the concept of 'interests'. The aim here is to use the conceptual tools of controversy analysis to present the concept of interests and its relevance to drug issues.

There are two major sides to the debate, which can be called the prohibitionists and the reformists. The prohibitionists believe that drugs should remain illegal and stigmatised: any other course would encourage greater drug use and attendant problems without undercutting existing drug cultures and related criminal activities. The reformists believe to the contrary that prohibition is counterproductive: it encourages a black market and organised crime, and it leads users to adulterated drugs and unhealthy practices, without substantially reducing the harmful use of drugs. (Actually, the groups are not as clearly distinguishable as this dichotomy of prohibitionists and reformists suggests; many people hold a mixture of views.)

Sometimes the debate between these positions is couched in terms of social costs: the costs of the health consequences of drug use versus the costs of promoting a criminal subculture. But there is obviously more to the debate than this, as evidenced by the passions involved and the extreme penalties for involvement with some drugs, far greater than for involvement in other potentially unsafe activities (such as selling or using defective automobiles).

In Western societies today, the position of the reformists is dominant for a number of drugs, including alcohol, tobacco and caffeine. The position of the prohibitionists is dominant for some other drugs, including heroin. The question here is, which groups in society have an interest — a vested interest, if you like — in these differing positions?

The concept of 'interests' can cover a range of things. There are financial interests, such as those of tobacco companies in selling cigarettes and governments in taxation revenue from tobacco; bureaucratic interests, such as those of welfare agencies dependent on managing a flow of 'clients'; career interests, such as the stake of researchers in acceptance of a position they have supported; and psychological interests, such as those of drug users who rationalise their own particular behaviours. Different types of interests often overlap. For example, a corporate executive may obtain lucrative contracts for selling a particular product and also develop strong personal commitments to the virtues of that product or to the operation of the free market.

What, then, are the principal interest groups in the debate over whether to hold a trial into the controlled provision of opioids to users? Any answer to this question is bound to be contentious. Certainly, large and medium-scale drug dealers, whose high returns could be undercut by the availability of legal drugs of established purity, are likely to oppose a trial. Heavy users of illegal drugs are likely to support a trial because it would provide access to high quality drugs at low cost and reduced social stigma. Other groups that might be examined in this fashion include: politicians who seek to gain votes by appealing to long-standing public concerns; senior public servants with a commitment to programmes based on prohibition or reform; public servants who would have increased workloads to implement any substantial change in policy; doctors, nurses and other health service providers; moral entrepreneurs who identify the use of certain drugs with moral decay or with a more progressive society; 'recreational' users of illegal drugs; police who enforce laws against drug use; pharmaceutical corporations and related manufacturers; legal workers; prison personnel; workers in drug rehabilitation programmes with differing approaches; workers running a trial; researchers studying a trial; and ex-users of illegal drugs.

In this brief itemisation, I have omitted the general interests most often raised in the debate, namely the health of users, the risks of the spread of AIDS, and the level of crime and corruption in the community. These are the subject of the debate. The groups I have listed are ones that have an immediate, obvious, identifiable interest in supporting or opposing a substantial change in the legal status of opioids. A trial would be seen, rightly or wrongly, as a step in this direction.

Even this is an oversimplification, since there are internal differences in any group. Some police may support a trial and others oppose it, for example. Indeed, because there have been no such trials before in Australia, it is impossible to do more than guess at how groups will respond. The test would be the trial itself.

The important point here is the very existence of interest groups. They have a number of influences on the debate.

The first is that the weight of evidence cannot be relied upon to win the day. If certain powerful groups decide to support or oppose a trial, they can always find reasons for their action.

Studies of scientific controversies show that any claims about scientific knowledge can always be challenged. Even apparently solid findings using randomised double-blind clinical trials have been challenged and undermined (Richards, 1991). So in an area such as opioids, where the evidence is patchy and a range of contentious social considerations are involved, it is always possible to counter evidence and arguments with other plausible evidence and arguments.

(This is not to say that all evidence and arguments are equally good. What is true is that there are evidence and arguments available that can be used, in the hands of a group willing to do so, to attack the other side.)

An examination of the literature by prohibitionists and reformists shows that the latter have presented far more extensive and effective arguments. This has not led, though, to implementation of reform policies for opioids. It could be that prohibitionists have not needed to develop their arguments because the prospects for reform seem so remote.

In the case of an opioid study, any evidence mustered to support a study could be countered by material critical of a trial. If this wasn't enough, legal or financial objections could be raised.

On the other hand, evidence against a study could be overruled by a simple argument: even though there are costs and risks that the study would fail, the benefits of success (however unlikely) — which would constitute a breakthrough in the intractable drug issue — warrant taking the chance.

A second implication of the involvement of interests in the drug issue is that success of a trial might be undermined by its opponents. This could happen in a number of ways. One would be the imposition of restrictive conditions on the trial, such as provision of heroin but not other drugs. Another way would be noncooperation by various groups, such as the police (who might change their enforcement practices), the Board of Health (which might change its evaluation standards) or the government (which might restrict funding). It is also possible for supporters to undermine the success of a trial by covering up things that go wrong, so that the problems escalate rather than being rectified.

A third implication of interests is that researchers, in designing their evaluation procedures of a trial, are likely to be influenced by their views about drugs. For example, researchers who disagree with prohibition might take special note of measures of benefit from the trial, such as the health of users.

It is probably inevitable that researchers will become de facto advocates, whether they like it or not (Scott et al., 1990). For example, if a researcher gives equal attention to the arguments of both prohibitionists and reformers, this will help the side which has less credibility to start with. One or both sides will try to enrol the researcher and his/her work as supporting their own case. So even if researchers make a valiant attempt to remain objective and neutral, it is very likely that they will be seen to be partisans and that their work will be used for partisan purposes.

This leads to a fourth implication of interests. Reformists will use a decision to go ahead with a trial as support for their position, whereas prohibitionists will use a decision not to go ahead to support their

position. In neither case is there much logic to this, since the decision undoubtedly will be shaped more by interests than logic and evidence. The point is that a decision either way becomes a potent tool in further debates about opioids.

It is illusory to imagine that the influence of interests can be avoided or counteracted. The realistic approach is to recognise that they are inevitable and to promote an open examination of their role.

The role of interests in maintaining the status quo on drug policies is the most intractable problem. The vested interests in legal tobacco and alcohol, like the interests in maintaining the illegality of opioids, are enormous. It usually requires a substantial social movement — such as the anti-smoking movement — to have much impact on the situation. A more flexible position would be to encourage diverse experiments and trials of various types, both in prohibition and legalisation. The lack of such experiments attests to the potency of interests supporting the status quo for each drug type.

The role of interests in obstructing the success of an opioid trial can be reduced by providing a relatively free hand to the proponents of the trial. Given the substantial hostility to opioids and to opioid users among some groups and the general environment of prohibition throughout the country, such a free hand for proponents would offer the best chance of a fair test of the benefits and costs of a change in opioid policy.

The contrary role of interests in assessing a trial could also be dealt with, either by inviting critics to run their own assessment parallel to that done by researchers, or inviting critics to join the research group carrying out the assessment.

In conclusion, interest groups will be involved at all stages of an opioid trial. Their most crucial role is in promoting or (more likely) hindering the establishment of a trial at all. They could also either facilitate or hamstring the running of a trial and affect its evaluation.

Needless to say, most individuals and groups involved in drug issues do not choose to analyse their own interests in particular conclusions or outcomes, and typically deny that they have anything but the best interests of society at heart. They are correct in this assessment, at a psychological level. It is me, the social analyst, who attributes interests to individuals and groups, and who points out that the arguments of various partisans in the debate are usually congruent with their interests. I do this to offer insight into the debate; I assume that everyone has the best of intentions.

Of course, as a social analyst, I have my own interests. I am not the best judge of this, but certainly I have an interest in providing a persuasive account of the debate which gives more than the usual small role for a social scientist as opposed to doctors, public servants, journalists and politicians.

It is worth mentioning one final influence of the role of interests on the debate about opioids. The very way that the debate is framed — most commonly, as one between prohibition and legalisation — eliminates various other perspectives.

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5: LEGAL ISSUES

Jennifer Norberry

Introduction

This paper examines the legal issues that relate to a trial of controlled availability of opioids in the ACT. Its primary concern is with heroin, because the use of that drug raises some of the most difficult problems which need to be examined in the feasibility study.

In brief, the paper discusses international treaties and Commonwealth, State and Territorial legislation which would impinge on a trial. It then examines some of the civil and criminal liability issues which need to be addressed. Possible police concerns are also raised.

International Treaties

The relevant treaties are:

. the Single Convention on Narcotic Drugs, 1961 as amended by the 1972 Protocol; and

. the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

(1) Single Convention on Narcotic Drugs, 1961

Australia ratified the Single Convention on 1 December 1967. Other countries whose drug policies may be of interest have also ratified the Convention. The United Kingdom ratified on 2 September 1964, Canada on 11 October 1961 and the Netherlands on 16 July 1965.

The Convention:

> '...replaces the eight treaties which had previously regulated international dealings in drugs. It is designed to limit the use of controlled drugs to medical and scientific purposes, by restricting the production of "narcotic drugs" to the assessed requirements of member countries and by establishing controls to eliminate diversion of legal supplies to the illicit market. The earlier system of estimates has been retained and operates under the supervision of the International Narcotics Control Board. Parties are obliged to adhere to their estimates and to provide annual reports on quantities of drugs required and used' (Royal Commission into the Non-Medical Use of Drugs South Australia 1979, p.225).

Narcotic drugs are listed in Schedules to the Convention. Schedule I includes the major opioids and, in addition, cocaine and cannabis. Schedules II and III contain less powerful opioids such as codeine. Schedule IV contains drugs regarded as having particularly dangerous properties. Drugs such as heroin, in addition to being included in Schedule I, are included in Schedule IV.

It is arguable that a trial of controlled opioid availability would be consistent with Australia's obligations under the Convention.

Article 36(1) of the Convention provides that 'subject to its constitutional limitations', each Party shall adopt measures to ensure that activities such as manufacture, possession, distribution, sale, transport, importation and exportation of drugs 'contrary to the provisions of this Convention ….. shall be punishable offences when committed intentionally ...'.

The general obligations imposed on Parties to the Convention are set out in Article 4. Article 4 provides that:

> 'The Parties shall take such legislative and administrative measures as may be necessary:
>
> (a) To give effect to and carry out the provisions of this Convention within their own territories;
>
> (b) To co-operate with other States in the execution of the provisions of this Convention; and
>
> (c) Subject to the provisions of this Convention, *to limit exclusively to medical and scientific purposes* the production, manufacture, export, import, distribution of, trade in, use and possession of drugs' (italics added).

It should be noted that Schedule IV drugs are subject to all the control measures specified in the Convention applicable to Schedule I drugs. In addition, Article 2(5) requires that:

> '(a) A Party shall adopt any special measures of control which in its opinion are necessary having regard to the particularly dangerous properties of a drug so included; and
>
> (b) A Party shall, if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare, prohibit the production, manufacture, export and import of, trade in, possession or use of any such drug except for amounts which may be necessary for medical and scientific research only, including clinical trials herewith to be conducted under or subject to the direct supervision of the Party.'

Although heroin is a Schedule IV substance, the additional controls specified in Article 2(5) are not mandatory but are to be adopted if, in the opinion of the Party, they are necessary. A further argument which could be raised is that the 'special measures of control' referred to in Article 2(5)(b) could include controlled availability of an opioid, a measure which recognises the precautions which must be used in relation to substances like heroin (D. Manderson, personal communication).

To bring a controlled availability of opioids trial within Australia's international treaty obligations it would be necessary to show that a trial was for a medical or scientific purpose.

While it is arguable that the controlled availability of opioids to drug dependent persons would not place Australia in breach of its international treaty obligations, their supply to users who are not drug dependent is more problematic for a number of reasons. These reasons are discussed in the concluding part of this section on international treaties.

(2) 1972 Protocol

Australia ratified the Protocol on 22 November 1972. The United Kingdom ratified on 20 June 1978, Canada acceded on 5 August 1976 and the Netherlands on 29 May 1987.

The 1972 Protocol provides for measures to treat and rehabilitate drug users in addition, or as an alternative to, punishment. It also contains provisions relating to the International Narcotic Control Board, and international narcotics trafficking.

(3) United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988

This treaty was ratified by Canada on 5 July 1990, signed by the United Kingdom on 20 December 1988 and signed by the Netherlands (with some reservations) on 18 January 1989.

The 1988 Convention was signed by Australia on 14 February 1989. It preserves the Single Convention.

Australian ratification awaits the enactment of associated Commonwealth and State legislation and adoption of appropriate administrative practices.

At this point, it may be useful to distinguish between signature and ratification. Australia's signature 'serves to "authenticate" the draft convention as an accurate reflection of what came out of the negotiations' (JP Fonteyne, personal communication). Ratification, on the other hand indicates a consent to be bound.

There is some controversy surrounding the scope and status of obligations arising from signature of a treaty (as against ratification). However, it is probably true to say that while a state 'should refrain from acts that are irreconcilable with the basic spirit and objectives of the relevant treaty, [it] stops significantly short of [the treaty's] provisions being, even provisionally, binding in the meantime' (JP Fonteyne, personal communication).

With respect to the 1988 Convention concern has been expressed (for example, Fox 1990) that it would seriously limit drug policy options in Australia. These concerns resulted in a number of seminars being held in this country to study the likely effects of ratification of the Convention. In Canberra a seminar convened by Justice Russell Fox and Ian Mathews was held in September 1989, and in Melbourne a seminar organised by the Victorian Drug Rehabilitation and Research Fund was held in November 1989.

Turning to the provisions of the 1988 Convention, article 3 obliges Parties to adopt such measures as are necessary to criminalise certain activities. These activities include production, manufacture, distribution, sale, importation, exportation, and possession for personal consumption of narcotic drugs and psychotropic substances '*contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention*' (italics added). (The 1971 Convention referred to is the Convention on Psychotropic Substances, which is not relevant for the purposes of this discussion.)

As we have seen, it can be argued that the Single Convention merely requires that the use of narcotic drugs is limited to medical and scientific purposes. Any additional restrictions or prohibitions on Schedule IV drugs are left to the discretion of the parties.

Some commentators have also emphasised that the 1988 Convention clearly distinguishes between trafficking and possession for personal consumption. Thus, Article 3(4)(d) provides that 'measures for treatment, education, after care, rehabilitation or social re-integration may be provided *either as an alternative* to conviction or punishment *or in addition* to conviction or punishment, regardless of how serious the possession, purchase or cultivation offence might be' (Woltring 1990, p.20) - in relation to offences of possession, purchase or cultivation for personal consumption.

(4) Conclusion

If a controlled trial of opioid availability can be regarded as a medical or scientific purpose, then it would not place Australia in breach of international treaty obligations. Indeed, reference could be made to the practice of other participating states - for example, the United Kingdom - as a guide to the interpretation of the relevant treaties, according to the Vienna Convention on the Interpretation of International Treaties (I Leader-Elliott, personal communication).

The question of who is included in a trial — drug dependent people only or non-dependent drug users as well —needs to be examined in the light of the treaties referred to above.

It may be possible to argue that a controlled availability trial involving non-dependent drug users is a medical or scientific purpose. A medical purpose might be argued if, for example, a trial was designed to reduce the risk of communicable disease transmission. A scientific purpose might be argued on the basis that the trial was an experiment, designed to test certain hypotheses, which would be rigorously controlled and evaluated.

However, the meaning of the words 'medical' and 'scientific' must be looked at in the context of the purposes of the drafters of the treaties - in other words, is such an interpretation a reasonable one? In order to assess such an interpretation, the relevant records of negotiation would need to be examined.

In addition, it is arguable that the general thrust of the Single Convention is away from 'recreational' use even where it is customary. For example, Article 49 enables the Parties to record transitional reservations in relation to such things as opium smoking and the non-medical use of cannabis. Such reservations can only be recorded in respect of traditional activities and must be phased out.

Finally, the usefulness of supply to non-dependent drug users as part of a controlled availability trial is questionable when it may be that the treaties preclude permanent supply to non-dependent users (JP Fonteyne, personal communication). Political considerations are also important here given the role of the Commonwealth in the importation, manufacture etc of opioids.

The 1961 Convention is of particular importance in determining whether a controlled availability trial would place Australia in breach of international treaty obligations. Its provisions have been described as 'regulatory as opposed to merely prohibitionist' (Woltring 1990, p. 19). The one policy option which the commentators appear to agree would not be accommodated by the Convention is that of legalisation (Woltring 1990, p. 19; Tongue 1989, p.3). (Woltring defines legalisation as 'total deregulation permitting the availability of drugs for purely recreational use', p.19.)

Woltring concluded that so long as they served a medical or scientific purpose, a number of policy options were available to the Government of a Party. These included the manufacture, trade in and distribution of heroin or cannabis either by a state enterprise or a licensed private enterprise, and supplying or dispensing 'drugs to drug abusers or AIDS/Hepatitis B risk users under appropriate programs' (p. 20).

Commonwealth Legislation

Commonwealth powers in respect to trade and commerce, and external affairs have a critical bearing on a proposed opioid availability trial.

(1) Customs legislation

(a) Customs Act 1901 (Cwlth)

The Customs Act provides that the Governor-General may, by regulation, prohibit the importation of goods into Australia (s.50(1)). Section 51(1) of the Act then provides that '[g]oods, the importation of which is prohibited under section 50, are prohibited imports'.

A variety of prohibitions may be placed on such imports. They may be absolute, they may prohibit importation in specified circumstances, from a specified place or unless specified restrictions or conditions are complied with (s.50(2)). Section 50(3) of the Act enables a system of licenses and permissions to be established by the Regulations in relation to the importation of prohibited goods.

Before referring to the importation of drugs under the Customs (Prohibited Imports) Regulations, it should be noted that the importation of a prohibited import constitutes an offence under the Customs Act. The Act creates special offences in respect of the importation of narcotic goods. These offence

provisions are contained in s.233B of the Act. 'Narcotic goods' are defined in s.4(1) as 'goods that consist of a narcotic substance'. In turn, a narcotic substance is defined as a substance or thing 'specified in column 1 of Schedule VI or any other substance or thing for the time being declared by the regulations to be a narcotic substance'. Heroin, morphine and methadone are included in column 1 of Schedule VI.

Thus, it is an offence, under s.233B, to possess a prohibited import which is a narcotic good, without reasonable excuse. Those holding licences and permits issued under the Customs (Prohibited Imports) Regulations would have such a reasonable excuse. The Regulations are discussed below.

(b) Customs (Prohibited Imports) Regulations

Until 1991 both the importation of drugs and the importation of all therapeutic substances was provided for in the Customs (Prohibited Imports) Regulations. With the commencement of the Therapeutic Goods Act 1989 (Cwlth) there is now a 'new import control regime for therapeutic substances, which has effectively been removed from Customs legislation and transferred to the Therapeutic Goods legislation (Customs (Prohibited Imports) Regulations (Amendment). Statutory Rules 1990 No. 23, Explanatory Statement. Attachment, p.1). The Therapeutic Goods Act 1989 is discussed below.

In relation to the importation of drugs, Schedules to the Customs (Prohibited Imports) Regulations designate categories of prohibited imports. The opioids, together with many other drugs, are listed in the Fourth Schedule to the Regulations. The Regulations do not treat heroin any differently to other drugs included in Schedules I or II of the Single Convention.

Regulation 5 governs the importation of drugs. Regulation 5(1) provides that the importation of drugs into Australia is prohibited except in certain circumstances. In particular, a person wishing to import a drug must obtain from the Secretary of the Department of Community Services and Health, both a licence to import drugs (r.5(1)(a)(i)) and a permission to import a drug (r.5(1)(a)(ii)). Current licensees include drug companies, universities, police and government departments.

A permission is granted in relation to a particular shipment of a drug. Before a permission is issued, a person must first be licensed to import. An application for a licence or permission to import must be made in writing to the Secretary of the Department of Community Services and Health (r.5(4)).

The Regulations (r.5(7)) provide that a licence shall not be granted unless:

. such information as is reasonably required by the Secretary of the Department of Community Services and Health is supplied by the applicant;

. the applicant is a fit and proper person to be granted a licence to import drugs;

. any agents or employees of the applicant are also fit and proper persons; and

. the premises on which the applicant proposes to keep the drugs are secure.

Regulation 5(9) provides that a number of conditions must be complied with by the licence holder. These relate to security, disposal of drugs, record keeping requirements and report making obligations.

Security precautions to ensure that 'there is no danger of loss or theft of any drug in the possession of the holder of the licence' may be specified either by the Department of Community Services and Health or the Comptroller-General of Customs.

The Regulations (r.5(10)) provide that a permission shall not be granted by the Secretary of the Department of Community Services and Health unless:

. any information reasonably required by the Secretary of the Department of Community Services and Health is provided by the applicant; and

. the applicant has made proper arrangements for the safe transportation and custody of the drug after it has been delivered for home consumption.

In addition, particular requirements must be satisfied in respect of drugs included in Schedules I and II of the Single Convention on Narcotic Drugs. Schedule I of the Convention includes heroin, morphine and methadone.

These additional requirements are set out in r.5(10(b)) and are as follows:

. where the applicant requires the drug for the manufacture of another drug, then the applicant must be the holder of a manufacturer's licence under the *Narcotic Drugs Act 1967* (Cwlth) (if applicable), and also (if applicable), the holder of a manufacturer's licence from the particular State or Territory in which the manufacturer's premises are located;

. where the applicant requires the drug for the purposes of his business as a seller or supplier of drugs, the applicant must be appropriately licensed under the relevant State or Territory law; or

. a permission may also be granted in relation to the use by the applicant of a Schedule I or II drug, if the use is for medical or scientific purposes. There is no legislative requirement that the applicant be licensed or otherwise authorised under State or Territorial law but, in practice, it is unlikely that a permit will be issued unless the licensing requirements of a particular State or Territory are complied with as, once imported, possession of the substance by the applicant would be in breach of that legislation.

Schedule I and II drugs are also subject to a requirement that a permission to import shall not specify a quantity of a drug that, together with already authorised and anticipated imports, 'exceeds the amount that, in accordance with the requirements of the Single Convention, has been determined to be the maximum amount of that drug that may be imported into Australia during the relevant year' (r.5(12)).

This estimate is determined by the Department of Community Services and Health in accordance with its obligations under the Single Convention and is notified annually to the International Narcotics Control Board (INCB). One of the purposes served by notification to the INCB is to prevent a build-up of stocks in excess of those required for medical and scientific purposes.

At present, there is no Australian estimate for heroin importation. As a result, exporting countries who are parties to the Single Convention would not export heroin to Australia. Nor could heroin be legally imported into Australia.

For heroin to be legally imported, Australia, through the Department of Community Services and Health, would have to notify the INCB of an estimate for heroin. In turn, the INCB would advise other parties to the Convention.

In keeping with Australia's Convention obligations, the heroin would have to be used for medical or scientific purposes. Although estimates of drug importations are made annually by the Department of Community Services and Health, it is possible for supplementary estimates to be notified to the International Narcotics Control Board.

(2) Manufacturing of narcotic drugs

The *Narcotic Drugs Act 1967* (Cwlth) was enacted in response to Australia's treaty obligations under the Single Convention. It enables the Minister for Community Services and Health to licence manufacturers of narcotic drugs covered by the Single Convention. The Act 'aims to ensure that licitly produced drugs for medical purposes are not leaked into the illicit trade' (Brown et al. 1990, p.1108). The Act does not treat heroin differently from the other narcotic drugs contained in the Single Convention.

Manufacturing is defined in the Act as 'the carrying out of any process by which the drug may be obtained, and includes the refining of a drug and the transformation of one drug into another drug, but does not include the separation of opium, coca leaves, cannabis or cannabis resin from the plants from which it is or they are obtained' (s.4(2)).

Manufacturers of narcotic drugs must be licensed by the Commonwealth. There may also be State or Territorial licence requirements which must be complied with.

Under the Act, a drug means any substance that is a drug for the purposes of the Single Convention and so includes heroin, morphine and methadone (s.4(1)).

The manufacture of drugs, so defined, is prohibited without a s.9 licence (s.15(1)). Under the Act, licences are granted by the Minister for Community Services and Health in respect of the manufacture of drugs at particular premises (s.9(1)).

A licence may be refused in a number of circumstances (s.9(3)). Grounds for refusal include failure by the applicant to provide information (s.9(3)(a)). A licence may also be refused if 'the Minister is of the opinion that the grant of the licence would not be consistent with the obligations of the Commonwealth under the Convention' (s.9(3)(c)).

A permit must also be obtained from the Secretary of the Department of Community Services and Health in relation to the manufacture of a particular quantity of a narcotic drug during a particular period of time (s.11(1)).

Directions with regard to the security of a manufacturer's premises and the handling of narcotic materials, may be given to licensed manufacturers by the Comptroller-General of Customs (s.12).

The Secretary of the Department of Community Services and Health may issue written directions with respect to the manufacturing or labelling of drugs (s.13).

The Act also contains record keeping, report furnishing and inspection provisions in respect of manufacturers and wholesale dealers, and offence provisions.

(3) Therapeutic Goods Act 1989 (Cwlth)

The ramifications of the Therapeutic Goods Act for a controlled availability of opioids trial need further investigation. The Act provides, 'so far as the Constitution permits, for the establishment and maintenance of a national system of controls relating to the quality, safety and efficacy of therapeutic goods that are supplied in Australia, whether those goods are produced in Australia or elsewhere, or are exported from Australia' (Australia. House of Representatives. Hansard, 5 October 1989, p.1612). The Act commenced on 15 February 1991.

The Act establishes an Australian Register of Therapeutic Goods in which therapeutic goods approved for supply are included. Special provision is made for goods not on the Register which are intended for use in clinical trials.

Generally speaking, drugs are classified as therapeutic goods under the Therapeutic Goods Act 1989 and Regulations and cannot be supplied in Australia unless they are exempt goods or they have been entered in the [Australian Register for Therapeutic Goods] (Therapeutic Goods Administration 1991, p.4). Therapeutic goods intended for use for experimental purposes in humans are exempt goods but certain conditions must be met or approvals gained before experiments (including clinical trials) can proceed.

The Therapeutic Goods Administration has an interest in new drugs and new uses for drugs already on the Register. Before approaching the Therapeutic Goods Administration for approval to conduct a clinical trial involving certain imported narcotic drugs, prior permission to import must be obtained from the Department of Community Services and Health (Ibid, Appendix 2/1).

(4) Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990 (Cwlth)

This Act has not yet been proclaimed. It is intended to make provision with respect to traffic in narcotic drugs and psychotropic substances in accordance with the 1988 Convention.

It will criminalise certain defined activities where such activities constitute an offence against a law of the Commonwealth, State or Territory, or the law of a foreign country (s.9). The Act 'is not intended to exclude or limit the operation of any other law of the Commonwealth or any law of a State or Territory'(s.5(1)). It should not affect lawful activities involving narcotic drugs.

(5) Conclusion

The role of the Commonwealth in any proposed trial is critical. In relation to a source of heroin for the trial, it controls the importation and manufacture of narcotic goods in this country. In addition, the Commonwealth has extensive powers in relation to therapeutic goods.

Offences would be committed if heroin or other narcotic drugs were to be imported, possessed or manufactured without the appropriate Commonwealth licences and permissions.

Finally, it should be remembered that if a trial were to proceed in the ACT unlawfully, then apart from legislative sanctions which already exist, the Commonwealth could legislate (for example, using its external affairs powers) to proscribe the trial and penalise its participants.

State Legislation

The information which follows describes the laws of Victoria and New South Wales in relation to the manufacturing of heroin. If it were decided to proceed with a trial using heroin manufactured in Australia these jurisdictions, especially Victoria, are the most likely source of licit heroin because of their drug manufacturing capabilities.

(1) Victoria

The *Drugs, Poisons and Controlled Substances Act 1981* (Vic) makes specific provision for the manufacture of heroin (Part III).

The Act was introduced in 1981 following the report of an Interdepartmental Working Party on the Drug Problem in Victoria (1980). The Act amended existing poisons legislation, introduced new provisions to assist in combating illicit drug trafficking and amended existing laws regarding the licit use of drugs.

According to the Second Reading Speech delivered by the then Minister for Health, Bill Borthwick:

> 'The manufacture of heroin has been prohibited in this State for nearly 30 years but it has been possible to make supplies available to medical practitioners from stock on hand where the use of the drug would be justified on medical grounds. These supplies are nearly exhausted and the quantity remaining is no longer of an acceptable medical standard.
>
> 'Following agreement between the Commonwealth and the State Ministers of Health, it is proposed to allow the manufacture in Victoria of fresh stocks of heroin for use both in this State and elsewhere in Australia under very strict controls. It is proposed to manufacture the heroin in Victoria as this State has a manufacturer with appropriate experience in the production of narcotic agents who is capable of carrying out the derivative process to recognized standards and who has the requisite security facilities to handle such a dangerous substance' (Victoria. Legislative Assembly, *Hansard*, 23 September 1981, pp.932-3). The Minister also referred to the issuing of a licence to a manufacturing chemist in order 'to authorize the conversion of the heroin into ampoules suitable for human therapeutic use as required' (Ibid, p.933).

In concluding his Second Reading Speech, the Minister referred to two Victorian companies and remarked that both were 'reputable and well experienced in the handling of narcotic drugs' (Ibid). For security reasons the Minister did not name the companies.

Section 56(1) of the Act provides that a licence to manufacture and sell or supply heroin by wholesale may be issued to a fit and proper person by the Governor in Council '[o]n the recommendation of the Minister, made after consulting with the Chief General Manager [of the Department of Health]'.

Section 56(3)provides for the issuing of a licence to formulate heroin to a fit and proper person 'on the recommendation of the Minister, made after consulting with the Chief General Manager'.

Subsections 56(7) and (8) refer to licence conditions.

The Act also specifies who may purchase or obtain heroin from a s.56(1) or (3) licensee and for what purposes. In the case of medical practitioners or pharmacists, the Chief General Manager may issue a permit in relation to 'such quantities of heroin as are specified in the permit and to use the heroin so obtained for such medicinal purposes as are specified in the permit' (s.56(9)).

Under s.56(10) a permit may be issued to a fit and proper person by the Chief General Manager in respect of 'such quantity or quantities of heroin as are specified in the permit and to use the heroin so obtained for such educational, experimental or research purposes and at such university or other institutions as are specified in the permit.'

Section 56(12) provides for the issuing of permit conditions.

It should be noted that in s.57(14) a number of offences are created. They include:

(a) licence holders who sell or supply heroin 'to a person other than a person permitted under this section to purchase or obtain heroin or otherwise in accordance with any permit granted under this section';

(b) a licensee who manufactures or formulates heroin 'otherwise than in accordance with a licence'.

Penalties are also provided.

(2) New South Wales

It may be possible for heroin to be manufactured in New South Wales. The relevant legislation is the *Drug Misuse and Trafficking Act 1985* (NSW), the *Poisons Act 1966* (NSW) and the Poisons Regulations.

Heroin is listed as a prohibited drug in Schedule 1 to the Drug Misuse and Trafficking Act. Section 24(1) of the Act provides that 'a person who manufactures or produces, or who knowingly takes part in the manufacture or production of, a prohibited drug is guilty of an offence'. An exception is provided in s.24(4)(a) in relation to a person licensed or authorised under the Poisons Act. A further exception is found in s.24(4)(b) and relates to a person acting in accordance with an authority granted by the Secretary of the Department of Health 'where the Secretary is satisfied that the manufacture or production of the prohibited drug is for the purpose of scientific research, instruction, analysis or study'.

In relation to s.24(4)(a), there appears to be no provision in the poisons legislation for the manufacture of heroin, which does not appear in any of the Schedules to the NSW Poisons List. However, it may be possible to lawfully manufacture heroin in New South Wales using s.24(4)(b) if the requisite authority were to be provided by the Secretary of the Department of Health, in relation to scientific research etc.

(3) Conclusion

If it were decided to proceed with a trial involving heroin manufactured in Australia, then it appears that Victoria is the most likely source of licit supply.

The approvals specified in the Drugs, Poisons and Crontrolled Substances Act would need to be obtained. In addition, a Victorian manufacturer would need the appropriate Commonwealth licences and permissions (see above).

The Second Reading Speech referred to above, refers to Commonwealth and State discussions about the manufacture of heroin in Victoria for distribution to other States. Information provided by Desmond Manderson indicates that the relevant documents may be housed in the Public Records Office in Victoria in Department of Public Health files.

ACT Leglisation

(1) Drugs of Dependence Act 1989 (ACT)

This legislation replaced major parts of the then Poisons and Narcotic Drugs Ordinance 1978, Poisons and Dangerous Drugs Ordinance 1933 and the Poisons Regulations (Explanatory Statement 1989, p.1).

It was proposed as model legislation following an agreement at the 1985 Drug Summit that 'there should be uniformity of approach among jurisdictions on legislation governing drugs of dependence and broad consistency on key issues such as the scheduling of drugs, the thrust of offences and penalties' (Ibid).

The Act covers both prohibited substances and drugs of dependence. Prohibited substances are specified in Schedule 2 of the Act and include heroin, cannabis and LSD. Drugs of dependence, listed in Schedule 1, include morphine and methadone.

The rationale for the distinction between prohibited substances and drugs of dependence is found in the Explanatory Statement and is that prohibited substances 'do not have a medical use and are harmful when used for recreational purposes' (p.4).

The Act covers a wide range of matters including the licensing of manufacturers and wholesalers, standards for the safekeeping, monitoring and recording of the lawful use of drugs of dependence, requirements for the ordering, delivery, requisition and prescription of drugs of dependence, and offences in relation to manufacturing, cultivation and supply of drugs of dependence and prohibited substances. The Act also provides for the establishment of treatment assessment panels, the referral of offenders to approved treatment centres by the courts, and the supply of clean syringes to intravenous drug users.

In this section, reference will be made to morphine and methadone, as well as to heroin. As heroin is dealt with quite differently from drugs of dependence such as morphine and methadone, it will be considered separately from them.

(a) Heroin

In relation to the possession, administration etc of heroin, the offence provisions contained in Part X of the Act are relevant. Broadly speaking they proscribe:

. manufacture (s.161(2));
. wholesale (s.163(2);
. sale or supply (s.164(3);
. advertising (s.166);
. false representation (s.168);
. possession and administration (s.171);

of a prohibited substance.

Penalties are provided in each of the above sections.

Statutory exemptions are provided in relation to some of the activities mentioned above. Some of these exemptions relate to authorised research personnel.

In Part IV of the Act, provision is made for research, education and first aid (a more detailed discussion of Part IV appears below). Section 32(1) provides, among other things, that a person who proposes to conduct a program of research that would require the possession or use by that person of a prohibited substance may apply to the ACT Board of Health for an authorisation in relation to the substance.

However, the offence provisions of the Act preclude the involvement of human participants in research involving prohibited substances.

Subsection 164(5) exempts an authorised researcher from the offence provisions relating to the supply of a prohibited substance (although not their sale). Authorised researchers are also provided with an exemption with reference to possession in s.171(4)(a).

However, there is no exemption in relation to the administration of a prohibited substance. Section 171(3) provides that a person 'shall not administer, or cause to be administered, a prohibited substance to another person'. Thus, an authorised researcher could not lawfully administer a prohibited substance to a trial subject. Further, there is no exemption to the prohibition contained in s.171(2) on the self-administration of a prohibited substance. In other words, a human subject in an authorised research program cannot lawfully administer a prohibited substance to himself or herself.

In relation to drugs of dependence such as morphine and methadone, supply is premitted (in certain circumstances) on prescription. It is not possible to lawfully prescribe heroin in the ACT.

(b) Morphine or methadone

The Drugs of Dependence Act contains provisions relating to research involving drugs of dependence, and the supply on prescription of drugs of dependence, which include morphine and methadone.

- research

Part IV of the Act covers research, education and first aid. Section 32(1) provides that a person may apply for an authorisation to use a drug of dependence in a program of research or education.

In granting an authorisation for research, the Board must be satisfied, among other things, that 'the research is to be conducted at, or under the auspices of, a recognised research institution' (s.33(1)(e)).

The Act defines a 'recognised research institution' as a 'recognised educational institution or the Commonwealth Scientific and Industrial Research Organisation' (s.31). In turn, a 'recognised educational institution' means 'the [ACT] Board [of Health], the Australian National University or the University of Canberra'.

Paragraph 32(2) of the Act contains detailed provisions about what must be provided in an application to the Board. In particular, the application must:

. be in writing and signed by the applicant;

. provide the name, address, and academic, professional or other qualifications of the applicant;

. contain details of the strength or form in which the drug is to be possessed and used, the maximum quantity to be possessed at any one time, and the total quantity to be possessed during the period of the program;

. provide details about how the drug would be used;

. specify the institution where the program is to be conducted;

. contain specified information about any other person under whose supervision the trial would be conducted; and

. detail proposed security arrangements.

In addition, under s.32(2)(c), the application must be accompanied by:

. a written description of the program, including its estimated duration;

. a clinical trial protocol - in the case of a program of research;

. a written statement approving the program signed by the person in charge of the institution; and

. the determined fee.

Section 33 provides that the Board must be satisfied of a number of matters before granting an authorisation. It also specifies what an authorisation will include. In particular an authorisation may specify conditions. Section 34 provides that such conditions will be those 'necessary and reasonable' for ensuring proper use and safe-keeping of drugs or substances, and proper record keeping, use and disposal for drugs or substances.

There are few research programs in operation in the ACT. According to the 1989-90 *Report on the Operation of the Drugs of Dependence Act 1989*, made under s.202 of the Act:

> 'Five persons were authorised to carry out research programs underÉ[Part IV] of the Act. Three of the research programs were medically based and conducted at the John Curtin School of Medical Research in conjunction with the Department of Medicine and Clinical Science at the Australian National University. One of the remaining programs was carried out at the Commonwealth Scientific and Industrial Research Organisation Division of Plant Industry and the other at the Australian National University Research School of Chemistry.'

It is understood that none of these programs involved human participants.

The following offence provisions contained in the Act are relevant to an authorised research program involving drugs of dependence:

. **possession**. Section 169(1) prohibits the possession of a drug of dependence. Certain exempt persons are defined in s.160(1) and include a person who is authorised under the research provisions to possess a 'quantity of a drug of dependence for the purposes of a program of research...';

. **self-administration**. Section 169(2) provides that a person 'shall not administer, or cause or permit to be administered, to himself or herself a drug of dependence'. This sub-section incriminates a person who administers a drug of dependence to himself or herself, or who permits another person to administer a drug of dependence to himself or herself.

. **administration**. Section 169(4) relates to the administration of a drug of dependence 'to another person'. Exemptions to the prohibition on administration of a drug of dependence to another person include 'a person authorised under Part IV, Division 1 to administer the quantity in question of the relevant drug' (s.170(3)(d)).

- supply on prescription

Before examining in detail the supply on prescription provisions of the Act, it should be noted that s.77 prohibits and penalises the supply of a drug of dependence otherwise than on an order, requisition or prescription. It is prescription which is relevant for the purposes of this discussion.

The supply on prescription provisions of the Act are contained in Part VI. Part VI provides procedures to regulate the prescription, requisition, supply and administration of drugs of dependence.

In general, only a medical practitioner or, in some circumstances, an intern may prescribe a drug of dependence to a person (s.57). The written approval of the Medical Officer of Health must first be obtained before a medical practitioner can prescribe a drug of dependence to a person who he or she believes on reasonable grounds to be drug dependent. Failure to obtain such approval attracts a penalty of $2000 or 12 months imprisonment or both (s.58). In certain circumstances, the Medical Officer of Health must refer the application to the Drugs Advisory Committee (s.69(2)).

Except in the case of methadone, the prescription of drugs of dependence is allowed only 'for the treatment of a person's mental or physical condition' (s.58(1)(b)). According to the Explanatory Statement for the Act, '[t]here are many circumstances where drug dependent people require the administration of other drugs of dependence for medical purposes'(p.10).

However, drug dependency itself is not a 'mental or physical condition'. These terms are defined in s.3(1) of the Act:

> • '"Mental condition" does not include drug dependence';
>
> • '"Physical condition" means -
> (a) a physical disease, illness, ailment, defect or injury;
>
> (b) pregnancy; or
>
> (c) a physical state which may be changed by surgery in the course of professional medical practice;
>
> but does not include drug dependence'.

Thus, it is not possible to prescribe a drug of dependence in the ACT, except in the case of methadone, for the treatment of drug dependence. Where methadone is prescribed for the treatment of a person's drug dependence, the prescription must be approved in writing by the Medical Officer of Health and the treatment must be provided at a methadone program treatment centre (s.59).

(2) Public Health Act 1928 (ACT) and Public Health (Infectious and Notifiable Diseases) Regulations

This legislation may be relevant if trial participants were to be tested for notifiable diseases by trial personnel as part of a controlled availability study.

Certain notification obligations are contained in the *Public Health Act 1928* (ACT) and the Public Health (Infectious and Notifiable Diseases) Regulations. The obligations are placed on medical practitioners, among others. Regulation 4 provides that a medical practitioner who has reason to believe that a person professionally attended by him or her is or may be suffering from a notifiable disease must notify the Medical Officer of Health.

The Regulations also impose notification obligations on pathologists who test a specimen for the purpose of ascertaining whether a person is suffering from an infectious or notifiable disease. Notifiable diseases include AIDS.

(3) Motor Traffic (Alcohol and Drugs) Act 1977 (ACT)

It is an offence to drive a motor vehicle while under the influence of alcohol or a drug 'to such an extent as to be incapable of having proper control of the motor vehicle'.

This offence has ramifications for the design of the trial, for trial participants and for trial personnel.

With regard to trial personnel, s.345 of the Crimes Act, 1900 (NSW) as it applies in the ACT, creates an offence in respect of a person who 'aids, abets, counsels or procures, or by act or omission is in any way directly or indirectly knowingly concerned in, or party to, the commission of an offence under a law of the Territory'.

The majority of the High Court of Australia in *Giorgianni v. The Queen* (1985) 156 CLR 473 decided that 'liability for complicity requires knowledge of the essential matters constituting the principal offence and that recklessness, wilful blindness, or negligence is insufficient' (Fisse 1990, p.331). The majority also held that the alleged accomplice must intend the commission of the offence by the principal offender.

While there is little case law on the meaning of the words 'knowingly concerned' which appear in s.345 (as opposed to case law on the meaning of 'intention'), 'the same sort of limit probably applies. One is not "concerned" in a crime unless it is one's purpose or intention that it be committed' (I. Leader-Elliott, personal communication).

Prior to *Giorgianni*, '[l]iability as an accessory before the fact has typically been imposedÉon the basis of foresight or knowledge of probability' (Fisse, p.332). The case thus severely restricts the scope of liability for complicity. However, the question must still be asked - in what circumstances would trial personnel be liable as aiders and abetters, even under the restricted test in *Giorgianni*, in respect of driving offences committed by trial participants? For example, would trial personnel face charges in respect of a trial subject who drove himself or herself to a clinic in order to receive an opioid and who then drove himself or herself away while under the influence of that drug and while incapable of exercising proper control over the motor vehicle?

In assessing the potential impact of s.345 on trial personnel, consideration would have to be given to the pharmacological effects of a substance like heroin and the design of a trial so that any harmful effects on driving skills could be minimised. Note also that the offence contained in the Motor Traffic (Alcohol and Drugs) Act relates to 'driving to such an extent as to be incapable of having proper control of the motor vehicle'. Recourse could also be had to the type of statutory exemption clauses contained in s.93 of the *Drugs of Dependence Act 1989* (ACT) which is discussed below.

(4) Poisons and Drugs Act 1978 (ACT)

The Poisons and Drugs Act has some residual effect with respect to narcotic drugs. Provisions relating to labelling and containers are relevant to drugs of dependence. However, they do not apply in respect of drugs supplied by a pharmacist on a prescription from a medical practitioner. In this case, simplified labelling provisions apply.

(5) Manufacture of heroin in the ACT

ACT legislation currently prohibits the manufacture of prohibited substances in the Territory.

Suggestions have been made about the use, in a trial, of illicit heroin which has been seized in the ACT. A number of considerations would impact on the use of such heroin (assuming of course that sufficient quantities of seized illicit heroin were available). In particular, the heroin would need to be purified - this would involve manufacturing.

Thus, the following matters need to be considered. First, a Commonwealth manufacturing licence and permission would be required. Second, an amendment would be needed to current ACT law to enable lawful manufacture (although query whether the Commonwealth Narcotic Drugs Act could be used to override ACT legislation). Third, the legal status of that heroin would need to be taken into consideration. Rinaldi states that '[p]roscribed narcotics forever carry with them the indelible mark of being "prohibited imports" so the mere fact that police have taken charge of an actual parcel of narcotics cannot rob that parcel of the status of being prohibited imports, a point stressed by the Court of Criminal Appeal, New South Wales in *Chow* (1987) 11 NSWLR 561 at 568' (Rinaldi & Gillies 1991, p.16).

The question which arises here is the potential exposure to liability under the Customs Act, of those involved in the use of prohibited imports. However, it may be that if a trial was otherwise approved, possession of seized and purified heroin would come under the 'reasonable excuse' provisions of Customs legislation (I. Leader-Elliott, personal communication).

Heroin can be manufactured from morphine, so once again it might be possible to manufacture in the ACT given the requisite licences and permissions from the Commonwealth, and amendments to Territorial legislation. The manufacture of heroin always involves concerns about security. Establishing a properly secured manufacturing site may involve its own logistical and financial problems.

(6) Conclusion

(a) heroin

Under present ACT legislation, it is not lawful to administer heroin in an authorised research program to a human subject. Nor is it lawful to provide heroin on prescription.

(b) morphine and methadone

Subject to the requisite authorisation being issued under Part IV of the Act, an authorised researcher could lawfully administer morphine or methadone to a human subject. However, the position of the human subject in relation to criminal sanctions is problematic. There are exemptions in respect of possession, self-administration and permitting another person to administer in relation to persons 'for the treatment of whomÉthe quantity of the relevant drug has been lawfully prescribed or supplied'. There are no specific exemptions in respect of participants in an authorised research program.

It is not lawful to prescribe morphine as a treatment for drug dependence. The conditions under which methadone may be prescribed are detailed above.

There are a number of approaches which could be adopted in order to carry out a trial of controlled opioid availability in the ACT:

(a) non-enforcement agreement

Because of the applicability of both Commonwealth and Territorial laws, an agreement would have to be reached with the Commonwealth, ACT (and perhaps also with State governments), and a range of agencies including the Australian Federal Police, the Director of Public Prosecutions and the ACT Board of Health (assuming, of course, that a supply of heroin could be obtained).

The advantage of such a course is that it obviates the need for statutory amendments in the ACT. On the other hand, principles of criminal justice militate against such an approach. It denies all those involved their rights to the sure and adequate protection of the law. The uncertainties of this approach, the potential for things to 'go wrong', and the possibility that all or any of the parties could revoke their agreement should be considered.

(b) amendments to existing Territorial legislation

Amendments could be made to existing ACT legislation to enable opioids to be provided under the research provisions of the Drugs of Dependence Act, under the supply on prescription provisions, or in a detailed omnibus provision inserted into the Act establishing the trial, 'Notwithstanding anything in this Act (or other Act)'.

The amendments needed would depend on which of these routes were to be taken, what opioid was involved, the way in which it was proposed to conduct the trial, and how the opioid involved was to be obtained.

Apart from appropriate amendments to the offence provisions mentioned above, consideration would need to be given to other provisions such as those relating to manufacturing, wholesaling, orders and delivery, storage and record keeping and their related offence provisions if, for example, heroin were to be used in a trial. The Act also contains secrecy provisions in Part XIII which should be examined.

It is useful to mention two other sections of the Drugs of Dependence Act. Once again, depending on the way in which the trial was established and designed, it may be necessary to amend sections 166 and 168 of the Drugs of Dependence Act. Section 166 relates to the advertising of drugs of dependence or prohibited substances. It prohibits the publication or display of an advertisement that 'promotes or encourages the use of a drug of dependence or prohibited substance', or 'indicates that a person, or any other person, is willing or authorised to sell or supply a drug of dependence or prohibited substance'. The penalty is $5000 or 2 years imprisonment or both. This provision would, for example, prohibit advertising for trial participants.

Section 168 makes it an offence for a person 'knowing that a substance is not a drug of dependence or prohibited substance, [to] sell or supply that substance to another person as a drug of dependence or prohibited substance'. The penalty is identical to that provided in s.166. This section would be relevant if it were decided to use placebos in the trial.

Consideration should be given to including a sunset clause with any such amendments.

(c) special legislation

An alternative legislative approach would be to enact special legislation to set up the trial, perhaps once again including a sunset clause.

The Act would need to override other relevant pieces of Territorial legislation. Its provisions would depend, once again, on matters such as the opioids to be used, the design of the trial and whether the opioids were to be manufactured etc in the ACT. The need for statutory exemptions relating to criminal or civil liability are discussed below.

Civil Liability and Other Issues

(1) Liability in Tort

The tort of negligence is discussed below.

Liability in negligence does not flow from every occurrence of injury or loss. There are three basic requirements in an action for negligence. They are:

. the existence of a duty of care owed by the defendant to the plaintiff;

. a breach of the duty owed by the defendant; and

. the suffering of damage by the plaintiff as result of the defendant's breach. The damage must not be too remote in law.

The concept of foreseeability is associated with all the three requirements mentioned above. Thus, if the plaintiff:

> 'was within the range of reasonable foresight this creates a relationship of neighbourhood or proximity between him and the defendant which gives rise to a duty on the part of the defendant to take care not to injure the plaintiffÉBreach of duty, or negligence, consists of failure to take reasonable precautions to guard against reasonably foreseeable and not insignificant risks of injury to the plaintiff. Whether the risk is significant or not is judged by weighing in the balance four factors: the likelihood of the risk materializing; the likely seriousness of its consequences if it does; the cost of guarding against it; and the social utility of the defendant's activity. The test of whether damage caused by negligence is too remote in law is basically whether it is a reasonably foreseeable consequence of the defendant's negligence,

> although there are qualifications to this principle which allow recovery for unforeseeable damage in many circumstances' (Trindade & Cane 1985, pp.279-80).

In discussing the potential for liability which might arise from a controlled availability of opioids trial, a useful paradigm is the duties owed by medical practitioners to their patients. Some reference will also be made to the duties of medical researchers, although there appears to be little Australian or English case law involving such researchers.

(a) trial participants

Applying the principles referred to above, duties of care would be owed to trial participants.

(b) third parties

In addition to duties that may be owed to trial participants, duties may be owed to third parties. If the tests of negligence are met, a person other than a trial subject could succeed in an action for negligence. Employment-related injuries and motor vehicle accidents involving third parties are examples.

Some examples of potential medical negligence situations might be instructive. In relation to medical negligence, it is possible that a doctor treating a patient with a contagious disease could owe a duty of care to those that he or she can reasonably foresee might be infected by the patient. A doctor who negligently certifies that an insane and dangerous person need no longer be kept confined may owe a duty of care to those he or she can reasonably foresee might be harmed by that person.

In relation to third parties, mention is often made of a duty to warn. However, it should be stressed that the existence and content of such a duty is far from settled in Australia. In the case of medical practitioners it must also be balanced against their duty of confidence, breach of which could give rise to an action for breach of confidence.

Tarasoff v Regents of the University of California (551 P2d 334 (1976)) is an oft cited United States case, although it has no binding effect in Australia. This was a case where the United States Supreme Court took the view that a 'psychologist who was aware, or who should have been aware that a patient presented a serious risk of danger to another, had a duty to take reasonable care to protect the victim. Depending on the circumstances this duty could be discharged by warning the victim, notifying the police, or confining the patient' (Neave 1978, p.26).

The case of third parties, such as foetuses born alive, is considered separately below.

(c) prenatal injuries

Once born, the law recognises that a foetus has its own rights which may be sued upon. Courts have held that medical practitioners owe a duty of care not only to their pregnant patients but also to the foetus. In the case of a controlled availability of opioids trial, damage to the foetus could include being born drug-dependent.

A duty of care will also apply to a child not conceived at the time of the negligent act. The recent NSW case of *X & Y (by her Tutor) v Pal* (Supreme Court of NSW, Court of Appeal, 3 May 1991) is an example. The facts of the case were as follows:

> 'Upon becoming pregnant X consulted Dr. P. He negligently failed to submit her for syphilis screening. The child was duly born deformed and shortly thereafter died. X become pregnant again and consulted Drs G & H. Both of them negligently failed to submit her for syphilis screening. Unknown to the doctors and herself X had syphilis. Y was born in a deformed condition and was found to be infected with syphilis' (ibid, p. 2054).

Two issues were before the NSW Court of Appeal. The first was whether Y was entitled to damages from Dr P even though Y was not conceived at the time of the tort. The second was whether Y's

deformities were caused by the syphilis. Although the second claim failed, the court did hold that Y was entitled to maintain a claim in negligence against Dr P (Ibid).

(d) injuries or loss occurring after the trial has finished

If the tests for negligence have been satisfied, then it is possible for an action for negligence taken after the trial has finished to succeed. While limitation statutes generally require legal actions to be commenced within a certain time, time commences running when the injury occurs, rather than when the breach of duty took place.

(e) failure to admit to the trial

Questions have been raised about liability for injury or loss suffered by a drug user (or even another person affected by the activities of that drug user) where admission to an opioid availability trial is refused.

The law is generally hesitant about imposing duties of affirmative action. Trindade and Cane explain the position with relation to omissions in the following way:

> 'Although a defendant can be held liable in the tort of negligence for both acting (misfeasance) and failing to act (nonfeasance), it is not every omission which gives rise to liability. ÉNegligent omissions in the course of an activity are treated in the same way as negligent actions. Mere omissions are not actionable unless the defendant was under some pre-existing positive duty to act' (p.305).

There are a number of reasons for such an approach, including the problems which would arise if there were a general duty to control the actions of others, especially where there was no existing relationship between the parties. Establishing causation is another difficulty (Ibid, p.306).

As examples, in the decided cases doctors have been held not to be liable in refusing aid to a stranger even in an emergency and, it has been held, that 'a good swimmer on the beach is free to ignore the call for help from someone in danger of drowning' (Fleming 1987, p.135).

(2) Consents to procedures and informed consent

The need for a valid consent arises in medical treatment and in medical research. Failure to obtain a valid prior consent from a patient could result, in appropriate circumstances, in actions for negligence or trespass.

Dix et al (1988) state that, to be effective, a consent must:

> '(1) be freely and voluntarily given;
>
> (2) cover the procedure to be performed;
>
> (3) be given by a patient who is competent (capable) of consenting;
>
> (4) be informed to some degree' (p.84).

Note that factors which may vitiate a patient's consent include being under the influence of drugs.

In (4) above, Dix states that an effective consent must 'be informed to some degree' (Ibid). The legal status of the doctrine of informed consent is not clear in Australia. However, some informational basis is required for a valid consent and, as mentioned above 'a practitioner Éremains potentially liable in either trespass or negligence if he fails to obtain the consent of a competent patient prior to undertaking a medical procedure' (Ibid, p.92). Information provided may include disclosure of any inherent risks in a procedure.

In respect of a doctor-patient relationship, it seems that sufficient information should be provided to a patient, so that a rational decision can be made by that patient in respect of the treatment.

There are few decided cases where consent in medical research or experimentation has been at issue. However, according to Dix et al., 'The Nuremburg Code of 1948 would impose an ethical obligation upon the researcher, as against the medical practitioner, to obtain the free and informed consent of the subject. However, the actual content of that obligation is unclear' (Ibid p.99). The extent of the information necessary to satisfy any obligation may also depend upon whether the case is one of pure experimentation or experimental procedures which are part of a patient's therapeutic regime (Ibid).

Irrespective of how a controlled availability trial was to be categorised, it would be necessary to obtain a valid consent from trial participants, including their specific consent to any experimental part of treatment administered to them (Ibid).

(3) Confidentiality

The *Privacy Act 1988* (Cwlth) will be involved where medical research is carried out by a Commonwealth instrumentality or where it involves personal information held by a Commonwealth instrumentality.

The Privacy Commissioner has approved *Guidelines for the Protection of Privacy in the Conduct of Medical Research* under s.95 of the Privacy Act. The Guidelines were in force until 30 June 1991 and relate to medical research involving any aspect of health. Epidemiological research is also covered. New draft guidelines have been submitted to the Privacy Commissioner for approval.

In relation to medical research involving personal information held by a Commonwealth instrumentality, the Guidelines recommend that the agency first attempt to avail itself of the provisions in the Act allowing 'the release of personal information in certain circumstances which could include medical research' (p.9). If this is not possible, then it is recommended that the Guidelines should be used in order to avoid breaching the Information Privacy Principles.

In the case of medical research being conducted by a Commonwealth agency, the Guidelines recommend the research be conducted in conformity with the Information Privacy Principles, a Public Interest Determination or the Guidelines (p.10).

Once again, with regard to a trial being undertaken by or on behalf of the Commonwealth, the *Epidemiological Studies (Confidentiality) Act 1981* (Cwlth) would be relevant if the trial were to be approved under Regulations to the Act. In addition to prohibiting the disclosure of identifying information obtained in the course of the study, the Act also confers legal privilege on those involved in the study against disclosure of information acquired in the course of the study.

If a trial were to be established under the auspices of a Territorial authority, the Privacy Act would still apply in relation to personal information sought from a Commonwealth agency.

Confidentiality is an important issue. It relates to the storage and use of personal information about trial participants - its use by trial personnel, the potential for actions for breach of confidence, and the potential for information to be used by the police and the courts. The very nature of a controlled availability of opioids trial means that mere disclosure of a subject's involvement in the trial may have adverse consequences for that person. In addition, information about the activities of trial participants might be used in legal proceedings against them. Legal action might involve not only criminal proceedings, but the use of information in family court matters, for example, where custody or access is at issue. On the other hand, there may be legitimate public and law enforcement interests involved in the disclosure of certain information. The likely concerns of the police are discussed below.

Consideration should be given to the following options (subject, of course, to any applicable requirements under the Privacy Act or the Epidemiological Studies (Confidentiality) Act):

. obtaining consents from trial participants;

. the use of waivers;

. appropriate security in relation to the storage and access of information collected;

. statutory limits on disclosure and the imposition of penalties for breach;

. the granting of legal privilege against disclosure to trial personnel; and

. provision for withdrawal of consent and the destruction of records where a subject withdraws from the trial.

Suggestions have been made that ACT legislation be enacted along the lines of the Epidemiological Studies (Confidentiality) Act.

(4) Minors

Once again, a useful paradigm is medical treatment or contraceptive advice. Legally speaking, the consent of a parent or guardian is a prerequisite to the treatment of a person below the age of 18 years.

However, according to Dix et al. (1988) 'Éthe common law recognises thatÉ[a minor]Émay have the capacity to consent on his own behalf. This exception will apply if the minor has sufficient capacity to understand the nature and effect of the procedures involved. However, the procedures must be for the therapeutic good of the minor and not be of a serious nature' (p. 86). Caution must be exercised.

(5) Conclusions

There are a number of approaches which could be taken with a view to minimising or excluding the potential for civil liability.

- consents

While consent can be given verbally or inferred, a properly worded consent form should be drafted, a careful explanation given to trial participants, and their signature obtained. In obtaining the consent, the requirement of a competent signatory must be remembered.

Where medical treatment is involved, pro forma consent forms are often used in an attempt to provide some protection against liability. Such consent forms often contain little information and do not provide details about the particular procedure being undertaken. As such, they provide little protection against actions in negligence (Ibid p.106).

Their 'utility may be limited both by the words used in the form and by the procedures adopted in securing the consent and signature of the patient' (Ibid p.105). In addition, it is likely that any ambiguity in the consent form will be construed against the defendant in legal proceedings.

- waivers

In a waiver, a person foregos his or her rights of legal action in respect of loss or damage suffered. A waiver should be obtained prior to the relevant procedure occurring and should be in writing.

In relation to waivers, a number of matters must be kept in mind. First, a waiver will only result in the signatory foregoing his or her rights. It will not bind third parties. Second, the courts are likely to read a waiver strictly, construing ambiguities or uncertainties against the defendant. Thus, in an appropriate case, a waiver may not protect a defendant in an action in negligence. Third, it could be argued by a defendant that their drug dependence meant that there was no real intent to assume the risk and waive rights.

- statutory exemption clauses

Statutory exemption clauses are sometimes used to exempt persons acting under the legislation from civil and/or criminal liability for their actions. Appropriately worded, such clauses will cover third parties. Once again, a number of points need to be raised. First, the courts are likely to interpret such clauses strictly and so exclude, for example, negligent actions. Second, there is the public policy question of whether trial participants and, particularly the public in general, should have their rights

abridged in this way. While this paper is concerned only with legal issues, the likely public response to legislation relating to a controlled opioid availability trial which sought to abridge or abolish rights to legal action should be taken into account.

In the case of a statutory exemption from liability in legislation containing a sunset clause, provision would have to be made to allow the exemption provision and any other relevant machinery provisions to continue after the sunset clause came into operation.

- selection of trial participants

Careful consideration needs to be given to the inclusion of pregnant women in the trial in the light of the discussion on negligence above, and particular caution should be exercised in relation to minors.

- confidentiality

Consideration must be given to the protection of confidentiality. In addition to the matters mentioned above, the possible concerns of the police (addressed below) should inform decision making.

Criminal Liability

(1) General

The subject of criminal liability is important in two respects. The first relates to the possible liability of trial participants and trial personnel under ACT criminal law. The second relates to liability under the criminal law of other jurisdictions.

In relation to the first matter there was, at one time in the ACT, an offence of misprision of a felony. It arose where a person, having information about the commission of a serious crime, failed to disclose that knowledge to the relevant authorities. This offence no longer exists in the ACT.

In relation to the provision of a substance like heroin to a trial subject, present ACT law proscribes such activities and, as has been discussed, would need amendment in order to protect trial personnel and trial participants from criminal liability in respect of activities authorised by the trial.

In relation to the aiding and abetting etc. of ACT offences, consideration should be given to providing statutory exemptions for trial personnel in respect of authorised activities associated with the trial. Such exemptions, in specified circumstances, are provided in s.93 of the Drugs of Dependence Act in relation to persons authorised to distribute syringes. The exemption contained in s.93 relates to Part VIII of the Crimes Act. Part VIII is concerned with offences such as aiding and abetting, attempts, incitement and conspiracy.

In relation to the law of other jurisdictions, a number of matters need to be considered. These matters are of particular importance because the ACT is surrounded by NSW, and because narcotics offences exist in every Australian jurisdiction. For convenience, particular reference will be made to NSW.

The general principle of the criminal law is that it does not operate extraterritorially. 'The general rule is that the criminal law of a jurisdiction applies to all crimes committed within that jurisdiction regardless of the nationality of the alleged offender. The second arm of the territorial ambit rule is that in most circumstances the criminal law of a particular jurisdiction does not have extra-territorial effect' (Bates et al 1979, p.130).

While, for example, the lawful manufacture of heroin in the ACT would not be a matter over which NSW courts have jurisdiction, difficult questions arise in respect of offences such as aiding and abetting the commission of offences in NSW.

These questions relate, for example, to the lawful supply of heroin in the ACT to a person who takes it into NSW, and to the administration of heroin in the ACT to a person who then crosses into NSW. In these circumstances, the question to be addressed is whether trial personnel aided and abetted the commission of a NSW offence.

Once again, reference must be made to *Giorgianni* and the elements of such offences (see above). The question of trial personnel being charged for aiding and abetting a NSW offence is a difficult one which needs further research.

Strategies designed to protect trial personnel from being prosecuted in the courts of other jurisdictions should be examined. Depending on the design of the trial, these could include having trial participants provide a written undertaking not to dispose of heroin in any way or from going into NSW while participating in the trial (P. Waight, personal communication). In addition, consideration could also be given to entering into arrangements with State governments not to prosecute trial personnel for aiding and abetting or similar offences.

The possibility of criminal liability also needs to be examined in the context of trial personnel entering another jurisdiction, such as NSW, in possession of a substance like heroin, and administering it or supplying it for the purposes of an ACT trial. A lawful trial in the ACT will not make lawful, related activities which occur in other jurisdictions.

Once again, with reference to NSW, trial personnel should not enter New South Wales in order to administer, or dispense heroin or otherwise make it available. Similarly, trial participants should not cross borders with an opioid in their possession or after having an opioid administered to them. This has implications for the involvement of NSW residents in any trial. ACT residents should also be warned about crossing into New South Wales or other jurisdictions in similar circumstances.

As mentioned previously, all jurisdictions have narcotic offences on their statute books. Using New South Wales as an example, these offences, under the *Drug Misuse and Trafficking Act 1985* (NSW), include supplying (and selling), possessing and administering.

If a trial were to go ahead, and opioids manufactured in Victoria for use in the ACT, the position of a person transporting the goods through New South Wales would also need to be examined. One practical way of overcoming any difficulty here would be to send the opioids by air (subject, of course, to approval by the Commonwealth or Victorian governments).

(2) Conclusion

Both trial participants and trial personnel should be aware of the potential for exposure to criminal liability if they enter other jurisdictions, for example, New South Wales with substances such as heroin.

In addition, further research is needed into the liability for aiding and abetting criminal offences under the laws of other jurisdictions by trial personnel who supply or administer to persons who then go interstate. Further, the position of a person bringing heroin lawfully manufactured in Victoria through NSW needs to be examined.

In relation to activities within the ACT, it may be necessary to provide statutory exemptions for trial personnel in relation to criminal offences. As stated previously, such exemptions are provided in s.93 of the Drugs of Dependence Act in relation to persons authorised to distribute syringes. The exemption is in relation to Part VIII of the Crimes Act, the Part which relates to aiding and abetting, attempts, incitement and conspiracy etc.

Police Concerns

The concerns of the police need to be addressed. They relate to the feasibility of a trial, and the design and implementation of any trial.

Their concerns may include the following:

- the entry into the ACT of drug users hoping to be included in the trial, whether or not those expectations are realistic ones;

- the possibility of an increase in drug-related crime in the ACT - for example, if drug users came into the ACT, were not accepted onto the trial and remained in the Territory;

- the possible involvement of organised crime in opioids diverted from the trial, or in marketing opioids claimed to be obtained from trial supplies. Such opioids might be regarded as desirable because of superior quality;

- the possibility of diversion of opioids by trial participants if, for example, the opioids were obtained on prescription by trial participants, or given to trial participants to 'take away'. There is also the possibility of diversion as a result of oral administration of a drug;

- the possibility of trafficking by trial personnel. Should security checks of trial personnel be implemented and, if so, what should they encompass. Security measures and record keeping procedures at any point of administration or distribution would need to be stringent;

- the possible increase in break and enters, and armed robberies in attempts to obtain opioids. Stringent security procedures would need to be designed and implemented in regard to transportation and storage. Particularly vulnerable sites would include mobile dispensing centres and pharmacies (if it were intended, for example, to supply opioids on prescription to trial participants via pharmacies);

- the risk that trial participants will supplement licit opioids with substances which are illicitly obtained. Questions raised here might include whether it is possible and appropriate to test trial participants to determine whether they have been consuming illicit substances, what sanctions will be put in place and in what circumstances if such a test were to prove positive, and how will it be possible for the police to know whether a suspect has been using licit or illicit substances;

- the tension between concerns to protect the confidentiality of trial participants and legitimate police needs to know their identity so that law enforcement can be carried out and trial participants in lawful possession of opioids are not harassed. A legitimate police need to know whether a person was a trial subject could occur when, for example, the police had reasonable cause to suspect that a person was committing a drug offence.

One suggestion that has been made is that a register of trial participants is kept at the clinic or hospital at which the trial is based and that access to information contained on that register could be provided to police following a request from the police officer to a designated person. The designated person would decide whether the requesting officer had a 'need to know' and, if appropriate, would proceed to make the request to the clinic or hospital. These decisions would need to be documented. Consideration would need to be given to what information should be kept on the register. For example, would it include a physical description of the trial subject for identification purposes, and information about dosage and dosage schedules of trial participants? The need for 24-hour availability of any register is another matter which would need to be looked at if this course were to be followed.

The police need to be fully informed and consulted about any trial, as their co-operation is vital.

Summary

The law relating to narcotic drugs is a complex array of Commonwealth, State and Territorial legislation. The following are important legal issues which need to be addressed when the feasibility and design of a trial is being considered:

. satisfying the Commonwealth that a trial would not place Australia in breach of its international treaty obligations;

. obtaining the requisite licences and permits from the Commonwealth and (possibly) a State (if Australian manufactured heroin were to be used);

. complying with any obligations imposed by the Therapeutic Goods Act 1989;

. addressing the statutory impediments which exist in the ACT in relation to a trial;

. addressing questions of liability in negligence, consent, confidentiality, minors etc. The design of a trial should be undertaken with reference to these matters.

. attempts to limit or exclude liability, especially using statutory exemption clauses, have ethical and 'political', as well as legal implications. Consideration should be given to providing appropriate indemnities to trial personnel;

. appropriate protection against criminal liability in the ACT should be provided. The design of the trial and information provided to trial personnel and users needs to take NSW criminal law into account, and the criminal law of other Australian jurisdictions; and

. further research into the complex questions of aiding and abetting the criminal offences of other jurisdictions is needed. The questions of other secondary offences should also be considered. The position of those involved in the transportation of substances like heroin through other jurisdictions needs further examination.

My final comment relates particularly to negligence. Reliable pharmacological evidence about the effects of heroin can inform decision making. The purpose of this paper does not include making assessments about the pharmacological effects of a drug like heroin, or about its efficacy as a therapeutic substance. However, heroin was used for many years in Australia - for example, in childbirth and for intractable pain.

During the course of research for this paper, it became apparent that some people viewed heroin in such a way that even its controlled use was regarded as posing acute dangers to life and limb both for trial participants and third parties.

Assuming that the pharmacological evidence is there, heroin can be viewed like other drugs supplied by the medical profession (even if it is to be regarded as one requiring careful controls). The point is that many of the problems associated with negligence and consent etc in regard to a heroin trial may also be encountered when drugs are prescribed in medical practice or when conducting trials of new drugs. Similarly, problems associated with confidentiality, negligence and consent would also be encountered in drug treatment programs, including methadone treatment programs. Finally, 'the possibility of diversion and supplementary use of illicit drugs are also matters of concern for methadone programs' (A. Wodak, personal communication).

Acknowledgements

The compilation of this paper would not have been possible without the assistance of many people. They include members of the Reference Group, officers of ACT and Commonwealth government departments, the Australian Federal Police and the Australian Bureau of Criminal Intelligence.

Particular thanks must go to Professor Terry Carney, Professor Jim Davis, Dr J. P. Fonteyne, Mr Ian Leader-Elliott, Mr Desmond Manderson and Mr Peter Waight.

Errors and omission are, of course, the responsibility of the author alone.

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6: POSSIBLE OPTIONS FOR A TRIAL

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Preamble

This draft report results from the work of the "Options Group" which explored the ways in which a trial might be conducted and identified logistical issues which will need to be resolved if a trial goes ahead.

This report has four sections:
- a review of the literature discussing ideas for programs,
- an in-depth description of one program in the UK where heroin and other illegal drugs are prescribed: the Marks/Parry program,
- the results of a survey of key informants, and
- recommendations.

LITERATURE REVIEW

Introduction

Part A of this review examines opinions on a range of options that have been suggested to minimise harm arising from illegal drug (opioid) use. Part B reviews opinion in the literature concerning specific issues (also addressed by the survey of key informants, see below).

In the time available it was not always possible to follow-up references cited in the papers reviewed; "(reference given)" and "(no reference given)" are used to distinguish claims made which are based on cited work from claims which seem to be assertion only.

Specific references to the Marks/Parry program are discussed in the next section. (See also Chapter 2 for evaluation of some British programs, including those offered by the Liverpool Drug Dependency Clinic.)

Part A. Options to minimise harm arising from illegal drug use

The 1989 Report by the Parliamentary Joint Committee on the National Crime Authority (the Cleeland Report) lists seven different suggestions to counter the social costs of illegal drugs. Four of these are relevant to the present study and are used as a framework for a review of the literature on program options.

Option A: Prescription of currently illegal drugs to registered drug users, as occurs in British clinics.

The NSW Bar Association (1989) in its submission to the Parliamentary Joint Committee on the National Crime Authority recommended that illicit drugs should be provided to 'selected drug users through regulated clinics following careful assessment of individuals with assistance provided in treatment programmes' (reported in Robert Marks,1990a).

Baldwin (1987) maintains that the use of heroin in the treatment of heroin dependent people is the best option. This option is based on a belief in the success of the British clinic system. Some authors, however, have suggested that the 'success' (measured in terms of the relatively small numbers of users) of the British system was a consequence of the small number of dependent users and not the reason that the numbers of users remained small. However, Robert Marks (1990a) feels that the clinics were part of a continuous evolution in dealing with the demand for drug use that was not dwindling and which was not appropriate for legal controls alone.

Robert Marks (1990a) points out that a system where heroin is only available to those who can demonstrate a prior addictive habit is one that provides a strong incentive to users not to remain occasional tasters. It can be seen as offering a reward for destructive drug use (also Chesher and Wodak, 1990).

Nevertheless Robert Marks thinks that this approach is better than the present system of prohibition, and is not very different from the methadone maintenance programs which are treating over 6,000 drug users in Australia today (reference given). He feels that the major difference between the two drugs is their legal status and the fact that dependent users prefer heroin to methadone.

Robert Marks (1990c) discusses programs in which drugs and dosages are determined by a doctor, who supplies the dependent user with a prescription to be filled by a pharmacist and administered by the dependent user. The drug could be either methadone (any British doctor and authorised doctors in Australia may prescribe maintenance doses of methadone syrup for drug-dependent patients) or heroin (which was available in Britain from doctors before 1968).

Prescriptions for heroin from doctors were available during the forty years in Britain between the release of the Rolleston Committee report in 1926 and before the clinic system was set up. Data are scarce and unreliable, but Robert Marks (1990c) quotes a study by Zacune (1971) of 25 Canadian dependent users who immigrated to Britain in the early 1960s in search of cheap pure heroin. It suggests a fall in the crime rate of this group of between 30% and 90%. (Heroin was prohibited in Canada.)

Robert Marks (1990c) also raises the idea of maintenance programs in which the drug and dosage are determined by medically qualified personnel and in which the doses are administered under close medical supervision. The drug could be methadone (as used in Australia since the late 1960s, and in the US and Britain) or heroin (as in British clinics since their establishment in 1968).

Chesher and Wodak (1990) claim that the advantage of this option is the reduction of harm to the drug user. It provides a safer, standardised product while drug use continues and ensures excellent access to primary health care. The disadvantage is that it attends only to the dependent drug user and does little to control the nature of the illicit market.

Baldwin (1987) points out that this option would involve the establishment of clinics similar to the methadone clinics, unless there was a major revision of the Poisons Regulations in each State. The cost of maintaining these clinics would increase health care costs. He feels that there are many issues to be resolved. For instance, this option would exclude non-dependent users (the majority) who would continue to use the black market. Thus this option would not reduce the cost of maintenance of the criminal-justice and customs systems. Baldwin feels that this option would produce a fall in the price of illegal heroin; an increase in numbers of and frequency of use of non-dependent users; an increased clientele for the heroin centres; and a fall in the property crime rate. [Other authors would disagree with these assertions.]

Mugford (1989) also feels that legal supply of opioids to registered dependent users has several flaws. First the unmet demand from non-dependent users creates a very similar black market to the one we have now. The temptation to abuse, for example, by reselling the drug to others, is clear. Second it is "plain silly to reward, via cheap supply, those who work to increase their use, and punish those who limit it. Surely this is the reverse of the optimum case?" A third point Mugford makes is that the extra power given to the legal profession is not necessarily a good thing. This option is often canvassed with the notion that the drug must be taken on the premises. This would achieve the goal of de-glamourising the drug, but would probably therefore only attract dependent users desperate enough to comply. Mugford feels that this case is the 'worst of both worlds': there would be almost as much fuss as for other options for only a small gain.

Pilotto and Navin (1990) consider the option of keeping heroin illegal but placing dependent users who wish to remain on heroin into a controlled environment where they are provided with daily heroin such that they are able 'to work and return to society'. However they consider that this was the approach adopted and subsequently abandoned in England in favour of the 'more therapeutic' approach that methadone use offered. It is their belief that heroin should not be legalised.

The prescription system has one major and intractable disadvantage, according to Kaplan (1983). 'Those addicts who pick up their supply of low-cost heroin will have a strong incentive to resell at least part of their supply, and the more they can sell, the more closely will the maintenance system then approximate free availability'. This system may be harder for police to contain and may create a whole new large class of regular sellers who will make heroin more accessible as well as cheaper.

Kaplan (1983) also feels that a prescription system might work in a situation where the dependent users are few in number and concentrated over a small area. Each dependent user's heroin supply could be marked with a harmless dye of a particular colour which would allow the police to check on diversion. However there would be difficulties in extrapolating from such a small-scale experiment to areas with large numbers of dependent users. [The Options Group questioned the practicality of this suggestion and pointed out that it could not detect continuing use of street drugs.]

Strang (1990a) makes the point that prescription of drugs would help increase retention rates of drug services and enable users to be available for secondary preventative and treatment approaches to be applied when appropriate.

Drew and Taylor (1988) recommend that 'to effectively change the behaviour of [intravenous drug users], and to more fully contain the spread of HIV and hepatitis, consideration should be given to providing heroin and dexamphetamine on prescription in non-reusable packages for intravenous use, and efforts should be made to encourage intravenous users to change to a different mode of drug use.' They go on to say that such a program 'would not be inconsistent with Australia's ratification of existing international drug treaties, although the United Nations would need to be informed of the change in policy...this program would lead to a decline in the illegal drug trade and to a decline in the pressure exerted on young people to begin intravenous drug use.'

Option B: Licensing drug users to enable them to purchase over-the-counter drugs, while being monitored.

John Marks (1990) argues for a 'happy medium' when looking at the availability of heroin. Prohibition 'peddles use' and results in a black market and gangsterism; a free market 'promotes use' and results in epidemic intoxication. He claims that 'controlled availability', such as rationing, produces controlled use. He concludes that ultimately drugs will only be controlled by culture - the 'social climate' (further references given) as shown in the Dutch situation with cannabis.

Mugford (1989) argues that open sale through pharmacies would need to be based on 'some kind of government monopoly sale'. Mark-up should be designed to undercut black market operators without being so cheap as to encourage use. Revenue should go into a special fund to be used for drug education and rehabilitation and for policing sale and use. Mugford's proposal would probably result in some increase in use levels. He suggests that indirect costs could be limited by a variety of practical measures, such as the use of a 'salivalyser' for breath testing to discourage drug driving. [It is not known how practical the idea of a salivalyser is.] Mugford concludes: 'I would strongly advocate this option, which maximises the potential for governments to scrutinise the general patterns of use; to

control quality of, and conditions of administration of, some drugs; to influence use patterns and to take a serious and credible position on drug use; and to reduce a host of extrinsic and indirect costs. I would not advocate this option if the current system worked, but it doesn't ' (Mugford, 1989).

Mugford suggests that users should take out a licence, obtainable at the age of 18 years upon proof of identity and granted after a 'cooling off' period. Completion of a drug education course might also be considered. Licensed users would be entitled to purchase, over the counter, pure drugs in limited formats, such as injectable heroin in single shot, disposable syringes. There should be few limits on the amount that a person purchases at one time. Purchase should only be possible on the production of a licence, which would be linked to a central computer. This would allow monitoring of individual levels of use. Those with heavy levels can be offered counselling. Those suspected of re-selling can be identified, as can stolen or abused licences. Mugford concludes 'I believe that this system would offer the best prospect for a control system which would minimise the overall pattern of costs, allowing the bulk of such costs as there were to be intrinsic direct costs, thus borne by those who freely choose to use drugs, and not by the rest of us.' (Mugford, 1989).

Drew (1988) recommends replacing prohibition of heroin with a rationing system specifically directed at limiting harm, as used in Sweden with alcohol. However he feels that the first step would be to make intravenous methadone available to established intravenous drug users who are not attracted by the offer of oral methadone.

Drew's model would include use of a licence card by adults provided after a mandatory interview with an authorised person (possibly a doctor). The goal would be to discourage the use of drugs. The licence would specify the drugs to which access would be available. Licence holders would obtain their drug supplies from special inconspicuous outlets which would be publically owned and would not be allowed to advertise or promote their products. The level of use of drugs would be recorded for each person and would be regularly reviewed. People who seriously jeopardised their health or welfare by high levels of drug use would be taken into compulsory care (Drew, 1988). [The Options Group suggested that this might need special legislation or special interpretation of the Inebriates Act.]

In Drew's model, prices would be set at a level to produce profits, all of which would be directed to research and preventative education. Illegal use and trafficking would remain offences. Initially a legal system of supply would need to compete with the illegal system which it would eventually largely replace in the same way that legal gambling has replaced illegal gambling. During the early period of competition drugs might need to be consumed on-site rather than being given as take-away doses (Drew, 1988).

Drew concludes that the more controlled the availability of drugs is, the less the level of use is likely to be and the lower the level of problems resulting from that use. A legal system of supply could lead to less drug use, particularly among juveniles (Drew, 1988).

Robert Marks (1990c) suggests an alternative in which the government would control the prices of over-the-counter heroin and methadone, making heroin sufficiently more expensive than methadone so that its 'excessive' use was discouraged, but cheap enough to completely undermine the black market. He maintains that complete collapse of the black market would require virtually no restrictions on the sale of heroin, and a price very close to that of methadone. 'Thus, the proposal will reduce the subsidy to organised crime from all Australians, as reflected in our home insurance premiums, via the benighted heroin users.'

Option C: Commercial supply of the illegal drugs.

There were no restrictions on the sale, possession or use of heroin in Australia, Britain and the US before the First World War (Robert Marks,1990c).

Robert Marks (1990c) claims that it is 'undeniable' that a policy of freely available heroin or methadone would lead to more widespread use, even if not addictive use, than would prescription heroin or methadone (reference given). The trade-off is the rise of the black or grey market (re-sale of prescribed drugs). He feels that it is impossible to imagine the government opening up a commercial market for opioids in general, especially given the situation with tobacco and alcohol.

Chesher and Wodak (1990) are concerned that although licensing of retail outlets and hours of trading could be restricted by regulation, there would be few other controls apart from mechanisms for the maintenance of quality.

Baldwin (1987) points out that unless the Poisons Legislation in each state was radically changed, the supply of opioids would have to be through retail pharmacies or other health care outlets. He feels that the benefits of this option would be a reduction in crime rate; relief for the criminal-justice system; and reduction in the cost of health care for users. However, he also acknowledges that no one knows what the demand for heroin would be under these circumstances. Increasing tolerance to heroin may lead some users to pursue additional supplies on the black market. There would be little incentive for users to restrict use and large numbers may be perpetually 'stoned'. There would be a cost to the community in terms of increased unemployment, car accidents, industrial accidents and family disruption. Baldwin goes on to say that deregulation of heroin may lead to pressure to deregulate other currently illegal drugs. He concludes that the disadvantages of this model may well outweigh the advantages.

Open sale by big companies Mugford describes as 'even worse than the status quo ' (Mugford, 1989).

Option D: Government monopoly supply with mandatory labelling of purity and strength, and with no advertising or price promotions

As an alternative to the completely unregulated and illegal markets we have now, Robert Marks (1990a) has argued for a regulated market in which drugs would be available through government outlets, which would ensure that the drugs were clearly marked with their purity and strength, in which minors would be precluded, with no advertising and which might provide some excise revenue. The price would have to be very low initially to undercut the black market. This option would require Australian withdrawal from our international obligations under the Single Convention on Narcotic Drugs, but as a sovereign state Australia can legally institute such a scheme, given the political will.

Robert Marks (1990a) feels that the Cleeland Report puts the case for this option very well, in attempting to balance the benefits of the existing prohibition in deterring new drug users and encouraging existing users to seek treatment against its costs both to society and to the users themselves (reference given). The big imponderable is the number of users under the new regime. Marks predicts a relatively small (10-15%) increase in the number of regular users, 'who anyway would not pose the problems of the junkies of the prohibition'. The number of occasional users may well grow proportionately more rapidly, however Marks sees no reason why they should be any more of a problem than they are now.

This option is also Chesher and Wodak's preferred option (Chesher and Wodak, 1990). Questions that they feel should be investigated include: the nature of the drugs to be sold (they recommend any that cannot be controlled via law enforcement); the age of clients; the amount of drug available to each client; and the effect of the number of drug users on society.

Part B: Issues

The type of drug used

Methadone

For Marks and Palombella (1990) methadone syrup has advantages: it has a long half-life and can be administered once in a daily dose. The drawbacks are: it does not give a 'buzz' and so dependent users will resort to black market supplies for their 'entertainment' and use the methadone to keep themselves stable; it is very addictive and dependent users can suffer withdrawal effects long after stopping the drug; and many users complain of nausea, vomiting, tooth decay, and weight gain after prolonged use. John Marks has observed clients prescribed methadone return to injectable drugs as they were unable to cope on methadone alone.

Lidz et al. (1975) feel that methadone maintenance has not been particularly successful. Large numbers of patients drop out of programs and a large percentage continue to supplement with illegal heroin (references given).

However, Hall et al. (1991) in a comprehensive review of the current research literature on methadone maintenance concluded that programs that follow the Dole and Nyswander model in particular were effective in reducing illicit drug use and criminal behaviour (see Chapter 2: 'Literature Review: Arguments For and Against Changing the Availability of Opioids').

Drew and Taylor (1988) recommend that the widespread use of oral methadone is promoted, and that it be supplemented with intravenous methadone to users who do not benefit from oral methadone.

Methadone maintenance has been criticised by Robert Marks (1990c). He claims that methadone is no better than heroin except for its legality and withdrawal from methadone can be harder than from heroin (reference given). There is also some reselling of methadone on the streets (the 'grey market', reference given).

Heroin

Many authors claim that properly administered in known quantities and known dosages, heroin is of very low toxicity with no long-term deterioration, psychological or physical (Robert Marks, 1990b; Strang, 1990b; Trebach, 1982; Kaplan, 1983; see also Appendix A).

Kaplan (1983) makes the point that a heroin maintenance scheme would be likely to 'lure away from methadone even those who could, in fact, adjust to that more convenient and therapeutic drug'.

Burr (1986) maintains that many British heroin users prefer illicitly manufactured heroin to pharmaceutical heroin. He also claims that most opioid users 'cut' their opioids with other drugs such as cocaine, Ritalin, Diconal and barbiturates; in fact, in 1982 in Britain there were as many Diconal overdoses reported to the Home Office as heroin overdoses.

Morphine

A follow-up study of an American morphine maintenance clinic that operated in 1920 indicated that long-term morphine use could be seen as 'only one more hazard of low socio-economic status, and that when viewed as a part of the life history of the group it did not necessarily predispose to lifelong addiction or to a quick, catastrophic death' (Musto and Ramos, 1981).

Opium

Trebach (1982) suggests that using the most natural of the opioids, opium, to treat heroin dependent users should be investigated. Tincture of opium is an accepted medical drug, provides a high that 'many addicts would like', and causes nausea if overused. He prefers the idea of oral opium maintenance to either heroin or methadone maintenance and would like to see it tried. Opium by mouth is long acting, easy to stabilise over time and much less liable to abuse. Trebach continues: 'The most powerful argument against methadone is that not enough addicts are willing to take it under medical supervision.'

Stimulants

Strang (1990b) maintains that given 'the urgent need for there to be major changes in the injecting habits of many ... stimulant users, the possibility [of prescribing a stimulant substitute for amphetamine or cocaine dependent users] should be at least considered'. However, he admits that this issue is not straightforward, especially as there is no stimulant equivalent of methadone. He claims that the only documented program involving prescription of stimulant drugs to dependent users was a short-lived experiment in the late 1960s which involved prescribing injectable methylamphetamine. It was not a success (no reasons given; reference given).

Mode of administration

The choice of drug is often debated extensively, with most attention usually focussed on whether or not heroin itself might be prescribed. However, Strang argues that in clinical practice a more critical issue is whether or not injectables are prescribed at all; 'the difference between injectable heroin and injectable methadone seems to be far less than the difference between injectable and/or oral forms of methadone, thus drawing attention to the importance that must be attached to the route of administration rather than merely the substance itself' (no references given; Strang, 1990b).

In practice in Britain the prescribing of injectable drugs is rare and is almost entirely restricted to injectable ampoules of methadone. Strang (1990b) maintains that: 'The potential for serious error is greater in view of the much higher black market value of these injectable drugs as well as more direct physical complications; a careful cost-benefit analysis must be undertaken to examine the advantages and disadvantages of oral-only or part-injectable methadone prescription. The ever present concern is that an injectable prescription might be given to a patient who could have been supported in making the move to an oral-only prescription but for whom the provision of a part-time injectable prescription has confirmed the injecting behaviour'.

Robert Marks (1990c) quotes research on US servicemen that suggests that the route of drug administration is significant. Those who had injected in Vietnam during the Vietnam War were almost four times as likely as non-injectors to use it on their return to the US; 75% of those who had injected before Vietnam continued to use the drug on their return. Twenty five percent of those who had first injected in Vietnam continued to use the drug on their return.

Gupta (1990) reports that injectors have more medical problems than non-injectors.

Stimson (1987) also claims that, whereas most regular heroin users in the 1960s in Britain injected the drug, in the 1980s 'the majority [of heroin users] use various methods of inhalation such as "chasing the dragon" (inhaling the fumes of heroin heated on tinfoil), "snorting" (sniffing) or smoking with tobacco (no reference given).

Heroin cigarettes/reefers

Gossop has reported on the apparent robustness of heroin smoking as a behaviour. Many drug users continue with this route of administration without beginning to inject (in Strang et al., 1990a).

Drew and Taylor (1988) recommend that attention be given 'to means of promoting the use of drugs via smoking, inhaling or ingesting rather than by injecting, thereby avoiding most health risks.'

A comparison of heroin smokers and injectors in the Mersey region (Cousins and Bentall, 1989) found that all the users began smoking before injecting and that both groups smoked more often than they injected. There was an overall decrease in the frequency of both methods of heroin use over time, indicating that there is no necessary progression in the frequency of heroin use. Whereas many smokers injected, there was no evidence that injecting became preferred over time; in fact, the smokers progressively decreased their injecting.

(See also Marks and Palombella in the next section.)

Effect of injection of opioids on HIV positive users

Brettle (1991) quotes several reports that indicate that continued injection drug use may accelerate progression of HIV positive users to AIDS. One study reported a relationship between the frequency of injection drug use and the loss of CD4 lymphocytes, whilst another study noted a similar increased rate of decline of CD4 lymphocytes amongst a group of injectors compared with a group of non-injectors. There was also a lower probability of disease progression amongst methadone users or ex-users compared with those that continued injection drug use reported from Switzerland. This issue is controversial as other groups have not found an increased risk for continued injection drug use. Nevertheless, Brettle concludes that: 'It is important to remember that injection drug use itself is an immunostimulant which, in the context of HIV, is a disadvantage, and that opioids not only increase susceptability for bacterial infections but also promote the growth of HIV in cell cultures'.

Client criteria

Trebach (1982) maintains that any person should be eligible to receive heroin by prescription if a doctor has determined that the person is addicted and that the person, now his/her patient, might be helped by the drug.

Pregnant women

The preferred management of a pregnant drug user according to Ghodse (1990) is to help her come off drugs as comfortably and as early in pregnancy as possible. He argues that: 'Ideally this will be achieved by at least two months before the expected date of delivery to ensure a non-addicted infant'. Ghodse goes on to argue that opioid dependent pregnant patients should be stabilised on methadone, which should then be withdrawn gradually to avoid precipitating foetal distress or premature labour. The withdrawal program should be individually tailored according to the severity of dependence, stage of pregnancy and the patient's motivation. Some patients may not be able to cope with being drug-free and some may present too late in pregnancy for withdrawal to be possible - these patients should be maintained on the lowest possible dose of oral methadone.

Batey et al (1990) cite several reports which maintain that oral methadone programs are an appropriate option for pregnant women.

Take-away heroin

Trebach (1982) asserts that the law should allow doctors to determine who should get take-home heroin, when, and how much. Some opioid users (recreational users, those not receiving the amounts of drugs they want, and those who do not want to enter treatment) would still create a market for illicit drugs, but Trebach feels that heroin prescription by doctors would change a 'virulent and violent black market for a gray market of middling proportions'.

Hawks (1988) claims that allowing dependent users to take heroin home is unacceptable because of the possibility of the drugs being diverted or shared. However, he acknowledges that supervised use would require that clinics were open 24 hours a day due to the short time span of action of heroin. His suggested solution in the case of those abusers who demonstrate withdrawal effects would be to provide one supervised intravenous injection of heroin and supplement this with supervised doses of methadone by mouth.

Kaplan (1983) feels that a substantial proportion of dependent users would not sign up for an on-the-premises system of heroin distribution.

Treatment options

Amount of drug supplied

Trebach (1982) believes that the dependent user should be given enough drugs to meet his/her needs for one day. On the weekends or on holidays, more may be given to 'trusted patients'. While the setting of doses is difficult, Trebach feel that it is not impossible: 'often patients have to be placed in hospitals and observed for some days under varying dosages before the appropriate dose is discovered'.

Capelhorn and Bell (1991) maintain that clinic dosage policies contribute significantly to retention in methadone maintenance treatment. They recommend that clinics develop dosage policies in negotiation with individual clients. (See also section on methadone programs in Chapter 2.)

Prescription length

Trebach (1982) maintains that doctors should be flexible enough to view the ingestion of drugs as 'presumptively neutral as long as the ingestor is living responsibly'. This might mean that a patient could be on heroin for years.

Factors that influence retention rates

Features that reduce retention rates of drug services include: long waiting lists; delay for appointments; an unfriendly environment; and a stigmatising service. Reattendance rates may improve with provision of assistance with housing, employment, and the provision of recreational activities and legal aid as well as direct drug services. Some of these are now being provided in the UK - no data is yet available on their effectiveness (Strang,1990a; Strang and Farrell, 1989).

A study by Hartnoll and Power (1988) of British drug users in and out of treatment showed that most users felt that drug services should provide an opioid prescription, though only a minority wanted long-

term maintenance. Of equal importance to users was help with practical issues such as housing, health, means of support, skills training, legal problems and childcare. Accessibility of agencies was another important influence on help-seeking.

Fleming (1988) reports on a low-threshold methadone maintenance program in Portsmouth, UK, that is proving successful in attracting opioid dependent users. Over its first year of operation (1987-1988) the number of opioid users coming to the clinic doubled. Longer-term users not previously in contact with services have also come forward, as well as injecting amphetamine users. The low-threshold program is part of an integrated district drug service - methadone is only one of the options offered.

The Portsmouth program has no waiting list and there are no fixed reduction programs. There is provision for on-the-spot prescriptions. No injectables are prescribed. Each client has a case manager. Initially methadone use is supervised, with clients drinking their dose on the spot. Clients are not expected to abstain from other drugs in the initial stages of treatment (no routine urine tests are done at this stage). Once clients feel confident enough not to use other drugs, a prescription for methadone is given and urine tests are done. If there is persistent evidence of other drug use, the client has to return to supervised use. Clients set their own goals for reduction of use (Fleming, 1988).

Prescribing guidelines

The British Advisory Council on the Misuse of Drugs (ACMD, 1989) recommends that prescribing of opioids should never be undertaken without an identified treatment goal. Access to treatment should be equally available to both presumed HIV seronegative and seropositive drug users. However, if a drug misuser is known to be seropositive, a wider range of goals should be considered, including the following:

(a) to attract seropositive drug misusers into regular contact with services;
(b) to promote behaviour change away from practices which carry a risk of transmitting HIV infection;
(c) to promote behaviour change in such a way as to maximise personal health and stability; and
(d) to encourage compliance with medical treatment, including regular check ups and the regular self-administration of antiviral drugs such as AZT (reported in Strang,1990a).

Although the ACMD considered that possible benefits may result from the short-term prescribing of injectable drugs as an intermediate goal in carefully selected patients, it warned of the danger that prescribing may inadvertently '...prolong the extent and frequency of continued injecting with the possibility of an increase in risk-laden behaviour'. This is supported by some British dependent users who have been in receipt of prescriptions since the clinics opened 20 years ago and feel that it has been a mixed blessing. Although they may have been at increased risk of drug-related illness or death without a prescription, they might also have been more likely to have become drug free (Strang, 1990b).

The ACMD have advocated a layered or 'stepped-care' approach to prescribing, whereby more straightforward prescribing responses such as oral methadone withdrawals in the short and medium term should be available from general practioners and district-level drug services, while more complicated prescribing responses such as injectable methadone or heroin would require referral to more specialist drug units with more experienced staff and higher staff-patient ratios, and the availability of checks such as random urine analysis, home visits and telephone monitoring (reported in Strang, 1990b).

Strang (1990b) concludes that 'the assurances of lifelong maintenance and consequent foreclosing of discussion about possible change would appear to have had some adverse effect on some of the long-term opiate dependent users who have been with the NHS drug clinics in the UK since their creation in 1968. [What is needed is] a more effective way of providing a service which is sensitive to the immediate needs of the individual while still promoting change in the drug-taking behaviour over time. Thus adoption of an end-state maintenance approach would be superseded by a more active approach which sought to identify a series of immediate goals...to encourage appropriate changes in behaviour... It is essential to understand that prescribing may occur within different contexts. A particular prescribing response may be life-saving or critical to a transition for one drug-taker, while wholly inappropriate for the next. Any analysis of the range of necessary prescribing options must also consider which forms of prescribing should be available within which settings; and should separately consider which forms of prescribing should exist within the total armamentarium of the overall service.'

Strang and Farrell (1989) quote a 1989 survey of drug users out of contact with drug services as showing that only a minority wanted a long-term maintenance prescription. They assert: 'Careful evaluation is urgently required of the role of prescribing in facilitating retention and reducing the extent and risk-laden nature of continued drug use. There is a disturbing blind presumption that prescribing is inevitably linked to benefit, with greater treatment and behaviour change; but there is as yet an absence of good research data to support or refute this'. They continue: 'there is now a strong case for instituting low-threshold oral methadone prescribing programmes with similar evaluation and capture and retention rates [as syringe exchange schemes]'. Such a flexible and accessible program in Portsmouth, UK, has resulted in a doubling of opioid users attending the clinic (see previous section).

Wodak (1991) has proposed a feasibility study in Sydney of the provision of injectable methadone to users under strict supervision in order to recruit them into treatment. Provision was made for providing intravenous morphine if no subjects had joined the study after two weeks. Participants were to be supplied with self-injected intravenous methadone for 16 weeks. After eight weeks each participant would be required to either transfer to oral methadone or leave the study. Pregnant women would be excluded, as would any people who had received psychiatric treatment within the past two years. All doses would be injected intravenously in the dispensary under the direct surveillance of a staff member.

Another program proposed by Wodak suggested the provision of intravenous methadone (or morphine if necessary) to a group of users in order to assess changes in their HIV risk-taking behaviours. This group would again be transferred to oral methadone (Wodak, 1991).

Other issues

Stimson (1987) reports that there has been some redefinition of terms: the 'addict' or the 'drug dependent user' have been replaced by the 'problem drug taker', who was defined by the ACMD in 1982 as 'any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as consequence of his own use of drugs or other chemical substances (excluding alcohol or tobacco)'. Stimson suggests that drug problems should now be seen as wide-ranging and that they do not always involve dependence and a medical response.

Trebach (1982) argues that there is no one solution to the problem of drug use - each community should be allowed to design their own systems of opioid use and control appropriate to their circumstances. Physicians should be authorised to treat dependent users with opioids if necessary.

Robert Marks (1990c) argues that the choice of policies to deal with the heroin problem can be substantially affected by how the problem is defined. Definition of the problem should entail exhaustively listing its attributes (the effects on users and on others) and the government's role and objectives, and listing possible policy instruments. Any solutions to the heroin problem must be judged by their ability to deal with both aspects of the issue: that of the individual user and that of society. The solution's long-term consequences must also be considered.

Strang (1988) feels that the current debate is in danger of getting bogged down about the type of treatment and might overlook the speed of the response (whatever the treatment). He claims that what matters to the drug dependent user is not the wait to the assessment interview, but the wait to the start of the treatment. It may be that many more current dependent users would be content with the present services if they were promptly and courteously delivered.

Chesher and Wodak (1990) argue that a primary objective for drug law reform is to gain some regulation over the illicit market and ideally to abolish it. They feel that this must be done in such a way as to maintain the present social disapproval which surrounds illicit drugs.

Strang and Farrell (1989) contend that joint HIV and drug clinics may significantly increase treatment compliance among the drug-taking population. They argue that there is a need to concentrate as many services as possible on one site so as to increase uptake of the services. They also warn that there is a danger of repeating the mistakes of the drug clinics of the 1970s where clinics "silted up" with people on maintenance prescriptions because help was not available to those who wished to stop taking drugs.

Farrell and Strang (1990) warn against searching for simple solutions to complicated problems. 'The danger is that this simplistic search will interfere with the development of the necessary integrated multi-faceted responses'.

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THE MARKS/PARRY PROGRAM

It is useful to have a description of a working program as well as models which have been suggested. The Marks/Parry program which operates in the Mersey region of the United Kingdom is one of the best known in Australia. As much as possible was learnt about it in the available time and is reproduced below. There was not enough time to have the information below checked thoroughly by John Marks or Allan Parry.

Information about the Marks/Parry Program has been gained from review of the published literature and from discussions with Dr John Marks, Mr Allan Parry and Dr Russell Newcombe. Dr Marks is the Consultant Psychiatrist with the Widnes and Warrington Drug Dependency Clinics and has been involved in prescribing opioids and other drugs since the early 1980s; Mr Parry is Director of the consultancy company 'The Atlantic Project' and was formerly Regional Drugs and AIDS Co-ordinator for the Mersey Regional Health Authority; Dr Newcombe was until recently with the Drugs and HIV Monitoring Unit of the Mersey Regional Health Authority.

History and Description of the Marks/Parry Program

A general description of drug prescribing in the United Kingdom and some information about other programs is given in Chapter 2 ('Literature Review: Arguments For and Against Changing the Availability of Opioids').

The Marks/Parry program needs to be seen in the overall context of drug prescribing in the United Kingdom. Basically the system is that the Department of Health delegates control of health services in England and Wales to 15 Regional Health Authorities and to several District Health Authorities within each region. The Mersey Regional Health Authority, for example, covers the counties of Merseyside and Cheshire (Newcombe, 1989). Each District Health Authority has a consultant psychiatrist who is responsible for prescribing heroin. General practitioners (GPs) have the power to prescribe oral and injectable methadone, as well as codeine and morphine. Only specially licensed GPs, who work at Drug Dependence Units, can prescribe heroin under the direction of the consultant psychiatrist. The type of prescribing therefore varies widely across Health Authorities and can vary markedly across time as consultant psychiatrists change or change their prescribing policies. Overall, only a small number of psychiatrists in the UK prescribe heroin, amphetamines and cocaine. Clinics in the Mersey region probably prescribe to more people per head of population than elsewhere in the UK. John Marks has been influential in prescribing practices in the Mersey region and the focus of what follows is on what he calls the 'Marks/Parry program' (Marks, personal communication, 1991).

The Mersey region has a population of 2.25 million and is composed of Merseyside (with a population of 1.5 million) and Cheshire (0.75 million). The city of Liverpool has a population of 450,000. There are 10 health districts: Liverpool, South Sefton (also known as Bootle), Warrington, Halton (where the Widnes clinic is located), Chester, St Helens, Wirral, Southport, Macclesfield and Crewe. Most of the information which follows is based on John Marks' experience at the Widnes and Warrington clinics. However, he was consultant psychiatrist seconded to set to the Liverpool clinic during the time when it was evaluated by Cindy Fazey (see Chapter 2: 'Literature Review: Arguments For and Against Changing the Availabiltiy of Opioids'). The prescribing practices of the current consultant psychiatrist to the Liverpool clinic are very different (Marks, personal communication, 1991).

Clients

Based on 1981 figures for the Widnes and Warrington clinics combined, there were about 200 regular addicts for a population of 300,000 (about 80 at Widnes and 120 at Warrington). The modal age was 26 years and the ratio of men to women was 3.75 to 1. Four were Chinese, the rest White. The ages of clients seen has ranged from 12 to 52; the ages of clients given prescriptions has ranged from 15 to 52. None of the clients came from social class 1 (1% of the population), 1% were from class 2 (5% of the population), 15% from class 3 (20% of the population), 44% from class 4 (40% of the population) and 40% from class 5 (35% of the population) (Marks, personal communication, 1991).

At the Widnes clinic in 1983, 14% of clients were in regular employment (Marks, 1991; Marks, personal communication, 1991). In 1991 in Widnes and Warrington 58 out of 220 clients (26%) were in regular employment (Marks, personal communication, 1991).

About 100 new clients are seen each year. About 20 of these come from outlying districts. (Marks, personal communication, 1991).

Some non-residents are seen by the clinics, after referral by the client's GP. They are given one assessment. They then stay in the care of their own GP and drugs are dispensed through a pharmacy in their home region although the scripts are written by the clinic. They are also required to see a counsellor such as a probation officer regularly (usually weekly). Continued prescribing relies on telephone reports from the GP (for medical information) and from the counsellor (for drug-taking information). The number of non-resident clients dropped in May 1991 when three Health Authorities (Wirral, Chester and Macclesfield) set up services run along Marks/Parry lines. Recently numbers have been rising again with an influx of people from North Wales and Crewe. Under special circumstances clients are taken from further afield, including South Wales, Yorkshire and London. The client's home health district has to pay for the service. Because of this clients fear they will be forced off their scripts after a few months (Marks, personal communication, 1991).

Five percent per annum achieve abstinence (comparable to other treatment programs) and the average input per client is one staff member at one session per week for five years (Marks, personal communication, 1991). Fazey (1990) found that for a sample of Widnes clinic clients the mean length of time in treatment was 2.8 years.

Drugs provided

Ampoules: methadone, heroin, morphine, amphetamine, cocaine
Syrup: methadone, dipipanone, amphetamine, cocaine
Tablets: methadone, morphine, cannabis
Reefers: methadone, heroin, morphine, amphetamine, cocaine (Marks, 1991).

One hundred and thirty five different combinations are prescribed. There are two common changes in drug use patterns. One is from heroin ampoules to methadone ampoules, which reduces the frequency of injections. Clients are persuaded to try this by being reassured that they can return to using heroin if they wish. The other is from injecting to smoking. Smoking mimicks injecting by providing rapid entry into the intoxicated state; this does not occur when drugs are taken orally (Marks, personal communication, 1991).

Reefers are generally made up by using cigarettes for asthmatics which have a herbal rather than a tobacco base and which have ingredients which are bronchodilators. The most common herbal base is Datura stramonium. Those who prefer them are given tobacco based reefers. Jeremy Clitherow, President of the National Pharmacists Association has developed a method of making reefers (Marks, personal communication, 1991).

There are no major sex, race or class differences in the type of drug used. More "with-it" people seem to take up reefers first. Women also prefer reefers because they have more difficulty finding veins (because women have more subcutaneous fat than men). Recently, the popularity of reefers has halved the injecting rate (Marks, personal communication, 1991).

It is relatively common for one person to be given both methadone and heroin ampoules (Marks, personal communication, 1991; O'Hare, personal communication, 1991)

Currently most clinic clients are in fact maintained on oral methadone. In 1981, the modal maintenance dose was 60 mg methadone syrup daily; now it is somewhat higher. No-one receives less than 10 mg daily unless on a withdrawal regime. At one time the modal drug at the Widnes clinic was injectable opioids, because GPs were prescribing methadone syrup. This has now changed (Marks, 1991; Marks, personal communication, 1991).

Marks and Palombella (1990) have described the effects of smokable alternatives prescribed at the Widnes Drug Dependency Clinic for clients who wish to stop injecting. At that time they prescribed tobacco reefers (cigarettes) injected with 60 mg of heroin, 40 mg of cocaine or 20 mg amphetamine separately or in conjunction with methadone syrup. The reefers provide the 'buzz' the users require in a safer, more controlled format. Reefers are also less addictive than methadone and therefore easier to withdraw from.

Marks and Palombella report that none of the 30 clients at the Widnes clinic maintained on either reefers or reefers and methadone had returned to injecting. Their health and relationships improved and several found employment. With the introduction of reefers in February 1989 the percentage of clients at the clinic on intravenous prescriptions fell from 65% to 51% (in February 1990). Some of the people changing to reefers had been injecting for more than 10 years. It needs to be noted, however, that Fazey (1990) found that two clients in her sample prescribed oral methadone and smokable heroin from this clinic were 'topping up' daily with illicit intravenous drugs.

General procedure

a. Location, hours and staffing

The Widnes clinic is located in the community, next to the probation office and near the police station.

The clinic is open 9 am to 10 pm on Mondays, Wednesdays and Fridays; 9 am to 5 pm on Tuesdays and Thursdays and 5 pm to 10 pm on Saturdays. From 9 to 5 there is a full complement of staff, after hours the clinic is staffed by outreach workers (Marks, personal communication, 1991).

The staff include: a manager, probation officer, social worker, community nurse, assistant to the manager (who organises and polices prescriptions and liaises with the pharmacist) and a secretary. In addition there are three counsellors/outreach workers. They work in the clinic, visit people's homes and work on the streets. Part of their job is to find new people at risk and encourage them to come to the clinic. Some of the staff are ex-users who have a University degree or some other training. The clinical psychiatrist and four GPs are employed on a sessional basis (Marks, personal communication, 1991).

b. Referral

Referrals to the Drug Dependency Units are via GPs and temporary residents will not normally be treated (but see above). Around 60 GPs refer clients to the Widnes and Warrington clinics (Marks, personal communication, 1991).

c. Initial screening

Everyone is initially offered detoxification as an in-patient. In Widnes, this is accepted by less than 5 people per year, despite there being no waiting list. In the past there was a problem with poorly-motivated people accepting detoxification thinking this was expected of them. The vast majority decline detoxification because they want drugs (Marks, 1991).

Initial screening consists of urinalysis to check that street drugs are in fact being used and what they are. The client must also have a letter from their GP. Once trust has been established with clients realising that they will be given drugs and not hassled, usually after 2 or 3 weeks, a history is taken and a medical examination given. Discussions are also held with local workers, such as probation officers, and the family of the client. When clients from other Health Authorities are seen for assessment, they are expected to be accompanied by a local worker and, if possible, relative (Marks, personal communication, 1991).

d. Routine procedure

Clients must attend at 9.30 sharp for a group lasting one hour or forfeit that week's prescription. There are usually about 12 clients in a group and one or two, sometimes three, staff.

Marks (1991) describes the sessions as follows: "The ground rules of the group meeting took at least six months to establish. Every chink of the regime was tested, resulting in some seemingly petty rules e.g. whether it was 9.30 was established by reference to the psychiatrist's watch, bladders had to be emptied before attending, no newspapers would be read etc, etc. The sanction in all these circumstances was loss of 'script for one week. One cigarette is permitted at 10 o'clock. A phase of grumbling resignation then lasted a month or so. This was characterised by irritated questions and remarks from them, such as, "What do you think this farce achieves?" and "This is so boring" (to the latter our usual answer was, roughly, "Well we're getting paid for it. If you don't want to use it more constructively then be bored"). For the past twelve months the group has been firmly in Prochaska's stage 1 (Prochaska et al., 1983) of talking about the pros and cons of drug taking. Roughly one per week thinks the cons outweigh the pros and starts considering strategies for stopping (Prochaska's stage 2). Most of these return to stage 1 by the following week. The group is told that the doctor co-operates with the drug squad and that offences may be reported."

This is followed by individual assessment of clients whose monthly prescription is due for renewal. Anyone can, however, be seen should they wish it. Reviews occur between 10.30 and mid-day. Clients have to convince a 'jury' consisting of psychiatrist, social worker, probation officer, and nurse if they want a change in drugs etc (Marks, 1991). The criteria used to agree to or refuse a change depend on the individual case at that particular time. For example, if the client continues to use street drugs, this will be a criterion for agreeing to an increase. If, on the other hand, the client is selling their prescribed drugs, this will be a criterion for a reduction. Information from clients, local workers and police is used as part of the decision making process. The decision is made on a simple vote; one vote per person (Marks, personal communication, 1991).

There has been some reluctance to prescribe increasingly high doses. However research by Allan Parry has suggested that clients may reach a ceiling at between 100 and 500 mg of pure heroin daily, therefore prescribing practices are currently being reviewed. If such doses are given, larger ampoules than those currently used (10 and 30 mg) will have to be produced (Marks, personal communication, 1991).

Prescriptions are posted one week in advance to pharmacists distributed throughout the district and pharmacists are provided with ID cards for each client. There are about 40 participating pharmacists for the Widnes and Warrington clinics. It is seldom that drugs are dispensed less often than weekly, especially syrups and reefers. Ampoules are dispensed three times per week. For people with very ‘chaotic’ lifestyles the distribution days are written on the script; for some the distribution is daily. Clients are entitled to one week's holiday per year and are given enough drugs for that whole period. It is possible for arrangements to be made for the drugs to be taken abroad. It is important that there is flexibility because clients vary greatly in their needs and ability to cope (Marks, personal communication, 1991).

Pat O'Hare (personal communication, 1991) indicated that occasionally people will use several day's allocation in one hit. The reactions of pharmacists are mixed; many would be glad not to have to dispense these drugs. They receive high dispensing fees, with about 80% of the drug cost being the pharmacist's dispensing fee.

There are regulations which govern how drugs must be secured, i.e. the type of safe and how it must be bolted etc. Break-ins at pharmacies were common in the early 1980s, but are rare now. Most pharmacies are open 9 am to 5 pm, but some keep longer hours. Some worry about losing other clients and may not take on drug users or may be selective about those they do take on (Marks, personal communication, 1991).

John Marks (personal communication, 1991) indicated that the Widnes clinic was about to open a 'fixing room' in their basement, where people could administer drugs (especially by injection) on site. This has arisen because the people that the users live with (partner, parents) are often hostile to them injecting at home and police move them on if they inject in parks, which means that they use public

toilets and railway stations. The fixing room is being modelled on that set up by Dr Robert HŠmmig in Bern, Switzerland. There will be two rooms, each about 10 meters square. One room will have half-a-dozen tables each seating 4 or 5 people. On one side there will be a booth with a nurse (not in uniform) and with tea and coffee making facilities. Resuscitation equipment will also be available. In the other room there will be about 30 booths with a mirror in each. The mirror is to aid users while injecting, especially for users who inject into the jugular vein (this is done by some women who have difficulty accessing other veins). This room is where users will inject. The idea of setting up a fixing room is not to condone injecting, but to minimise harm associated with it, given that users will inject anyway.

Clients are taught injection techniques if they are not injecting safely. Early in their contact with the clinic they are watched for their technique and to monitor the effects of the drug (Marks, personal communication, 1991).

Examination for intravenous use, urinalyses or naloxone provocations are performed randomly. While these have a punitive 'feel' they are done to check which street drugs are being used, so that they can be prescribed if necessary. These tests are also carried out to ensure that prescribed drugs are in fact being used and not sold. Tests are done on all clients on a particular day; they are not aimed at individuals (Marks, personal communication, 1991).

Excuses for non-attendance must be notified a week in advance and are usually only permitted for court attendances or regular employment. Checkable documentary evidence must be produced. Those in regular employment need only attend, to be seen individually, once per month (Marks, 1991).

Close liaison is kept with the local drug squad in order to police 'leakage' of drugs. The clinic staff reserves the right to report any criminal activities to the police. In practice much borrowing and lending of drugs between clients at the clinic is ignored, but sale to outsiders is scrupulously forbidden. Clinic staff ask the drug squad to observe clients they think are deceiving staff. The system appears to work well and police and staff are confident of it. Clients have been prosecuted as a result of this procedure but, in thousands of clients, there have been fewer than a dozen such cases (Marks, 1991).

Clients who are prosecuted or who misbehave in other ways (e.g. if they are rude to the pharmacist or GP) are not thrown off the program, but will have their scripts stopped. The length of time scripts are stopped for depends on the behaviour. If, e.g., they are caught trafficking the script will be stopped for a month and they will be reported to the police. Drugs are not provided to people while they are in jail, but they are taken back onto the program after release (Marks, personal communication, 1991).

In 9 years the police have only been called twice to control client behaviour; in both cases the clients left before the police arrived (Marks, personal communication, 1991).

e. Liaison with police

The police do not have a heavy presence around the clinic and do not appear in uniform. The police encourage users to go to the clinic. If they find a user carrying a needle and syringe, these are confiscated and the user is cautioned and given a leaflet with the clinic's address. The user can use the leaflet as evidence for admission onto the program. Police will pick up prescrptions for people in their cells. The co-operation is extraordinary (Marks, personal communication, 1991).

Results of evaluations of programs in the Mersey Region are discussed in Chapter 2 (‘Literature Review: Arguments For and Against Changing the Availability of Opioids’)

Points made by John Marks on Options for a Trial in the ACT

All drugs in all forms should be given out, otherwise the study will be skewed. If there is not a range of drugs, people will sell what they are given in order to buy something they would rather have. In addition, offering injectable heroin which has the best reputation among users will 'get people in' and

they may then be able to be persuaded to try methadone or smokable heroin (on the understanding that they can go back to injectable heroin if they wish). Some will find that they prefer the other drugs or routes.

The trial should be open to people who use any illegal drug otherwise users will switch to heroin to get on the trial. If the trial is only open to people who are currently on a treatment program, the population will be very biased because 80-90% of users never go into treatment.

People who have not taken drugs should not be started on them. The first screen should be urinalysis and if the results are negative people should be automatically excluded. Otherwise urinalysis is rather unnecessary; it is only good for picking up people who are selling their drugs and who should therefore be thrown off the program. People should also be checked for signs of injection and should not be given injectables unless there are 'track marks'.

There need to be waterproof criteria of residential status and the trial should be restricted to local residents. If this is not done the population base is unknown and evaluation becomes much more difficult.

It may also be possible to screen people using hair samples rather than urine. Dr Colin Brewer, from London, has devised such a method and it can be used to assess degree of dependence as well as past drug use.

Dependency status cannot be measured in any but an arbitrary manner and will be fraught with arguments about reliability and validity. It would be better to consider problems resulting from use.

Pregnant women should have the highest priority for inclusion on a trial. If they use black market drugs they are alternatively intoxicating and withdrawing the baby because of the vagaries of the concentration of these drugs. Stabilisation is better for the baby and the mother. They should be offered treatment in preference, but 90% do not want this.

One distribution site per 100,000 people is suggested. It should be like a clinic. A mobile bus would have too high a profile and would be unusual because no other goods are distributed that way. It would also be likely to lead to more complaints from the public, because it would come close to more people. The distribution sites should be in centres of population, places where people gravitate to. It is not a bad idea to locate the distribution points near police stations or probation offices to deter unseemly behaviour. It will not deter people from coming to the site if the police support it. There should be some facility for evening and outreach work, eg see Widnes clinic opening times above. A description of a 'fixing' room is given above.

The drugs should be paid for. As they are very cheap to manufacture, the price should be pitched at an equivalent to the cost for similar levels of use of alcohol or tobacco.

Users must be expected to behave responsibly like every other citizen. The laws applying to drunkeness should be extended to apply to 'druggedness', so if 'drunk and disorderly' is against the law, 'drugged and disorderly' should be too. Criminal behaviour should be treated as it would be for any other citizen. Drugs should not be withdrawn in response to criminal behaviour, just as people who commit crime are not prevented from going to a hotel to drink alcohol. Thinking through what would be done for alcohol and replacing that with drugs is a useful guide.

If there is a control group which does not receive drugs, it will be difficult to keep the control and 'drug' groups separate. Heavily dependent people in the control group will put pressure on those in the 'drug' group to trade, especially on the less heavily dependent in the latter group. A comparison with a 'control city' rather than a 'control group' was suggested.

There must be sanctions to control violent behaviour, continued selling of drugs, commiting of offenses under the influence etc. Marks suggests that the sanction should be cutting off people's prescriptions for varying lengths of time, but maintains that they should never be thrown off the program.

Child care is an important issue. Creches are not provided at 'pubs' and should not be provided at drug distribution points. In addition children should not be allowed in 'fixing' rooms. However distribution points should be accessible (eg retail pharmacies). If children are neglected, welfare should be notified.

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Acknowledgement
Mr Pat O'Hare, Director, Mersey Drug Training and Information Centre also provided useful background information for this section.

SURVEY OF KEY INFORMANTS ON THE WAYS IN WHICH A TRIAL MIGHT BE CONDUCTED

The questions in the section of the report, which were also used as the foundation for many other parts of the report were devised by Gabriele Bammer, Phyll Dance, Remo Ostini and Keith Powell.

Introduction

This report reflects the views of 40 people surveyed about the possibility of setting up a trial in the ACT to make opioids available to users in a controlled manner[12]. They comprise users and ex-users of illegal opioids (n=5), ex-users and users who are also service providers (n=6), other service providers (n=18), and people with academic or bureaucratic interests and experience in the area of illicit drug use (n=11). Responses to the survey questions were gained by interview (n=26) and questionnaire (n=14). Twenty-five of the respondents are male, and fifteen are female. Two are Human Immunodeficiency Virus (HIV) positive.

Those surveyed do not in any way represent a random sample of users, service providers, academics or bureaucrats. On the contrary, they are people who have been selected on the basis of their having given thoughtful consideration to the possibility of such a trial, although they do not necessarily favour conducting one. Consequently, percentages of respondents for or against particular positions have not been given in summarising their views. Instead particular attention has been paid to reflecting the diversity of opinions offered.

From analysis of the material, it is apparent that there is something of a dichotomy in the way respondents have viewed the basis for such a trial. On the one hand the trial was seen as a different approach to drug treatment, the underlying philosophy of which is to help people stop using illicit drugs. Respondents with this perspective generally seemed to view the objectives, conduct, and evaluation of the trial within a medical model, largely consistent with that of current methadone programs. The other view was that the trial was purely for harm minimisation and should be conceived, conducted and evaluated outside the conventional medical model. This is not to say however, that those viewing the trial as operating within a treatment paradigm did not see harm minimisation as a goal - rather that this goal should ultimately be accomplished by getting people to stop using drugs.

It is also necessary to give recognition to a number of issues raised either explicitly or implicitly by respondents which need clarification in order for a trial to be conducted, but are not central to this report. These are the specific objectives of a trial (and whether or not abstinence for participants is one of them), what is meant by harm minimisation, and how dependency can be defined.

Throughout this report, [ ] indicate the analyst's [Beverly Sibthorpe's] comments. Otherwise the statements and opinions are those of the respondents.

Q1. Which opiates* should be made available and which routes of administration should be made possible?

Which opioids?

Methadone only, heroin only, a combination of heroin and methadone, and all opioids (including dilaudid) were options cited. The overall consensus was that a range of opioids should be offered, although a number felt that there was no reason to offer morphine. Methadone was the most contentious drug, some arguing that it works well and therefore "meets all the needs of such a program", while others argued that it should not be used because it is "toxic and harmful", "backward", "horrible" and "hard to get off", and "very unpopular on the streets".

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[12] A copy of the survey questionnaire is at Appendix C.

* The term 'opiates' is used incorrectly in these questions. The correct term is 'opioids' (see Appendix A). It is unlikely, however, that the subtle difference in terminology misled respondents.

Disadvantages noted in offering heroin included that tolerance will occur, requiring larger and larger doses and causing participants to seek the drug on the street as well as from the program. It was claimed that such problems do not occur with methadone.

Advantages claimed in offering heroin included that it is less harmful than methadone, including less harmful to the foetus.

An argument in favor of using methadone and not heroin was the shorter half-life of the latter, necessitating more frequent dosing. One option for overcoming the problem of more frequent dosing with heroin was to offer it in combination with methadone.

An argument against offering methadone was that it is already available to opioid users through current treatment programs. However, such programs were also noted to be too restrictive in terms of their eligibility criteria, behavioural expectations and service delivery.

An argument for restricting the trial to methadone was that dependent users want methadone so that they can get off the heroin "cycle", that they do not want either detoxification or long-term treatment, that all the current rules regarding methadone eligibility should be lifted since they are too restrictive, and that methadone programs should all be public.

One respondent stated that dilaudid is synthesised to be the same as heroin, comes in injectable form, and could be used as a substitute for heroin without users knowing the difference. He felt that the use of dilaudid instead of heroin would have greater community support.

Two respondents, both users, argued that all injectable drugs of addiction should be offered by the program. [This single opinion cannot be taken as an indication of the level of support among respondents for opening the trial to drugs other than opioids, because the wording of the question would have precluded getting such an opinion from most of them.] It was felt that the deliberations of the Select Committee on HIV, Illegal Drugs and Prostitution had failed to take account of the role of other drugs in the issues being reviewed by it.

Which routes of administration?

Oral, inhaled (snorted and smoked) and injected routes of administration were all cited as options. There was a fair degree of consensus that user-choice should be a determining factor.

Points in favor of injection of heroin were that it is the route of administration that participants would want most, it requires less of the drug, and it provides an opportunity to teach proper injection technique. However, the issue of potential lack of community acceptance of injection as the route of administration because it is "self-mutilating", and therefore feared by the community, was also raised. It was felt by this respondent that it would be politically more acceptable for the study to be involved in steering participants away from injection as the route of administration. The poor quality and purity of injectable heroin currently available on the street was seen as a possible motivator for injectors to accept good quality smokable heroin through the program.

Other arguments against injected use included that the trial should be steering users away from injection use because of the risk of HIV. Injecting was also claimed to have a negative impact on the immune system, an important consideration for HIV positive participants. It was also argued that smokable heroin should be offered to get people away from injecting, and that the "rush" from smoking heroin is the same as from injecting it, but because it requires more of the drug to get the same effect through smoking, it is usually too expensive to buy it on the street.

The issue that needle use is in and of itself a key feature of addiction for some people was also raised.

One respondent suggested that only single-use syringes should be made available for injection.

Q2. What should be the characteristics of users who participate in the trial?

Q10. What should be the criteria for screening people who wish to come onto the trial?

Q11. What should be the process for screening people who come onto the trial?

These are all interrelated and complex questions with the most divergent responses!

There was broad disagreement among respondents whether the trial should be confined to dependent opioid users or open to all opioid users, but the weight of opinion tended to favour restricting the trial to those dependent or "hard-core". While those in favour of this position tended not to state why they felt this way, a few indicated that they thought that it was the only option that was politically feasible.

Those in favour of less restrictive recruitment argued that if the trial was for harm minimisation it should be open to all those at risk. In particular, the risk of needle sharing among binge users was cited as a reason for including them in the trial. It was also felt that the trial could not be properly evaluated if non-dependent users were excluded. An argument in favour of including non-dependent users was that this would remove the incentive for them to become dependent in order to get on the trial.

For those in favour of restricting the trial to dependent users, factors such as long-term use, "trackmarks", a history of legal, health and social problems, previous failed attempts at treatment and being on a waiting list and unable to get methadone, were cited as eligibility criteria. It was argued by one respondent that enrolling "less involved" users could give a false sense of the value of the trial and that it would subsequently be difficult to argue that such people could not have done just as well on methadone. Another respondent argued for careful selection of [heavy] users because he had himself become a heavy opioid user after being allowed on a methadone program through inadequate screening. It was also argued that the trial should not include occasional users because they could just stop [using drugs]. "Having a habit for two years" was suggested as a criterion for eligibility.

One respondent saw value in the trial for a wide range of users from young people who could not get their lives under control and faced possible imprisonment, people who have had unsuccessful attempts at rehabilitation, and 20-year users who have no desire to stop using drugs.

In general respondents felt that the trial should be restricted to primary opioid users, [which does not however exclude primary opioid users who also use other drugs.] Only one respondent (a service provider) felt that the trial should be restricted to people who used only heroin.

It was also argued however, that the trial should not be restricted to primary opioid users because the primary drug used is not fixed, but depends on a range of factors such as availability. This respondent felt that if the aim of the trial was harm minimisation then it should include everyone at risk for HIV, including polydrug users.

In relation to this issue, one respondent noted that the trial population should be representative of the population which would be targeted for program implementation (should it go ahead after a successful trial), rather than a subset of it. He felt that it would be hard to limit such a program to anything less than all heroin users.

Being currently in drug treatment was cited as a criterion for both exclusion and non-exclusion. A number of respondents noted that many people currently on methadone would want to switch to the trial. It was also argued however, that long-term heroin users who switched to the trial would need very large doses of heroin for very long periods, and that this would be unacceptable to the community. One respondent felt that the trial should be restricted to those people already accepted for or meeting the criteria for a methadone program, but excluded from such a program because of their behaviour - i.e. continuing to use drugs or not conforming to other program rules.

One respondent felt that the trial would attract [dependent] heroin users who were not attracted to methadone as an option, and would thus constitute an important harm minimisation strategy for this population.

The issue of participation for those on remand was also raised by one respondent who felt that such people should be included in the trial but that their possible coercion into it [by the courts] could be a confounding factor. [See also Desland and Batey, 1990].

Harm minimisation was seen by one respondent to be a good reason for letting young people join the study, but others argued that there should be a lower age limit (e.g 18-20 years, and 21 years were suggested). In particular, it was felt by one respondent that the trial should not be seen to be "giving opiates to children".

It was also argued that both partners in user-couples should be included in the trial. It was stated that this is not done with methadone programs and that as a result one person "pulls the other down". The need to put parents on the trial was raised by one respondent who felt that mothers, in particular, had considerable demands on their time, and that being on the trial would free them up to cope with these demands. Couples in which only one partner was a user were identified as problematic in the context of conventional treatment, but it was argued that having the user on the trial could bring some stability back into the lives of such couples.

One respondent felt that people with a history of violence should be excluded and others that people on psychiatric drugs should be excluded. People whose lives were "so chaotic" that they would be unlikely to benefit from the trial were suggested as exclusions. Another respondent argued for including only compliant and non-manipulative people. It was also argued however, that all users should have access to the trial, not just "good people", in order for it to be properly evaluated. One respondent, assuming that there would be more people than places in the trial, wanted to select only those who were knowledgeable about the politics of drug use.

It was suggested that people at legal risk should have priority access to the trial in order to keep them out of jail, but it was also argued that the trial should not just be a "keep-out-of-jail" process.

Current significant physical disease was suggested as a criterion for exclusion from the trial.

A very small minority felt that pregnant women should be excluded, and one that women at risk from pregnancy should be excluded. It was also suggested that breast-feeding mothers should not be allowed on the trial.

Alluded to by only a small number of respondents was the issue of whether or not participants would have to be interested in changing their drug use behaviour. One respondent felt that a "commitment" to opioid use should be an eligibility criterion, which implies that a lack of desire to stop using opioids should be a reason for inclusion. An opposing view was that people should only be allowed onto the trial if they were looking to overcome their dependence on drugs.

Eligibility criteria and the screening process

Defining eligibility criteria and the screening process were widely seen to be problematic, given the difficulties associated with measurement of dependency (see Q13 below), self-identification of use-status, and determination of a cut-off for trial inclusion.

In line with the weight of opinion favouring restricting the trial to dependent users, screening criteria were generally seen in terms of making a distinction between dependent, "long-term", or "heavy" users and others. Three broad options were suggested. The first was for some form of social screening process, the second was for physiological screening and the third was for a combination of the two.

There was broad consensus among those favouring a restricted trial that a combination of social indicators would be sufficient to determine who really had a "habit". A number of respondents suggested that staff at organisations such as the Drug Referral and Information Centre, the ACTIV League and methadone programs, and doctors working in the field would "know" who the heavy users are. There was general agreement among those favouring exclusion of non-dependents however, that determining eligibility could be difficult to do.

One respondent felt that eligibility could be determined by finding out the cost of a user's habit, inclusion being based on expenditure of more than $400 in the previous two weeks.

It was argued that self-identification would not be a reliable method to determine eligibility and one respondent felt that users would lie about themselves to get on the trial. On the other hand, it was also argued that drug dependents know who they are and that "if a user says they are dependent then they are."

Lifestyle factors, level of dependency, HIV risk behaviours, residency, legal issues, age, period of drug use, mental and physical health, and pregnancy status were all mentioned in relation to eligibility criteria. One respondent felt that sets of participants with different characteristics - no previous drug treatment, long-term dependent, long-term methadone user etc. - should be selected from the applicant pool to evaluate the trial's effect on different users.

Some people felt that strict eligibility criteria should be established, but it was also argued that this could be setting people up to tell lies. Others felt that the screening process should be flexible, particularly more flexible than methadone programs.

There was widespread agreement that the screening process should be done by a group of people such as a "panel" or a "committee". Doctors, counsellors, and the users themselves were seen as the people who should be involved. Medical screening was seen to be important in light of the "dangerous" nature of opioids. It was also argued however, that doctors and other "medical-model" people should be kept out of the screening process. One respondent felt that the screening process could be the same as for methadone but "more sympathetic".

Several respondents were concerned that the screening process could be quite threatening to users.

One respondent felt that there should be no waiting list for assessment and users should be able to start on the trial within two to three days of assessment.

Another respondent felt that the trial would be a failure if screening was through a court process.

Q2a. How should people be recruited?

This question was added to the survey after the questionnaires had been sent out, so responses have been gained only from those subsequently surveyed by interview. Sixteen out of 40 respondents were asked this question.

Most respondents felt that current government and non-government agencies and providers working with illicit drug users would be sources of referrals for the trial. Suggestions included the Drug Referral and Information Centre, the Needle Exchange Program, ACTIV League, methadone programs, and general practitioners. However, it was also argued that some providers already had too much power over drug-users and that alternate sources of referrals should be sought.

Word-of-mouth was also thought to be a way that a range of drug users would hear about the trial. One provider felt that a publicity campaign and public meetings should be held about the trial and that this would cause users to enquire about it.

There seemed to be a consensus that there would be no problem finding participants.

Q13. How can people's dependency status be measured?

The was some consensus that dependency status is difficult to measure and opinions on how to do it were diverse. Overall however, most respondents were in favour of non-physiological approaches. Thus, it was widely felt that a drug use history, with or without a physical examination, was the way to measure dependency status. The severity of opiate dependence questionnaire (SODQ) was cited as an instrument that has been tested for reliability and validity. [See Sutherland et al, 1986].

Supervised withdrawal was seen as an option to assess dependency, but one user-respondent argued that she "wouldn't wish it on anyone". The World Health Organization's definition of dependency

status, which includes behavioural, physiological, social and psychological factors was also cited as an appropriate model [see Johns, 1990, p10]. Using a narcan/naloxone challenge was the most contentious method, some suggesting it be used either alone or in conjunction with a history and others arguing that it is "ethically doubtful", "has largely been discarded as cruel and unusual punishment", and "is not very helpful". It was argued that if this method were to be used the possibility of sore joints, cramps and diarrhoea among participants would have to be considered.

A review of the procedure for naloxone challenge by Judson and Goldstein (1983) was cited. Also mentioned was a protocol for using naloxone eye drops to measure dependency status (Creighton & Ghodse, 1989; Allen et al.,1983).

One respondent felt that the medical model used for methadone programs was most appropriate because user reports about their level of dependency could not be relied on.

Institutional records, urine tests and blood tests were also suggested as adjuncts to the measurement of dependency status.

Psychological rather than physical dependence was noted by several respondents to be an important factor which cannot be measured physiologically, but should be included as a criterion for trial eligibility. Other respondents argued that dependency is not a fixed state, but is determined by context and circumstance, and that the label "dependent" is an attempt to "medicalise behaviour".

Those who thought that the trial should be open to occasional users did not see any need to assess dependency. It was also argued that dependency is not a fixed state, but something that people "wander in and out of" and experience to different degrees throughout their drug-using history. Measurement of dependency was seen by this respondent to be making people into "victims". Another respondent felt that even people who use only once a month are still dependent on that use.

A small number of respondents interpreted this question as relating to determination of the doses for trial participants. While some felt that participants would be able to say how much they needed, others thought that "starting small" and increasing the dose gradually was the best way to decide on individual doses. One respondent argued that participants would be unlikely to take more drug(s) than they needed, and that only a few would be wanting to build up their dose. Another noted that under-dosing would force participants to search for other drugs.

Q15. Should pregnant women be allowed on the program?

There was a high level of consensus among respondents that pregnant women should be allowed on the program. It was argued that pregnant women would continue to use drugs and being on controlled doses of pure heroin was better for the mother and the foetus than using street drugs; that being on heroin was better for a pregnant woman than being on methadone; that being on the trial would minimise their risk of contracting HIV and hepatitis; and that pregnant women would get better ante-natal care by being on the trial.

Some of those who supported the inclusion of pregnant women on the trial were also supporters of the trial drug being methadone, rather than heroin. Reference was made to research showing the positive effects of a good methadone maintenance program on pregnant women (Giles et al, 1989; Patterson et al, 1990).

A small number of respondents argued that pregnant women should be given priority for inclusion in the trial, and one person that it should be mandatory to include them. In the latter case however, the respondent was referring to methadone.

It was also argued that controlled dosing would be very beneficial for pregnant women because they tend to have to use [other opioids] over their methadone while they are pregnant because they are not given enough. After the baby is born the pregnancy dosage of methadone is too high for their needs and they are "sleepy and out of it".

A number of respondents felt that while pregnant women should be included on the trial, efforts to get them to reduce the dose or stop using drugs altogether should be a condition of their participation.

Arguments against the inclusion of pregnant women were that they do well enough on methadone; that it is encouraging rather than discouraging drug use during pregnancy; that the foetus would be an unwitting research subject; and that there are the problems of neonatal withdrawal and pregnancy complications. One respondent argued that the available evidence suggests that women on heroin who become pregnant should be given methadone.

One respondent raised the issue of a strong desire for a child among many heroin dependent women, and their increased risk of needle sharing because of their dependency on their drug-using partners for access to both drugs and syringes. It was argued that this would be an important reason to include both pregnant women and their partners on the trial. This respondent also felt that pregnant women were already subject to other forms of discrimination and excluding them from the trial would simply be another dimension of this discrimination.

Q3. What should the distribution point(s) be (e.g. health care centre, mobile bus)?

Q4. Where should the distribution point(s) be (considering particularly accessibility and driving under the influence)?

Q5. When should the distribution points be open?

Q6. Who should staff the distribution points?

Q7. If the drug has to be administered at the distribution site, how can this be made a pleasant/acceptable experience for both users and staff?

Where?

Most respondents thought that a fixed distribution point or points, rather than a mobile unit (such as a bus), was the best option.

Health centres, methadone clinics, doctors' offices, hospitals, the Drug Referral and Information Centre and pharmacies were all suggested as possible sites. Many respondents did not make the point directly, but by inference, that a separate program site was also an acceptable option. Responses were determined to some extent by the drug that the respondent thought should be distributed and the route of administration. For example, pharmacies were suggested as a possible option for distribution of trial drugs if participants were not going to be injecting the drug(s) on-site.

A point that was made in support of siting the distribution point in a health centre was the availability of other health services on site. A counter argument was that people who never come to health centres would not come to a clinic-based distribution point. However, opinion in favour of siting it/them in health centres far outweighed the negative view.

Hospitals seemed to be the most contentious of the possible sites, some saying that a hospital setting would be an acceptable option and others arguing against it because, for example, "of the judgmental bigotry of nursing staff" towards drug users. An argument in favour of hospital-based distribution was the ready availability of emergency medical services.

Methadone programs were suggested by one respondent who also pointed out however, that the limited number of methadone places could give the appearance that those who could not get methadone were being put on "compulsory heroin" instead.

Two alternatives to fixed distribution points were suggested. The first was a bus as a mobile distribution point and the second was for home delivery. Arguments against a bus largely centred around potential problems with security but there was also a sense that the general community would not tolerate a bus. One respondent also felt that dispensing the drug(s) from a bus would be a confounding variable in the evaluation of the effect of the trial relative to [fixed point] methadone

programs. An advantage of home delivery was that it would protect the privacy of people on the trial. In contrast, it was felt by one user that going to a bus parked in the street would be "too obvious".

How many?

There was widespread support for having multiple distribution points, located in the main commercial centres around the city, near the bus interchanges. If the trial was to be restricted to one site only, Civic was suggested as the best option. One respondent felt that a "secret" house in Turner, with beds so that people could relax after taking their doses, would be an option.

With respect to siting of the distribution points several key points emerged including that they should:

1) "blend in" with the community
2) be in a busy, public place
3) be close to public transport
4) be safe and secure

One respondent felt that the distribution points should be away from residences.

Transport was seen to be a barrier, largely but not totally overcome by location of the distribution points close to public transport. Having some service, staffed by volunteers, to transport participants to the point(s) was suggested as an option. One respondent felt that such a service would help to foster social ties among participants. It was noted however, that there would be significant administrative problems in running such a service, and another respondent felt that the problems associated with getting people to the points on time would not, in fact, enhance community feeling among the participants.

One respondent felt that users would be happy to travel to be on the trial, that the problem [of travel] for dependent users would be no worse than usual, and that the non-dependent would have more time to travel and possibly have a car.

There was little consensus on the issue of the dangers of travelling from distribution points while under the influence of drugs. Some felt that this was a concern which had to be considered while others felt that it was an overrated problem, at least with respect to heroin. It was also noted that this is not currently seen to be an issue with methadone programs.

One suggestion for distribution was a vending machine which dispensed the drug following keying in of a participant's PIN number.

Hours of operation

The key point to emerge in relation to the hours of operation of the distribution points was that they would need to cater to the needs of working users. There was a difference of opinion as to whether or not the points would have to be open 24 hours a day, but most respondents seemed to think this would not be necessary. However, the issue of whether or not take-away doses would be allowed was a factor which clearly influenced this. In general, it seemed that respondents felt that take-aways would have to be allowed if the points were not open 24 hours.

One respondent argued for 24 hour access because of the individualised nature of drug use, some people using all night and some people using all day [but take-away doses could overcome this problem]. The short effect of heroin (only 4-6 hours) was cited as a reason for the distribution centres to be open 24 hours.

Several respondents thought that "split-shifts" with opening times in the morning and evening and closures during the middle of the day would be an option. It was also argued however, that the centres should cater for all types including workers and people who do not get up until the middle of the day.

Opening hours of 12noon-12midnight, 7am-7pm, 7am-10pm, 7:45am-10am and 3pm-6pm, and 24 hours were all suggested as possible hours of operation for the distribution points.

One respondent thought that the opening hours should be flexible, not "hard and fast", so that the facility would stay open if someone was expected to collect a dose but had not yet arrived. It was also

argued that participants should not have to collect their doses at fixed times in the regimented way used by methadone programs. One respondent who thought the trial should be open to occasional participants thought the points should be open for "party time" on Friday night.

One respondent suggested that trial participants be asked what times the distribution points should be open.

Staffing

There was general acceptance that medical personnel would be appropriate staff for the distribution points. Counsellors were also cited as being appropriate, although one ex-user argued against alcohol and drug counsellors on the basis of their "punitive and myopic" approach to drug users. Social scientists and consultant psychiatrists were also mentioned as staffing options.

Ex-users and users were not usually considered to be the best staffing option because it was "too risky" to put them in a heroin clinic. However, one respondent thought that users would be a staffing option as long as they were on doses themselves, and another that medical staff who were themselves ex-users would have the greatest awareness of participants' needs.

It was variously noted that the staff would need to be:

1) well-trained
2) non-judgmental
3) empathetic and understanding
4) able to establish rapport with participants
5) committed to the program
6) free of a vested interest in seeing the trial fail
7) without an abstinence-based philosophy.

It was noted by a few respondents that staffing of the distribution points would be determined by legal controls over who can dispense opioids. This may have been an unacknowledged factor in the widespread support for medical personnel to staff the distribution points. Public acceptance of the trial was also seen as being enhanced by having trained medical personnel staffing the distribution points. A few respondents saw the best staffing option as having some division of labour where medical personnel were on hand but non-medical staff actually distributed the drug(s).

The issue of security was raised, both in relation to the siting and the staffing of the distribution points. It was not clear in most instances however, whether security was thought to be necessary to protect staff from participants, or staff and participants from outsiders. Some respondents thought that security staff (as opposed to a secure site) would not be necessary, and it was noted that it would be offensive to participants. Others argued for having security staff, including an armed guard, but this was a minority opinion. One proposal was for a bank-type security system, to allow contact with police in the event of trouble. Another was to have a keycard security door.

The facility/facilities

The factors most obviously influencing responses to the question regarding the distribution environment (Q7) were whether or not respondents thought that the drug(s) should be administered on site and how they thought they should be administered.

For those who were in favour of on-site administration of heroin, either by injection, oral or inhaled routes of administration there was widespread agreement that the environment should be safe, pleasant, comfortable and non-clinical; should afford some combination of privacy and surveillance; and should be conducive to unhurried drug use. Posters (none anti-drug), health information brochures, artwork by "addicts", music, TV, tea and coffee, biscuits, and comfortable chairs/couches were all suggested as part of the setting. Implicit in all the responses regarding on-site injection was a belief that participants would be injecting themselves, with or without direct supervision.

Specific issues relating to the facility included that vomiting would be a problem after dosing with heroin and needed to be considered in the planning. Making provision for smoking of cigarettes and/or other drugs, was also raised as a facility issue. One respondent suggested the need for a non-draughty

room for smoking heroin, while another raised a concern about the effect on staff of smoke (from any drug). A structure which would allow staff to obtain supervised urine specimens was suggested.

Child-care and a playroom were also cited as necessary components of a facility.

Minority opinions regarding the facility included that the drugs should not be administered on-site; that they be administered orally, immediately, along the lines of current methadone program procedures; that users not be encouraged to stay around after taking their doses; that injection could take place in the toilet; that there needed to be provision made for people to inject in a communal setting; and that the best outcome might be that participants did not enjoy the experience of shooting up.

Burglar alarms, push button dispensing and bullet proof glass were suggested for security. One-way screens and video cameras and "spy holes" were suggested as ways to provide both privacy and surveillance.

The need to be able to supervise the injection technique of large numbers of users was seen as a facility design issue.

Q14. Should participants be restricted to those living in the ACT? Should people living in Queanbeyan be included? How could we enforce residency criteria?

Respondents were divided on the issue of whether or not to include Queanbeyan users in the trial but more were in favour of including than excluding them. Some of the reasons given for including them were that Canberra and Queanbeyan function as one area and this is formally recognised by the Australian Bureau of Statistics in their demographic analyses; that the ACT drug scene started in Queanbeyan; and that Queanbeyan residents would benefit from a trial.

Problems of interstate negotiations, particularly in relation to the movement of a controlled substance such as heroin across the state border, and the cost of providing the service for non-ACT residents were cited as reasons for excluding Queanbeyan residents. One respondent was ambivalent about the inclusion of Queanbeyan because of what she felt was a tendency on the part of NSW to leave the ACT to provide services for NSW residents.

The issue of trial numbers was raised as an argument both for and against including Queanbeyan users. It was felt on the one hand that trial places would be very limited and therefore should be restricted to ACT residents, and on the other hand that Queanbeyan residents would have to be included in order to get sufficient numbers to run a trial.

For the majority who agreed with some residency criteria, determining eligibility did not seem to be particularly problematic. Driver's licenses, electoral rolls, bank statements, bills, rates notices, social security records, Medicare cards, police records, the telephone directory, drug counsellors, methadone programs, Needle Exchange Program staff, and mail to an ACT/Queanbeyan address were all cited as potential sources of proof of residency.

A very small number of respondents felt that the catchment area should include ACT, Queanbeyan and the surrounding district; that there should be no residency criteria, as for methadone in the ACT; and that residency criteria would be unenforceable. However, many more respondents expressed concern about the possible "honey-pot" effect of a trial, which could attract users to the ACT if residency criteria were not enforced.

One respondent felt that the issue of residency was problematic because drug users tend to be mobile. She felt that users who had lived in Canberra but were not doing so immediately prior to wanting treatment still had family and close friends in the area [for support?] and should be allowed to join the trial.

One respondent felt that people should have to produce evidence of living within reasonable access to the distribution points to be included in the trial.

A few respondents apparently interpreted this question as relating to enforcing residency throughout the duration of trial participation, rather than as a means of establishing eligibility to join the trial. There was some sense among them that enforcing it throughout the trial would be difficult to do, but home visits were suggested as an option which would have the added benefit of being a "desirable feature of the treatment process".

For those few who suggested a period of prior residency for eligibility, responses ranged from 6 months to 2 years.

Q8. If the drug is allowed to be taken away, what insurance could there be that it is not diverted or used in a way which is harmful to community interests?

Responses to this question were influenced in the first instance by whether or not respondents felt that take-aways should be allowed. Without take-aways there was seen to be no risk of diversion and this was in fact put forward as one of the main reasons for not allowing take-aways. It was noted that diversion is a problem with the current methadone distribution system.

The opinions of those who were considering take-aways as an option fell into two broad groups - those who felt that there was no way diversion could be prevented (and, by implication, that it would happen), and those who felt that it was not likely to occur. In general, respondents were more likely to support the view that there was no way that diversion could be prevented. Diversions to non-participating partners and to other users in participants' households were seen as particular problems, which could be dealt with by ensuring that user-partners or user-householders were included in the trial (see also Q2 above).

Among those who thought that diversion was a minimal risk with take-aways, dose controls were seen to be the major factor in preventing it. Such opinions included that people given the correct dose would "get their lives in order" and have no need to sell the drug(s); that participants would not sell pure heroin to get money to buy "crap" on the streets; and that users' priorities were using, not selling. Only allowing smokable not injectable heroin as take-away was seen as a way of reducing the likelihood of diversion.

A few respondents commented on the impact of diversion on the street market. It was felt that the quantities likely to be diverted would have little impact on this market, but the point was raised that an appearance of diversion to the street market could have negative consequences in terms of community support for the trial.

Specific strategies suggested to *monitor* diversion included biochemically labelling the drug(s) with some harmless or inert compound such as pyridoxine and performing routine urinalysis to ensure that the doses had been taken; random urinalysis for the drug(s) distributed; and keeping close links with services familiar with the drug scene to find out whether or not diversion was occurring. One contrary opinion was that urinalysis (for drugs) would not be an effective method for monitoring diversion.

Specific strategies suggested to *prevent* diversion were first and foremost to not allow take-aways; to only allow smokable drugs to be taken away; to tag containers, vials, ampoules etc and distribute dose(s) on an exchange basis (empty for full); to dispense the drug(s) in single-dose containers not easily opened for splitting or diluting; to supply only the minimum amount of drug(s) required; and to be suspicious of requests for dosage increases once individual dosage patterns had been established. One user-respondent thought that doses should be delivered to participants' houses where they would then be taken under supervision - if the drug was not needed immediately then the dosage should be reduced.

It was also argued that laying out the terms of the trial to participants, telling them that its success or failure depended on their co-operation, and keeping them involved through on-going liaison with trial staff could prevent the majority of diversion.

One issue raised in relation to this question had to do with the problems/dangers to participants of allowing take-aways. One respondent noted that he was "hassled" by other users for his methadone, and another raised the issue of participants being robbed of their doses after they left the distribution

points. Take-aways were also seen to make trial participants vulnerable to break-and-entry crimes by other users.

Q9. Should the drug be free or should the users pay? If you think users should pay, how much or how should the price be determined?

Responses to this question ranged widely from providing the drug(s) free, charging a small nominal fee, charging the standard prescription fee, having a means test, charging it to Medicare, having participants do community service in lieu of a fee, recovering the cost of the drug(s) from participants and recovering the cost of the whole trial from participants. Sums of $1-$2, $5, $7, and 20% of the street price were also suggested. The majority were in favour of providing it free or for a nominal sum.

Arguments in support of charging included that participants would value the service more and take it more seriously; that users had to pay for their drug(s) now and could therefore do so on the trial; and that having some charge would enhance the likelihood that a full-scale program would be implemented because it would counter financial arguments against it. There was broad agreement amongst those favouring some sort of charge that no-one should be refused a dose because of inability to pay. One respondent, a user, felt however, that the cost of the drug to participants should be high enough to provide some sort of motivation to reduce drug use. Another argued that the cost should be sufficient to discourage first time or casual use, and that there should be no cost to the tax-payer for the trial.

One respondent suggested that participants should pay for their syringes to give them some "onus of responsibility".

Arguments in support of providing the drug(s) free were that it was to the benefit of the community so the community should pay for it; that it was immoral to charge people to take part in a research project; that it was self-defeating to offer a service to counteract the effects of (illicit) drug use and then make people pay for the drugs (because they may still have to steal to pay for them); that most of the participants would be unemployed and unable to pay; and that the harm minimisation objective made it necessary to provide the service free, as with methadone. It was also argued that charging for the trial drugs would create confusion in interpreting the results relative to those of other treatment modalities which are free.

Two respondents suggested that payment during the trial should be determined by whether or not payment would be required in a full-scale program should implementation proceed.

Q12. What are the advantages and disadvantages of setting up a register of dependent people or of users generally?

This question was interpreted by some respondents as relating to a register only of participants in the trial, while others interpreted it as having to do with an overall register of dependents or users in the region. For a third group it was not clear whether they were responding to the idea of a trial or a general register.

Those who seemed to be thinking of it in relation to the trial saw the following advantages; it would protect participants with take-away doses from police harassment because they could prove they were carrying the drugs legitimately; it would allow tracking of participants and collection of statistics on them; it would validate the study and allow anyone who got involved to see that it was legal and "upfront"; and it would prevent participants from registering more than once or collecting multiple doses from multiple distribution points. It was also noted that many dependent users are already registered for methadone.

Those who were considering the setting up of a general register felt that its advantages included that it would allow people to prove they were dependent without having to go through painful withdrawal tests (i.e. if it was a register of known dependents compiled from drug-service agencies etc); that it would allow a better estimate of the number of drug users to be made; and that it could be used as a resource for targeting education campaigns.

The overwhelming concerns or disadvantages reflected in both the trial and the general register responses were those of confidentiality and infringement of civil liberties. The possibilities of the register being used for other than its specified purposes, becoming known to the police, courts, taxation or other public entities, or being computerised and "hacked" were all seen as important issues. A related but not identical point was that if the police gained access to such a register they could use it for the purposes of locating people in relation to criminal activity.

One user-respondent said that drug-use information was supposed to be confidential but "drug and alcohol problem" went on all his documents. He believed however, that "most addicts didn't care" unless they were "high-profile" people like doctors or lawyers.

Using only coded identifiers, or fingerprints, on the register was suggested as a possible solution to the problem of confidentiality.

Other disadvantages of a general register were that it was a labelling device with negative social implications; that it would never be current or complete; that attempting to maintain and update it would be a waste of resources; and that it would give a false impression of the extent of drug use in the community, because of its likely inaccuracy. In particular, it was thought unlikely that occasional users would want to disclose their drug use and go on a register of users. The resulting under-estimation of the extent of the drug problem was seen to have a potential negative influence on funding of services for harm reduction amongst drug users.

One respondent argued that it would be embarrassing and degrading to have one's name on a register and pointed to a dilemma for users in that the worse you are, or say you are in terms of your drug use, the more likely you are to get registered and get help (e.g. methadone). A related point raised by other respondents was that there was the potential for users to increase their habit to get on the register and thus be eligible for inclusion in the trial. For this reason it was argued that the register of dependent users should be set up *before* any public announcement about the trial was made. Other respondents felt that having a trial register would deter users from participating.

Overall, more disadvantages than advantages were seen in having a register and a number of respondents felt that it would serve no useful purpose.

One respondent argued that the possibility of setting up a register should be one of the issues assessed as part of the trial.

Q16. Are there particular issues around the inclusion of people who are HIV positive or who have Hepatitis B or C?

HIV

Almost all the respondents argued either explicitly or implicitly that HIV positive users should be included on the trial, and a significant number of respondents thought that they should be given priority. An argument for including them on the trial was that it would reduce the risk of transmission associated with street use of drugs. In support of their priority access, one respondent argued that HIV seropositives have been proven to have better immune function on pharmaceutical than street heroin [but there does not appear to be any evidence to support this].

A cautionary note about making priority access for seropositives public knowledge was that this might encourage users to become HIV positive in order to get on the trial. One respondent said that this had happened among "street kids" in Sydney.

The problem of potential transmission of the virus was raised. In particular, allowing take-away injectable drugs was seen to be problematic, necessitating strict drug administration guidelines; "guarantees" that no needle sharing took place; restricted administration to linctus of heroin only; or banning of take-away injectables. One respondent who wanted methadone to be the only drug distributed on the trial felt that all people at risk for HIV or hepatitis should be on methadone.

Confidentiality of participant serostatus was mentioned as being an important issue. Some respondents felt that the staff would have to be informed as to who was HIV positive. The issue of testing for HIV in association with trial participation was also raised. It was argued that testing could not be compulsory for trial participation. (See Q20 below for other comments about HIV testing).

Risk to staff of HIV transmission from participants was mentioned, but it was noted that this was no different from the risk to staff in other medical settings. Safe needle disposal was also mentioned as an HIV-related issue.

Integrating trial participation with medical care was seen as being important for seropositives. Thus, one respondent felt that primary care providers would have to be informed that their HIV positive patients were on the trial, and that the providers would have to play a major role in their overall management. The effects on the immune system of continuing to use drugs was also seen as an issue for HIV positive participants.

Safer sex counselling, free condoms, health education, nutrition education, instruction in injection technique, safe needle disposal, well educated staff (around HIV issues), and careful monitoring for potential drug interactions were all mentioned as HIV positive related issues.

Hepatitis

There were fewer issues around hepatitis raised by respondents. One respondent thought that around 80% of participants would be positive for either B or C.

Among those who commented, it was generally felt that people with either hepatitis B or C should have priority. It was also argued however, that using has an adverse effect of the health of people with hepatitis. The need for health and nutrition education in relation to hepatitis was also raised.

Q17. Should people on the trial be allowed to continue to use other illegal drugs?

Responses to this question ranged from no other drug use, to only marijuana/cannabis, any drugs except opioids, any drugs but with an expectation of reduction in their use, and yes (any drugs). An often repeated comment was that "ideally" no other drug use should be permitted, but that it would be impossible to prevent. Banning the use of other drugs was also seen as a possible deterrent to continued participation in the trial.

Several other points were raised in relation to the use of other drugs. It was felt that if the dose of opioid given to trial participants was appropriate for their needs they would not have any desire to use other opioids. A related point was that use of non-trial opioids would be an indication that the trial was not working. Opioid use through the trial was thought to be unlikely to change the use of other drugs and a number of respondents argued against expulsion from the trial on this basis, because it would not accomplish anything and was reminiscent of the punitive regulations used by methadone programs. A counter argument was that the trial should have the same requirements as methadone programs regarding use of other drugs. It was also argued that other drug use should be allowed because the aim of the trial was harm minimisation, not abstinence.

One respondent felt that use of other opioids should not be permitted because of the danger of overdose, while use of other drugs by participants was of little interest to the trial. Another (user-respondent) felt that people who continued to use "speed" and heroin while on the trial should be expelled because they would be showing they did not want help and would spoil the program for others.

Several respondents argued that banning the use of other drugs by trial participants would be undermining the research, one of the objectives of which was to determine whether or not providing opioids to users would reduce illegal drug use. One respondent thought that use of other drugs would have to be quantified as part of the evaluation. He argued that if trial participants still used 20% of the time, then the trial would not have accomplished anything that could not have been accomplished on methadone.

Q18. Should there be behavioural standards which people on the trial should be expected to meet in conducting their daily lives?

There was some consensus among respondents that behavioural standards, particularly relating to physical or verbal violence or abuse, should be expected and enforced at the distribution points. A small number also felt that participants should be expected to arrive on time for their doses. Dealing drugs was also mentioned as an activity that should not be permitted at the distribution points.

Beyond the distribution points it was generally felt that behavioural standards could not be enforced or would be intrusive. Some argued that the purpose of the trial was to bring about improvements in participants' behaviour so this should be evaluated, not prescribed, as part of the conditions of the trial. Respect for participants' privacy and human rights were seen as relevant to the trial as to any other service.

On the other hand, a few respondents did feel that behavioural requirements, including no criminal activity, no other illegal drug use, responsible sexual practices, no violence and improvement in social functioning should be incorporated into the trial conditions. Wanting the trial to be a "success" and being concerned about the public's perception of the trial if participants continued to engage in anti-social behaviour were given as reasons for instituting such requirements.

One user-respondent argued that stabilisation on heroin would lead to significant changes in participants' lives because of the time they would have available that had previously been taken up "maintaining their addiction". She felt that it would be important that the trial incorporated help in the development of interactive skills to help foster the formation of social ties and a constructive lifestyle.

Q19. Should people on the trial be required to undertake counselling?

Regardless of whether the trial was perceived as drug treatment or an alternative there was widespread agreement that counselling should be optional not required. Arguments in support of this view were that you cannot force people into counselling; that if it is coercive it is not effective; that participants would already have had "heaps" of counselling; and that mandatory counselling would act as a deterrent to trial participation.

A small number of respondents thought that counselling should be mandatory so that the success of the trial could be gauged; so that evaluation data could be collected; and so that participants could be encouraged to "open up" which they would not do without counselling. Mandatory counselling options proposed were for an initial session then optional follow-up sessions; fortnightly sessions; and a varied schedule to allow for brief encounters at dose collection times.

A number of respondents had questions about what was meant by counselling in this context. Help in adjusting to lifestyle changes, "practical support", advice about safer sex, and an opportunity for staff to keep in close touch with participants were all seen as valid reasons for having counselling.

Two respondents who appeared to support the treatment trial paradigm thought that, with or without counselling, there should be regular (e.g. monthly) reviews of "treatment".

One user-respondent and one provider-respondent had concerns about the potential for any counselling to be moralistic, to imply that participants were sick, and to be directed towards getting participants to stop using drugs, which was not seen as a trial objective.

Q19a. What treatment options should be made available?

Q19b. Should they be compulsory?

These questions were added to the survey after the questionnaires had been sent out, so responses have been gained only from those subsequently surveyed by interview. Sixteen out of 40 respondents were asked these questions.

"Treatment" was generally not interpreted as relating only to drug treatment, but to a much wider range of services including general health, sexually transmitted diseases and nutrition advice, counselling, employment assistance, a half-way house to get users off the streets, dental care, detoxification, drug rehabilitation, and "faith healing". There was broad agreement that a range of services should be available to participants.

There was a high degree of consensus that treatment, however it was interpreted, should not be compulsory. However, two respondents saw a need for regular consultation with the client or a periodic review of the client's addiction. One respondent, claiming to recognise her own "conservative bent", felt that drug treatment should be compulsory.

One ex-user provider felt that participants should be put in a half-way house, told that they are "guinea pigs", and taught some skills because users needed forceful guidance ("a kick in the arse") to get their act together.

Q20. To examine whether or not the trial has been successful in reducing harm related behaviours, the people on the trial will be required to provide information about themselves. This will include answering questionnaires about drug-taking, criminal and other behaviours, urine tests, HIV tests and possibly other medical and behavioural tests. Do you have any comments about this?

There was general consensus that data collection was a necessary part of the trial. Recognising the personally intrusive nature of the data, informing the participants at the outset what was going to be expected of them, gaining consent, and keeping the information confidential were seen as critical issues in relation to data collection. One respondent thought that it may be necessary to pay participants to provide the information sought.

A number of respondents took issue over the relevance of particular pieces of information and others over the need to collect any data at all. Urine tests were thought to be both necessary and unnecessary. One respondent thought that HIV testing should not be compulsory, another that there should be no forced disclosure of serostatus, and still another that HIV testing had nothing to do with the trial. One seropositive respondent thought that HIV was not a valid piece of information to collect and that learning of a positive serostatus simply gave users a "whole lot of new problems". In contrast, another seropositive respondent thought that all participants should be tested for HIV.

Four respondents argued against any data collection, one of them saying that participants could not be expected to talk about their criminal activity, that questions about drug-taking would not yield honest answers, and that urine tests were unreliable. Another said that she loathed and despised this kind of data collection and that methadone programs only did it "for themselves". One respondent thought that data collection was not required for the feasibility study.

Other issues raised were that the collection of so much data would be restrictive and that its collection would result in selection only of "educated users who could stand all the pressure". One respondent apparently saw data collection as relating specifically to monitoring compliance with trial guidelines and suggested the need to set up criteria for trial exclusion.

Proposed options for collecting data were for a small number of self-report questionnaires and interviews, at the distribution or "treatment" site, and away from it. Two respondents argued for the need to have validation procedures in place. Additional variables which were suggested as part of the evaluation were measures of networking activities, nutrition levels, socialisation, hygiene, sickness, employment status, and trial drop-out rate.

Q21. What sort of legal protection should be offered to people taking part in the trial?

Confidentiality of information and its protection from subpoena; indemnity from prosecution for staff and clients in relation to the distribution and use of trial drugs; legal protection of the distribution centres; and protection of clients from police harassment were all raised in relation to the question of legal protection.

A number of respondents also argued that there should be no indemnity from prosecution for participants who commit illegal acts, including the sale or purchase of street drugs. The need for Australian Capital Territory (ACT) legislation, similar to the Commonwealth Epidemiological Studies (Confidentiality) Act 1981, to protect staff and participants from being forced to divulge confidential information, was also raised by several respondents. Others thought similar legal protections to those currently in place for methadone programs would suffice for the trial. One respondent raised a concern about the role of trial staff, should they find out from participants that they were involved in illegal activity, such as drug dealing.

One respondent thought that the trial would need a special exemption from drug laws relating to the prescription/dispensation of Schedule 8 drugs, which he felt was a reason for confining the drugs distributed during the trial to legal opioids only. Another noted that the trial would have to receive "approval" under the Drugs of Dependence Act.

Whether or not take-aways should be allowed was seen to have a bearing on issues of legal protection. Thus it was felt that there was a need to determine what would be permissible quantities to have in "stockpiles".

One respondent thought that participants who were arrested should stay on the trial and trial staff would need to be notified by police of such an event.

Another felt that in the event of the trial being abandoned all participants records should be destroyed, so that there could be no danger of legal or welfare repercussions resulting from participation (see also Q22 for comments about what should happen at the end of the trial). It was also suggested again here, that all participant documents be coded to obscure their identity.

The need for close liaison with legal advisers and with police were noted. One respondent felt that law enforcement issues had not been adequately thought through and that there would need to be close involvement with state [Territory?] law enforcement. A few respondents however, appeared to be arguing to keep the police excluded from any association with the trial. In particular, no police access to trial records was seen as an important protection.

Q22. What should happen to people on the trial when the trial ends?

It was argued by many respondents that informing participants at the outset that they were taking part in a trial, and obtaining consent, were critical issues in relation to termination.

Being guaranteed the option to transfer to a methadone program or to drug-free treatment; phasing out their use of opioids; and going through detoxification were seen as options that needed to be made available to participants. Some of those who saw the trial as operating within a treatment paradigm felt that abstinence by the end of the trial should be the goal for all participants.

Other respondents felt that trial participants should be maintained on their trial drugs, for as long as they needed them (or for 2 years only), after the trial ended. It was variously argued that if respondents did well on the trial it would be crucial that they be allowed to continue; that offering the program as a trial did not relieve the implementers of their long term responsibilities to the participants; that participants who tried to phase out their drug use by the end of the trial should be given the right to come back if they could not do without it/them; that it would be destructive to simply cut people off at the end of the trial; and that participants could be worse off [at the end of the trial] than they were before. One respondent felt that it was in fact not very ethical to have a trial of this nature and argued that somehow it should be ensured that trial participants had their drugs made available to them after the trial ended, including through doctors continuing their current discretionary prescription of opioids. Another argued that in order to avoid the potentially destructive effects of trial termination, it should be ascertained that the trial would work before it was implemented. It was also suggested that if the trial were to go ahead, swapping back to any current alternative may be very difficult, although it was not stated in what areas the difficulties would lie.

One respondent called for periodic review of the trial throughout its operation so that decisions could be made as to the appropriate time to terminate it or transform it into a service program, the latter being seen as the ideal outcome. Another argued for the legalisation of heroin for everyone as a way of providing long-term maintenance of participants.

One respondent was concerned about possible stigmatisation of those participants who were still on opioids when the trial ended and felt that absolute safeguards would have to be in place to protect them. Another expressed concern about the subsequent impact of changes that participants would be likely to make while on the trial. Thus he argued that there was the potential for participants to get stabilised on their drug(s), find a job, stop criminal activity, and lose touch with their contacts in the drug scene, making it hard for them to survive if the trial ended.

One respondent suggested there be very long term follow-up (5, 10 and 20 years) of trial participants, although this was probably meant to be an evaluation issue rather than a recommendation for drug maintenance.

Q23. Any other comments?

Where appropriate, comments made under Q23 have been included in other sections of this report.

Trial objectives etc

One respondent thought that there were two important questions; 1) would the trial recruit into treatment people who would otherwise not be recruited and 2) would recruitment result in a reduction in risk behaviour.

Number of participants

It was argued by one respondent that there should be a few hundred participants in the trial, both so that there would be room for casual users and there would be a large enough number to show significant changes in the crime rate.

Dosage of trial drugs

Several issues were raised in relation to dosage of trial drugs and dealing with changes in the lives of participants. One respondent felt that the trial should not have a punitive system of "cut-off" (maximum) doses such as currently exists at methadone programs, but rather incorporate into its dosage protocols a recognition that participants' tolerance will go up. She also noted the problems of participants needing to go interstate for their jobs (requiring, she suggested, methadone maintenance to cover these periods), and the need to make provision for participants who become ill and required pain management in hospital. [This comment presumably relates to the special pain management needs of such people because of their habitual use of opioids.]

Participants with psychiatric conditions

One respondent raised some concerns about the management and monitoring of participants being treated for psychiatric conditions, specifically in relation to their use of psychiatric drugs; possible changes in their psychiatric condition while on the trial; and the need to have a consultant psychiatrist to monitor them.

Regulatory control of the trial

One respondent thought that there would be a need for a regulatory committee to determine trial participation and dosage so that users could not put pressure on individual trial staff.

Another noted what she believed to be a lack of confidence in the ACT government, and expressed some concern over the possibility of government funding and control of the trial.

Ethical issues

It was argued that if the trial goes ahead then heroin should also be made available for pain relief in the clinical setting.

One respondent noted what she saw to be a moral dilemma in conducting the trial which was to reduce the risk of HIV and hepatitis while not giving users their drugs "on a platter".

A number of respondents expressed the view that the trial needed to go ahead, but one of them cautioned that it could be a "disaster".

Housing

One respondent noted the need for long term accommodation for participants, so that they would not be on the streets or placed in accommodation that put them in close proximity to users and people with other social problems, which could lead to discrimination.

Evaluation

The need for the widest possible reference group, not confined to either the medical or the drug-using communities, for the evaluation of the trial was raised. One respondent suggested that users be involved in evaluating the trial.

Impact on users' lives

One respondent felt that legalising heroin, as in providing it through a trial, would have a considerable impact on users' lives, in that it would remove a whole lifestyle that was familiar to them, even if it was not liked. She quoted users as saying "I don't know anything about life when I'm straight." Another had concerns about the necessity of providing support for users who "bust" because of the emotional issues they have to deal with.

One respondent felt that the trial would be particularly beneficial for users who are parents because it would allow them to spend their money on essentials like food, rather than on drugs.

Other comments

It was stated that the majority of users are not dependent users but most crimes are committed by dependent users.

One suggested outcome of a trial was that the provision of licit access to drugs for dependent users would have a significant impact on the drug scene because it would take out the dealers (the dependent users) who currently pass the drugs on down the line. [The point being made was that much of the street marketing of drugs is done by dependent users whose habits are sufficiently expensive to force them to sell drugs to pay for their own doses. By providing such users with licit access this compulsion would be removed, and the street market, which acts as the conduit for drugs to casual and new users, would be largely eliminated.]

One respondent commented on the need for better regulatory procedures to control the prescribing of drugs such as Serepax and Rohypnol by users who "work" doctors to get prescriptions.

A point was raised about sex-industry workers not being allowed to use drugs with the legalisation of prostitution, and that this would be a problem for the sex-industry workers.

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RECOMMENDATIONS

Preamble

The objectives of stage 1 of the feasibility study are to determine whether or not a trial is feasible and, if so, to propose what a trial should look like. It was intended that such a proposal, if it was to be developed, should be a broad outline of in principle recommendations and that logistical details should be considered in stage 2 of the feasibility study. Of course, the logistics may mean that parts of the proposed trial design need to be modified.

The recommendations which follow are informed, not only by the deliberations of the 'Options Group', but also by the reports of the 'Evaluation', 'Ethics', 'Legal' and 'Attitudes' groups. It is useful to reiterate here that the trial design proposed by the 'Evaluation Group' is a randomised control trial, with participants in the control group receiving only oral methadone. Other than that the conditions in the 'opioids' and control groups should be identical.

In principle recommendations are made and grouped under various subheadings. They are followed by the rationale underlying the recommendations and by logistic and other issues which need further consideration in stage 2.

In principle recommendations

The drugs

1. The range of opioids to be made available to the 'opioids' group should be restricted to heroin and methadone.

2. The routes of administration available to the 'opioids' group should be injectable, oral and smokable.

3. The number of administrations per day for the 'opioids' group will depend on pharmacological evidence about the drug, route of administration and dose. However, no more than three administrations of opioids per day should be provided. The control group should receive one administration per day (of methadone orally).

4. For the 'opioids' group initial determination of drug, dose and route of administration should be a matter of negotiation between service provider and user. For the control group similar negotiations will revolve only around dose. Safety will also be a prime consideration, so that initial doses will have to be low with a build up to a holding dose.

5. For the 'opioids' group, there should be regular review of drugs taken, routes of administration and dose and, where applicable, encouragement should be given to users to move from heroin to methadone, to move away from injecting routes of administration and to decrease the dose and the frequency of drug administration. There should be a similar regular review for the control group, with encouragement to decrease the dose and frequency of methadone administration.

Criteria for Inclusion of Users

6. The trial should be open to dependent users of heroin, with screening based on the presence of drug metabolites in urine or hair, other physical evidence of use (e.g. evidence of injection, so-called 'track marks') and drug-taking history.

7. The following categories of people should be excluded from the trial: non-ACT residents, people dependent on prescribed opioids for pain relief, and dependent people with current or recent major psychiatric illness.

8. The trial should be designed with the ability to allow all dependent users who meet the selection criteria to participate. However in Stage 2 further detailed consideration should be given to whether or not the following groups should be eligible for the trial: pregnant women, people who are HIV positive, people under the age of 18 and people who would be referred to the trial from the courts. Applicants for the trial who do not meet the selection criteria should have a different (i.e. outside the randomised controlled trial) oral methadone program available to them.

Distribution Points

9. All drugs should be administered at the distribution points. After participants have been on the trial for 3 months, consideration should be given to allowing those taking oral methadone (in either the 'opioids' or 'control' groups) to administer at home.

10. In Stage 2, consideration should be given to the number of distribution points and hours of opening which are feasible, particularly in terms of resources. Ideally, there should be three distribution points with extended hours of operation. While it should not be necessary for each point to be open for 24 hours per day, consideration should be given to at least one distribution site being open at any one time. There should be one principle site, where medical and social assessments are also conducted.

11. Distribution points should be inconspicuous and should be located in busy public places, close to public transport and to medical facilities.

12. The distribution sites and the procedures used will have to be adequately secure to prevent theft of drugs.

13. Each distribution point should have a special 'fixing room' where injectable drugs are administered under supervision.

14. The distribution sites should be staffed by a mixture of medical and non-medical personnel.

Recruitment

15 Recruitment should not be through widespread public advertisement, rather it should be through low-key methods like word of mouth.

Payment for Trial Drugs

16. No payment should be required for participation in the trial.

Data Collection and Registration of Users

17. Data collection is fundamental to a trial and the provision of information will be a requirement for trial participation. There are also three other fundamental principles which govern data collection: informed consent, confidentiality, and protection of privacy. Trial participants and researchers should be protected by the Epidemiological Studies (Confidentiality) Act 1981 and/or an ACT equivalent drafted especially for the trial.

18. There should be a register and identification system for trial participants.

19. There should be appropriate legal protections for trial participants.

Continued Use of Illegal Drugs

20. The legal protections which will need to be instituted for the use of trial drugs should not be extended to non-trial drugs. In other words use of 'street' drugs should continue to be a criminal offence.

21. Use of illegal drugs should not bar people from receiving trial drugs, except when this might lead to a risk of overdose.

Standards of Behaviour for Trial Participants

22. At the distribution site, there should be certain behavioural standards which trial participants will be required to meet, including non-violence and courtesy.

23. Diversion (i.e. selling) of trial drugs should be strictly forbidden.

24. There should be sanctions for not meeting behavioural standards and for diversion of trial drugs. Consideration of effective standards should be undertaken in Stage 2. In addition, if people are found to be selling rather than using trial drugs there should be a review of the drugs they are taking and of the doses and frequency of administration. The procedure for imposing sanctions should be clearly laid down and should not be at staff discretion.

25. There should be no other requirements for behavioural standards.

Counselling, Other Treatment and Service Provision

26. There should be no compulsion on trial participants to undertake counselling or other treatment, although these should be freely available and trial participants should be encouraged to use them.

27. Trial participants in both the 'opioids' and control groups should be regularly assessed with regard to their social functioning and referred to appropriate services (legal aid, housing assistance etc) as necessary.

Staffing Issues

28. There should be no compulsion on medical or non-medical staff to work on the trial.

29. Stage 2 of the feasibility study should explore ways to facilitate rotation of trial staff to positions away from the trial, if and when staff request a transfer.

30. There should be appropriate legal and safety protections for trial staff.

Termination of the Trial

31. At the conclusion of the trial all participants should have oral methadone available to them. At the commencement of the trial, participants need to understand that there is no guarantee that provision of heroin (or methadone through other than oral routes of administration) will continue after the trial has concluded.

32. If in practical terms the methadone program instituted for the control group runs successfully, it should be continued after the trial is terminated.

Rationale

Recommendation 1. The range of opioids to be made available to the 'opioids' group should be restricted to heroin and methadone.

It was decided to restrict the trial opioids to heroin and methadone. Heroin is the most widely used illegal opioid. Illegal use of other opioids is much less common (see, for example, Chapter 8: Attitudes to A Trial, Table 2.41). Oral methadone is a standard treatment for people with problems resulting from illegal opioid, especially heroin, use. It should be possible for people in the 'opioids' group to use a combination of these two drugs if they wish, as this may be the way they find most acceptable for reducing heroin use. For example, of the users we surveyed who were interested in participating in a trial, 71% indicated that they would be interested in volunteering if the standard option was oral methadone plus two injections of heroin/opiates per day (Chapter 8: Attitudes to A Trial, Table 5.10).

It also needs to be noted that opioids “in pure form and administered cleanly, are non-toxic to body tissue” (see The Drug Offensive Information Brochure on Heroin and other Narcotic Analgesics, reprinted as Appendix A).

It needs to be recognised that restriction of trial drugs to heroin and methadone will only impact on part of the drug using population. There is widespread agreement that there is a group of users for whom heroin is the preferred drug, but there are other users who prefer drugs such as cannabis and/or stimulants such as amphetamines and cocaine. There is a third group who prefer to use a variety of illicit drugs. A trial such as that proposed will only impact on the first group. It needs to be noted that people who use amphetamines and cocaine also commonly inject (see Chapter 1: Illegal Drug Use in Canberra and Chapter 8: Attitudes to A Trial, Table 2.42) so that a trial such as this does not impact on the whole illegal drug using population for factors such as HIV risk, for example.

Recommendation 2. The routes of administration available to the 'opioids' group should be injectable, oral and smokable.

One of the hypotheses to be tested by the trial is that injectable heroin will attract to the trial people who have not previously been attracted to treatment. Given that injection is the most hazardous route of adminstration, other routes should also be available and users encouraged to try them and move to them. Heroin administration by smoking can produce a 'high' similar to that produced by injection, whereas this cannot be obtained by oral administration. There is some evidence from the Marks/Parry program in Liverpool that users will switch from oral to smokable routes of administration (see Chapter 5: Options for A Trial). Smokable heroin can be provided in either tobacco or herbal cigarettes or in 'bongs'. While there are well-documented health hazards associated with smoking tobacco, it should also be noted that the majority of people dependent on illicit drugs already smoke tobacco.

It should be possible for people to use a combination of routes of administration, as this may be the way they find most acceptable for reducing the frequency of injection.

Recommendation 3. The number of administrations per day for the 'opioids' group will depend on pharmacological evidence about the drug, route of administration and dose. However, no more than three administrations of opioids per day should be provided. The control group should receive one administration per day (of methadone orally).

There is some evidence that many users of illegal heroin inject only two or three times per day (Wodak, personal communication 1991 citing data from the ANAIDUS study; see also Chapter 8: Attitudes to A Trial, Table 2.43). A restriction in the number of administrations is also necessary to make it feasible for drugs to be administered at the distribution site (see Recommendation 8). It may be possible to encourage users to combine methadone and heroin: methadone to minimise withdrawal symptoms and heroin to provide a "buzz".

However, such a restriction may encourage users to 'top up' with illegal drugs. Withdrawal effects (such as uneasiness, diarrhoea and abdominal cramps) may occur within a few hours (see Appendix A). Further, there is evidence that some users may inject 5 or more times per day (see Chapter 8: Attitudes to A Trial, Table 2.43). This has important implications not only for law enforcement and the relationship of the police with the trial but also for the likely success of the trial. These potential effects should be considered further in Stage 2.

Recommendations 4 & 5

Recommendation 4. For the 'opioids' group initial determination of drug, dose and route of administration should be a matter of negotiation between service provider and user. For the control group similar negotiations will revolve only around dose. Safety will also be a prime consideration, so that initial doses will have to be low with a build up to a holding dose.

Recommendation 5 For the 'opioids' group, there should be regular review of drugs taken, routes of administration and dose and, where applicable, encouragement should be given to users to move from heroin to methadone, to move away from injecting routes of administration and to decrease the dose

and the frequency of drug administration. There should be a similar regular review for the control group, with encouragement to decrease the dose and frequency of methadone administration.

The exact nature of the initial and continuing negotiation processes on type of drug, dose and route of administration must be clearly defined so that comparability between trial participants and between people in 'opioids' and control groups can be maintained. It is envisaged that the process would be analagous to the negotiations between doctor and patient over the prescription of ordinary pharmaceuticals.

A particular issue which needs further consideration is whether or not maximum dose limits should be set and, if so, how they should be determined.

Recommendation 6. The trial should be open to dependent users of heroin, with screening based on the presence of drug metabolites in urine or hair, other physical evidence of use (e.g. evidence of injection, so-called 'track marks') and drug-taking history.

The combination of screening criteria chosen means that there is a high degree of certainty that those given entry into the trial are heavy users of heroin. Dependence is not an absolute and the screening criteria have to be carefully developed.

The use of naloxone eye drops may also be an effective screening tool and should be investigated in Stage 2. [Naloxone reverses the effects of opioids and one effect of opioids is to constrict the pupils.]

A trial such as this would not be suitable for non-dependent users for a variety of reasons. It is difficult to adequately screen non-dependent users to ensure that provision of trial drugs does not increase use. In addition, for many non-dependent users of heroin the setting and context of the use is as important as the drug. A treatment setting is regarded as inappropriate (see Chapter 1: Illegal Drug Use in Canberra). An analogy with alcohol may be useful here. If trial conditions were applied to the consumption of alcohol, a convivial drink after work would be impossible; instead individuals would need to attend a clinic to obtain a glass of beer and would have to drink it under supervision.

Australia's international treaty obligations would also seem to prohibit inclusion of non-dependent users on a trial (see Chapter 5: Legal Issues).

A disadvantage of restricting a trial to dependent users is that non-dependent users are at risk of the same health problems as dependent users of illegal heroin. In addition, such restrictions may provide an incentive for non-dependent users to become dependent in order to qualify for participation on the trial. About one in six of the non-dependent users surveyed as part of this study indicated that they would increase their use a little or a lot to get on the trial (see Chapter 8: Attitudes to A Trial, Table 4.69) and police and service providers also thought that at least a few non-dependent users would do this (Table 4.15). Ethically it may ultimately be an open question as to whether the incentive effects are a problem if the trial generally has a good effect on participants. However the question of balancing undesirable incentive effects against the positive outcomes of a trial requires measurement of the extent of incentive effects and not simply whether they exist (see Chapter 7: Ethical Issues). This problem should receive further consideration in Stage 2. On the other hand, as indicated above, if non-dependent users were included in a trial, ready access to high quality heroin might also be a stimulus for them to increase their use.

A number of authors (see Literature Review above) have also suggested that if non-dependent users are not included their demand for illegal drugs would keep the black market flourishing so that the cost of maintaining the criminal justice and customs systems would not be affected.

Recommendation 7. The following categories of people should be excluded from the trial: non-ACT residents, people dependent on prescribed opioids for pain relief, and dependent people with current or recent major psychiatric illness.

There is some concern that an ACT-based trial would attract users from interstate (see Chapter 8: Attitudes to a Trial; Table 4.56) and that this would increase crime and place a large burden both on the trial and on law enforcement and welfare services. This must be minimised by clear and rigidly enforced residency criteria. Careful consideration needs to be given to how those people who do not meet residency criteria should be dealt with. For example, consideration should be given to liaising with state-based (especially New South Wales and Victorian) treatment sevices so that non-ACT residents can be offered assured access to treatment in their home state.

People who are dependent on prescribed opioids for pain relief should be excluded from the trial. The aims of the trial are directed at users of illicit opioids. Despite a number of studies which have shown that heroin has no major analgesic benefits over other narcotics, there is still great interest in heroin being made available for pain relief. Consideration of this issue is outside the terms of this feasibility study.

Dependent users with current or recent major psychiatric illness should also be excluded from the trial. They are unlikely to be able to provide informed consent or participate in the negotiation process which underpins the trial (see Recommendations 4 & 5). In addition, severe psychiatric illness may significantly affect the outcomes being measured by the trial, so that changes produced by the trial drugs might not be clear-cut.

Recommendation 8. The trial should be designed with the ability to allow all dependent users who meet the selection criteria to participate. However in Stage 2 further detailed consideration should be given to whether or not the following groups should be eligible for the trial: pregnant women, people who are HIV positive, people under the age of 18 and people who would be referred to the trial from the courts. Applicants for the trial who do not meet the selection criteria should have a different (i.e. outside the randomised controlled trial) oral methadone program available to them.

There are a number of in principle reasons for including all eligible people who wish to participate in the trial. One is that evaluation of trial outcomes will be facilitated by larger numbers. Another is that the more people who are able to participate, the smaller the likelihood of people being 'hassled' by those not on the trial. This may impact significantly on the likelihood of trial drugs being diverted onto the black market and on episodes of violence between drug users. However logistical factors may be a constraint. In particular, because people will have to administer drugs at the distribution sites, there will be a limit to how many can be accommodated comfortably. There is also legitimate concern regarding large numbers of people congregating in public places near the distribution points.

It is difficult to obtain an accurate picture of the number of heroin users in the ACT. There are various ways of making estimates and the range is from around 700 to around 8000 (see Chapter 1: Illegal Drug Use in Canberra). The best evidence available suggests that there are around 1000 dependent heroin users in Canberra. It may therefore be reasonable to use a figure of 600 participants in considerations of trial logistics. Stage 2 of the feasibility study should investigate more closely the likely numbers of participants and how many would be needed to allow proper evaluation of different outcomes.

There is some debate about whether or not four particular groups of users should be included in or excluded from the trial. The groups are: pregnant women, people who are HIV positive, people under the age of 18 and people for whom participation in the trial is an alternative to gaol. On one hand it can be argued that people in these groups have the greatest need for access to a range of treatment options (pregnant women, people who are HIV positive and people sent through the court system) or would be most likely to benefit from a trial (people under 18). On the other it can be argued that there are only relatively few such people and that there are particular problems with including them in a trial, which may make evaluation of outcomes difficult. These issues need further investigation in Stage 2.

If a decision is made not to include these people, they should be offered access to a methadone program or some other form of treatment.

Careful consideration also needs to be given to the options which should be offered to any people who become HIV positive or pregnant while on the trial.

Recommendation 9. All drugs should be administered at the distribution points. After participants have been on the trial for 3 months, consideration should be given to allowing those taking oral methadone (in either the 'opioids' or 'control' groups) to administer at home.

Drugs must be administered at the distribution site. The main consideration here is that allowing drugs to be taken away increases the possibility that they will become available to people not on the trial. It is thought likely by users, service providers and police that trial participants would be 'hassled' for their drugs by those not on the trial (see Chapter 8: Attitudes to A Trial, Table 4.40) and that this would be likely to lead to physical violence which could even be life threatening (Tables 4.47 & 4.48). There was strong support among all of the groups surveyed for drugs to be administered at the distribution site (Table 5.6).

This requirement has important logistic disadvantages. It means that the number of people who can be accommodated on the trial will be limited by space and staffing considerations to a much greater extent than if trial drugs could be taken home. A take-home system would be also be more likely to be able to be geographically dispersed, for example through pharmacies. The need for frequent travel by trial participants also becomes an important consideration (see below: Rationale for Recommendation 10). It is also likely that distribution sites will be a point of congregation for users, and the fewer distribution sites there are, the greater the number of people likely to congregate.

Administering the drugs at the distribution site will impose constraints and structure on the daily lives of trial participants. To that extent, they lose the ability to structure their lives for themselves. This may be an advantage for people whose lifestyles are very 'chaotic', but will be an important difficulty for people who have other commitments (e.g. through employment or family responsibilities) and may inhibit the development of more autonomous forms of personal organisation.

The risks of diversion of oral methdone, especially if it is readily available to users through treatment services are likely to be much smaller than the risks for diversion of heroin. A number of the disadvantages listed above associated with drug administration at the distribution site could be overcome, for at least some trial participants, if 3 days' doses of oral methadone could be collected at any one time and taken home by trial participants after they had been on the trial for three months. It might also be necessary for them to meet other criteria (such as being in paid or voluntary employment). Such criteria must be carefully defined and should not be at staff discretion. The option of take-away methadone needs to be examined further in light of the trial design, to ensure that it does not make outcomes difficult to measure or interpret.

Recommendation 10. In Stage 2, consideration should be given to the number of distribution points and hours of opening which are feasible, particularly in terms of resources. Ideally, there should be three distribution points with extended hours of operation. While it should not be necessary for each point to be open for 24 hours per day, consideration should be given to at least one distribution site being open at any one time. There should be one principle site, where medical and social assessments are also conducted.

It is desirable for there to be a number of distribution sites (possibly three) in different locations so that travelling by participants is minimised. A number of considerations are relevant to this:

- Participants who need to visit the clinic three times per day will have difficulty doing so if the travelling time involved is long. Such inconvenience may lead either to people dropping out of the trial or to their waiting at or near the distribution site between administrations, which is likely to be publically unacceptable.
- It is not known to what extent opioids impair the ability to drive safely. While there is evidence that users currently drive under the influence of both legal and illegal opioids (driving under the influence of methadone is legal for those attending methadone clinics), it would be problematic to introduce a trial without detailed knowledge of the effects of opioids on driving. Depending on the results, this may lead to a limitation in the dose prescribed (which is likely to encourage top-ups), requirements for people to stay at the distribution site for a set length of time after drug adminstration (which may cause space difficulties and inconvenience to participants) or the need to ensure that alternative forms of transport are used (provision of transport would probably be an expensive option).
- More than one distribution point would also make it possible for users to avoid other users if there were personal difficulties.

Extended hours are necessary for a number of reasons. One is to cater for people who are given three doses per day; the doses will have to be spread out across the day. Another is to cater for people in paid employment or who have other constraints on their time who will have to be able to come to the sites before and/or after work. Another is to cope with the volume of people.

While it should not be necessary for each point to be open for 24 hours per day, consideration should be given to at least one distribution site being open at any one time. At least some trial participants may not be able to schedule their visits to distribution points within restricted hours. A disadvantage is that the risks to staff (from, for example, armed robbery) may well be much greater between midnight and 5 am. Public transport is also not available at these hours (and is restricted at weekends).

Recommendation 11. Distribution points should be inconspicuous and should be located in busy public places, close to public transport and to medical facilities.

Distribution points should be inconspicuous and should be located in busy public places so that the people using them can also remain relatively inconspicuous. They should be close to public transport so that they are accessible to people who cannot or do not wish to drive. Because there is always a risk of overdose, the distribution points should be close to medical facilities.

Recommendation 12. The distribution sites and the procedures used will have to be adequately secure to prevent theft of drugs.

Attention will also need to be given to the design of the distribution points from a security angle. Heroin is a highly attractive commodity and there is a real risk of robberies being attempted. Security measures must also be taken to minimise the risk of theft by trial participants and staff.

Recommendation 13 Each distribution point should have a special 'fixing room' where injectable drugs are administered under supervision.

Other design aspects which need to be considered are the provision of 'fixing' rooms where people can inject drugs under supervision and the provision of adequate ventilation if drugs are smoked. There will also need to be suitable waiting rooms and rooms for people to relax after they have administered their drugs.

Recommendation 14. The distribution sites should be staffed by a mixture of medical and non-medical personnel.

It will be essential to have at least some medically trained staff so that the health of trial participants can be adequately assessed and to deal with unforseen emergencies. A mixture of medical and non-medical staff is likely to be most cost-effective and acceptable to the trial participants.

Recommendation 15. Recruitment should not be through widespread public advertisement, rather it should be through low-key methods like word of mouth.

Advertising for such a trial would be illegal under current laws (Chapter 5: Legal Issues), but should also be restricted to avoid attracting people other than dependent users. It is also important that the trial is kept low-key, so that participants can remain inconspicuous. Further, it is important to avoid 'glamorising' heroin use, especially to young people.

A disadvantage of using recruitment techniques such as word of mouth is that recruitment to the trial may be slow and that mis-information or only partial information about the trial may be passed from person to person. Posters at service agencies could partly overcome this problem.

Recommendation 16. No payment should be required for participation in the trial.

The results of the survey undertaken as part of this feasibility study showed that there is a high level of support for charging for trial drugs (see Chapter 8: Attitudes to A Trial, Table 5.5). There are also in principle reasons why participants should pay for the drugs.

However, enforcing payment for trial drugs may be difficult. While this could potentially be solved in a program, it causes a real problem for a limited-term trial. It is likely that issues surrounding payment for trial drugs may influence the outcomes being measured, particularly if there are sanctions for non-payment. This may then make interpretation of the results difficult. Two other factors mitigate against a charge. First, it is unusual for people to be asked to pay to participate in a trial and second, oral

methadone is currently available free of charge, so it may be difficult to institute a requirement to pay for that drug.

Recommendation 17. Data collection is fundamental to a trial and the provision of information will be a requirement for trial participation. There are also three other fundamental principles which govern data collection: informed consent, confidentiality, and protection of privacy. Trial participants and researchers should be protected by the Epidemiological Studies (Confidentiality) Act 1981 and/or an ACT equivalent drafted especially for the trial.

It is essential that a trial asks real questions which can be adequately answered. Data collection is, of course, essential for this. Ethically, it is important that information is only collected from people with their knowledge and consent, and only for specific valid purposes. It is also important that the information is only used for the purposes that it was gathered for (see Chapter 7: Ethical Issues).

Recommendation 18. There should be a register and identification system for trial participants.

There obviously must be some record and identification system for people participating in a trial. The exact form for such a system needs further consideration in Stage 2.

Recommendation 19. There should be appropriate legal protections for trial participants.

This issue is dealt with in Chapter 5: Legal Issues.

Recommendation 20. The legal protections which will need to be instituted for the use of trial drugs should not be extended to non-trial drugs. In other words use of 'street' drugs should continue to be a criminal offence.

This is not a trial of legalisation but of controlled availability and an important outcome measure is whether or not controlled availablity reduces the amount of illegal drug use. The criminality associated with illegal drug use should therefore not be changed. It is intended that this also means that continued use of 'street' opioids is illegal and that trial participants who are arrested for using or selling illegal drugs would be dealt with in the usual way.

Recommendation 21. Use of illegal drugs should not bar people from receiving trial drugs, except when this might lead to a risk of overdose.

If use of illegal drugs was a bar to continuation on the controlled trial, an important outcome could not be measured and it would significantly skew the trial. It might also lead to a large reduction in the number of participants.

Consideration should be given to using information about ‘top-ups’ with illegal street opioids to review the drugs, doses and routes of adminsitration of trial drugs.

Consideration should be given to the possibility of ill-effects through drug interactions. This may occur if trial participants have used street opioids shortly before using trial drugs. It is more likely, however, that ill-effects will result from combining trial drugs with alcohol or benzodiazepines. Mechanisms for preventing this need careful consideration in Stage 2.

Recommendation 22. At the distribution site, there should be certain behavioural standards which trial participants will be required to meet, including non-violence and courtesy.

This is self-evident.

Recommendation 23. Diversion (i.e. selling) of trial drugs should be strictly forbidden.

It would clearly be undesirable for trial drugs to become available to people not on the trial. Whether or not trial participants try to divert drugs should also be an important outcome measure.

Recommendation 24. There should be sanctions for not meeting behavioural standards and for diversion of trial drugs. Consideration of effective standards should be undertaken in Stage 2. In addition, if people are found to be selling rather than using trial drugs there should be a review of the drugs they are taking and of the doses and frequency of administration. The procedure for imposing sanctions should be clearly laid down and should not be at staff discretion.

Further consideration should be given in Stage 2 to effective sanctions which could be applied. This is likely to be a difficult issue and may need on-going work in Stages 3 and 4.

The Marks/Parry program has found withholding of (in their case, prescription) drugs for varying lengths of time (depending on the infraction) to be effective (see the section on theMarks/Parry Program above). A disadvantage of such sanctions is that if people return to using street drugs during the time when trial drugs are withheld, their health is at risk and they commit criminal offenses. It is for this reason that sanctions should not include barring people from the trial.

If trial participants are found to be selling their trial drugs on the street, it is possible that they are receiving higher or more frequent doses of drug than they really need or that they are not receiving their preferred drug (hence selling the drugs they are receiving in order to buy other drugs). It is for these reasons that there should be a review of the drugs they are taking and the doses and frequency of administration. It is unlikely to be problematic to cut down dose or frequency of administration. It will be more difficult to deal with people (in either the opioids or control group) for whom the trial drug is not the drug of choice. This must be given further consideration in Stage 2.

Recommendation 25. There should be no other requirements for behavioural standards.

There should be no other behavioural standards for two reasons. The first is that behavioural change in people on the trial is an outcome measure and should not be artifically manipulated. The second is that it is likely to be difficult to impose sanctions against behaviours committed away from the premises. This can be illustrated with an example. If it was decided that sanctions should be imposed if criminal offences were committed, this could not be done until the person had been found guilty of committing the offenses through the due processes of the law. There is generally a long delay between charging and the court process, by which time the drug trial is likely to be over.

Recommendation 26. There should be no compulsion on trial participants to undertake counselling or other treatment, although these should be freely available and trial participants should be encouraged to use them.

While trial participants should be encouraged to use counselling and other treatment services and these should be freely available, there should be no compulsion on them to do so. It is unreasonable to attach unrelated ‘strings’ to a trial, as this can be seen to constitute unethical manipulation of people. Compulsion is also unlikely to lead to successful counselling or treatment. It also needs to be noted that the review of methadone programs by Hall and co-workers (1991) found that those which provided methadone in the context of a comprehensive treatment program were an effective form of treatment for opioid dependence.

Recommendation 27. Trial participants in both the 'opioids' and control groups should be regularly assessed with regard to their social functioning and referred to appropriate services (legal aid, housing assistance etc) as necessary.

The social functioning of trial participants should be regularly assessed, both as an outcome measure and as a way of helping them improve their lives. This assessment should be the same for both opioids and control groups. As above, it needs to be noted that the review of methadone programs by Hall and co-workers (1991) found that those which provided methadone in the context of a comprehensive treatment program were an effective form of treatment for opioid dependence.

Rather than set up parallel services, referrals should be made to existing services.

Recommendation 28. There should be no compulsion on medical or non-medical staff to work on the trial.

It is clearly unethical to compel staff to work on the trial.

Recommendation 29. Stage 2 of the feasibility study should explore ways to facilitate rotation of trial staff to positions away from the trial, if and when staff request a transfer.

It is possible that working on the trial will be highly stressful. As well as considerations for the well-being of staff, stressed staff also become ineffective; thus, if it is at all possible, it should be easy for staff to transfer
away from working on the trial.

Recommendation 30. There should be appropriate legal and safety protections for trial staff.

These legal protections are dealt with in Chapter 5: Legal Issues. Occupational health and safety considerations are clearly also important.

Recommendation 31. At the conclusion of the trial all participants should have oral methadone available to them. At the commencement of the trial, participants need to understand that there is no guarantee that provision of heroin (or methadone through other than oral routes of administration) will continue after the trial has concluded.

If a trial is successful according to pre-determined criteria established by both opponents and proponents of a trial, there should be some political commitment to instituting a program based on it, so that participants should continue to receive trial drugs. If the trial is unsuccessful, there are likely to be a number of problems associated with continuing trial participants on heroin and routes of administration other than oral. Trial participants should however be guaranteed access to methadone which is the standard treatment.

While this stance can be defended ethically, the issues are not clear-cut. One approach is to argue that, provided that informed consent was given, the participants received the benefits of the trial for its duration, so that there is minimal obligation to them. There is however some argument about whether consent is meaningful when it is given by people for whom a short-term inducement far outweighs possible long-term ill-effects. Another approach is to argue that it is highly likely that the trial will be successful for at least some participants, particularly in allowing them to stabilise their lives in terms of family relationships and employment. Ethically, it would be desirable to continue to provide assistance as long as it was needed in such cases (see Chapter 7: Ethical Issues).

Stage 2 must consider what would happen to trial participants in the time between the evaluation of the trial and the establishment of a long-term treatment program if the trial is successful.

Careful consideration of all these issues may mean that the trial needs to run for more than two years.

On a rather different tack, it is possible that a trial may have unintended negative consequences. It is crucial to have a list of reasons for halting a trial or for modifying it, even before detrimental effects can be shown to be statistically significant (see Chapter 7: Ethical Issues).

Recommendation 32. If in practical terms the methadone program instituted for the control group runs successfully, it should be continued after the trial is terminated.

A secondary evaluation should be made of the control methadone program. If it is found to be more successful than traditional methadone programs, it should be continued. This may best be done by incorporating it into the ACT drug treatment service program.

STAGE 2

Stage 2 requires examination of a number of logistic issues which would affect the structure of a trial. Some of the most important issues which will require careful consideration are outlined below.

It is important that the issues to be addressed in Stage 2 are considered, where appropriate, in consultation with community groups, police, relevant service providers and illegal drug users.

Research Issues

There should be an extensive process of consultation with community groups, police, relevant service providers and illegal drug users on the above recommendations to determine whether or not a trial so structured should proceed.

Further information should be collected on injecting behaviour (especially frequency) among heroin users, to determine the effects of restricting the number of administrations per day.

Research needs to be conducted into the development of tolerance to opioids among dependent users and the implications this may have to setting upper limits for the trial drug doses.

There should be careful review of cannabis and other illegal drug use in the likely trial population and of the potential of continued cannabis and other illegal drug use to influence the success of the trial.

Research should be conducted into the reliability and cost of using analysis of hair to monitor trial opioid and illegal drug use.

Research needs to be undertaken on the effects of heroin on the ability to drive safely.

Current information on the health effects of both active and passive smoking of herbal cigarettes needs to be assessed.

Research needs to be conducted into how well heroin is absorbed by the body when smoked.

The value of naloxone eye drops as a screening tool for people who apply to be part of the trial needs to be assessed.

Current information on the comparative effects of heroin and methadone on maternal and fetal health during and after pregnancy needs to be assessed.

Current information on the comparative effects of methadone and heroin, and of injecting itself, on the progression of HIV needs to be assessed.

Consideration needs to be given to the effects on the ability to evaluate the trial if it includes people who are HIV positive or have hepatitis B or C, people under the age of 18 and people referred to the trial from the court system. This needs to be balanced against other considerations for these groups.

Current information about drug interactions needs to be assessed and further research may need to be conducted.

Issues Relevant to the Day to Day Running of the Trial

A number of practical issues must be resolved through consultations with police, relevant service providers and illegal drug users. They include:

- the likely impact of restricting the number of administrations to three per day.
- the maximum dose of heroin and methadone to be prescribed.
- the structure of the initial interviews with people seeking trial participation to ensure that they would not be willing to undertake some other form of treatment and that they are not primarily attracted by the possibility of obtaining methadone under a more liberal regime.
- screening criteria for trial participants.
- how residency criteria could be enforced.
- the review process to ensure that trial participants are given adequate opportunity (without coercion) to reduce the harm associated with their drug using behaviour and that the review is comparable for the 'opioids' and control groups.
- options which should be made available for people who become HIV positive and to women who become pregnant while on the trial.
- criteria for reviewing the social functioning of trial participants.
- the process which will be gone through each time the trial participant is administered the drug. Problems may result from interactions between opioids and tranquillisers, and opioids and alcohol and there needs to be some way of checking that trial participants have not been using other drugs which may put them in danger. Similar considerations also apply if trial participants continue to use illegal opioids.
- the hours distribution sites should be open.
- ways of dealing with users if they congregate at or near distribution points.
- ways in which trial participants can safely access distribution points, particularly if it is found that heroin significantly impairs the ability to drive safely.
- under what conditions trial participants should be given take-home methadone.
- how trial participants can best be recruited.
- sanctions for diversion of trial drugs.
- the likelihood of violence and ways of dealing with it, including sanctions.
- criteria for administering sanctions.
- ways to minimise the stressful and unpleasant aspects of the work of trial staff.

In addition, detailed consideration must be given to whether or not people resident in Queanbeyan should be able to participate in the trial. Legal and policing issues are particularly important if Queanbeyan residents can participate and likely effects on housing and welfare services in the ACT as well as 'hassling' of trial particpants are important if they cannot participate.

Administrative Issues

Possible locations for distribution sites need to be determined.

Expert consultants should be hired to advise on the range of security issues relevant to the trial.

Expert consultants should be hired to advise on the best design for waiting rooms and entrances and exits to minimise the contact trial participants have with each other. Expert advice is also needed on ventilation.

Further consideration should be given to the desirability of allowing reliable trial participants to take methadone home.

There needs to be liaison with welfare, housing and other services to facilitate a smooth referral process for trial participants facing social difficulties.

Consideration must be given to a number of health and safety issues for trial staff, including ways of minimising the possibility of needle-stick injuries and avoiding the passive ingestion of drugs (if, for example, they are smoked by trial participants).

Careful consideration must be given to the possible circumstances, if any, under which the identity of trial participants might be revealed, so that this can be included in the process of seeking informed consent.

Consideration must be given to an effective way of obtaining informed consent to the conditions of trial termination.

Consideration must be given to the exact way in which the recommendations for trial termination would be implemented to minimise risks to trial participants. The wind-down of the trial needs to be carefully planned and budgeted for.

Reference

Hall W., Ward J. and Hando J. (1991) *A Review of the Research Literature on the Efficacy of Methadone Maintenance.* National Drug and Alcohol Research Centre, Sydney.

7: ETHICAL ISSUES

Working Group: Gabriele Bammer, Phyll Dance, Robert Goodin, Remo Ostini
Rapporteurs: Remo Ostini and Gabriele Bammer

The considerations of the 'Ethics Group' focussed on micro-level rather than macro-level ethical issues. We did not deliberate on, for example, the ethical issues resulting from State restrictions on, and punishment of, people who use heroin and other opioids. Instead we dealt with the likely ethical issues which would result if a trial was conducted. The aim was to provide a comprehensive overview of appropriate approaches to the issues. Of course, the way that specific issues are addressed in a trial will depend largely on how a trial is structured. At the time of our deliberations that was still an unknown, although we were guided by the early considerations of the 'Options Group'. Thus we attempted to deal with a range of ethical issues that could be potentially relevant and that could be important constraints on the structure of a trial. We recognised that in the end, depending on the structure of the trial, some might not matter.

Ethical Issues for the Feasibility Study Itself

Actively investigating the feasibility of conducting a trial in a way that includes widespread consultation has two consequences. The first is the effect of raising the expectations of opioid users that a trial will proceed. The second consequence concerns the potential effects of opposition to a trial from groups with a vested interest in opioids remaining illegal.

Raising the expectations of opioid users

On one hand, the issue of raised expectations can be seen as spurious. Taking it to an extreme would mean that even discussion of the effectiveness of current drug policy is unethical, because it may raise expectations among the illegal drug using community. Nevertheless in a feasibility study such as this, where there is widespread consultation with the illegal drug using community, thus informing them of the possibility of a trial, expectations may be raised to a degree that can be seen as problematic. The publicity resulting from such a study will exacerbate this. A related issue is that the exact nature of a trial is still unclear and that this may lead to speculation and false expectations.

The question then arises as to whether or not ethical issues apply to people who are acting illegally. That is, are the raised expectations of opioid users legitimate ethical issues, given that their behaviour is illegal in any case? It could be argued that drug users are not entitled to have any expectations at all.

In response to this point, it should be noted that the law is not the final arbiter on ethical issues. Laws can be changed, quite apart from the fact that it is widely recognised that it is ethical to disregard 'bad' laws. (We do not argue the merit of laws prohibiting use of opioids, merely that the law is not the final arbiter on ethical issues.) The relevant point in this discussion is that a section of the community is experiencing health problems related to illegal drug use and furthermore is perpetrating harm on the wider community in the form of criminal acts. Since it can be argued that it is the illegality of the opioids rather than their pharmacological properties which is associated with the health problems and criminal behaviour, it is not reasonable to sustain the argument that the illegality of opioid taking *per se* negates the expectations of this section of the community. More fundamentally, the purpose of the current feasibility study is to investigate a possible way of reducing the health problems and criminal behaviour of this section of the community, and thus the associated harm to the wider community. In that context it would be bizarre to ignore or repudiate the expectations of the very part of the community whose problems the project is trying to address.

One way of addressing the issue is for the feasibility study to proceed as quickly as possible in making its recommendation on whether or not a trial should proceed. If a trial is recommended clear guidelines for its format should be laid down, so that unreasonable expectations are not raised.

Opposition to a trial

The second issue of the potential effects arising from artificial mobilisation of opposition to a trail is addressed in the section on general ethical issues for the trial.

This issue can also be addressed by coming to a resolution on the feasibility of a trial as a matter of urgency, thus limiting the time available for artificial mobilisation. This means that the feasibility study should proceed as expeditiously as possible, taking into account the need for consultation and for full consideration of relevant issues.

In addition, it should be noted that the urgency for a trial arises not only in response to the two issues raised above, but also because of the potential impact of a trial in containing the spread of HIV, both among the illicit drug using population and from there into the general community. The urgency of the feasibility study therefore also arises from the urgency of tackling the spread of HIV (Wodak, 1991, personal communication).

General Issues for a Trial

Should a trial be an experiment or an exercise in public policy?

A supervening issue which has a bearing on many of the more specific issues that this project gives rise to revolves around the question of whether this trial is primarily conceptualised as an 'experiment' in a scientific context (Miller, 1987); either an experimental investigation of the effects on users and/or the general community, or as an exercise in public/social policy. This question ultimately centres on how adequate a trial conceived as an experiment would be in terms of fulfilling the rigourous demands of scientific method. The information required to implement social policy with confidence does not have the same rigourous demands (and the outcomes may be correspondingly less clear-cut).

It is unethical to use people as 'subjects' for scientific research unless it is clear that the results of a trial can be adequately evaluated and that they will have a meaningful bearing on later policy considerations. However, there is a difficult balance to be achieved between obtaining clear results with a minimum of confounding variables and producing results that are generalisable and meaningful in terms of instituting policy.

Issues that militate against conceiving a trial as an experiment include the following:

- It will not be possible to obtain a random sample of opioid users, because the exact number and composition of the total population of opioid users is unknown. This will also make it difficult to know how representative the trial participants are of the general illegal drug using population.

- It may be difficult to devise an ethically acceptable way of randomly assigning volunteers to a control group where this assumes that controls will actively persist with behaviours that endanger their health and with criminal behaviours.

- In some ways Canberra is socially and demographically atypical. This may limit the generalisability of any results that a trial might produce. While this in itself does not invalidate a trial, it may limit its wider usefulness. The atypicality of Canberra as a social location should be openly stated so that the results of a trial will be seen in context.

•The limitations inherent in trials, including the limited time span, will not allow all the conditions that would occur in a fully fledged program to emerge.

•The size and scale of a trial are important for a number of reasons. First, the number of participants needs to be large enough to allow outcomes to be clearly demonstrated. However, the number also needs to be small enough so that if a trial is unsuccessful or cancelled for political reasons, the number of people adversely affected is minimal. Second, the size of a trial may in itself influence the likelihood of its success. A small trial may be seen as relatively innocuous and may therefore be less subject to pressures from local, national and international interest groups, such as illegal drug suppliers and governments opposed to any reduction in sanctions. However, the participants in a small trial may be subject to harassment from users not on the trial, who also want access to high quality opioids. Further, limiting a trial to one city may attract users from the rest of the country. Even though they may be debarred from participation in the trial because of residency criteria, they may contribute to hassling trial participants and may be a source of community problems, especially crime, as well as a drain on welfare services.

•There are numerous pressure groups with strong interests in this area. These views and interests range from being strongly in favour of the type of project currently being investigated, to being strongly against it. The result is that a trial may well run in a highly politicised atmosphere. In that context it may be difficult to arrive at a considered judgement on whether the trial should proceed to a full scale program. Those opposed to a trial may have an interest in contriving to adversely affect the trial results, while participants in the trial may behave in a manner that would not be sustained once a full program was instituted (i.e. they may be very conscious that 'good behaviour' is essential for the success of the trial).

If a trial is conceived as an experiment, therefore, the considerations raised above must be carefully balanced. It should be noted that should a trial demonstrate the efficacy of this form of intervention in a way that is reasonably generalisable, it is unethical not to proceed to the policy implementation stage. Of course it is likely that the outcomes of a trial will be mixed; for example it may be successful in reducing harm-related behaviours, but it may not be cost-effective. To counteract this, the criteria for success and failure of the trial should be determined before the trial begins and these determinations should include resource considerations. Having said that, a commitment to running a trial should include a commitment to implementing the resultant policy if the trial is successful.

Consideration should also be given to abandoning the idea of a trial as an experiment and to making a policy implementation decision directly, based on the best information available. This option would not be hindered by the methodological constraints of the experimental paradigm, and would circumvent many of the political considerations by, in fact, being a part of them. An important additional factor in this case is that a complete policy should be implemented immediately. The reason for this is that past experience (Hochschild, 1984) has shown that gradual implementation of politically sensitive policy results in a parallel gradual build up of opposition. This in turn means that the policy is never fully implemented and the rationale for the policy becomes superfluous in the face of public opposition (Goodin, 1982).

Issues which militate against this are:

•there is little 'hard data' which can be used to decide whether or not changed availability of opioids is likely to be successful and which can be used to structure the details of a policy.

•if the outcomes of change were detrimental, either to users or to the community at large, it is likely that more people would be affected than if a trial conceived as an experiment was instituted. It is also likely that a trial could be terminated more easily than a policy.

Acts and omissions

The general issue of acts and omissions covers the degree to which a trial (or more correctly the people responsible for a trial) is ethically culpable if something goes wrong (Glover, 1977). For example, what if someone overdoses, or if a person is involved in a car accident after receiving opioids on a trial?

There are some moral philosophers who argue that there is an enormous difference between causing harm and allowing harm to happen, so that harm resulting from intentional intervention is a major problem, regardless of the harm that might otherwise have happened. Other philosophers argue for a more utilitarian approach which considers both the harms caused by the intervention and those which would have happened had there been no intervention.

The following arguments could therefore be made with regard to the initial examples given. People who drive after administering their drugs on the trial might well have driven after administering their drugs on the street, probably with equal risk of having an accident. It should also be noted that in any trial the drug provided would be of pharmaceutical quality and of known strength and purity, unlike street drugs. The risks of overdose are therefore lessened in that respect, although there is still a risk of overdosing at the initial administrations (even if all possible precautions are taken), until the appropriate doses for each individual are determined. There is also a risk of ill effects if there is continued use of other illegal drugs in conjunction with the opioids provided.

Countermobilisation

It is likely that opposition will come from two sources. The first is from people whose value position is incompatible with a trial or who have genuine concerns about its likely outcomes. This opposition is legitimate and should not be discouraged. The second is from people who have a vested interest in opioids remaining illegal, particularly because they benefit financially from the sale of illegal drugs. Countermobilisation from this group is less legitimate. People in the second group are likely to attempt to use the legitimate concerns of the first group for their own ends, in other words legitimate concerns will be used illegitimately.

Countermobilisation can be avoided by instituting the program as social policy rather than conducting a trial (Hochschild, 1984). While this may be effective in over-riding those who have a vested interest, it also stifles legitimate opposition.

It is therefore important to carefully consider the arguments and values of those who legitimately oppose a trial and to balance them against those of the trial supporters. It is important that both sides have equal access to information about the trial and its supporting and opposing arguments. If a trial goes ahead, the evaluation should, where possible, measure variables considered to be problematic by trial opponents.

This does not overcome the concern that manipulation of public opinion by those with vested interests may compromise the effectiveness of a trial and have an unwarranted negative effect on the possibility of a trial proceeding to a full scale program.

Termination of a trial

It is likely to be easier to terminate a trial than a policy if detrimental effects occur. On the other hand, in the face of detrimental effects and a desire not to terminate, it may be easier to modify policy than a trial, especially if the trial is conceived as an experiment.

It is crucial to have a list of reasons for halting a trial, or for modifying it, even before detrimental effects can be shown to be statistically significant. In that sense, it may be necessary to compromise the scientific integrity of the trial. It is important that the criteria are determined, and agreed on, by both proponents and opponents of a trial, to prevent political interference.

It is also important to be clear about what the short- and long- term implications of terminating a trial could be, before a trial begins, and that this is taken into account when deciding whether or not to proceed with a trial.

There is also the issue of what happens to participants at the end of a trial. One approach is to argue that they at least had the benefits of a trial for its duration, so that there is minimal obligation to them.

In this case participants would need to provide informed consent on this basis at the beginning of the trial. There is however some argument about whether or not consent given by people for whom a short-term inducement far outweighs possible long-term ill-effects is meaningful. Another approach is to argue that it is highly likely that a trial will be successful for at least some participants, particularly in allowing them to stabilise their lives in terms of family relationships and employment. Ethically, it would be desirable to continue to provide assistance as long as it was needed in such cases.

Payment for drugs and for the trial

There are at least three issues here: should trial participants pay for the opioids; if so, how should the price be determined; and how should the costs of the trial be covered?

a. Should trial participants pay for the opioids?

On one hand, particularly if a trial is conceived primarily as an experiment, it could be argued that participants should not pay as it is unusual for people to have to pay when taking part in an experiment. On the other hand, it can be argued that the conditions of the experiment should be close to those which would hold if policy was instituted, in which case the need to pay for the drugs is a possibility.

b. How should price be determined?

It could be argued that opioids should be treated in the same way as other pharmaceuticals with the same consumer charges applied to them. The major expense in a trial however, is likely to arise from staff, security and administration costs, rather than from the cost of the drug itself. Requiring participants to cover these costs is likely to make the expense of participating in a trial prohibitive. This could in large part negate the value of a trial. (Similar arguments apply to the policy itself, not just the trial.)

c. How should the costs of a trial be covered?

Following the argument given immediately above, it seems that it may be necessary for a trial to be publicly subsidised at least in terms of meeting staff, security and administration costs.

Ideally, a trial would be funded from a budget separate from those of other programs. In particular other programs should not suffer financially if a trial proceeds. Realistically, however, funding may have to be at the expense of some other area. There may be some question as to whether a trial should be funded from health or law and order or research budgets. In any case it will be important for a trial to be able to justify its funding. This is unlikely to be easily done until the trial is completed and any effects on improved health or reduced crime can be demonstrated.

Specific Issues for a Trial

Selection of trial participants

a. Informed consent

Informed consent is the fundamental principle underlying participant selection and, depending on the design of a trial, allocation to 'opioid' and 'control' groups (Miller, 1987; Veatch, 1981).

b. Volunteers

Another fundamental principle is that trial participants should be volunteers. There is considerable literature on what constitutes volunteering, particularly in certain situations such as recruitment from actual or potential jail inmates.

It may be decided to recruit trial participants from the court system, so that people are given the option of participating in a trial or being sent to jail or given some other punishment. Diversion from the courts may be considered to be consent under duress. On the other hand, it can be argued that the individual has the choice, since they are not being threatened with punishment for not participating, rather, they are being presented with an alternative to punishment. The basic issue here is whether or not the person really has a choice.

c. Selection criteria

It is possible that the number of people who can participate in a trial will be limited and/or that certain groups may be excluded to enhance the ability to interpret the outcomes of a trial. Several issues arise from this.

One is that some people who volunteer to participate will have to be rejected. The issue of rejecting volunteers can be defended on the basis of the reasons for the selection criteria, and/or on the basis of random selection so that no favouritism is shown in the selection process.

Selection criteria may be seen as a form of discrimination and the discrimination may be either positive or negative. Positive discrimination will generally be defended on the grounds that those meeting the criteria are at highest risk or in greatest need. Negative discrimination will generally be defended on the grounds that people in these groups are unrepresentative of the total population and that they will make evaluation of outcomes more difficult.

The particular groups for which selection criteria are most likely to be important are: people who are HIV positive or who have hepatitis B or C; users who are mentally ill; users who are very violent; pregnant women; women likely to become pregnant (i.e. all fertile women); and users under the age of consent (it needs to be noted here that the age of consent varies with what is being consented to; further, ethically it may be possible to justify a lower age of consent than the legal age).

An argument against negative discrimination against these groups is that they are either particularly in need of intervention (e.g. HIV, hepatitis, pregnant women), that they are a significant section of the population (e.g. fertile women), or that intervention may be particularly successful in preventing problems from escalating (e.g. young people).

An argument against positive discrimination for HIV, hepatitis or pregnancy is that it may provide an incentive for people to become HIV positive, contract hepatitis or become pregnant. (There is more on incentives and on pregnancy in a later section.)

The aims and underlying conception of a trial (as experiment or exercise in public policy) will be important in determining the resolution of these issues.

d. Incentives

Specific ethical problems arise from the possibility of a trail providing incentives for people to engage in undesirable behaviours in order to be recruited onto a trial. Examples include initiation of use of opioids by people who had not used them before, formerly dependent users restarting use, and low level, non-dependent users increasing use and developing dependence. (These all presuppose that both use of opioids and dependent use of opioids are in and of themselves problematic.)

There is also the possibility of a 'heroin trap' analogy of the 'poverty trap', where a trial would provide a disincentive for people to reduce their opioid use. Alternatively, people who may otherwise have stopped using the drug because of the chaotic lifestyle associated with it, may remain dependent because of the relatively congenial nature of the trial.

It may ultimately be an open question as to whether the incentive effects are a problem if a trial generally has a good effect on participants. The question of balancing undesirable incentive effects against the positive outcomes of a trial requires that it is possible to measure the extent of incentive effects and not simply whether they exist. If a particular incentive effect does remain a problem then it

may be necessary to adjust the trial design, for example, by not making dependent use an entry criterion.

e. The comparison group

Allocation of people to a comparison group is another important issue. If people are randomly allocated to 'opioid' and 'comparison' groups, the most reasonable option would be to proceed in a similar manner to that suggested for selection procedures (Miller, 1987). Specifically, this means that participants give informed consent to participate in the trial on the basis that they may be allocated to a comparison group, and the allocation process itself must not be seen to show favouritism or punishment to any person or group of people.

It will also be necessary to provide some incentives for people in the comparison group to participate by providing information. This is fundamentally a justice consideration (Campbell, 1988) since it is unfair to use people without there being some benefit to them.

f. Inclusion of pregnant women

The question of whether or not pregnant women should be allowed to participate must ultimately rely on medical, pharmacological and social advice and will also be determined by the exact nature of a trial. The issue is a question of what is best for the mother and baby.

g. Competition with other programs

Whether or not a trial becomes a 'competitor' for clients in (other) treatment programs should be determined by which program will make the client better off. Placing restrictions on a trial to stop participants leaving (other) treatment programs to join it may bias results from a trial. It is also possible that a trial may be a conduit into treatment for people who could not otherwise be reached.

There may be opposition to a trial from service providers in abstinence programs, based on a clash of philosophies. However one of the important unknowns of a trial is whether or not it may produce changes in its participants which lead to abstinence.

h. Distributive justice

There are a number of areas with respect to recruitment where distributive justice issues arise (Campbell, 1988; Rescher, 1966). For example, if it is agreed that unadulterated opioids are much safer than adulterated, then not giving everyone who uses opioids access to unadulterated drugs is an issue of distributive justice.

The distributive justice issues can be addressed in terms of the temporary and investigative nature of a trial. In this way it can be seen as being similar to trials of vaccines for serious diseases. It is not yet proven that provision of opioids in a controlled manner will be successful in reducing health problems and criminal behaviour.

Privacy

In terms of the privacy issues, it is important that information is only collected from people with their knowledge and consent, and only for specific valid purposes (Veatch, 1981). It is also important that the information is only used for the purposes that it was gathered for. The only information kept on a register should be information that is demonstrably needed for a trial to function. This information should be disseminated only to those others who need access to the information and there should be strict controls on the sharing of information with other public agencies.

It can be argued that people will be able to be identified as illegal drug users because they need to attend the distribution point(s). The only counter to this argument is that it is the participant’s choice to be there. This issue should, however, affect the siting of the distribution point(s).

This is related to the problem of participants (having been identified) being at increased risk of prosecution if and when a trial ends. This could be dealt with by specific legislation, perhaps providing a period of moratorium from prosecution after a trial ends. Alternatively, this potential difficulty could be seen as further support for the direct implementation of policy without a prior trial.

Intrusiveness resulting from the need to obtain sensitive information from the participants in order to evaluate a trial can best be dealt with by ensuring that only information that is definitely required is obtained. The information which this involves should be determined *a priori* on scientific grounds.

A particular example is requiring people to undergo HIV tests before being accepted for a trial. This can be considered to be a permissible intrusion if the participants are given the opportunity to provide informed consent, are given pre- and post-test counselling, and if there is good reason for the tests.

Issues relating to staff working on a trial

The question of potential risks to trial staff and indemnification for the service providers has two aspects relevant to ethics (See also Chapter 6: Legal Issues). The first is that a trial should be designed to minimise the risk for service providers. For example, universal precautions need to be taken to minimise the risk of contracting HIV or hepatitis through needle-stick injuries. The second is that the staff should be fully informed as to the nature of their responsibilities and the risks involved, and should have the opportunity to provide informed consent for working on a trial. Assuming that a trial is run through the existing public health care and/or social welfare system, it should also be made possible for staff to transfer to work not involved with the trial at any time. This last condition is to ameliorate the effects of 'burn-out', which are possible as working on a trial is likely to be highly stressful.

Coupling a trial with specific forms of treatment

It is possible that trial participants will be required to undergo counselling or specific forms of treatment, depending on the aims and structure of, or the political realities surrounding, a trial. The question of informed consent is again involved but a further issue is that it may be unreasonable to attach unrelated "strings" to a trial, which would constitute unethical manipulation of people.

Issues for researchers

People conducting research for the feasibility study or evaluating outcomes of a trial must not have restrictions placed (through either internal or external pressure) on their ability freely to publish the results of their investigations. Further, any empirical data which is collected should be made publicly available after a reasonable length of time (with appropriate protection to prevent identification of individual participants). It seems reasonable to suggest that such data be lodged with the Social Science Data Archives at the Australian National University 12 months after it is collected, for immediate accessibility by *bona fide* researchers.

Conclusions

As indicated in the opening paragraph, the way that specific issues are addressed will depend largely on how a trial is structured. In this paper we have attempted to deal with a broad range of ethical issues that may be potentially relevant; in the end some may not pose a problem. Some ethical criteria which must be met have been identified. Other criteria will be important in shaping the trial and have also been highlighted.

The minimum ethical standards which must be met, regardless of the nature of the trial are that:

- there is a reasonable chance that the trial will 'prove' something, i.e. the outcomes of the trial can be adequately evaluated
- there is a list of reasons for halting or modifying the trial, which is drawn up before the trial begins
- participants and trial staff are volunteers and give informed consent
- selection of trial participants and their allocation to 'opioid' or 'comparison' groups is without prejudice or bias
- information is only collected from people with their knowledge and consent, only for specific valid purposes, and only used for the purposes for which it was gathered
- trial conditions do not involve needless manipulation of participants
- the conclusions of the trial and the evidence on which they are based are publicly available.

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8: ATTITUDES TO A TRIAL

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Introduction

The aims of Stage 1 of the feasibility study were to determine whether or not a trial should go ahead and, if so, how, in principle, it should be structured. Eliciting the attitudes of the general community and a range of key groups was an essential part of this. The following approaches were used:

- A random sample of the general community was surveyed by telephone
- Canberra-based police, people providing treatment and support services to illegal drug users (service providers), and illegal drug users and ex-users were surveyed using self-administered questionnaires
- Key community groups were sent an invitation to comment on a proposed trial, and
- The community generally was invited to comment through a newspaper advertisement.

It needs to be noted that no specific proposal about the structure of a trial was put to any of these groups. Instead, in the first two approaches, responses were invited to a range of advantages and disadvantages which could be associated with a trial and to a number of difficult issues which a trial would have to deal with. Police, service providers and users/ex-users were also asked how a trial might impact on their work (police and service providers) or their lives (users/ex-users). These groups were also asked more specific questions about how a trial should be structured and the possible effects of a trial on various user behaviours.

In the last two approaches only a general statement about the broad aims of the trial was presented.

The time available to collect this information was limited. This particularly affected the ability of agencies to distribute questionnaires to service providers and users/ex-users. Further, only one follow-up letter (for police) or word-of mouth message (service providers and users/ex-users) could be sent to encourage responses. The time available to key community groups and individuals for comment was also very short. We were aware, however, that if the feasibility study proceeded to stage 2, there would be further and more realistic opportunity for this sort of public input and that it could be focussed on a specific proposal.

The limited time frame also meant that a more detailed analysis and discussion of the results could not be presented. Consistency of responses between questions needs to be more completely checked. The results will be fully analysed and published in due course.

This chapter is structured in the following way:

(A) For the telephone interviews and the self-administered questionnaires:
- Survey methods and response rates (Section 1)
- Background information relating to the groups surveyed (Section 2)
- General views on drugs (Section 3)
- Awareness attitudes and perceived effects of a trial (Section 4)
- Structure of a trial (Section 5)
- Analysis of qualitative data (Section 6)

(B) For the invited comments:
- Qualitative analysis (Section 6)

Section 1: Survey Methods and Response Rates

Survey questionnaires

Four separate questionnaires were designed to elicit the views of the general community, police, service providers and drug users/ex-users. Prior to administration, versions of each questionnaire were pretested on small 'convenience' samples. In addition the community survey was pretested on a random sample by the survey research company. Each of the questionnaires contained a common 'core' of questions. The police, service provider and drug user surveys also included a number of common questions. Copies of each of the questionnaires are included in the appendices.

General community

The community survey was conducted by an experienced social survey research company using a Computer Assisted Telephone Interview (CATI) system. A copy of the questionnaire used in the telephone interview is included in Appendix D.

A random selection of telephone numbers drawn from the Canberra-Queanbeyan-Yass white pages yielded 843 telephone numbers within the ACT.

During the period June 7th to June 16th 1991 these telephone numbers were called, on several occasions at various times of the day if necessary, in an attempt to establish contact. The selection criteria limited respondents to persons aged 18 years or older who had been resident in Canberra for more than the previous month.

The telephone calls yielded the following results:

Successful interviews	517
Refusals and abandoned interviews	165
No contact made	116
Not eligible to participate	44
Total	843

This represents a response rate of 76.9% (i.e. successful interviews / number of contacts of eligible respondents).

Police

The Australian Federal Police Association forwarded questionnaires with a covering letter and reply-paid envelope to their Canberra-based members (which represents 98% of all Canberra-based Federal Police). A copy of the questionnaire and covering letter is included in Appendix F.

A total of 1173 self-administered questionnaires were sent out in late June and approximately one week later they were followed by a reminder notice.

Over the following two week period 449 questionnaires were returned completed or partially completed and 43 were returned as undeliverable.

This represents a response rate of 39.7% (completed questionnaires / questionnaires delivered to those selected in sample).

Service Providers and Drug Users/Ex-users

In mid June 1991 those groups and organisations within Canberra which provide treatment and support services to illegal drug users/ex-users were contacted to determine their willingness to distribute questionnaires to their workers and to their clients. A total of 25 groups and organisations were

contacted. Over 90% of these agreed to provide assistance and based on their estimates 311 self-administered questionnaires were left for distribution to their workers and 863 were left for distribution to their clients. A reply-paid envelope was distributed with each questionnaire. Copies of the questionnaires are included in Appendices G (Service Providers) and H (Users/ex-users).

Approximately one week after the questionnaires were left with the various agencies they were contacted again to ensure that the questionnaires were being distributed.

Over a two week period 94 questionnaires were returned completed or partially completed by service providers. Fifty-three undistributed service provider questionnaires were collected at the end of this period. A total of 538 surveys were actually distributed to the drug users/ex-users and 134 were returned completed or partially completed.

This represents a response rate of 37.9% for the service providers and 24.9% for the drug users/ex-users (questionnaires completed / questionnaires distributed).

Analysis of the results

Data collected by telephone interview were entered directly into a data base and then transferred into an SPSS file. The results of frequency analysis and selected cross-tabulations are reported here.

The self-administered questionnaires were individually checked and coded and the responses to open-ended questions were grouped and coded. The data were key punched and analysed using SPSS software. This report includes only the results of frequency analyses and selected cross-tabulations.

Responses made under the last question "Do you have any other comments?" were compiled using standard qualitative analysis techniques.

Comments made by key community groups and by the individuals who responded to the newspaper advertisement are presented in Appendix E. Everyone who made substantive comments gave permission for them to be reproduced. A breakdown of the key results is given in Section 6.

Unless otherwise specified, results are presented as proportions, i.e. percentages.

General demographic description of the survey samples

A breakdown of the general demographic characteristics of the four survey samples is presented in Table 1.

For the general community a comparison was made with 1986 census data provided by the Australian Bureau of Statistics. The sex and age distributions of the sample were similar to those reported for the ACT community. However within the survey sample people with tertiary qualifications tended to be over-represented.

At the time of writing the report comparative data for the police were unavailable.

Most of the groups and organisations which provided access to their workers also provided sex and age breakdowns of all their workers. The sex distribution of the study sample matched that provided. However, it appears that younger service providers (aged under 35 years) were slightly over-represented in the sample.

We have no way of knowing how representative the users/ex-users who participated in the survey were.

Table 1: General demographic description of the survey samples

	% General Community	% Police	% Service Provider	% Drug Users*
Sex	*(n = 517)*	*(n = 445)*	*(n = 92)*	*(n = 130)*
Male	*49*	*88*	*25*	*59*
Female	*51*	*12*	*75*	*41*
Age (years)	*(n = 511)*	*(n = 444)*	*(n = 92)*	*(n = 129)*
18 - 19	*3*	*-*	*-*	*5*
20 - 29	*23*	*28*	*28*	*47*
30 - 39	*28*	*35*	*32*	*40*
40 - 49	*24*	*30*	*32*	*9*
50 - 59	*12*	*9*	*7*	*-*
60 - 69	*6*	*-*	*1*	*-*
70 and over	*5*	*-*	*1*	*-*
Have children under 25	*(n = 516)* *58*	*(n = 446)* *69*	*(n = 93)* *54*	*(n = 130)* *44*
Practice a religion	*(n = 517)* *35*	*(n = 439)* *32*	*(n = 91)* *24*	*(n = 130)* *18*
Qualifications	*(n = 514)*	*(n = 420)*	*(n = 91)*	*(n = 129)*
None since school	*28*	*42*	*15*	*47*
Certificate or diploma	*26*	*25*	*43*	*21*
Trade or apprenticeship	*11*	*15*	*1*	*9*
Bachelor or higher degree	*35*	*8*	*37*	*19*

* In all tables and accompanying discussion, 'drug users' (unless further specified) refers to both users and ex-users. This expediency may be offensive to ex-users, if so we apologise.

Section 2: Background Information

General Community (Tables 2.1 to 2.6)

- A significant proportion of the respondents to the general community survey have used or been affected in some way by illegal drugs.

- One third of the general community reported that they had tried an illegal drug at some time, with 6% of them having experienced health problems caused by illegal drug use. Approximately 10% of the respondents had used marijuana in the previous twelve month period. Two people had used other illegal drugs; one of them had used heroin.

- Twenty-five percent reported they or someone close to them had been affected by a crime they believed was committed by illegal drug users. Approximately one in five reported that someone close to them currently used illegal drugs and a similar proportion knew someone who had suffered health problems as a result of illegal drug use.

Police (Tables 2.7 to 2.24)

- Slightly more than 40% of police reported that 'some' of their present job involves dealing with illegal drug users or drug related crime and 27% indicated that 'most' or 'all' of their work involved this.

- Half of the police believed that opiates* /heroin are the drugs most responsible for the drug related crime they deal with and 59% felt opiates/heroin are the drugs most responsible for the serious drug related criminal behaviour they currently deal with.

- Two thirds of the police thought that 'most' stealing (e.g. breaking and entering) in the ACT takes place to finance illegal drug use. Between 35% and 45% believed 'most' robbery, fraud and illegal drug supplying takes place for this purpose.

- Driving under the influence of heroin/opiates and other illegal drugs was perceived to be a 'major problem' by about one in six police and a 'minor problem' by a further 55%.

- Violence related to heroin/opiate use was considered to be a 'major problem' by 37% of police and a 'minor problem' by 43%.

- With regard to both driving and violence, alcohol was considered to be a 'major problem' by many more of the police.

- Slightly more than half of the police believed that current policing of drugs in the ACT is ineffective. There is also a widespread belief, held by more than 70% of police, that the current penalties for using and for supplying illegal drugs as provided for in the law are 'too lenient'. Some 90% of police felt that the penalties handed out by the judiciary were 'too lenient'.

Service Providers (Tables 2.25 to 2.31)

- Two in three service providers had ever used illegal drugs, with one in four having used heroin/opiates and half of this number having previously been dependent on them.

- When asked to describe their own treatment philosophy, a range of responses was tendered. The most common were 'consumer oriented' (45%) and 'abstinence' (32%).

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* The term 'opiates' is incorrectly used throughout. The correct term is 'opioids' (see Appendix A). However the subtleties of the difference are unlikely to have misled the respondents.

- Almost all of the service providers believed their own program was effective in meeting its goals. Of other programs, the methadone maintenance and withdrawal programs were seen as ineffective by 30% and 50%, respectively.

Drug Users/Ex-users (Tables 2.32 to 2.56)

- The respondents to the survey included ex-users, dependent users, binge users and non-dependent users. With regard to heroin use: 12% are ex-users, 27% are dependent users, 7% are binge users and 19% are non-dependent users.

- Five percent of respondents are HIV positive.

- In the previous month one in three drug users surveyed had used heroin; a similar proportion had used amphetamines; 25% had used benzodiazepines; 25% had taken codeine or 'homebake'; and 65% had used cannabis.

- For heroin, amphetamines and codeine/homebake, injection was the most common route of administration.

- All of the heroin users injected. In the previous month 88% 'usually' injected one, two or three times a day. However 44% reported that the 'most' number of times they had injected was 4 or more times per day.

- Of those who currently used heroin, 31% reported that they would use heroin only if they could always get it; 44% would use heroin and cannabis only; and 24% would use heroin and a range of other illegal drugs. Of those dependent on heroin 45% said they would use heroin only and 48% said heroin and cannabis only. In contrast 44% of non-dependent users said they would use heroin and a range of other illegal drugs if they could always get them (data not tabulated below).

- Seventy-five percent of the drug users surveyed reported suffering from health or other problems because of illegal drug use. The health problems ranged from constipation, weight loss and skin problems to hepatitis, leg ulcers and brain damage (qualitative data not yet analysed).

- Thirty-five percent had lived away from Canberra for any length of time in the past 12 months.

- One in three drug users surveyed live with dependent or non-dependent heroin/opiate users. In addition, 80% of their friends are heroin/opiate users and/or use cannabis or other illegal drugs.

- At the time of the survey, 37% of the users were in some form of treatment for their heroin/opiates use. Sixty-four percent of the users reported having previously been in treatment. Nearly two-thirds of those currently in treatment were on methadone maintenance or withdrawal. Just over half of those who had ever been in treatment had been on methadone maintenance or withdrawal (results not tabulated). Only 1% were on a waiting list to get into treatment.

- More than one third of people currently using drugs reported that they raised money to pay for them by supplying illegal drugs; 12% by shoplifting; 10% by other stealing; 4% by robbery; 6% by fraud and 8% by prostitution.

- Of those who reported that they supplied illegal drugs, most supplied a range of drugs, including heroin/opiates. Most only supplied enough to cover the cost of their own drug use.

- Forty-five percent of drug users reported having driven under the influence of heroin/opiates in the previous twelve months, with 30% having done this on at least ten occasions.

- Over the previous year more than one in five users had been a victim of violence because of heroin/opiates and about one in ten had assaulted another person because of these drugs.

Background Information: General Community

Table 2.1: Have you or has someone close to you been affected by a crime that you think was committed by illegal drug users? (n = 517)

Yes	*25*
No	*74*
Don't know	*1*

Table 2.2: Does anyone close to you currently use illegal drugs? (n = 517)

Yes	*22*
No	*78*
Don't know	*<1*
Has in past	*<1*

Table 2.3: Has anyone close to you ever suffered from health or other problems resulting from illegal drug use? (n = 517)

Yes	*19*
No	*81*
Don't know	*<1*

Table 2.4: Have you ever tried an illegal drug? (n = 517)

Yes	*34*
No	*66*

Table 2.5: Amongst only those who have every tried an illegal drug: Have you suffered from health or other problems because of illegal drug use? (n = 178)

Yes	*6*
No	*94*

Table 2.6: Which illegal drugs, if any, have you used in the past twelve months? (n = 517)

Never taken illegal drugs	*66*
Haven't taken any in past 12 months	*25*
Marijuana	*10*
Cocaine	*<1*
Heroin	*<1*
Amphetamines	*<1*
Ecstasy	*<1*

Background Information: Police

Table 2.7: How long have you been a member of the police force? (Any police force in Australia) (n = 444)

< 2 years	*5*
2-5 years	*10*
5-10 years	*25*
10-20 years	*39*
> 20 years	*21*

Table 2.8: What is your current employment status? (n = 446)

Full Time	*98*
Part Time	*1*
Other	*1*

Table 2.9: What area are you **currently** *working in? (n = 443)*

Uniform - operations	*36*
Uniform - administration	*5*
Plain Clothes - operations	*35*
Plain Clothes - administration	*11*
Training	*8*
Other	*5*

Table 2.10: How long have you been in your current section (e.g. accident squad, drug squad)? (n = 439)

< 2 year	*37*
2-5 years	*41*
5-10 years	*13*
> 10 years	*9*

Table 2.11: What is your current rank? (n = 443)

Constable	*55*
Sergeant	*32*
Superintendent and above	*11*

Table 2.12: What proportion of your present job involves dealing with illegal drug users or criminal behaviour related to or resulting from illegal drug use? (n = 445)

None	*16*
Very little	*15*
Some	*42*
Most	*23*
All	*4*
Don't know	*1*

Table 2.13: Think of the area you have **ever** *worked in which had the* **most** *involvement with illegal drug use. What proportion of your time in that job involved dealing with illegal drug users or criminal behaviour related to or resulting from illegal drug use? (n = 444)*

None	*1*
Very little	*10*
Some	*48*
Most	*27*
All	*13*
Don't know	*1*

Table 2.14: Of **all** *the drug-related criminal behaviour you currently deal with, which of these illegal drugs is most responsible? (n = 414)*

None of my work involves illegal drugs	*15*
Cannabis	*21*
Opiates/heroin	*49*
Other illegal drugs	*7*
Don't know	*9*

Table 2.15: Of the **serious** *drug-related criminal behaviour you currently deal with, which of these illegal drugs is most responsible? (n = 419)*

None of my work involves illegal drugs	*17*
Cannabis	*8*
Opiates/heroin	*59*
Other illegal drugs	*6*
Don't know	*10*

Table 2.16: What proportion of the following activities do you think takes place to finance illegal drug use in the ACT? (n = 443)

	Don't know	None	A little	Some	Most	All
Shoplifting	*5*	*4*	*26*	*58*	*6*	*<1*
Other stealing (including breaking and entering)	*3*	*-*	*1*	*28*	*66*	*3*
Robbery (eg mugging, hold-ups)	*3*	*<1*	*10*	*39*	*43*	*6*
Fraud	*5*	*1*	*13*	*46*	*35*	*1*
Supplying illegal drugs	*3*	*-*	*4*	*32*	*43*	*18*
Prostitution	*8*	*1*	*18*	*53*	*19*	*2*

Table 2.17: How much of a problem do you think the following are in the ACT? (n = 443)

	Major problem	Minor problem	Not a problem	Don't know
Driving under the influence of alcohol	*66*	*31*	*3*	*0*
Driving under the influence of cannabis	*15*	*56*	*7*	*22*
Driving under the influence of heroin/opiates	*14*	*55*	*6*	*26*
Driving under the influence of other illegal drugs	*15*	*55*	*5*	*25*
Violence related to alcohol use	*85*	*12*	*0*	*3*
Violence related to cannabis use	*11*	*52*	*17*	*20*
Violence related to heroin/opiates use	*37*	*43*	*4*	*17*
Violence related to other illegal drugs	*27*	*48*	*3*	*22*

Table 2.18: How much of a problem do you think drug-related corruption is in the ACT police force? (n = 445)

Not a problem at all	*53*
Minor problem	*14*
Moderate problem	*4*
Major problem	*1*
Don't know/No opinion	*28*

Table 2.19: How effective do you think current policing in the ACT is with regard to illegal drugs? (n = 444)

Very effective	*2*
Effective	*34*
Ineffective	*45*
Very ineffective	*7*
Don't know/No opinion	*12*

Table 2.20: Do you have any suggestions as to how the ACT police force could deal more effectively with drug offenders, both users and suppliers? (n = 315)

More funding and resources	*8*
Education and media campaigns	*6*
Changes to legislation (legal system)	*22*
Heavier penalties (particularly for suppliers)	*30*
Improved health/welfare/rehabilitation programs	*10*
Better police procedures/greater powers	*21*

Table 2.21: What do you think of the current penalties in the ACT for **using** *illegal drugs* **as provided for in law***? (n = 445)*

Much too harsh	*0*
Too harsh	*1*
Adequate	*29*
Too lenient	*29*
Much too lenient	*39*
Don't know/No opinion	*2*

Table 2.22: What do you think of the current penalties in the ACT for **using** *illegal drugs* **as handed out by the judiciary** *(eg magistrates, judges)? (n = 447)*

Much too harsh	*0*
Too harsh	*0*
Adequate	*9*
Too lenient	*27*
Much too lenient	*61*
Don't know/No opinion	*2*

Table 2.23: What do you think of the current penalties in the ACT for **supplying** *illegal drugs* **as provided for in law***? (n = 447)*

Much too harsh	*0*
Too harsh	*0*
Adequate	*23*
Too lenient	*27*
Much too lenient	*48*
Don't know/No opinion	*1*

Table 2.24: What do you think of the current penalties in the ACT for **supplying** *illegal drugs* **as handed out by the judiciary** *(eg magistrates, judges)? (n = 448)*

Much too harsh	*1*
Too harsh	*0*
Adequate	*3*
Too lenient	*24*
Much too lenient	*70*
Don't know/No opinion	*2*

Background information: Service Providers

Table 2.25: What is your current employment status? (n = 91)

Full time paid	*60*
Part time paid	*31*
Full time volunteer	*2*
Part time volunteer	*2*
Other	*3*

Table 2.26: Drug using behaviour of service providers (n = 91)

	Yes	**No**
*Have you **ever** used illegal drugs?*	*66*	*34*
*Have you **ever** used illegal heroin/opiates?*	*25*	*75*
*Have you **ever** been dependent on illegal heroin/opiates?*	*12*	*88*
*Do you **currently** use illegal heroin/opiates?*	*2*	*98*
*Are you **currently** dependent on illegal heroin/opiates?*	*0*	*100*
*Have you ever been in **methadone treatment** for illegal heroin/opiate use?*	*5*	*95*
*Have you ever been in **other treatment** for illegal heroin/opiate use?*	*11*	*89*

Table 2.27: What are the main functions of your treatment service? (n = 93)

Detoxification	*14*
Therapeutic community	*14*
Half-way house	*9*
Methadone program	*8*
Advice and education service (eg counselling, group education, drop-in centre, private practice)	*57*
Refuge	*15*
Outreach	*23*
Other	*16*

Table 2.28: Please describe the treatment philosophy of your **organisation/service** *(For example: abstinence model, feminist, medical model, consumer oriented.) (n = 87)*

Abstinence	*31*
Feminist	*2*
Medical	*23*
Consumer oriented	*40*
Education/information	*6*
Social justice	*2*
Harm reduction/prevention	*18*
Psycho social model	*1*
Assistance/friendship	*1*
Counselling	*1*
Referral	*1*
Therapeutic community	*1*
Self help	*1*
Non intevention	*3*
Humanistic	*1*

Table 2.29: Please describe your **own** *treatment philosophy (For example: abstinence model, feminist, medical model, consumer oriented.) (n = 84)*

Abstinence	*32*
Feminist	*7*
Medical	*13*
Consumer oriented	*45*
Education/information	*5*
Alternative	*4*
Social justice	*2*
Harm reduction/prevention	*13*
Psycho social model	*4*
Assistance/friendship	*4*
Holistic approach	*2*
Therapeutic community	*1*
Self help	*2*
Systems model	*1*
Non intevention	*1*
Humanistic	*1*

Table 2.30: How effective do you think the following programs are in meeting their goals? (n = 84)

	Very effective	Effective	Ineffective	Very ineffective	Don't know
The program you work on	*25*	*67*	*6*	*-*	*3*
Methadone maintainence	*3*	*48*	*21*	*9*	*19*
Methadone withdrawal	*2*	*19*	*34*	*16*	*29*
Hospital detoxification	*6*	*52*	*21*	*7*	*15*
Other detoxification	*6*	*57*	*14*	*5*	*19*
Therapeutic community eg Karralika, Mancare	*15*	*54*	*10*	*5*	*16*
Counselling	*8*	*67*	*13*	*1*	*11*
12-step programs eg Narcotics Anon	*23*	*53*	*10*	*3*	*10*
Outpatient treatment	*2*	*39*	*26*	*6*	*27*
Brief interventions	*2*	*35*	*29*	*12*	*21*
Other programs	*6*	*15*	*9*	*-*	*67*

Table 2.31: What proportion of your clients are under 18 years? (n = 93)

Most	*24*
Some	*31*
Few	*28*
None	*15*
Don't know	*1*

Background information: Drug Users/Ex-users

Table 2.32: What is your current employment status? (n= 129)

Full time	*33*
Part time	*13*
Student	*6*
Home Duties	*9*
Unemployed	*38*
Other	*1*

Table 2.33: What is your current living situation? (n= 130)

With partner only	*9*
With partner and children only	*18*
With children only	*6*
Alone	*11*
In a group house	*32*
With parents	*10*
Other	*14*

Table 2.34: How many times have you changed your address in the past 12 months? (n = 127)

None	*41*
Once	*16*
2 - 4 times	*36*
5 or more times	*7*

Table 2.35: Have you lived away from Canberra for any length of time in the past 12 months? (n=130)

Yes	*35*
No	*65*

Table 2.36: Drug users' relationships with other drug users (n = 128)

	None	One	A few	About half	All or most	Don't know	Not applicable
How many of the people you live with are dependent heroin/opiate users?	*67*	*16*	*4*	*2*	*5*	*2*	*4*
How many of the people you live with are non-dependent or recreational heroin/opiate users?	*62*	*14*	*6*	*4*	*6*	*2*	*7*

Table 2.37: Drug users' friendships with other drug users (n = 124)

	None	A few	About half	All or most	Don't know
About how many of your friends (apart from any you live with) are dependent heroin/opiate users?	*21*	*50*	*18*	*11*	*1*
About how many of your friends (apart from any you live with) are non-dependent or recreational heroin/opiate users?	*18*	*55*	*16*	*9*	*3*
About how many of your friends use cannabis only?	*14*	*41*	*11*	*29*	*4*
About how many of your friends use illegal drugs apart from heroin/opiates and cannabis?	*12*	*45*	*15*	*23*	*5*
About how many of your friends use no illegal drugs at all?	*21*	*57*	*11*	*8*	*2*

Table 2.38: How would you describe your own current heroin/opiate use? (n=129)

Non-use	*35*
Nondependent use	*19*
Binge use	*7*
Dependent use in recovery (ex-user)	*12*
Dependent use in treatment and still using street opiates	*9*
Dependent use in treatment and not using	*12*
Dependent use, not in treatment	*6*
Other	*1*

Table 2.39: How would you describe your current illegal drug taking other than heroin/opiate use? (n=128)

Non-use	*27*
Nondependent use of all other illegal drugs	*19*
Binge use of at least one other illegal drug, but not dependent on any	*19*
Dependent use in recovery (Ex-user)	*9*
Dependent use of at least one other illegal drug, in treatment and still using illegal drugs	*4*
Dependent use of at least one other illegal drug, in treatment and not using	*6*
Dependent use of at least one other illegal drug, not in treatment	*9*
Other	*7*

Table 2.40: How would you describe your current use of heroin in relation to other illegal drugs? (n=127)

I don't use heroin	*46*
I would use heroin only (no cannabis or other illegal drugs) if I could always get it	*17*
I would use heroin and cannabis only (no other illegal drugs) if I could always get them	*24*
I would use heroin and a range of other illegal drugs, if I could always get them	*13*

Table 2.41: In the past month, which of the following drugs have you used, and how often have you used them? (n = 121)

	Not used	More than once a day	Once a day	More than once a week	Once a week	Less than once a week
Heroin	*64*	*7*	*5*	*9*	*4*	*12*
Methadone	*75*	*1*	*22*	*-*	*1*	*2*
Morphine	*92*	*-*	*1*	*1*	*1*	*6*
Opium	*95*	*-*	*-*	*1*	*1*	*4*
Pethidine	*97*	*-*	*-*	*-*	*2*	*2*
Codeine/Homebake	*77*	*2*	*2*	*6*	*1*	*12*
Palfium	*99*	*-*	*-*	*-*	*1*	*1*
Dilaudid	*100*	*-*	*-*	*-*	*-*	*-*
Amphetamines (speed)	*66*	*2*	*4*	*8*	*9*	*12*
LSD	*92*	*-*	*-*	*-*	*2*	*7*
Ecstasy	*95*	*-*	*-*	*2*	*-*	*4*
Cocaine	*92*	*-*	*-*	*2*	*1*	*5*
Crank (mixture of cocaine and other drugs)	*97*	*-*	*-*	*1*	*1*	*2*
Crack (free based cocaine)	*98*	*-*	*-*	*1*	*-*	*2*
Barbiturates (eg reds, nembies)	*93*	*-*	*1*	*2*	*-*	*5*
Benzodiazepines (eg Serepax, Valium, Mogadon)	*75*	*5*	*2*	*9*	*2*	*8*
Cannabis	*35*	*22*	*11*	*17*	*6*	*9*
Tobacco	*17*	*78*	*2*	*2*	*1*	*1*
Alcohol	*35*	*15*	*6*	*17*	*14*	*13*
Amyl nitrate	*94*	*2*	*-*	*1*	*-*	*4*
Other	*87*	*4*	*1*	*1*	*3*	*4*

Table 2.42: How have you mainly taken the drugs you have used in the past month? (n = 121)

	Not used	Shoot	Snort	Smoke	Swallowed
Heroin	*61*	*39*	*-*	*-*	*-*
Methadone	*74*	*1*	*-*	*-*	*25*
Morphine	*91*	*8*	*-*	*-*	*2*
Opium	*94*	*2*	*-*	*3*	*2*
Pethidine	*95*	*5*	*-*	*-*	*-*
Codeine/Homebake	*79*	*14*	*-*	*-*	*8*
Palfium	*99*	*1*	*-*	*-*	*1*
Dilaudid	*99*	*1*	*-*	*-*	*-*
Amphetamines (speed)	*65*	*31*	*2*	*-*	*2*
LSD	*89*	*3*	*-*	*-*	*8*
Ecstasy	*95*	*2*	*1*	*-*	*2*
Cocaine	*89*	*8*	*3*	*-*	*-*
Crank (mixture of cocaine and other drugs)	*95*	*3*	*2*	*-*	*-*
Crack (free based cocaine)	*97*	*2*	*1*	*-*	*-*
Barbiturates (eg reds, nembies)	*91*	*2*	*-*	*-*	*8*
Benzodiazepines (eg Serepax, Valium, Mogadon)	*73*	*-*	*-*	*-*	*27*
Cannabis	*34*	*-*	*-*	*66*	*-*
Tobacco	*15*	*-*	*-*	*84*	*1*
Alcohol	*34*	*-*	*-*	*-*	*66*
Amyl nitrate	*94*	*-*	*6*	*-*	*-*
Other	*88*	*3*	*1*	*-*	*7*

Table 2.43: Heroin injecting habits of current drug users (n = 40)

	Once	Twice	Three times	Four times	5 or more times
In the last month what was the least number of times you injected heroin/opiates per day?	*77*	*16*	*7*	*-*	*-*
In the last month, what was the most number of times you injected heroin/opiates per day?	*21*	*30*	*5*	*16*	*28*
In the last month, what was the usual number of times you injected heroin/opiates per day?	*45*	*25*	*18*	*3*	*10*

Table 2.44: Have you ever suffered from health or other problems because of illegal drug use? (n = 106)

Yes	*75*
No	*22*
Don't know	*4*

Table 2.45: Are you currently on a waiting list to get into treatment for heroin/opiates use? (n=128)

Yes	*1*
No	*90*
Not applicable	*9*

Table 2.46: Are you currently in any of the following treatments for heroin/opiates use?

	Yes (n = 105)	Is it helpful? (Amongst those in treatment) Yes	No
Methadone maintenance	*18*	*79*	*21*
Methadone withdrawal	*6*	*80*	*20*
Detoxification	*2*	*0*	*100*
Outpatient treatment	*4*	*100*	*0*
Therapeutic community eg Karralika, Mancare	*13*	*100*	*0*
Counselling	*24*	*77*	*23*
A 12-step program, eg Narcotics Anonymous	*15*	*100*	*0*

Table 2.47: Have you ever been in any of the following treatments for heroin/opiate use?

	Yes	Was it helpful? (Amongst those who have had treatment)	
	(n = 110)	Yes	No
Methadone maintenance	*31*	*69*	*31*
Methadone withdrawal	*29*	*40*	*60*
Detoxification	*33*	*44*	*56*
Outpatient treatment	*7*	*83*	*17*
Therapeutic community (eg Karralika, Mancare)	*24*	*64*	*36*
Counselling	*41*	*63*	*37*
A 12-step program, eg Narcotics Anon	*28*	*69*	*31*

Table 2.48: Are you HIV positive? (n = 120)

Yes	*5*
No	*77*
Don't know	*18*

Table 2.49: If you are currently using, in what ways do you usually raise money to pay for your illicit drug use? (n=124)

Not currently using drugs	*50*
Full-time employment	*22*
Part-time employment	*7*
Dole, pension or other benefits	*26*
Supplying illegal drugs	*18*
Shoplifting	*6*
Other stealing (including breaking and entering)	*5*
Robbery (eg mugging)	*2*
Fraud	*3*
Prostitution	*4*
Other	*12*

*Table 2.50: If you are **not** currently using, in what ways **did** you **usually** raise money to pay for your illicit drug use? (n=88)*

Full-time employment	*42*
Part-time employment	*25*
Dole, pension or other benefits	*52*
Supplying illegal drugs	*50*
Shoplifting	*15*
Other stealing (including breaking and entering)	*30*
Robbery (eg mugging)	*10*
Fraud	*27*
Prostitution	*19*
Other	*14*

Table 2.51: How frequently, if at all, have you raised money for illegal drugs in the following ways **in the last 12 months***? (n = 102)*

	Never	**Less than 10 times**	**10-100 times**	**More than 100 times**
Shoplifting	*77*	*13*	*5*	*5*
Other stealing (including breaking and entering)	*74*	*14*	*9*	*4*
Robbery (eg mugging)	*90*	*7*	*1*	*2*
Fraud	*73*	*22*	*5*	*-*
Supplying illegal drugs	*47*	*20*	*18*	*16*
Prostitution	*80*	*10*	*4*	*7*

Table 2.52: How frequently, if at all, have you driven under the influence of these drugs, **in the last 12 months***? (n = 120)*

	Never	**Less than 10 times**	**10-100 times**	**More than 100 times**	**I don't drive**
Alcohol	*44*	*31*	*15*	*3*	*7*
Cannabis	*40*	*12*	*22*	*18*	*7*
Heroin/opiates	*48*	*15*	*16*	*14*	*7*
Other illegal drugs	*58*	*14*	*14*	*8*	*7*

Table 2.53: How frequently, if at all, have you been a victim of violence because of these drugs, **in the last 12 months***? (n = 123)*

	Never	**Less than 10 times**	**10-100 times**	**More than 100 times**	**Don't know**
Alcohol	*57*	*30*	*10*	*3*	*-*
Cannabis	*89*	*11*	*1*	*-*	*-*
Heroin/opiates	*72*	*24*	*4*	*-*	*-*
Other illegal drugs	*81*	*15*	*3*	*-*	*1*

Table 2.54: How frequently, if at all, have you assaulted another person because of these drugs, **in the last 12 months***? (n = 124)*

	Never	**Less than 10 times**	**10-100 times**	**More than 100 times**
Alcohol	*83*	*11*	*6*	*-*
Cannabis	*98*	*2*	*-*	*-*
Heroin/opiates	*91*	*6*	*3*	*-*
Other illegal drugs	*90*	*9*	*2*	*-*

Table 2.55: What illicit drugs, if any, do you supply? (n=119)

I don't supply drugs	*63*
Just marijuana	*13*
Just heroin/opiates	*7*
A range of drugs including cannabis and heroin/opiates	*18*

Table 2.56: Do you: (n=118)

only supply to friends and do so at cost price	*12*
only supply enough to cover your own drug use	*25*
get a profit through dealing over and above what you need for your own drug use	*6*
I don't supply drugs	*58*

Section 3: General Views on Drugs

- More than 90% of respondents to the general community survey considered heroin use to be a serious problem. Similiarly, almost all of the police and approximately three quarters of the service providers and drug users felt that heroin use is a serious problem for the community (Table 3.4).

- More than 90% of each of the groups surveyed also believed excessive alcohol consumption to be a serious problem (Table 3.7).

- Interestingly, alcohol and tobacco use were ranked ahead of marijuana use as serious problems by all of the groups. Slightly less than 80% of police considered marijuana a serious problem, as did 56% of the community, 41% of service providers and 26% of drug users (Tables 3.1, 3.3 and 3.7).

- A majority of respondents in the community survey felt that taking heroin is basically wrong (82%) and that it is a type of illness (69%). The police tended to hold similiar views to the general community, while a significant proportion of service providers (43%) and drug users (48%) disagreed with the notion that taking heroin is basically wrong. Users also felt that taking heroin was a type of illness (54%), but service providers were least likely to think so (38%) (Tables 3.9 and 3.11).

- Relatively few of the respondents to the community survey agreed that taking heroin is a pleasant experience (17%), a way of dealing with life's problems (21%) or that it is really no different from getting drunk (15%). Again, the police had similiar views while more than 40% of service providers and drug users agreed with these propositions (Tables 3.8, 3.10 and 3.12).

- These last results are interesting in light of models of drug use (Appendix B). 'Taking heroin is basically wrong' may reflect belief in an 'enforcement model'. Agreement with this statement was strongest amongst police and the general community. 'Taking heroin is a pleasant experience' may reflect a belief in the 'pleasure model'; this view was most stronlgy agreed to by users and service providers. Service providers were least likely to agree that 'taking heroin is a type of illness', which may reflect the extent of their belief in the 'disease' model.

Table 3.1: How strongly would you agree or disagree that tobacco use is a serious problem for the community?

	%General Community (n = 517)	% Police (n = 447)	% Service Providers (n= 93)	% Drug Users (n= 133)
Agree	*79*	*74*	*89*	*74*
Neutral	*10*	*17*	*5*	*15*
Disagree	*11*	*10*	*5*	*11*

Table 3.2: How strongly would you agree or disagree that use of amphetamines or speed is a serious problem for the community?

	%General Community (n = 517)	% Police (n = 447)	% Service Providers (n= 93)	% Drug Users (n= 133)
Agree	*82*	*94*	*72*	*73*
Neutral	*15*	*3*	*16*	*14*
Disagree	*3*	*3*	*12*	*13*

Table 3.3: How strongly would you agree or disagree that marijuana/hash use is a serious problem for the community?

	%General Community (n = 517)	% Police (n = 447)	% Service Providers (n= 93)	% Drug Users (n= 133)
Agree	*56*	*79*	*41*	*26*
Neutral	*18*	*13*	*22*	*20*
Disagree	*25*	*9*	*38*	*53*

Table 3.4: How strongly would you agree or disagree that heroin use is a serious problem for the community?

	%General Community (n = 517)	% Police (n = 446)	% Service Providers (n= 91)	% Drug Users (n=132)
Agree	*93*	*98*	*76*	*72*
Neutral	*5*	*1*	*9*	*8*
Disagree	*1*	*1*	*15*	*21*

Table 3.5: How strongly would you agree or disagree that use of hallucinogens or trips like LSD or magic mushrooms is a serious problem for the community?

	%General Community (n = 517)	% Police (n = 447)	% Service Providers (n= 93)	% Drug Users (n= 133)
Agree	*80*	*90*	*60*	*50*
Neutral	*11*	*7*	*19*	*22*
Disagree	*8*	*4*	*21*	*29*

Table 3.6: How strongly would you agree or disagree that cocaine/crack use is a serious problem for the community?

	%General Community (n = 517)	% Police (n = 449)	% Service Providers (n= 92)	% Drug Users (n= 131)
Agree	*91*	*93*	*70*	*58*
Neutral	*6*	*4*	*10*	*21*
Disagree	*3*	*3*	*21*	*21*

Table 3.7: How strongly would you agree or disagree that excessive drinking of alcohol is a serious problem for the community?

	%General Community (n = 517)	% Police (n = 447)	% Service Providers (n= 93)	% Drug Users (n= 133)
Agree	*95*	*94*	*97*	*92*
Neutral	*2*	*4*	*0*	*4*
Disagree	*3*	*2*	*3*	*5*

Table 3.8: How much do you agree or disagree with the following description: Taking heroin is a way of dealing with life's problems

	%General Community (n = 516)	% Police (n = 447)	% Service Providers (n= 92)	% Drug Users (n= 131)
Agree	*21*	*23*	*65*	*55*
Neutral	*9*	*5*	*11*	*12*
Disagree	*70*	*72*	*24*	*33*

Table 3.9: How much do you agree or disagree with the following description: Taking heroin is basically wrong

	%General Community (n = 516)	% Police (n = 446)	% Service Providers (n= 93)	% Drug Users (n= 129)
Agree	*82*	*89*	*29*	*33*
Neutral	*9*	*5*	*28*	*19*
Disagree	*10*	*6*	*43*	*48*

Table 3.10: How much do you agree or disagree with the following description: Taking heroin is really no different from getting drunk

	%General Community (n = 516)	% Police (n = 442)	% Service Providers (n= 93)	% Drug Users (n= 128)
Agree	*15*	*11*	*43*	*42*
Neutral	*11*	*6*	*14*	*10*
Disagree	*74*	*83*	*43*	*48*

Table 3.11: How much do you agree or disagree with the following description: Taking heroin is a type of illness

	%General Community (n = 516)	% Police (n = 444)	% Service Providers (n= 93)	% Drug Users (n= 130)
Agree	*69*	*54*	*38*	*54*
Neutral	*10*	*11*	*18*	*8*
Disagree	*21*	*35*	*44*	*38*

Table 3.12: How much do you agree or disagree with the following description: Taking heroin is a pleasant experience

	%General Community (n =516)	% Police (n = 406)	% Service Providers (n= 88)	% Drug Users (n= 128)
Agree	*17*	*6*	*40*	*68*
Neutral	*29*	*53*	*44*	*20*
Disagree	*54*	*41*	*16*	*12*

Section 4: Awareness, Attitude and Perceived Effects of a Trial

- A majority of all the groups surveyed had previously heard of the proposal to run a 'heroin trial' in the ACT (Table 4.1).

- More than 70% of service providers and drug users, and two thirds of the general community were in favour of a trial going ahead. However, only 31% of those police who responded to the survey were in favour of a trial being conducted, with over 60% against the idea (Table 4.2).

- For the community group, those people who practised a religion were significantly more likely to be against a trial (33% compared to 23%). For police, those aged 30 to 39 were more likely to favour a trial going ahead than younger and older groups (42% compared to 25% in the older and younger groups). Where the effects of demographic variables listed in Table 1 did not produce significant differences, they are not reported.

- Other interesting background variables looked at in relation to whether or not people were in favour of a trial were (percentages are only given for those differences which are statistically significant):

  For the community, 74% of those who had ever used an illegal drug thought a trial should go ahead compared to 62% of those who had not.

  For the police, 22% of those who thought current policing for drugs was effective thought a trial should go ahead compared with 34% of those who thought policing was ineffective. There was a trend which suggested that the proportion of an individual's duties which involved drugs was related to their attitude to a trial. More of those most involved with drug-related crime (currently or ever) tended to be against the trial. There was no difference by rank.

  For service providers, 36% of those with a personal philosophy of abstinence were in favour of a trial compared with 86% who did not report an abstinence philosophy. There was no difference by whether or not individuals had ever used an illegal drug.

- Eighty-two percent of current heroin users were interested in applying for a place on a trial (Table 4.66).

- A significant majority of service providers (76%) reported they would be supportive of any of their clients who wished to join the 'heroin trial' (Table 4.65).

Perception of general benefits and problems (Tables 4.3 to 4.12)

- Survey respondents were asked for their opinions about five potential benefits and five potential problems associated with a trial. Within the general community a majority believed that a trial would mean users would not have to deal with criminal elements, that corruption would be reduced and that it would reduce the spread of HIV/AIDS. In addition, more than half of the general public felt that since there would always be some people who take heroin/opiates, it is important to provide them with the drugs in the safest way and more than 40% believed the trial would improve the health of drug users.

- Compared with the general community, service providers and drug users were even more likely to believe the trial would have positive effects on users' health, the spread of HIV/AIDS, crime and corruption. In contrast, the police were far less likely than all other groups to perceive that a trial would have any beneficial outcomes.

- In terms of the potential problems resulting from a trial, 40% of the general community agreed with the proposition that the trial would mean users had no incentives to reduce their drug use and that the provision of heroin to users sets a bad example for young children. One third of the public

agreed that the notion of providing heroin to users is illogical and that it would be bad for road safety (since more drug-affected people would be driving). In addition, approximately one in four felt that the trial would increase the number of heroin users.

- Service providers and drug users were less likely to agree that there would be negative outcomes resulting from the trial, while police were far more likely than all of the other groups surveyed to perceive problems. For example, more than 70% of police felt the trial would set a bad example for young people and over 50% believed the trial would increase the number of users.

Crime and corruption (Tables 4.29 to 4.39, 4.50 to 4.53, 4.57)

- Compared to the service providers and those drug users who were interested in participating in the trial, the police were less likely to believe the trial would reduce users' criminal behaviour. For example, less than a third of the police felt the trial would reduce users' shoplifting, fraud, drug supplying and prostitution. In addition more than 40% of police felt the trial would have no effect on robberies, or breaking and entering.

- One quarter of the police felt that driving under the influence of opiates would increase as a consequence of a trial. This view was less likely to be shared by service providers and users.

- Approximately twice as many service providers (54%) as police (27%) believed the trial would reduce violence by users.

- A third of the police and 40-50% of service providers and drug users believed that the price of street heroin/opiates would fall as a result of a 'heroin trial'. However, about 30% of the police and slightly more than 20% of the service providers felt street opiates would become more available. Between 40% and 60% of police, service providers and drug users believed the price and availability of other illegal drugs would be unaffected by the trial.

- Less than 5% of the police believed the trial would reduce corruption in the ACT police force.

Effects on drug use (Tables 4.13 to 4.15, 4.56, 4.67 to 4.69)

- Thirty percent of police believed 'many' ex-opiate users would start using again in order to get on the trial (compared to only 10% of service providers). Ten percent of the police and 4% of service providers felt that 'many' people who have never used heroin would do so to get on the trial (a further 34% - 39% believed 'a few' would start using to join the trial). In addition, more than half of the police and service providers thought that non-dependent users would increase their use. Slightly more than one in ten ex-users said they would begin using again to get on the trial and about one in six non-dependent users would increase their use if it was necessary to get on the trial.

- Ninety percent of police, 60% of the community and just over 50% of service providers and drug users were worried that a trial would attract heroin/opiates users to the ACT from elsewhere in Australia.

Effects on users' relationships (Tables 4.25 to 4.28, 4.40 to 4.49)

- Service providers and police tended to agree that as a result of being on the trial users' relationships with other opiate users not on the trial (either because they were not accepted or because they did not want to be on the trial) would worsen. Users felt this was only the case for relationships with people who were not accepted on the trial. However, all three groups felt that users' relationships with non-users close to them would improve as a result of a trial.

- Approximately 50% of drug users, 60% of service providers and 80% of police felt it 'very likely' that people on a trial would be hassled for their drugs if the drugs could be taken home. Far fewer

(less than 40% of any group) saw this as a problem if the drugs had to be taken at the distribution point. More than 50% of those in each of the three groups believed this hassling would be physical and a significant proportion (19% users; 34% service providers; 55% police) felt it would be life-threatening.

- Drug users were more likely than other groups to believe the trial would decrease the possibility of users being hassled by the police (40% users; 27% service providers: 19% police). Some police found this question offensive and one in ten did not respond to it.

How money saved would be used (Tables 4.16 to 4.24)

- More than 80% of those users who were interested in a place on a trial said they would use the money saved to look after themselves or others better, pay bills and buy things they wanted. Very few said they would use the money to buy other drugs either for themselves or others. Few police thought the money would be used for purposes other than for buying drugs. Service providers tended to be more evenly divided on each option.

Effect on resources, policing and treatment program effectiveness (Tables 4.58 to 4.64)

- Half of the police surveyed believed that a 'heroin trial' would tie up scarce resources, 46% felt it would make policing of the illegal drug scene more difficult and 39% claimed a trial would create more work for police.

- More than one third of the service providers felt that a trial would improve the effectiveness of their own treatment program as well as other programs in the ACT. Less than 16% believed it would reduce the effectiveness of existing programs. More service providers (46%) disagreed than agreed (29%) with the suggestion that the trial would tie up resources or funding for other more important drug related projects.

Table 4.1: Have you heard of this proposal before?

	%General Community (n = 517)	% Police (n = 448)	% Service Providers (n= 93)	% Drug Users (n= 133)
Yes	*59*	*81*	*84*	*81*
No	*40*	*17*	*13*	*18*
Don't know	*1*	*2*	*3*	*2*

Some people think there are so many problems caused by illegal drug use that something new urgently needs to be tried. They would say that the proposed trial should go ahead.

Other people think setting up a trial is just too risky because it might make the problems even worse. They would argue that it should not go ahead.

Table 4.2: Do you think a trial should go ahead or that a trial should not go ahead?

	%General Community (n = 516)	% Police (n = 446)	% Service Providers (n= 93)	% Drug Users (n= 133)
Should go ahead	*66*	*31*	*71*	*76*
Should not go ahead	*27*	*63*	*19*	*14*
Don't know	*7*	*7*	*9*	*10*

There are likely to be a number of potential benefits and potential problems with a trial to provide heroin or other opiates under controlled conditions. Below is a list of some of them. How much do you agree or disagree with each of them? (Tables 4.3 to 4.12)

Table 4.3: Providing users with heroin/opiates in a controlled trial will simply increase the number of people taking heroin/opiates

	%General Community (n = 517)	% Police (n = 447)	% Service Providers (n = 92)	% Drug Users (n = 133)
Agree	*23*	*54*	*15*	*14*
Neutral	*12*	*15*	*16*	*11*
Disagree	*65*	*31*	*68*	*75*

Table 4.4: Providing users with heroin/opiates in a controlled trial will improve their overall health

	%General Community (n = 517)	% Police (n = 449)	% Service Providers (n = 92)	% Drug Users (n = 133)
Agree	*43*	*26*	*69*	*74*
Neutral	*20*	*16*	*14*	*8*
Disagree	*38*	*59*	*17*	*18*

Table 4.5: Since governments are worried about the consumption of drugs like alcohol and tobacco, it seems illogical to provide heroin/opiates to users

	%General Community (n = 517)	% Police (n = 446)	% Service Providers (n = 92)	% Drug Users (n = 131)
Agree	*35*	*57*	*21*	*28*
Neutral	*11*	*9*	*12*	*4*
Disagree	*54*	*34*	*67*	*68*

Table 4.6: Providing users with heroin/opiates in a controlled trial will reduce the spread of HIV/AIDS in the community

	%General Community (n = 517)	% Police (n = 446)	% Service Providers (n = 92)	% Drug Users (n = 133)
Agree	*60*	*41*	*69*	*83*
Neutral	*13*	*16*	*14*	*5*
Disagree	*27*	*43*	*17*	*13*

Table 4.7: There will always be some people who take heroin/opiates so it is important to provide them with it in the safest way

	%General Community (n = 516)	% Police (n = 448)	% Service Providers (n = 93)	% Drug Users (n =132)
Agree	*57*	*28*	*82*	*88*
Neutral	*12*	*11*	*8*	*5*
Disagree	*31*	*60*	*11*	*7*

Table 4.8: Providing users with heroin/opiates in a controlled trial sets a bad example for young people

	%General Community (n = 517)	% Police (n = 446)	% Service Providers (n = 93)	% Drug Users (n = 133)
Agree	*39*	*71*	*20*	*17*
Neutral	*10*	*7*	*13*	*9*
Disagree	*51*	*22*	*67*	*75*

Table 4.9: Providing users with heroin/opiates in a controlled trial means there will be no incentives for them to give up or cut back on their use

	%General Community (n = 517)	% Police (n = 445)	% Service Providers (n = 94)	% Drug Users (n = 131)
Agree	*43*	*76*	*33*	*33*
Neutral	*12*	*7*	*16*	*14*
Disagree	*45*	*16*	*51*	*53*

Table 4.10: Providing users with heroin/opiates in a controlled trial means they will not have to mix with criminal elements or steal to pay for their drugs

	%General Community (n = 517)	% Police (n = 447)	% Service Providers (n = 94)	% Drug Users (n = 133)
Agree	*74*	*38*	*68*	*84*
Neutral	*9*	*7*	*13*	*4*
Disagree	*18*	*55*	*19*	*12*

Table 4.11: Providing users with heroin/opiates in a controlled trial will be bad for road safety because more drug-affected people will be driving

	%General Community (n = 517)	% Police (n = 447)	% Service Providers (n = 92)	% Drug Users (n = 132)
Agree	*30*	*48*	*19*	*11*
Neutral	*13*	*25*	*25*	*21*
Disagree	*56*	*27*	*56*	*66*

Table 4.12: Providing users with heroin/opiates in a controlled trial will reduce the amount of corruption in our community

	%General Community (n = 517)	% Police (n = 446)	% Service Providers (n = 91)	% Drug Users (n = 132)
Agree	*55*	*26*	*59*	*74*
Neutral	*12*	*13*	*15*	*8*
Disagree	*33*	*62*	*25*	*18*

Table 4.13: How many ex-opiate users do you think would start using again to get on the trial?

	% Police (n = 444)	% Service Providers (n = 92)
Many	*30*	*10*
A few	*36*	*41*
None	*5*	*19*
Don't know	*29*	*30*

Table 4.14: How many people who have never used heroin/opiates do you think would start using to get on the trial?

	% Police (n = 445)	% Service Providers (n = 91)
Many	*10*	*4*
A few	*39*	*34*
None	*22*	*37*
Don't know	*30*	*24*

Table 4.15: How many nondependent heroin/opiate users do you think would increase their use if that was necessary to get on the trial?

	% Police (n = 445)	% Service Providers (n = 91)
Many	*27*	*13*
A few	*45*	*55*
None	*8*	*10*
Don't know	*20*	*22*

How do you think people on the heroin/opiate trial would use the money they saved?
(Tables 4.16 to 4.24)

Table 4.16: Use money saved to: buy other drugs

	% Police (n = 440)	% Service Providers (n = 90)
Yes	*73*	*46*
No	*6*	*13*
Don't know	*21*	*41*

Table 4.17: Use money saved to: buy drugs for others

	% Police (n = 439)	% Service Providers (n = 90)
Yes	*50*	*20*
No	*24*	*40*
Don't know	*26*	*40*

Table 4.18: Use money saved to: pay bills

	% Police (n = 439)	% Service Providers (n = 91)
Yes	*19*	*53*
No	*54*	*23*
Don't know	*27*	*24*

Table 4.19: Use money saved to: purchase other things they want

	% Police (n = 438)	% Service Providers (n = 90)
Yes	*48*	*78*
No	*29*	*9*
Don't know	*23*	*13*

Table 4.20: Use money saved to: look after themselves better

	% Police (n = 438)	% Service Providers (n = 91)
Yes	*21*	*55*
No	*53*	*17*
Don't know	*26*	*29*

Table 4.21: Use money saved to: look after others they care about better

	% Police (n = 437)	% Service Providers (n = 90)
Yes	*16*	*52*
No	*56*	*18*
Don't know	*28*	*30*

Table 4.22: Use money saved to: get better housing

	% Police (n = 437)	% Service Providers (n = 89)
Yes	*11*	*46*
No	*61*	*21*
Don't know	*28*	*33*

Table 4.23: Use money saved to: other

	% Police (n = 231)	% Service Providers (n = 23)
Yes	*17*	*17*
No	*15*	*8*
Don't know	*68*	*74*

Table 4.24: Drug Users - If you were accepted on the trial, how would you use the money you saved? (n=45)

I would use the money I save to:	Not applicable	Yes	No	Don't know
buy other drugs	*13*	*11*	*70*	*7*
buy drugs for others	*13*	*4*	*76*	*7*
pay bills	*6*	*94*	*-*	*-*
purchase other things I want	*6*	*92*	*0*	*2*
look after myself better	*6*	*94*	*-*	*-*
look after others I care about better	*8*	*83*	*6*	*2*
get better housing	*27*	*60*	*10*	*2*

What effect do you think being on the trial would have on users' relationships? *(Tables 4.25 to 4.28)*

Table 4.25: What effect would it have on relationships with: people close to them (eg family and friends) who don't use opiates?

	% Police (n = 441)	% Service Provider (n = 90)	% Drug Users interested in the trial (n = 51)
Improve	*39*	*56*	*64*
No change	*31*	*18*	*29*
Make worse	*10*	*3*	*-*
Don't know	*21*	*23*	*N/A*
Not applicable	*N/A*	*N/A*	*8*

Table 4.26: What effect would it have on relationships with: people close to them who also use opiates and were also on the trial?

	% Police (n = 443)	% Service Provider (n = 89)	% Drug Users interested in the trial (n = 51)
Improve	*29*	*57*	*57*
No change	*45*	*18*	*39*
Make worse	*6*	*2*	*-*
Don't know	*21*	*23*	*N/A*
Not applicable	*N/A*	*N/A*	*4*

Table 4.27: What effect would it have on relationships with: people close to them who also use opiates and were not accepted on the trial?

	% Police (n = 443)	% Service Provider (n = 90)	% Drug Users interested in the trial (n = 51)
Improve	*4*	*8*	*8*
No change	*16*	*14*	*50*
Make worse	*59*	*46*	*34*
Don't know	*21*	*32*	*N/A*
Not applicable	*N/A*	*N/A*	*8*

Table 4.28: What effect would it have on relationships with: people close to them who also use opiates and didn't want to be on the trial?

	% Police (n = 443)	% Service Provider (n = 90)	% Drug Users interested in the trial (n = 50)
Improve	*4*	*10*	*20*
No change	*33*	*31*	*67*
Make worse	*38*	*23*	*6*
Don't know	*26*	*36*	*N/A*
Not applicable	*N/A*	*N/A*	*8*

What effect do you think being on the trial would have on the following user behaviours? *(Tables 4.29 to 4.39)*

Table 4.29: Shoplifting

	% Police (n = 444)	% Service Provider (n = 87)	% Drug Users interested in the trial (n = 51)
Not applicable	*N/A*	*N/A*	*65*
Don't know	*14*	*16*	*N/A*
Increase	*5*	*2*	*2*
No effect	*55*	*20*	*4*
Reduce	*26*	*60*	*10*
Stop	*1*	*2*	*20*

Table 4.30: Other stealing (including breaking and entering)

	% Police (n = 441)	% Service Provider (n = 87)	% Drug Users interested in the trial (n = 52)
Not applicable	*N/A*	*N/A*	*67*
Don't know	*11*	*10*	*N/A*
Increase	*7*	*3*	*2*
No effect	*44*	*16*	*4*
Reduce	*38*	*61*	*2*
Stop	*1*	*9*	*25*

Table 4.31: Robbery (eg mugging, hold-ups)

	% Police (n = 444)	% Service Provider (n = 89)	% Drug Users interested in the trial (n = 52)
Not applicable	*N/A*	*N/A*	*71*
Don't know	*12*	*10*	*N/A*
Increase	*6*	*3*	*-*
No effect	*41*	*17*	*4*
Reduce	*39*	*61*	*-*
Stop	*2*	*9*	*25*

Table 4.32: Fraud

	% Police (n = 445)	% Service Provider (n = 87)	% Drug Users interested in the trial (n = 51)
Not applicable	*N/A*	*N/A*	*55*
Don't know	*14*	*13*	*N/A*
Increase	*6*	*3*	*-*
No effect	*48*	*14*	*6*
Reduce	*32*	*63*	*-*
Stop	*1*	*7*	*39*

Table 4.33: Suppplying illegal drugs

	% Police (n = 444)	% Service Provider (n = 88)	% Drug Users interested in the trial (n = 52)
Not applicable	*N/A*	*N/A*	*31*
Don't know	*14*	*18*	*N/A*
Increase	*13*	*7*	*-*
No effect	*45*	*17*	*6*
Reduce	*28*	*56*	*23*
Stop	*1*	*2*	*40*

Table 4.34: Prostitution

	% Police (n = 442)	% Service Provider (n = 88)	% Drug Users interested in the trial (n = 51)
Not applicable	*N/A*	*N/A*	*75*
Don't know	*15*	*14*	*N/A*
Increase	*6*	*3*	*-*
No effect	*55*	*27*	*2*
Reduce	*23*	*51*	*4*
Stop	*1*	*5*	*20*

Table 4.35: Violence

	% Police (n = 444)	% Service Provider (n = 90)	% Drug Users interested in the trial (n = 52)
Not applicable	*N/A*	*N/A*	*73*
Don't know	*15*	*18*	*N/A*
Increase	*9*	*3*	*-*
No effect	*50*	*23*	*2*
Reduce	*27*	*53*	*6*
Stop	*0*	*2*	*19*

Table 4.36: Driving under the influence of alcohol

	% Police (n = 443)	% Service Provider (n = 89)	% Drug Users interested in the trial (n = 50)
Not applicable	*N/A*	*N/A*	*50*
Don't know	*16*	*21*	*N/A*
Increase	*9*	*6*	*-*
No effect	*71*	*47*	*18*
Reduce	*3*	*24*	*16*
Stop	*1*	*2*	*16*

Table 4.37: Driving under the influence of cannabis

	% Police (n = 443)	% Service Provider (n = 89)	% Drug Users interested in the trial (n = 52)
Not applicable	*N/A*	*N/A*	*48*
Don't know	*21*	*24*	*N/A*
Increase	*10*	*7*	*-*
No effect	*63*	*52*	*35*
Reduce	*6*	*18*	*10*
Stop	*1*	*-*	*8*

Table 4.38: Driving under the influence of opiates

	% Police (n = 443)	% Service Provider (n = 87)	% Drug Users interested in the trial (n = 52)
Not applicable	*N/A*	*N/A*	*40*
Don't know	*20*	*21*	*N/A*
Increase	*25*	*14*	*2*
No effect	*43*	*43*	*33*
Reduce	*11*	*22*	*15*
Stop	*1*	*1*	*10*

Table 4.39: Driving under the influence of other drugs

	% Police (n = 441)	% Service Provider (n = 90)	% Drug Users interested in the trial (n = 52)
Not applicable	*N/A*	*N/A*	*54*
Don't know	*25*	*26*	*N/A*
Increase	*14*	*8*	*-*
No effect	*52*	*47*	*19*
Reduce	*9*	*19*	*6*
Stop	*0*	*1*	*21*

Table 4.40: How likely do you think it is that people on the trial would be hassled for their heroin/opiates by people not on the trial, **if the heroin/opiates could be taken home?**

	% Police (n = 443)	**% Service Provider (n = 92)**	**% Users (n = 129)**
Very likely	*82*	*63*	*48*
Likely	*14*	*28*	*31*
Unlikely	*2*	*3*	*12*
Very unlikely	*0*	*-*	*5*
Don't know	*2*	*5*	*4*

Table 4.41: How likely do you think it is that people on the trial would be hassled for their heroin/opiates by people not on the trial, **if the heroin/opiates have to be taken at the distribution point?**

	% Police (n = 443)	**% Service Provider (n = 92)**	**% Users (n = 129)**
Very likely	*17*	*12*	*9*
Likely	*22*	*17*	*18*
Unlikely	*37*	*40*	*37*
Very unlikely	*22*	*23*	*30*
Don't know	*3*	*8*	*5*

If you think people on the trial might be hassled for their heroin/opiates, who do you think would be likely to hassle them? *(Tables 4.42 to 4.45)*

Table 4.42: Partner/Spouse

	% Police (n = 426)	% Service Provider (n = 90)	% Users (n = 120)
Yes	*59*	*74*	*66*
No	*13*	*2*	*13*
Don't know	*22*	*19*	*9*
Don't think users would be hassled	*7*	*4*	*12*

Table 4.43: Friends

	% Police (n = 430)	% Service Provider (n = 90)	% Users (n = 123)
Yes	*82*	*77*	*69*
No	*4*	*2*	*12*
Don't know	*11*	*18*	*8*
Don't think users would be hassled	*3*	*3*	*11*

Table 4.44: Suppliers/Dealers

	% Police (n = 431)	% Service Provider (n = 87)	% Users (n = 118)
Yes	*80*	*58*	*41*
No	*7*	*13*	*36*
Don't know	*10*	*23*	*14*
Don't think users would be hassled	*3*	*6*	*10*

Table 4.45: Others

	% Police (n = 226)	% Service Provider (n = 59)	% Users (n = 109)
Yes	*48*	*32*	*36*
No	*5*	*9*	*19*
Don't know	*42*	*49*	*34*
Don't think users would be hassled	*5*	*7*	*11*

If you think people on the trial might be hassled for their heroin/opiates, do you think that this will be*: (Tables 4.46 to 4.48)*

Table 4.46: Verbal

	% Police (n = 437)	% Service Provider (n = 90)	% Users (n = 125)
Yes	*92*	*89*	*84*
No	*1*	*-*	*1*
Don't know	*6*	*10*	*6*
Don't think users would be hassled	*2*	*1*	*10*

Table 4.47: Physical

	% Police (n = 436)	% Service Provider (n = 89)	% Users (n = 122)
Yes	*89*	*64*	*49*
No	*1*	*6*	*18*
Don't know	*8*	*27*	*24*
Don't think users would be hassled	*1*	*3*	*9*

Table 4.48: Life-threatening

	% Police (n = 435)	% Service Provider (n = 89)	% Users (n = 119)
Yes	*55*	*34*	*19*
No	*17*	*21*	*40*
Don't know	*27*	*40*	*31*
Don't think users would be hassled	*1*	*5*	*11*

Table 4.49: Do you think being on the trial would increase or decrease the possibility of users being hassled by the police?

	% Police (n = 408)	% Service Provider (n = 92)	% Users (n = 129)
Increase	*5*	*13*	*10*
No difference	*62*	*42*	*34*
Decrease	*19*	*27*	*40*
Don't know	*14*	*17*	*16*

If there was a 'heroin/opiates trial' what do you think would happen to the price/availability of street drugs? *(Table 4.50 to 4.53)*

Table 4.50: What would happen to the price of street heroin/opiates?

	% Police (n = 441)	% Service Provider (n = 90)	% Users (n = 130)
Fall	*33*	*42*	*51*
Stay the same	*53*	*31*	*38*
Rise	*6*	*6*	*2*
Don't know	*8*	*21*	*9*

Table 4.51: What would happen to the availability of street heroin/opiates?

	% Police (n = 440)	% Service Provider (n = 91)	% Users (n = 129)
Fall	*7*	*10*	*26*
Stay the same	*54*	*48*	*50*
Rise	*33*	*22*	*12*
Don't know	*6*	*20*	*12*

Table 4.52: What would happen to the price of other illegal drugs?

	% Police (n = 438)	% Service Provider (n = 90)	% Users (n = 129)
Fall	*16*	*21*	*23*
Stay the same	*61*	*42*	*51*
Rise	*13*	*10*	*8*
Don't know	*10*	*27*	*19*

Table 4.53: What would happen to the availability of other illegal drugs?

	% Police (n = 438)	% Service Provider (n = 89)	% Users (n = 129)
Fall	*4*	*6*	*9*
Stay the same	*65*	*52*	*62*
Rise	*22*	*15*	*15*
Don't know	*9*	*27*	*15*

Table 4.54: Do you think people who apply but don't get on the trial will be adversely affected?

	% Police (n = 441)	% Service Providers (n = 88)
Yes	*42*	*43*
No	*32*	*23*
Don't know	*26*	*33*

Table 4.55: Do you think there are any special issues for people who are HIV positive with regard to the proposed trial?

	% Police (n = 432)	% Service Providers (n = 87)
Yes	*46*	*60*
No	*29*	*24*
Don't know	*24*	*15*

Table 4.56: If a trial was conducted how worried would you be that heroin/opiates users would be attracted to the ACT from elsewhere in Australia?

	% General Community (n = 517)	% Police (n = 442)	% Service Providers (n = 93)	% Drug Users (n = 132)
Very Worried	*31*	*70*	*20*	*14*
Somewhat Worried	*32*	*21*	*33*	*44*
Not worried	*35*	*6*	*40*	*38*
Don't know	*1*	*2*	*5*	*4*

Issues specific to the Police

Table 4.57: What effect do you think a proposed heroin/opiates trial would have on corruption, if any, in the ACT police force? (n = 439)

Reduce a lot	*3*
Reduce a little	*1*
No effect	*29*
Increase a little	*2*
Increase a lot	*2*
Corruption is not a problem	*38*
Don't know/ No opinion	*24*

Table 4.58: What effect do you think a proposed heroin/opiates trial would have on police time? (n = 446)

It will create more work for police	*39*
It will make no difference	*29*
It will free up police time	*14*
Don't know/ No opinion	*17*

Table 4.59: What effect do you think a proposed heroin/opiates trial would have on the difficulties associated with policing the illegal drug scene? (n = 440)

It will make policing harder	*46*
It will make no difference	*26*
It will make policing easier	*15*
Don't know/No opinion	*13*

Table 4.60: Do you think a proposed heroin/opiates trial would have any effect on the way police **enforce** *the laws relating to illegal drugs? (n = 438)*

Yes	*38*
No	*43*
Don't know	*18*

Table 4.61: Some people argue that a heroin/opiates trial would tie up scarce resources so funding would not be available for more important police work. (n = 437)

Agree	*50*
Neutral	*23*
Disagree	*27*

Issues specific to Service Providers

Table 4.62: What impact do you think a heroin/opiates trial in the ACT would have on the effectiveness of **your** *program? (n = 85)*

No effect	*24*
Improve effectiveness	*35*
Reduce effectiveness	*12*
Don't know	*28*

Table 4.63: What impact do you think a heroin/opiates trial in the ACT would have on the effectiveness of **other** *programs? (n = 87)*

No effect	*6*
Improve effectiveness	*33*
Reduce effectiveness	*16*
Don't know	*44*

Table 4.64: Some people argue that a heroin/opiates trial would tie up scarce resources so funding would not be available for more important drug-related projects. Do you agree or disagree? (n = 90)

Strongly agree	*10*
Agree	*19*
Neutral	*24*
Disagree	*32*
Strongly disagree	*14*

Table 4.65: How supportive would you be of any of your clients who wanted to get on the heroin/opiates trial? (n=89)

Very supportive	*38*
Supportive	*38*
Neutral	*15*
Unsupportive	*2*
Very unsupportive	*6*
Don't know	*1*

Issues specific to Drug Users/Ex-users

Table 4.66: If you currently use heroin/opiates and if the trial was to go ahead, would you be interested in applying for a place on it? (n = 116)

Yes	*45*
No	*6*
Don't know	*4*
Not applicable	*45*

Table 4.67: If you are an ex-heroin/opiate user, would you start using again to get on the trial? (n = 129)

I am not an ex-user	*43*
Yes	*5*
No	*43*
Don't know	*9*

Table 4.68: If you have **never** *used heroin/opiates would you start using to get on the trial? (n = 128)*

I have used heroin/opiates	*57*
Yes	*-*
No	*41*
Don't know	*2*

Table 4.69: If you are a non-dependent heroin/opiate user how much would you increase your use if that was necessary to get on the trial? (n = 121)

I am not a non-dependent user	*55*
Not at all	*23*
A little	*5*
A lot	*3*
Don't know	*14*

Section 5: Structure of the Trial

- A majority of the general community, police, service providers and drug users felt that a trial should only include dependent heroin/opiate users, although 35% - 40% of service providers and users thought occasional users should also be included. Regardless of whether they believed a trial should be limited to only dependent users or whether it should also include occasional users, the general community, police and service providers were approximately equally split as to whether all users or only a limited number should be included. A majority of drug users felt that all users should be eligible for a trial (Tables 5.1 to 5.3).

- The police and drug users surveyed were almost evenly divided on the issue of whether the trial should include users under 18 years of age. Almost 70% of the general community and 60% of service providers indicated that young drug users should be eligible for a trial (Table 5.4).

- Approximately six in ten respondents to the community, police and service provider surveys indicated that trial participants should have to pay for the heroin/opiates provided. Thirty-nine percent of drug users agreed with this proposition (Table 5.5).

- More than 90% of the general community and police and approximately 70% of service providers and drug users believed that trial participants should be required to take their drugs at the distribution point (Table 5.6). This is consistent with results for police and service providers, most of whom believed trial participants should not be provided with heroin/opiates in take-away syringes (Table 5.10). Of users who wanted to be on the trial, however, 72% thought trial participants should be provided with heroin/opiates in take-away syringes. A possible explanation for all but the last of these results is the finding that most of those surveyed believed users would be hassled for their drugs if they could be taken home (see Section 4).

- Between 11% and 23% of police, service providers and the community thought a trial should also provide cannabis as well as heroin/opiates, and 19% - 25% of these groups thought other illegal drugs should also be provided. Approximately one third of drug users were in favour of trial participants also receiving cannabis and other illegal drugs (Tables 5.7 and 5.8).

- More than 90% of the police believed it is desirable that a trial is run with the aim of making participants reduce their use, compared to some two thirds of users interested in volunteering for the trial and a similar proportion of service providers. Over 90% of police felt that an aim of the trial should be to make users abstinent. About 45% of service providers and users felt that this is desirable (Table 5.10).

- Fifty seven percent of users interested in participating in the trial, 50% of police and 40% of service providers felt it is desirable that the trial aim to make participants substitute other routes for IV injection. Similar proportions of each of the groups believed the trial should attempt to make participants substitute IV methadone or morphine for IV heroin/opiates. Slightly more than 70% of users interested in a trial would agree to participate if the standard option was oral methadone plus two injections of heroin/opiates per day. Police and service providers did not think this was a desirable option (Table 5.10).

- There was considerable support for the notion of compulsory HIV testing of trial participants and for other routine medical checks (Table 5.10).

- In terms of monitoring trial participants' continued illegal drug use, over 90% of police, 70% of

users interested in the trial and 57% of service providers felt that participants should be required to provide urine samples for drug testing on random occasions. The proportions were similar for a requirement to provide urine on a regular frequent basis (Table 5.9).

- Ninety percent of police and some 70% of users and service providers believed it should be compulsory for participants to provide information about drug taking. More than 90% of police and 40% - 50% of the other groups felt that other illegal drug use should be forbidden (Table 5.9).

- There was a widespread view that participants should provide information about criminal activities (80% police; 54% users; 38% service providers) and that they should be required to disclose their name and address (Table 5.9).

- More than 80% of all respondents agreed that education about safe needle use, safe sexual practices and other forms of education should be a part of the trial. More than 90% of police, 70% of users and 60% of service providers believed users on the trial should be required to undergo counselling. There was somewhat less support for the suggestion that users undergo other forms of treatment as part of the trial (90% police; 40% service providers; 30% drug users) (Tables 5.9 and 5.10).

- Almost 80% of police and users interested in the trial and 60% of service providers felt it was desirable that opiates are only guaranteed for the life of the trial (6 - 12 months) (Table 5.10).

- Slightly more than a half of the police surveyed were against trial drugs being made legal for participants, 80% were opposed to the proposition that all opiates (including street opiates) be made legal for participants and 86% were opposed to the legalisation of other illegal drugs for those users on the trial (Tables 5.12 to 5.14).

- Approximately one quarter of the police believed they could assist a trial by showing more tolerance and providing protection for participants. A similar proportion felt a register of users would assist the trial (Table 5.11).

Table 5.1: If a trial to provide users with heroin or other opiates was conducted, do you think that it should only include people who are dependent on these drugs or should people who occasionally use heroin/opiates also be included?

	% General Community (n = 517)	% Police (n = 431)	% Service Providers (n = 92)	% Drug Users (n = 128)
Dependent users only	*70*	*76*	*55*	*59*
Both	*24*	*16*	*35*	*39*
Don't know	*5*	*8*	*10*	*2*

Table 5.2: If users were to be provided with heroin as a trial in the ACT, do you think all dependent users or only a limited number should be included?[*]

	% General Community (n = 358)	% Police (n = 327)	% Service Providers (n = 50)	% Drug Users (n = 76)
All dependent users	*43*	*46*	*46*	*63*
Only a limited number	*55*	*51*	*54*	*27*
Don't know	*3*	*2*	*-*	*9*

Table 5.3: If users were to be provided with heroin as a trial in the ACT, do you think all users or only a limited number should be included?[*]

	% General Community (n = 159)	% Police (n = 99)	% Service Providers (n = 32)	% Drug Users (n = 50)
All users	*40*	*53*	*56*	*74*
Only limited number	*44*	*28*	*31*	*24*
Don't know	*16*	*19*	*13*	*2*

Table 5.4: If a trial was conducted, do you think that it should include heroin/opiates users aged under 18 years?

	% General Community (n = 517)	% Police (n = 430)	% Service Providers (n = 91)	% Drug Users (n = 130)
Yes	*68*	*49*	*59*	*53*
No	*26*	*45*	*26*	*35*
Don't know	*5*	*6*	*14*	*12*

[*] *The responses to the question asked in Table 5.1 determined whether people answered the question posed in Table 5.2 or 5.3.*

Table 5.5: If a trial was conducted, do you think users should have to pay for the heroin/opiates?

	% General Community (n = 516)	% Police (n = 437)	% Service Providers (n = 93)	% Drug Users (n = 132)
Yes	*58*	*66*	*58*	*39*
No	*36*	*25*	*26*	*49*
Don't know	*6*	*9*	*16*	*11*

Table 5.6: If a trial was conducted, should users be allowed to take their drugs home or should they be required to use them at the distribution point?

	% General Community (n = 517)	% Police (n = 431)	% Service Providers (n = 90)	% Drug Users (n = 127)
Take home	*3*	*2*	*18*	*28*
Take at distribution point	*93*	*96*	*76*	*69*
Don't know	*4*	*2*	*7*	*4*

Table 5.7: Since most heroin/opiates users also take a range of other illegal drugs, should the proposed trial provide only heroin/opiates or should cannabis also be provided?

	% General Community (n = 517)	% Police (n = 425)	% Service Providers (n = 91)	% Drug Users (n = 130)
Heroin/opiates only	*67*	*83*	*76*	*55*
Cannabis also	*23*	*11*	*14*	*35*
Don't know	*10*	*6*	*10*	*10*

Table 5.8: Should the proposed trial provide only heroin/opiates or should other illegal drugs like amphetamines, cocaine and hallucinogens also be provided to those who generally use them?

	% General Community (n = 517)	% Police (n = 425)	% Service Providers (n = 91)	% Drug Users (n = 128)
Heroin/opiates onlys	*63*	*72*	*59*	*58*
Other drugs also	*25*	*19*	*24*	*32*
Don't know	*12*	*10*	*17*	*10*

Table 5.9: How desirable or undesirable do you think it is that users on the trial meet the following conditions?

	Proportion nominating desirable		Proportion interested in volunteering who agree to conditions
	% Police (n = 436)	**% Service Providers (n = 90)**	**% Drug Users (n = 57)**
Compulsory HIV testing	*94*	*50*	*85*
Other routine medical checks	*94*	*82*	*88*
Compulsory provision of urine for drug testing on a regular frequent basis	*93*	*57*	*72*
Compulsory provision of occasional random urine specimens for drug testing	*90*	*66*	*79*
Compulsory provision of information about drug taking	*92*	*70*	*71*
Compulsory provision of information about criminal activity	*80*	*38*	*54*
Other illegal drug use is forbidden	*91*	*52*	*43*
Disclosure of name and address (given that these are kept confidential)	*92*	*51*	*71*
Requirement to undergo counselling	*96*	*63*	*74*
Requirement to undergo other forms of treatment	*92*	*41*	*30*

Table 5.10: How desirable or undesirable do you think it is that the trial meets the following conditions?

	Proportion nominating desirable		Proportion interested in volunteering who agree to conditions
	% Police (n = 418)	% Service Providers (n = 88)	% Drug Users (n = 55)
The trial is run in a similar fashion to the current Methadone program	*50*	*40*	*51*
It is run with the aim of making participants abstinent	*93*	*46*	*44*
It is run with the aim of making participants reduce their use	*92*	*67*	*67*
Only non-IV routes of administration are offered	*65*	*44*	*51*
The trial is run by medical or nursing staff only	*78*	*32*	*67*
The trial is run by both medical and non-medical staff	*37*	*74*	*N/A*
There is only a guarantee of opiates for the life of the trial, say 6-12 months	*77*	*57*	*79*
Education about safe needle use is a part of the trial	*93*	*98*	*95*
The trial is run with the aim of making participants substitute IV methadone or morphine for IV heroin/opiates	*48*	*32*	*57*
Education about safe sexual practices is a part of the trial	*81*	*95*	*81*
Other forms of education, for example on nutrition, are a part of the trial	*86*	*92*	*91*
Heroin/opiates is provided in take-away syringes	*5*	*15*	*72*
Oral methadone plus two injections of heroin/opiates per day is the standard option	*15*	*16*	*71*
Oral methadone is the only option offered at the end of the trial	*53*	*30*	*54*
The trial is run with the aim of making participants substitute other routes for IV injection	*50*	*40*	*57*

Issues specific to the Police

Table 5.11: For a trial to be successful, police support in a number of ways will be essential. What sort of things do you think the police could or should do to assist the trial? (n = 339)

I am opposed to the trial	*69*
Register users	*24*
Show tolerance/be supportive/provide protection	*27*
Policing of illegal drug scene	*11*
Povide counselling and eduction	*6*

Table 5.12: Would you be in favour of trial drugs being made legal for trial participants? (n = 440)

Yes	*38*
No	*56*
Don't know	*6*

Table 5.13: Would you be in favour of all opiates (including street opiates) being made legal for trial participants? (n = 441)

Yes	*13*
No	*80*
Don't know	*5*

Table 5.14: Would you be in favour of all other illegal drugs being made legal for trial participants? (n = 438)

Yes	*7*
No	*86*
Don't know	*4*

Issues specific to Drug Users/Ex-users

Table 5.15: Do you think a 'heroin/opiates trial' should be used as a way of encouraging dependent heroin/opiate users…? (n=123)

	Yes	No	Don't know
to cut down	*64*	*22*	*14*
to become non-dependent	*68*	*22*	*11*
to stop using	*56*	*30*	*14*

Table 5.16: Do you think a trial should be used as a way of encouraging non-dependent heroin/opiate users…? (n=121)

	Yes	No	Don't know
to cut down	*53*	*34*	*13*
to stop using	*48*	*36*	*16*

Section 6: Analyses of Qualitative Data

Police

Because of time constraints all police questionnaires could not be analysed. A random sample of one in five questionnaires was selected for qualitative analysis, of these half contained comments in response to the question 'Do you have any other comments?'. In total 40 responses were analysed.

On a range of key demographic/background variables this subsample was similar in most regards. However those police included in the qualitative analysis were less likely to practice a religion (21% compared with 32% of all police who responded) and more likely to think ACT policing was effective (54% compared with 36%).

Care was taken to remain close to respondents' actual statements. These statements focus on the following issues:

- Health issues (including HIV and Hepatitis, as well as drug education)
- Legal issues (including crime and violence as well as remarks concerning the legality of drugs *per se*)
- Economic issues (including comments about costs to the community as well as about funding issues)
- Continued drug use (including comments about drug users and addiction as well as about community attitudes towards drug use)
- Quality of life (including comments about the vulnerability of young people to drug-taking as well as about public morality)
- The trial (this includes the issue of residency criteria for trial participants as well as remarks about possible trial "abuse" by drug users from interstate), and
- The questionnaire itself.

Whilst comments from service providers (see below) were dominated by health issues, police respondents focused more on the legislative and law enforcement issues raised by the proposed trial.

Health issues

Most of the statements concerning health issues related to specific problems, i.e. HIV or hepatitis, but one respondent characterised the proposed trial as a "program designed to add to the bad health of others".

HIV

Police respondents were very concerned about the possibility of (trial) drug users being carriers of the "AIDS" (HIV) virus and about the risks this posed both for the community at large and for the police themselves.

Some replies focused on the increase in numbers of people who are HIV positive generated by the potential influx of drug users from elsewhere in Australia. Others drew analogies with the "legalisation" of homosexuality, implying that this had instigated the "AIDS" problem and that legislation of opiates would only compound the problem further.

There were also suggestions that education about hepatitis B and C be provided. For one respondent there needed to be much greater emphasis on education before such a trial would be successful "in other than statistic compilation". For another respondent too, the crux of the whole issue was education and control, which, according to this respondent, would lead to better community health.

Drug Education

Others commented that the education currently provided to illegal drug users was very substantial, and

that the responsibility for health care lay with the individual drug user.

There were also suggestions that funding for the education of children of all ages against drug use be increased. In this way, it was alleged, the whole community would benefit.

Another suggestion concerning a trial was that it be conducted in a way which would help rehabilitate severely "addicted" people. This respondent intimated that the whole point of the exercise should be eventual freedom from "addiction".

Yet another suggestion was for extensive drug use programs throughout Australia with more emphasis on the results of "addiction".

Legal issues

Comments from police respondents were dominated by legislative and law enforcement issues. These latter included concerns about funding and other resources, as well as about crime and violence.

The potential ambiguities brought about by "legal" trial drugs/drug users versus "illegal" drugs/offenders emerged as a source of considerable perplexity for many respondents. For some, this ambiguity introduced an element of discrimination into laws concerning drugs, whilst for others the practical problems of enforcing "discriminatory" laws were uppermost.

Some representative statements on these issues were:

> "Who is legally responsible if a user overdoses and dies while on the program?"
>
> "Consider a user receiving narcotics and when (whilst still under the effects of the drug) committing a serious criminal offence, e.g. murder/serious assault/serious motor vehicle injury - death, etc."

One respondent drew parallels with alcohol with the comment that making alcohol free to users would not reduce the problem of alcohol induced violence.

There were also many suggestions that, instead of an opiates trial, the severity of sentences in current drug legislation be increased. Most comments to this effect were based on a sharp distinction between non-using suppliers/dealers on the one hand and addicted users on the other. These latter were characterised as "victims" by many police respondents, who favoured rehabilitation options for these "offenders".

According to one respondent, for example:

> "...rather than a trial, these people should be dried out, rather than given a fine and allowed to leave court. Breach this, they breach their bail."

There were also some suggestions that legislation concerning the seizure (or freezing) of all assets and/or the proceeds of crime be modified in order to increase effectiveness.

Many respondents pointed to the need for increased funding (for customs, for example, or for investigational support branches of the AFP). They favoured such increased funding over an opiates trial.

Other respondents were concerned with what they saw as the potential "abuse" of the trial by drug users and the likelihood that there would be an increase in drug use as a result of the trial. There was also concern about the potential effects on young people:

> "Kids that now indulge in cigarettes and dope for a thrill will be able to step up to first grade and try heroin".

Other issues of concern to police respondents were the potential for corruption at the distribution centres (as well as break-ins and drug thefts, for example), and the increased numbers of drug users who will "wander around [outside the centres] with no place to go."

There were also comments such as the following, which were more supportive to the proposed trial:

> "The controlled availability of opiates in other programs has proven to be effective in reducing criminal activity to a degree."
> "I believe the equation for this type of program should be education and control = decreasing dependency, less crime."

Economic issues

Most of the general comments relating to economic issues concerned what was seen as the "wrongful waste" of taxpayers' money, in supporting what was perceived to be an unproductive minority group who had brought their problems upon themselves.

Attitudes were divided about the extra costs to the community.
For some respondents, these would be enormous, while for others education and control would result in less cost to the community.

For others again, the important concerns lay with the question of who exactly would fund a trial. Would it be, for example, a local or a federal government responsibility?

One respondent suggested that the money would be better spent on medication for the

> "thousands of children in this country with terminal diseases... to keep them pain-free and alive for a short time to be enjoyed by their parents."

(See also "Health Issues" above)

Continued drug use

With one exception, respondents expressed pessimistic views about the likelihood of such a trial making any difference to drug use. Most comments implied an expectation of increased usage. This implicit view was based on a number of different criteria, such as:

- dependent heroin users can never overcome their addiction
- the trial would make available an extra supply of drugs
- the trial would advertise and appear to condone drug use
- drug users would abuse this extra supply of "free drugs"

In contrast, one respondent suggested greater support for those users wanting to get off illegal drugs.

Another respondent raised the issue of how to assess the user's degree of dependence in order to avoid making drugs available to non-addicts.

Quality of life

Some respondents felt that legislation would result in easier access to drugs for children, and showed concern for homeless youth and their vulnerability in this area.

For others, the major issues were about waning "morality" and "common decency"; law-breaking was being condoned instead of punished, according to these respondents, and drug users were being rehabilitated at an enormous cost to the community.

Many expressed the view that the community aim should be to heal and rehabilitate addicted persons.

The trial

In addition to issues that relate in a straightforward way to the proposed trial itself, this section includes (a) comments about effects on police work and (b) residency criteria for trial participants. These two issues will be dealt with after the more general comments below.

The negative responses to the trial proposal comprised characterisations such as:
.

> "too simplistic a way of dealing with drug use in the ACT"
>
> "naive and irresponsible".
>
> displaying "a lack of integrity" on the part of the instigators;
>
> "a dangerous farce, given the ineptitude of [the] current political structure".
>
> "liberal attitudes amongst relevant participating bodies would destabilise idealism of the concept".
>
> "no guarantee of any positive result, only unpredictable consequences".
>
> "a trial period should not be introduced. It failed in the UK and it will fail here".
>
> "NOT EVEN the drug dealer would support such an idea."

A trial was also seen as the kind of program that could only be administered by medical staff who, it was added do not need the "added strain."

One respondent saw the corruption of medical staff and the security of the trial drugs as two potential problems ensuing from such a trial.

Others also raised similar questions:

> "Who is going to be responsible for the supply - storage and distribution of these drugs?"
>
> "Who is going to check that the drugs are only going to the persons on the trial?"

Others were in favour of a trial, but pointed to issues of control and other procedures:

> "Each user must be thoroughly counselled/interviewed before starting."
>
> "Abstinence and intensive counselling is the most appropriate method to break their addiction."
>
> "Strict use guidelines must be stated so all participants know exactly where they are."
>
> "Do NOT bend the rules for anyone."

There were also suggestions that a trial only be for drug users who are genuinely trying to become drug-free. One respondent believed there would be a waiting list, so people who were not making a genuine effort to break their dependency should not be allowed to continue on teh trial. Others felt that people who joined a trial were making an overt request for assistance and should be afforded all the help they needed.

One respondent claimed that the State should supply drug addicts with their requirement free of charge.

Another commented:

> "A drug use trial is a good idea. However, do not go too far too fast. If it works, slowly expand."

As mentioned above, two specific issues which dominated respondents' comments were effects on police work and the potential problem of dealing with interstate drug users.

Effects on Police Work

There was general consensus amongst respondents that the proposed trial would create more work for police. This was based partly on an expectation that there would be an increase in the number of drug users in the ACT, and partly on respondents' perceptions of having to adopt new roles.

The following comments from respondents reflect police concerns on this issue:

> "...the influx of users from interstate, ...will increase the number of users by 1000's."
>
> "I don't want to police the drug capital of the world. Stop this stupid idea now or be responsible for stuffing up a great city."
>
> "As a serving police officer, I can see... police will be called to these centres to "calm down" users who are high."
>
> "Police are here to fight drugs, not to go along with this stupid idea of handing out drugs to users and potential users."

Some respondents, moreover, showed concern at not having been consulted earlier on the issue of a trial:

> "I think it is an absolute disgrace that the ACT assembly can try such a trial without a consultation with the police, and yet let minority groups like N.A. and the sex-workers have an opinion."
>
> "It is about time Police, Magistrates and the general community stopped bowing to the pressure of minority groups and joined together to bring back basic values and to uphold the law."

Drug users from interstate/residency criteria

Apart from creating extra work for police, the potential migration of drug users from other states was seen as generating a need for specific residency criteria for participation in such a trial.

One respondent suggested holding a register of (trial) drug users' names and addresses, and specified that these addresses only be in the ACT. Another suggested that prior to any person joining the list, their home address be visited in order to ascertain that they are actually an ACT resident, while a third remarked that all genuine users who apply should be allowed on the trial assuming they are resident in the ACT/Queanbeyan area.

There was also the suggestion that the trial should be conducted in other cities at the same time in order to avoid attracting interstate users to the ACT, as well as the comment that any persons who the distribution point staff believed were from interstate be reported immediately to the police.

Other general comments about interstate drug users concerned where they were going to live and the prospects of their "hassling" or "abusing" the proposed system.

Yet other general comments characterised the ACT as either a future "Mecca" for drug users or as

another potential Kings Cross:

> "Users from all over Australia will be on the streets within 3 months."
>
> "Your proposed trial will only increase the number of illegal drug users in the ACT, as a large number will come ... from other states so they can partake of your or [our] free handouts."
>
> "ACT could become "Mecca" for addicts, with resultant increase in crime, regardless of regulations for admission to program. It will not decrease crime related to drug usage - only increase the usage."
>
> "At least there will always be a job for police with the increase of addicts and CANBERRA might even become a massive 'KINGS CROSS'."

(See also Health - HIV above)

The Questionnaire

The questionnaire itself drew mixed reactions from police respondents too. The following examples are representative of their comments:

> "I don't like this questionnaire very much. Most of the questions concern moral judgments, but then I am asked to dismiss my original answer and answer as though I were in favour of the trial (which I am not)."
>
> "I have completed it because I feel that "attitudes" need to be judged, but your questionnaire seems to get attitude mixed up with facts."
>
> "I would not be happy if the results of this survey were used to set up or dismiss the trial - a lot more detailed work needs to be done."
>
> "Is this questionnaire REALLY going to make any difference to what eventually happens? I doubt it!"
>
> "I commend you for this research paper. I have faith in such a scheme and believe if given support by members of the AFP totally then it might work."
>
> "It is good to see that most of these issues [degree of reduction of criminal activity, ACT residency criteria for trial, assessment of users' drug dependency] have been addressed in this questionnaire."

Service providers

Forty-two of the 94 replies from service providers yielded substantial extra comment which is analysed here. In order to maintain clarity and conciseness, the analysis remains close to people's actual remarks.

This subsample was similar to all those responding to the survey in terms of age, sex, education, religiosity, number of children under 25 and whether they had ever used illegal drugs. However those service providers included in the qualitative analysis were more likely to have an abstinence philosophy (44% compared with 31% of all those responding to the survey). Consistent with this was the finding that more individuals in the subsample were not in favour of the idea of a trial (38% compared with 19%). Further, more people in the subsample had ever been in treatment for illegal heroin/opiate use (23% compared with 11%).

The comments made by the service providers range over a number of issues:

- Health issues: these include HIV and other medical issues, as well as counselling, therapy, health education and suggestions concerning trial participants and the distribution/monitoring of trial drugs
- Legal issues: these include issues of crime and violence as well as remarks concerning the legality of drugs *per se*, confidentiality and participants' rights to information
- Economic issues: these comments concern costs to the community as well as to the individual user, and are separate from questions of funding which are included in "trial issues" below
- Continued drug use: these comments are about users/addiction, as well as about issues of supply and availability of drugs
- Quality of life: these comments range across moral, social, community and individual issues
- Trial issues: a) questions concerning what a trial would entail; b) funding; c) possible "abuse"and finally,
- The questionnaire itself.

Health issues

Amongst respondents' replies there were some suggestions that heroin be used for physical pain relief as it is allegedly more effective than morphine, and would be of more use to cancer patients than to drug users.

One respondent claimed that the issue of drug tolerance had not been properly considered:

> "as tolerance increases, so too will illegal use of drugs in order to maintain balance."

Most of the straightforward medical comments made by service providers, however, concerned HIV and methadone.

HIV

One respondent claimed that HIV motivations (for the trial) were largely a diversion:

> "...we are not focusing on IV speed/coke problem in response to HIV, yet speed users inject more often than opiate users. Why?..."

Another considered that providing heroin was an attractive approach for harm reduction philosophy, especially for HIV positive people, to get them out of the drug scene.

Whilst some people did not think that people who are HIV positive should be included in the trial, they did not specify their reasons. Most respondents favoured giving priority/preference to HIV positive people, and many respondents advised regular medical check-ups and increased medical monitoring. Others suggested that education and/or counselling (particularly for needle use and safe sex) be compulsory. The danger of needle-stick injury was prominent in respondents' replies.

One respondent suggested health maintenance issues that need research, i.e
- the impact on the immune system
- interaction with HIV/AIDS drug treatments.

There were also suggestions that people who are HIV positive be restricted to trial opiates only. It was not exactly clear whether this implied that they be discouraged from using "illegal" drugs or from using other "medically sanctioned" drugs. Some respondents commented that their access to drugs should be unrestricted if it was for their own use.

There were suggestions too that trial workers needed to have special awareness of issues facing people who are HIV positive. Attitudes were divided about whether "problematic contacts" (either social or criminal) would be reduced. Possible IV or sexual contacts between participants were also raised as an issue.

Opinions were also divided about whether people should have to disclose the fact that they are HIV positive, or whether indeed the trial workers should have this information. The possibility that people would discover they are HIV positive was also raised. One respondent suggested that, although priority should be given to people who are HIV positive, this should be kept quiet in order to prevent desperate users putting themselves at risk.

This same respondent had experienced addicts desperate for methadone, who sought to be HIV positive in order to gain priority, but others also raised this as a possibility warranting consideration.

Another claimed that:

> "...high drop-out rates for methadone programs often without urine surveillance indicates needle use amongst the population..."

and queried whether the provision of other opiates would be any better.

An STD clinic doctor who is happy to be a resource person for STD/HIV education, counselling, consultation, writing, etc. supplied her name and address.

Methadone

Many respondents thought a trial worth going ahead with as an alternative to methadone, but one raised the issue of new dependence caused by the methadone program, implying that this could happen also with a "heroin trial". Other comments focused on the relationship between heroin and methadone, claiming that methadone was not as attractive (as heroin) because users "love the high", but that for this reason it was more likely that methadone could be used to wean someone off heroin.

Monitoring/Distribution of Trial Drugs

There were many suggestions about distribution of the trial drugs and the monitoring of effects and behaviour. One respondent suggested that the program should be strictly administered and monitored, that there be regular "on the spot" testing of blood and urine for other drugs and also to determine activities of the participants outside the regular testing/sampling. Another suggested that participants should be given no choice but to enter into a contract allowing the trial workers to analyse/counsel behaviour for a set period after the trial finished, while another claimed that distribution had not been thought through properly and that this would depend on tolerance and degree of dependence.

Several people pointed out potential problems if the heroin was provided on a take-away basis:

> "...means it could be sold or used by others hassling people on the program"

> "...the cost of providing dispensers could be very high, i.e. two registered nurses covering not less than 16 hours/day??"

> "...strongly disagree with "users" being able to take needle home; feel it should be IV given by nursing staff at distribution point, and

> should be individually and privately administered"
>
> "...if orally administered, [the heroin] should be ... signed for, and would not need to be [administered] privately"
>
> [If taking dose home], "...all users in the ACT should be included for fear of assault"

While acknowledging that the appropriate administration approach changes according to the trial philosophy, one respondent suggested that "legal heroin" should be provided on an "as needed" rather than on a regular "treatment" program (e.g. like the methadone program) where addicts top up with illegal heroin if the regular dose is not enough. If it was provided to any individual "hanging out" at presentation, rather than guaranteed for the term of a program, according to this respondent:

> "...then people [would] have a choice when desperate: commit crime for money to buy and hit OR present for a free fix."

Furthermore, if administration points were situated in accessible areas, more people would use these as their preferred option even if they were not desperate, because it was free. This same respondent commented that there are advantages to the methadone bus approach in Holland.

Another respondent raised queries about the precise dosage and administration:

> would this be -
> - 3 intravenous doses a day;
> - 3 intramuscular doses a day;
> - or 2 intramuscular doses [of heroin] plus methadone a day, for example?

Therapy/Education/Counselling/Intervention

There were suggestions that 12-step group work and counselling were very effective and many people were eager to see education and intervention work done. One respondent mentioned streetwork as very effective, but most suggested on-going counselling and/or therapy and attention to lifestyle, especially if clients aimed to become drug-free. Concerning the trial itself, one respondent suggested that counselling would be necessary to ascertain a clear picture of the history, present circumstances and motives of the participants, and also pointed to the need to provide participants with a very clear picture of what the trial would entail.

Legal issues *(including confidentiality and information for participants, as well as issues of crime and violence)*

Attention to legal issues came from a range of vantage points, some focussing on the individual's right to choose his/her own destiny, others more concerned with potential crime reduction in the community.

Many comments were critical of prohibition, and parallels were drawn with alcohol. One respondent commented that although prohibition (in the U.S.) did lead to organised crime, fewer people were alcoholics, and added:

> "...are we more concerned with our possessions than with the health of the young?"

Another remarked that when alcohol was prohibited, the problems did not disappear.

One respondent saw the proposed trial as "the thin edge of the wedge", i.e. as a probable commitment to legalisation. On this issue of legalisation, another claimed that in making drugs/prostitution legal we educate the next generation to view these as acceptable.

Drawing parallels with the English drug program, and quoting [John] Marks, one respondent commented that if participants had a 10-year using pattern, this raised issues of social control to keep someone quiet and medicated, and asked what the potential benefits might be over and above what we already have.

Others raised issues of the costs of control and prohibition, stating that it was important that such a trial not become a restrictive, punitive exercise, and that in any event drug use still continues.

Some respondents were concerned that trial drugs could either become a potential source of cash or be exchanged for other drugs. One mentioned having experienced problems of illegal sale of methadone supplies given for weekends etc., and there was one suggestion that funding be diverted to protect the community against amphetamine related crime, which this respondent saw as increasing rapidly.

It was also suggested that the program should provide complete confidentiality of information disclosed, recording legal and personal issues that had resulted from prior experience with drug use.

Finally, there was some opposition to the idea of a trial being held in Canberra, with suggestions that Sydney, Melbourne or Brisbane would be better locations in view of their large drug crime rates. Canberra, it was commented,

> "... is very naive towards crime that is drug related."

Economic issues

From an economic viewpoint, most respondents saw problems with the notion of a trial. There were suggestions that it would be better to provide cheaper home insurance or securities strategies, or that the money would be better spent on other alcohol and drug services. There were also claims that there is currently a complete lack of adequate and appropriate services for women and for young people.

Some claimed that the need for other services would increase, and that there was no evidence that the community or the funding bodies were willing to provide for this. The methadone program was cited as costly and inefficient.

Other comments were less specific:

> "...Fail to see the point of such a program. Expensive and for what purpose?"

(See also the remarks in "Health: Monitoring/Distribution" above concerning costs of take-away trial drugs).

Continued drug use

Attitudes to continuing drug use were tempered by the individual philosophies of different respondents. Those who saw abstinence as the ultimate goal, were pessimistic about the likelihood of positive change for drug users, whilst those who viewed the issue in the light of harm minimisation saw the link with drug-induced crime as an area of potential change.

A variety of images of drug users also emerged in respondents' comments. They were seen by some as incapable of making reasonable decisions about drug use, as not wanting to be normal, as having nothing left in life, as using drugs to block out the problems they did not want to face or as opportunists ready to accept free shots but otherwise continuing their usual drug intake. They were also seen as ready to accept any available narcotic and/or of being unenthusiastic about any non-drug treatment. Moreover, IV users were seen as being addicted to the ritual aspects of their drug use.

The idea of controlled availability was seen by some respondents as not addressing the issues that cause addiction, while others saw the current focus on drug substitution programs as being beneficial

to the general public, but not as a viable long-term solution for addiction. These programs were, to quote one respondent,

> "...an 'easy fix' for what is considered a 'hopeless' problem."

This same respondent found the focus on clients' rights to be a disturbing trend.

The issue of increased drug tolerance going hand in hand with increased drug use was raised again in this context.

With regard to the issue of the supply and availability of drugs themselves, respondents commented that there would be no likely difference in the short term, but that there may be in the long term.

Quality of life issues

There were many conflicting attitudes on this issue, ranging from:

> "...root of the problem is sinful humans",
> "...love and relationship with the creator [are] more important than money and/or more programs"

to comments focusing on the plight of the dependent users themselves. These latter concerned issues such as homelessness, ill health and economic disadvantages, but paid attention also to encouragement and support of dependent users and to the individual/social causes of dependency.

One respondent claimed that the community had a false comfort in alcohol, and that excessive drinking was a serious community problem, thus implying that a false dichotomy was being drawn by the public between the effects of heroin and those of alcohol.

There were also comments pertaining to the generational aspects of drug-use/treatment, which pointed to the detrimental effects on children of their parents' addiction.

The trial

Attitudes towards the trial itself were mixed. Many respondents felt there were potential beneficial outcomes which would outweigh problems and any negative response from the community, while others felt it was a ridiculous idea and that we should concentrate on the "real needs of the community" instead.

The respondents who were positively disposed to the idea claimed that heroin is vitally important and that the trial should have been put in place years ago. Others stated that they would be grateful for the trial if it went ahead, or that it was worth pursuing as an alternative to methadone.

Others drew parallels with the English program and were concerned that such a trial would mean supporting addicts for long periods. They quoted [John] Marks as stating that most [English addicts] had a "ten year using pattern".

The age of potential trial participants was also raised as an issue of concern, with many respondents reluctant to countenance the inclusion of minors. One respondent mentioned having experienced problems of adolescents increasing their usage in order to get onto programs.

On the issue of drug costs, one respondent felt the trial opiates should not be free, and suggested a nominal charge of $3 per session.

One respondent suggested that monitoring of blood and urine would give indications of people potentially "abusing" the trial, while others suggested that it would be necessary to provide counselling to participants in order to give a very clear picture of what the trial would entail. Yet others worried that "addicts" and non-users would be encouraged to experiment because they would perceive heroin to be sanctioned by the health and legal services.

There was considerable opposition to the notion of having such a trial in Canberra, with people voicing concern about users being drawn from all over the country, with comments such as:

> "Canberra will end up being raped by the people we will attract with this trial..."

Trial funding

Questions about trial funding elicited general comments such as:

> "...if we can afford to go to war, there is not a problem."

Respondents generally commented that a trial such as this would tie up scarce resources, but added that the funds available depended on values and that hence the priorities were determined by those allocating funds.

The questionnaire

There were several comments about the questionnaire itself: it was described as "ambiguous", "very difficult", "too prescriptive" or people found that there were "too many depends" to be taken into account. Some people found it too hard to answer without more knowledge of the proposed trial, and others stated that there were too many variables.

Two respondents felt that the questions were loaded:

> "...one is being steered into giving answers the survey wants to hear..."

> "...questions... seemed to be steering me to answer in certain ways that would support the trial..."

One respondent commented on the ambiguity inherent in Q.50 (about drug use), and claimed that it created a false dichotomy:

> "Q.50 suggests "tried" drugs and then given up, or "used" illegal drugs..."

A further comment from the same respondent was that marijuana constituted only minor usage.

Finally, one respondent commented that it was good to have this survey.

Illegal drug users/ex-users

The qualitative analysis presented here is based on comments from the 68 respondents who responded to the request for further comments. A few comments were related to personal issues, philosophical observations or statements of a very general nature and will not be included in this analysis.

On a range of key demographic/background variables this subsample was similar in most regards. However those users included in the qualitative analysis were less likely to have a post-secondary school qualification (29% compared with 40% of all those responding to the survey), and more likely to be heroin/opiates users (ie 24% were non-users compared with 35% in the total sample).

Care was taken to remain close to respondents' actual statements. These statements focus on the following issues:

- Health issues: HIV and other infections, users' physical health and lifestyle, illegal drug use, methadone, families of users, community health
- Legal issues: "legalisation" of other drugs, crime reduction, suppliers, corruption
- Trial issues: general negative and positive comments about a trial, community education about a trial , eligibility for a trial, other advice on how a trial might be run, trial leading to abstinence, trial ending, ramifications of a trial, and
- The questionnaire.

Health issues

A few respondents made comments about infections including HIV and Hepatitis and several about how they felt a trial would affect the health of users. Many of these related to physical health or lifestyle issues and many to illegal drug use and/or methadone. A few made comments about how they thought a trial would affect the families of users or the community.

HIV and other infections

There were four comments relating to the way in which a trial might reduce the spread of infections; one was related to a general reduction in infections, two were related to a reduction in the spread of HIV/AIDS, and the fourth to an opinion that although HIV/AIDS is:

> "...devastating...hepatitis is at epidemic proportions among IDUs in terms of scale and poses a far greater risk to the community and the trial would help stop [that] spread."

Users' physical health or lifestyle

One respondent expressed a belief that a trial would:

> "Save the lives of users."

and many respondents thought that a trial would lead to improvements in users' lives. Such comments included perceptions that the trial would make:

> "...drug users better",

or that it would:

> "...halt the misery of users."

Several respondents thought that a trial would lead to a healthier financial situation, or improvements in the lifestyles of users; one respondent indicated that if they were on the trial there would be more money for food. Another respondent commented that there would be a reduction in degradation since users would not have to:

"...steal and rort just to be able to feel better."

A similar comment related to a belief that a trial would detach users from:

"...the lifestyle of illegal drug use and naturally [make them] more relaxed etc."

A few respondents believed a trial would help with career prospects:

"I haven't worked for a long time 'cos I'm not dependable - this trial will help me do it all right."

"[A trial would mean] least disturbance to career and life decisions."

One person predicted that with a trial:

"People would start enjoying the place a lot better without the ever-darkening black cloud that society places on us."

Others felt that a trial would be better than the current situation since it would stop users from committing crimes adding that:

"The jails are full of addicts who have suffered enough."

Talking of their personal experiences one respondent stated that:

"... if drugs were not illegal I would never have ended up in jail."

Illegal drug use

Several respondents postulated that a controlled trial would be better for both social and physical health of users since it would offer them cheaper, pure, clean drugs of a consistent quality as encapsulated in the following comment:

" [I] have to pay $400 for a weight of bad heroin and lots of my friends hate me now. If it were cheap and clean I'd be much happier."

Another comment relating to the price of drugs came from a respondent who simply said:

"People who are using are just being ripped off."

One statement related to supply and its effects on services:

"Canberra is the last link in the drug trade - users here are paying high amounts for generally low quality of highly cut heroin and supply is inconsistent compared to other areas in the country leading to a great strain on health and counselling services in our city."

Some respondents offered opinions on their perceptions of the problems associated with drug use:

"Heroin is a medical problem not a criminal one."

"It's the illegality of heroin and the associated woes...that makes the problem so much worse."

"[The] drug is not the problem but all the untoward behaviours surrounding supply and demand."

Others gave reasons why they thought drug use occurred:

> ".. drug use cannot be prevented - our societies are too difficult to live in and we need to escape through drugs - its a survival technique."
>
> "...the majority of dependent users have horrendous childhoods relating to violence, sexual abuse, rejection, abandonment, and generally unstable dysfunctional families and emotional immaturity. The use of opiates is the easiest way to deny how you feel [these memories are] replaced by euphoria."
>
> "...addiction is taught to all people in our homes and workplaces and by our organisations in the roles we have to play in our lives...humans are addicted to a lifestyle of obsession and denial."

Two comments of a related nature came from respondents who saw the trial as a way of collecting data which would enhance understanding of why people use drugs.

Methadone

There was a plethora of comments relating to methadone, several respondents believing that a trial that offered heroin would be an improvement on methadone:

> "...heroin is better healthwise than methadone."
>
> "...heroin is natural and cleaner than methadone."
>
> "Since heroin is supplied pharmacologically pure there will be little, if no, long term side effects as with methadone."

One respondent asked:

> "Why no choice of methadone or heroin as methadone is more habit forming and is harder to withdraw from than heroin is?"

Others believed that:

> "Heroin is not a substitute [and is therefore better than methadone]."
>
> "80 mgs of methadone is not enough on its own."

A few respondents made comments about the current Methadone Program itself:

> "I hope the trial is conducted with more respect for the clients than shown to those on the current Methadone Program, we users are human beings also."
>
> "The trial will negate the rotten Methadone Program."
>
> "The current Methadone Program in Canberra is a national disgrace and doesn't comply with NCADA recommendations, or the National Methadone Guidelines."

Some respondents commented on their perceived problems with getting on the Methadone Program:

> "...a comprehensive heroin trial, particularly one which is accessible to the majority of IDUs who can't get methadone, would put the ACT in the commendable position of leading the

> community away from the draconian past."
>
> "A trial has to be made a lot more available than getting on methadone."
>
> "If the Methadone Program were easier to get on...I would never have ended up in jail."
>
> "Would prefer that methadone were more freely available - or have controlled heroin distribution."

One respondent currently on methadone, and who reported that she was still occasionally using "street opiates", commented that she:

> "...would jump at the chance to receive controlled use of heroin since I could easily become addicted [again] to street heroin in the future."

Two respondents, also currently on methadone, made the following comments:

> "...would prefer to get off Methadone Program and on to heroin program."
>
> "On methadone and it's harder to get off [it] than heroin, therefore in favour of heroin since it's more natural and cleaner than methadone and easier to get off in the long run."

A respondent who had been on methadone twice in the past commented that:

> "[I was still using then] and I'm still using now."

One respondent offered a reason for users continuing heroin use whilst on methadone saying it was:

> "...because they are used to putting a needle in their arm, this is part of the habit and methadone doesn't fill that need."

A somewhat more positive comment about methadone came from one respondent who said that:

> "I'm currently on methadone - it's helpful but it's not my drug of choice."

Another respondent believed that:

> "The Methadone Program is not extensive enough in terms of numbers and places available"

but added that it:

> "... is well organised, seems to be reasonably successful and helps alleviate some problems."

Families of Users

Three respondents anticipated that a trial would improve conditions for children or other family members in that it would halt current misery or improve their lifestyles, or would mean that the children of users could lead normal lives.

Community Health

Three respondents believed that a trial would be safer for the community (one mentioning children specifically) in that it:

> "Would get drugs off the streets."

There were another two comments relating to the community: one respondent postulated that because of crime and imprisonment the present cost of heroin use to the community is very high, and another respondent hoped that a trial could be:

> "...the start of a process of making heroin a more acceptable drug and remove the myth that creates a panic in the community."

Legal issues

Remarks revolving around legal issues concerned general comments about "legalisation" of other drugs, crime reduction (credited to trial participants not having to commit crimes) and issues around corruption and supply.

"Legalisation" of other drugs

One respondent believed that there should either be "legalisation" of heroin and cannabis, or prohibition of all drugs (inferentially tobacco and alcohol). Two others confined such comments to "cannabis", one saying that:

> "If cannabis was legalised harder drugs would not be used as much...on many occasions cannabis or speed is not available but heroin is."

Another believed that:

> "My friends on heroin started because of a lack of softer drugs..."

adding:

> "...heroic busts of cannabis only make me mad, with every bust an extra gram of heroin is sold."

Crime reduction

Several respondents commented on this issue and all such comments related to a perception that because trial participants would not have to steal to support their "habit" their criminal behaviours such as shoplifting, thefts, violence, and mugging would be reduced, or would stop completely.

Suppliers

One respondent offered the opinion that the trial would:

> "Stop current heroin users from distributing heroin to support their own habit."

Others confined their comments to bigger suppliers:

> "Big dealers would not be getting so rich."

> "[A trial would] deal a major blow to organised crime involved in supply of illicit drugs."

Adding an economic rationalist perspective one respondent offered the following theory:

> "The community impact of heroin based crime would possibly be lessened hence removal of massive revenue losses. Many pluses for controlling supply none for keeping it totally black market orientated."

According to two respondents, a trial would not affect the heroin trade, one of them adding:

> "I suspect they'll [big suppliers] just go wherever fortunes are to be made."

Corruption

Two respondents believed that "legalising" drugs would minimise or reduce corruption, one adding that Mafia control would also be minimised.

Trial issues

Comments about a trial formed the majority of the responses and covered general statements for and against a trial, community education about a trial, issues of eligibility for a trial, advice on how a trial might best be run (including comments based on a perception that an underlying goal of a trial should be abstinence), and what might happen when the trial ended.

General negative comments about a trial

There were several comments from those who opposed a trial, some of which related to the benefits of abstinence programs; these were mostly based on personal experiences.

A respondent, who had also been on methadone, thought that:

> "This trial is a negative step and will not help our community or the using addict - when you're using or on methadone you're insane and don't think straight. Once in recovery the fog lifts and you can see the insanity of your using life."

One respondent simply stated that:

> "We do not need drugs to live by."

An ex-user asked:

> "What happens if there are no positive results? How much will this cost me as a non-using tax-payer? Have other alternatives been looked at? How many people have to die if it [a trial] does go ahead, before it stops?"

Another respondent asked:

> "How are you ever going to give an addict enough? How are you going to deal with ever-increasing tolerance? A trial won't stop addicts using or make them careful about AIDS - the headspace is I need more and it won't happen to me. Addicts are more likely to stop if it's hard to use, not if there's the least hope or possibility of getting it easily."

Another respondent was also concerned with a trial causing tolerance stating that:

> "I don't agree with program as any addict on program will become tolerant to the drugs and therefore need to go and obtain more drugs - you will be adding to addicts' consumption. Methadone has caused many problems why would this be different?"

A respondent, who was in general in support of a trial, was worried that:

> "...some elements in the heroin community might consider that the introduction of the trial makes heroin alright and this will encourage others, especially teenagers, to use."

Another respondent believed that a trial would increase both free and illegal heroin use and one believed that:

> "To introduce a ridiculous closed minded program like this would be nothing but detrimental; we need more awareness socially, not pathetic wishy-washy bandaid solutions."

Writing in very big letters one respondent simply said:

> "Please don't go ahead with the trial to make heroin legal."

A comment of a somewhat different nature from the others came from a respondent who was:

> "Not happy to have drug users tied to a medical system which treats addicts with disrespect and even contempt. It creates addicts - with Dr's prescriptions - and it won't [help us]. Not willing to support a system which has people on methadone for 20 years with no other options offered. I support harm reduction and keeping drug users healthy but like most addicts I reckon I won't stop unless I have to. If I had an unadulterated guaranteed supply I would be happy in the short term but my soul would be dead and I think that's what we seem to want - to keep addicts quiet by co-opting them."

General positive comments about a trial

Anticipating possible negative comments about a trial one respondent offered the following advice:

> "Don't let red tape with negative arguments get you down."

Many of the respondents supported a trial without giving a rationale and such comments ranged from simply thinking that it would be a good idea, that it must go ahead, to simply wishing:

> "Good luck."

or stating:

> "Good work, you're real and in touch."

One respondent believed that although a trial was not a cure it had to be better than the present system and comments of a similar nature came from one respondent who approved of:

> "...giving alternatives to the addicts so they can make their minds up and not be dictated to by old and failed systems."

Another respondent felt that:

> "Legal supply is only going to improve the current situation."

Postulating that a trial might also be used to get users off heroin one respondent said:

> "I don't know the impact on individuals or society but can't see it making things worse. Hope it would keep people out of jail, off the streets and keep them alive until they are ready to give up drugs, if at all."

One respondent suggested that a trial would be good since:

> "Users could use in the right environment with the right people."

Demonstrating their belief that initially a trial rather that a full blown program go ahead four

respondents stated that a trial should be run to see how it goes and that without a trial:

> "...we'll never know."

A few respondents alluded to overseas programs:

> "With contacts in Sweden and Switzerland of decriminalisation of heroin [I believe that] a controlled trial has to be more appealing than current system here."

Two respondents commented on the English programs which they perceived to be successful.

One respondent currently in "Detox" said that they supported the trial because they:

> "...would like to help others who need help".

One respondent believed that although:

> "... a trial will help [it will] never cure."

Another approved of a trial because they did:

> "... not believe anyone is happy to be dependent..."

adding:

> "so please try and help them."

Personalising the issue one respondent said that they had:

> "...wanted a legal program for many years."

Two respondents believed that a trial should go ahead because people are always going to use and two others said:

> "Drugs should be legalised - people ought to take responsibility for their own lives."

> "Make the right decision legalise medical use, listen to people who know."

One respondent referred to friends who had died due to drug use:

> "Why has this taken so long? Why [have I had to] bury so many friends with overdoses and from cut drugs and now from AIDS? I hope to see something done in my lifetime."

Another respondent was concerned that a trial might be abused but if not it:

> "... could have an overall good effect."

Community education about a trial

One respondent commented that there is unjustified hysteria connected with hard drugs and that this will need to be overcome if this trial is to be a success.

Eligibility for a trial

There were many comments on this issue; one respondent simply said that:

> "Prospective clients should be extremely carefully screened."

and another that:

> "Applicants should be chosen according to their individual cases and should undergo any necessary testing to prove that they are actually heroin users and not just freeloading to get out of it."

One respondent anticipated that a trial would provide opioids to non-users stating:

> "Giving drugs to non-users is insane",

and another, with a similar belief, qualified his statement saying;

> "I'm concerned about non-users and very occasional users getting on the trial to get free drugs but doubt that this would happen since people don't willingly get themselves addicted to a hard drug."

Without making comparisons with other levels of users, some respondents stated that they believed a trial should be available to dependent users. One respondent in this category stated a belief that:

> "You should direct the program to long term users - they are the ones with the big contacts [inferentially suppliers]. If you can control big or long term users you can control a large proportion of street use to the young generation."

A few respondents held the belief that "occasional" users should be excluded from a trial offering such reasons as a trial:

> "... may create a habit."

and another believed that:

> "If you don't include occasional users this may give them the incentive to stop - just like tobacco, greater stress should be put on the fact that you're a better person off heroin - the reason why more people are on smack now is that it's more acceptable."

Several respondents explicitly believed that non-dependent users should also be allowed on a trial with one stating:

> "If [the trial were] only open to dependent users people would increase their use to qualify."

A similar comment came from a respondent who said that the trial:

> "Should be available to recreational users as heroin can be psychologically addictive, ie a person may be used to having a shot every Friday which is still a threat to others' health eg Hepatitis and HIV."

A similar belief came from a "recreational user" who was using heroin two to four times a week and who said that:

> "I tried to get on methadone unsuccessfully because (I don't have) a bad enough drug problem...a trial would be most helpful to people in my situation - if I used in a controlled manner if would make my life easier and happier and I would cut dose down to nothing at all."

A respondent who was currently on methadone and who was still occasionally using street opiates was adamant that:

> "If my partner was accepted and not me I would increase use of street opiates if that was necessary to get on the program."

Whilst noting that some people may wish to stay on methadone she added that:

> "The program should also be open to addicts not currently using but feel they could use again [and that it should also] include people currently on methadone who are only on methadone because they feel there's no better alternative."

Without offering a rationale another respondent also believed that the trial should be open to people currently on the methadone program.

One respondent believed that trial participants:

> "Should not have to get a street habit again to get on the program."

One comment came from someone who described himself as an:

> "old dependent user...with a career in the the public service."

This respondent was:

> "...hopeful that people like me are not rated ineligible because they are not down and out enough - such users are not taken seriously at the Methadone Clinic because they have a decent job and don't look like junkies. Counsellors believe lies about excessive drug use. Older junkies with good jobs are very unlikely to sell their dose for money to live on. This should be taken into account when targeting people for the trial."

One respondent was worried that:

> "...if [the trial was] only open to people with HIV some people might be desperate enough to contract HIV."

Other issues around eligibility concerned a belief from one respondent who was concerned that a trial should not be:

> "…for teenagers unless there are extenuating circumstances and no other avenues",

and another believed that trial participants:

> "Must be residents of the ACT for eg 12 months."

She added that proof of residence could be achieved by:

> "...previous/current addiction eg previous methadone, residential program, NA [Narcotics Anonymous] criminal records."

Other advice on how a trial might be run

One respondent simply noted that a:

> "Trial should be run properly and for the help of the addict."

Another believed that:

> "Counselling cannot be overemphasised in regard to addictive

behaviour."

For one respondent education about safe sex and safe drug use:

"...would be fantastic."

Another believed that there:

"Should be separate pick-up points for heroin or methadone withdrawal patients as opposed to patients who have no desire to become drug free...",

explaining that:

"...addicts congregate in Methadone Clinics and therefore drugs are bought and sold there."

One respondent recommended that:

"The smaller the dose, the longer clean urines are provided then limited access should be given to oral take away doses for long weekend etc."

Three comments related to the monitoring of trial drugs, one respondent suggested that trial drugs should be given at the hospital to start with to:

"see how it goes",

the second that drug administering should always be supervised and the third that there should be:

"No take-away IV heroin as this will encourage standover tactics and robbery."

Trial leading to abstinence

Three respondents believed that other help with a trial could be sought to enable trial participants to become abstinent. This included offering drug and alcohol programs for under 18's since:

"...they are the so-called grown up street junkies who corrupt society."

The second thought that:

"Those with addiction should be encouraged to give up their addiction through therapeutic communities and NA etc."

and the third that:

"With appropriate ancillary service some people can be taught to get their lives together [including drug using] with no severe withdrawal."

Recognising that some people may wish to stay on heroin during a trial one respondent hoped that a trial would help those who wished to, to stop.

Offering a personal perspective one respondent postulated that:

"I could bring myself off heroin with heroin?" (sic)

One person on methadone had found that:

> "...it's harder of get off than heroin, therefore in favour of heroin since it is more natural and cleaner than methadone and easier to get off in the long run."

A similar comment came from someone who was:

> "In favour of a heroin trial since heroin would be easier to get off than methadone."

One respondent believed that a trial should be:

> "Proposed to dependent addicts who have a problem and those people should be encouraged to give up their addiction."

and another that:

> "Supplying heroin through a reduction program might work but abstinence is the only way to get off heroin."

For one respondent there was the impression that:

> "...although some users would be genuine in wanting to come off heroin on the trial some, perhaps even the majority, will abuse the trial."

For another respondent there was no notion that the trial might be used in this way since they saw the trial as something that could be offered until such time as people wanted to come off drugs.

One respondent discussed the problems with coming off heroin, saying:

> "...it's easier to get out of it with heroin than staying straight, staying off heroin is the hardest part and help should be given to people to help them find a rewarding job because of the danger of boredom."

Trial ending

One respondent expressed concern about what would happen to people when a trial was over if it was decided not to continue permanently. They believed that trial participants would be back on the streets and that:

> "...a life and death game was being played here."

Another respondent expressed concern that the trial would increase both drug use and crime because when it was over people would be using more than before the trial.

Ramifications of a Trial

One respondent believed that:

> "A successful trial will be hard to define and then not necessarily guaranteed that drugs like heroin will be made available to registered dependent users in the ACT and elsewhere."

another that:

> "Trial is a reasonably good idea but with with no long term solution."

and a third reported that they had:

> "Heard people in rehab say the trial will put them out of business."

One respondent asked why a trial was only being conducted in the ACT, another believed that a trial would benefit every Australian if it were successful and made nationwide and a third believed that the issues were of an international nature and exhorted the trial organisers to disseminate their results.

The Questionnaire

Three respondents commented on the questionnaire itself; one of them believed that some of the questions were a bit confusing, another that the questionnaire was:

> "...in its entirety framed...by some knowall psychologist or (someone in) a similar discipline."

and the third commented that the questionnaire was:

> "A bit tricky guys."

Key Community Groups

A one page letter was sent to 69 community groups in the Canberra region inviting submissions (see Appendix E). The letter asked whether or not the groups felt that a trial should go ahead and what aspects of a trial would be of major concern to their members. In addition, ACT Adult Corrective Services were verbally invited to make a submission.

Replies were received from 17 groups representing a response rate of 24%. Amongst those community groups which responded, concern was expressed at the limited time made available to formulate a response. We acknowledge that the time allowed for responses was too short; however, given the overall time constraints, we felt that providing a limited opportunity to express a view was better than none at all. Some groups commented that they found it difficult to provide a response without knowing the details of the proposed trial. As already noted in the introduction no specific proposal was put to the groups because the aim of this stage of the feasibility study was to see if the development of a specific project was warranted. It is anticipated that there will be extensive consultation on a specific proposal if the feasibility study proceeds to the next stage.

Of the 17 responses six were supportive of a trial taking place. They either demonstrated group consensus or, where polarisation of opinion had occurred, represented the majority view. A member of one other group supported a trial but could not respond on behalf of the group that she represented. Two community groups registered opposition to a trial while five took no specific position, instead providing a general discussion of the issues that concerned their groups. Three community groups replied that they had no submission to make.

All letters which made substantive comments are reproduced in Appendix E (permission to do so was given in all cases).

Responses to the newspaper advertisement

Three written responses were received and are reproduced in Appendix E with the authors' permission.

Conclusions

Sixty-six percent of people in the general community agreed that a trial should go ahead, as did over 70% of the service providers and drug users/ex-users surveyed. Only 31% of police surveyed were in favour of a trial. Of the 17 responses to a request for comments received from 'key' community groups, six were supportive of a trial and two registered their opposition. In all cases the responses were to a notion of a trial and not to a specific proposal.

Eighty-two percent of the current heroin users surveyed expressed an interest in participating in a trial.

A majority of the general community, service providers and drug users/ex-users surveyed believed there would be a number of benefits resulting from a trial to provide heroin/opiate users with a controlled source of drugs. It was felt that a trial would reduce the spread of HIV/AIDS and that crime and corruption would be reduced. The view was also held by these groups that since there will always be some people who take heroin/opiates, it is important to provide them with the drugs in the safest way. In addition, many of those surveyed believed the trial would improve the overall health of drug users. Compared to the other groups, the police were less likely to believe a trial would have any beneficial outcomes.

Police were far more likely to perceive that a trial would create problems. It was commonly felt that the provision of heroin/opiates to drug users would set a bad example for young people and that it would mean users would have no incentives to reduce their drug use. A number of respondents also believed a trial would be bad for road safety and that it would increase the number of heroin users. These views tended to be shared by up to half of the general community and by a far smaller percentage of service providers and users/ex-users.

A majority of all of the groups surveyed were concerned that a trial would attract heroin/opiates users to the ACT from elsewhere in Australia.

Service providers and users/ex-users felt that criminal behaviours, including shoplifting, breaking and entering, fraud, and supplying of illegal drugs would be reduced. Less than one-third of police shared these views.

There was concern in all three groups that participants would be 'hassled' for trial drugs, especially if they did not have to be taken at the distribution point.

All groups were asked for their views on how a trial should be structured and the following key points emerged:

- There was a widespread view that a trial should only include dependent users.
- Half or more of each of the groups surveyed felt drug users under 18 years should be eligible for a trial.
- While users/ex-users strongly supported inclusion of all users on a trial, the other three groups were more evenly split on whether or not a trial should be limited in number, or include all users.
- A small proportion of all groups believed a trial should provide heroin/opiate users with other illegal drugs.
- A significant majority of all of the groups believed trial participants should be required to take their drugs at the distribution point.
- Approximately 60% of the community, police and service providers believed participants should pay for the heroin/opiates provided in a trial, as did almost 40% of drug users/ex-users.
- Most of the drug users interested in participating said they would agree to comply with the data collection requirements of a trial. These might include HIV testing and other medical checks, testing for illegal drug consumption, and providing information on criminal behaviour. They also expressed a willingness to participate in education and counselling programs.

Acknowledgements

The support and assistance of the following individuals is gratefully acknowledged: Kate Braid, Stacey Butler, David Cameron, Beverley Garlick, Sue Godkin, Karen Hansen from Perfect Processing Plant, Malcolm Mearnes from Datacol, Jennifer Rainforth, Kate Stevens.

We are also grateful to the Australian Federal Police Association, especially the National Secretary, Jeff Brown. The following organisations and individuals provided assistance in distributing service provider and user/ex-user questionnaires: Aaron Crocker; Aboriginal Education Consultative Group; ACT Drug Referral and Information Centre; ACT Needle Exchange Program; ACTIV League (an ACT Injecting Drug Users (IDU) peer-based organisation); AIDS Bus workers; Ainslie Village; Alcohol and Drug Foundation of the ACT; Alcohol and Drug Services Community Unit; Alcohol and Drug Services Detoxification Unit - Royal Canberra Hospital (South); Melissa Bull; Crisis Detox Centre; Cura Casa; Downer Youth Refuge; Dr Peter Rowland's and Dr Bob Hain's surgery and staff; Drugs In The Family; Family Planning; Lasa House; Mancare; Alcohol and Drug Services Hospital Unit including the Methadone Clinic - Royal Canberra Hospital (South); Michelle Morrison; Ngunnawal Centre for Aboriginal and Torres Strait Islander Education-University of Canberra; Open Family; 'Roger Mitchum' (a pseudonym for an illicit drug using contact); Short Cuts Information Service for Young People; STD/AIDS Reference Clinic - Royal Canberra Hospital (South); Charles Roberts; The AIDS Action Council of the ACT Inc.; Toora; Winnuga Nimmityjah Clinic - Aboriginal Health Service; Youth Affairs Network.

9: EVALUATION BY A RANDOMISED CONTROLLED TRIAL

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Preamble

In an area as contentious as changing the availability of currently illegal opioids, a trial should produce unambiguous answers to the the leading questions. Despite widespread debate about the advantages and disadvantages of changing availability, there has been little good data to inform it (see Chapter 2: Literature Review: Arguments For and Against Changing the Availability of Opioids). A trial such as the one under consideration can make a significant contribution to the Australian and international debate. Proponents and opponents of the trial should be involved in determining the outcomes to be measured.

There are many issues within this debate. Any one trial can only answer a limited number of questions. One of the working group's tasks was therefore to determine what the key aims of a trial should be. We also canvassed a range of options for evaluation and concluded that only one met the necessary requirements for rigour and clarity of answers, namely a randomised controlled trial.

We recommend therefore that the notion of 'a trial' which has been broadly conceived throughout Stage 1 of this feasibility study should now be more precisely conceived as a randomised controlled trial. Thus, 'the trial' becomes synonymous with a randomised controlled trial

The trial has as its ultimate aim an improved and more sustainable lifestyle both for those who are dependent on opioid drugs and for the communities in which they live. Such a trial will need to be conducted under careful medical supervision. It must offer all its participants potential benefits, and respect their dignity and individual need. It must not expose them to known increased risks, and must not increase known hazards for the broader society. The trial must be very carefully planned and monitored and its aims and methods must be well understood by the community.

What should the aims of the trial be?

We propose that the principle aim of the trial should be to compare results of treatment for opioid users who have a choice of drugs and routes of administration in their treatment regime with results for those who only have oral methadone available to them. The choice of drugs involves a choice of heroin or methadone or both, in injectable, smokable or oral forms. The results to be examined are health and social behaviours, including criminal behaviour.

What questions should the trial answer?

Can a treatment program which offers heroin (as well as methadone) and injectable and smokable routes of administration (as well as oral) increase the likelihood that participants will be able to:

a. lead a more structured lifestyle in terms of employment, relationships and day-to-day activity?
b. reduce their criminal activity?
c. reduce behaviours which place them at risk of contracting HIV and hepatitis B and C?
d. increase behaviours important in the maintenance of health and well-being?

A range of variables which could be collected to answer these questions are listed in Addendum 1. It is anticipated that only a selection, determined in Stage 2, would be used.

What is a randomised controlled trial?

A randomised controlled trial is a method widely used to evaluate innovations in medical treatment. It involves a comparison of defined outcomes between groups of people who are randomly assigned to one or other treatment group on the basis of chance. One of the ethical requirements for undertaking such a study is that there should be no clear evidence at the beginning of the trial that one treatment is more effective than the other. If there is already proof that one treatment is less effective, it is unethical to allocate people to that treatment (see Chapter 7: Ethical Issues). In the current proposal, such proof does not exist.

Before being assigned to their treatment, participants must give informed consent to the random process of assignment. This process is like the selection of a lotto ball or drawing sealed envelopes from a hat. The random assignment ensures that the groups being compared on outcomes are truly comparable in their baseline characteristics, and that there is no bias in the way people have been allocated to the two groups.

We propose that after eligible participants have given their informed consent to the procedures of the trial, a random process will determine which "arm" of the study each individual will enter. Those who enter the methadone or control arm will receive oral methadone under medical supervision while those in the "expanded availability" or opioids arm will also be able to obtain heroin in one or more forms. The purpose of the comparison is to determine whether one group has better outcomes than the other.

Why a randomised controlled trial?

Evidence presented elsewhere in this report (see Chapter 8: Attitudes to a Trial) suggests that the community is ready to consider widening the range of opioids available to dependent drug users. However, this should only be done if the evaluation of such a policy is rigorous and will stand up to scientific scrutiny. The most rigorous way to evaluate new options for treatment in medicine is to conduct a randomised controlled trial.

The long acting opioid, methadone, is currently available in oral form through medically supervised programs for treatment of drug dependent individuals in Australia. These government supported programs are broadly acceptable to the community and have successfully returned many heroin dependent people to productive roles in society. They do not suit all drug dependent clients and attract only a small proportion of drug users to treatment. Methadone maintenance is the "gold standard" against which any proposed new treatment must be compared. If there is to be an expanded range of opioids available for treatment of dependent individuals, we need to demonstrate that this provides benefits that are not available through methadone treatment. The randomised controlled trial is the most powerful scientific method by which to make such treatment comparisons.

Fragmentary evidence from centres in Britain, where an expanded range of opioids is available in controlled fashion to dependent users, suggests that benefits could follow an expansion of the therapeutic regimen to include heroin in oral, smokable and injectable forms and methadone in injectable and smokable forms (see Chapter 2: Literature Review: Arguments For and Against Changing the Availability of Opioids; Chapter 6: Options for A Trial - the Marks/Parry Program). The evidence available from these centres is open to challenge because of the types of evaluation conducted; a randomised controlled comparison provides much stronger evidence. Before embarking on widespread or continuing use of a treatment which many Australians perceive to be risky, we need hard evidence of its superiority.

The only reason not to undertake a randomised trial would be if such a trial were prohibitively expensive, or logistically or ethically impossible. Stage 1 of the feasibility study shows that the legal and ethical issues associated with a trial do not prohibit it, but that more work needs to be done on some logistical issues. The questions a trial could answer are important enough to justify its cost. It could materially assist the evaluation of policy options, not only for the ACT and other Australian States and Territories, but also internationally. We believe there are features of the ACT which make it an ideal location to undertake a trial.

Apart from the limitations of a randomised controlled trial with regard to the questions that can be addressed, the other disadvantages of this method are:

• There is the potential for disruption of the trial by forced or voluntary sharing of opioids by people on the trial with

people in the control group or outside the trial.
- There is potential for ill-feeling in the control group, which may disrupt social and other networks and therefore make trial outcomes difficult to interpret.
- It is possible that there may be a 'disappointment effect', i.e. people who are not successful in gaining admission to the opioids group may change their behaviour in ways which may not have occurred otherwise, again making trial outcomes difficult to interpret.
- It may be difficult to retain the control group.

Participants: logistics and numbers

Participation will be restricted to bonafide residents of the ACT and will be open to all volunteers who meet strict eligibility criteria and who give their informed consent to the aims and procedures of the trial.

Stage 2 of the feasibility study should consider the upper limit of numbers of participants enrolled in the study. It should determine if there are special issues which prevent the inclusion of pregnant women, people who are HIV positive and people under 18 on a trial where allocation is random. It should also consider the question of whether, in circumstances where two or more members of a family or household are volunteering to participate in the trial, the household or the individuals should be treated as the unit of randomization. There are potential problems if two residential partners have access to totally different treatment regimes, but they are not insurmountable.

We cannot at present estimate with confidence how large a population would be involved in the trial because of uncertainties about the size of the dependent drug using community in Canberra (see Chapter 1: Illegal Drug Use in Canberra) and the extent to which they are likely to volunteer to participate in such a trial. Our best estimate at present is that each treatment arm might, after one year of the study, have as many as 300 dependent users. The study would be following each of these 600 people carefully to monitor their outcomes in relation to each of the stated study questions. (These estimates would be progressively refined in later stages of testing feasibility and piloting for the trial.)

During Stage 2 careful consideration needs to be given to the numbers needed to reliably detect changes for each of the outcome measures.

Existing treatment services will need to continue as before the trial for dependent users who are not eligible to enter the trial, or who do not agree to the trial procedures.

Supplementary questions

The following questions could be grafted on to a randomised control trial and answered using supplementary evaluation methods. These questions are not as central to the overall aim of the trial and determination of the best evaluation strategy should be an important task for Stage 2. The range of potential strategies is listed in Addendum 2.

Can such a treatment program bring into treatment illicit opioid users who have not sought treatment before, and can it maintain clients in treatment for a longer time? How satisfied are participants and workers with the program?

Can such a treatment program have measureable benefits to society at large, in terms of reducing the level of drug-related problems and the social and economic costs of drug use?

Would such a treatment program be cost-effective?

Would such a treatment program have major impact on existing drug treatment services and on law enforcement?

A range of variables which could be collected to answer these questions are listed in Addendum 1. It is anticipated that only a selection, determined in Stage 2, would be used.

An independent evaluation team

The treatment aspects of the trial would most likely need to be under the control of ACT Drug and Alcohol Services personnel. They would need to cooperate actively with an independent team whose task would be to ensure that the evaluation activities, including the design of the study are rigorously maintained. The evaluation team would design data collections across a range of issues which include both the impact of the trial on individuals and the ACT community. The size and terms of reference of the evaluation team would be determined as part of the Stage 2 feasibility study.

Conclusion

We have presented only an outline of the evaluation task. During the Stage 2 feasibility study, a series of important details of the study design would be decided. Evaluative instruments would be designed, and pretested. Firmer estimates of the size of the eligible opioid dependent population would be made, which would permit a clearer specification of the logistics of the study, and its budgetary requirements. We have not seriously begun to develop the economic side of the evaluation, having concentrated most of the initial effort on development of an acceptable trial model. Development of an economic evaluation procedure is an essential part of the Stage 2 exercise.

Good evaluation does not come cheaply. But in a field as contentious as this one where the costs of current policies are often estimated in the billions of dollars and the thousands of wasted lives, careful and scientifically credible evaluation is fundamental.

Our preliminary investigation of the issues involved in evaluation leads us to believe that a randomised controlled trial in the ACT is feasible. We would also argue that the questions which such a trial could answer are important ones. To answer them will require a substantial commitment by the ACT community and by its political representatives. To bring a trial of the kind described here to a successful and informative conclusion is well within the capacity of the ACT, and would be an important contribution to the local, national and international debate on these matters.

ADDENDUM 1

Outcome measures

Trial Participants

One of the conditions of their participation would be that trial participants would have to agree to collection of relevant information about their medical, social and environmental circumstances both at the time of their acceptance onto the trial, and at six monthly intervals after their enrolment in it. These data would remain confidential to the evaluation team and would be subject to legal privacy and confidentiality constraints which might require special legislative protection as part of the study.

Drafting and pretesting of data instruments will be part of the Stage 2 feasibility study. A list of items from which the variables to be studied will be chosen is given in Table 1. It is important to recognise that many of these variables are difficult to measure, and that there will be a limitation on the information that can be collected from individuals. Further, both opponents and proponents of the trial should be involved in deciding (in consultation with the researchers) which variables should be measured. A further consideration will be whether or not changes can be reliably detected within the time frame for the study and with the number of people participating.

Extensive pretesting of questionnaires and interviews will be required both in the Stage 2 feasibility and the Stage 3 pilot phases.

Table 1

Information collected on each individual would include a <u>selection from</u> the variables listed below.

general medical health, including gastro-intestinal disorders and venous disorders
mental state (emotional, anxiety, psychological, psychiatric)
HIV status
hepatitis B and C status
HIV and hepatitis sexual risk behaviours
HIV and hepatitis injecting risk behaviours
HIV risk knowledge
other infections and problems caused by use of injecting equipment
needle fetishes
morbidity and mortality (including overdoses) caused by using trial drugs
morbidity and mortality (including overdoses) caused by using non-trial illegal drugs (including those caused by adulterants)
illegal drug use, including amounts, routes of administration, contexts and settings
level of dependency on opioids
use of health services for both drug-related and non-drug related reasons
use of drug treatment agencies
experience of treatment offered by health services
experience of treatment offered by drug treatment agencies
prescription drug use, including amount, route of administration and diagnosis
alcohol consumption
tobacco consumption
driving under the influence of alcohol or other drugs
nutritional status
dental health
respiratory diseases
sexually transmitted diseases
libido and fertility
general gynecological/obstetric effects (for women)
effects on ante- and post-natal care and effects on infants (for pregnant women)
imprisonment and associated health risks
physical violence (both perpetration of and suffering the effects of)
sexual violence (both perpetration of and suffering the effects of)
accidents, including workplace, home and road
criminal behaviours, including shop-stealing, breaking and entering, fraud, traffic offences, possession of drugs
contact with legal services, including Legal Aid, Probation Board, courts and police
prostitution
self esteem
friendships
housing, homelessness, residential stability
employment
changes in economic status, including finance-related stress, amount of money spent on drugs, amount of money spent in other ways
relationships with spouse or partner, children, other family members
effects on child abuse (physical, sexual, emotional, neglect)
education
leisure activities
general lifestyle stability
contact with welfare services, including unemployment benefits, counselling services, aid organisations

The ACT Community

The Stage 2 feasibility study will develop mechanisms to monitor the impact of the trial on the ACT community. Optimally, similar data would be obtained from other Australian communities to serve as a source of comparisons between the trial community and areas where opioids continue to be more restricted in their availability. Issues which could be studied in this part of the evaluation are included in Table 2.

Table 2

Possible issues to be considered in an evaluation of the impact on the community will include a selection from the following:

prevalence of HIV/AIDS
prevalence of hepatitis B and C
HIV risk behaviours in the general community
needles discarded in public places, including number, location, and who found needles
prevalence of sexually transmitted diseases
physical and sexual abuse
use of health care and drug treatment services
number of people using illicit drugs, both opioid and non-opioid
number of new people using illicit drugs, both opioid and non-opioid
availability, purity and price of illicit drugs, both opioid and non-opioid
illicit drug suppliers
diversion of trial drugs
migration of drug users into the ACT
attitudes and behaviours of users not on the trial
crime
general community attitudes to the trial and to illegal drug use
corruption
prostitution
contact with legal services
backlog of court cases
contact with welfare services
drug-related absenteeism

Other Effects (on families and significant others of trial participants, drug treatment services, workers on the trial and the law enforcement community)

If the trial is to be policy relevant, it must provide evaluative data in each of these areas. For each of these four groups there are ethical, logistic and practical issues which will need to be considered and measured. Instruments will be developed during Stage 2 to measure some of the items listed in Table 3.

Table 3

A list of items and issues for which measurement instruments may be developed during Stage 2 Feasibility.

a) family members and others close to the participants:
. the quality of the relationship, including violence,
. their perceptions of the general health of the trial participant,
. use of non-trial drugs (both legal and illegal) by the trial participant and the family members,
. their perceptions of the criminal behaviour of the trial participant,
. their perceptions of general lifestyle changes for the trial participant, including housing, employment, and effects on other relationships.

b) drug treatment services:
. the number of new and existing clients seen by each service as well as the type of problems the clients have,
. impact on service providers
. service funding issues.

c) workers on the trial:
. staff morale, job satisfaction, relationships with clients, problems with users who are not on the trial and with

people in 'control' groups,
. needle-stick injuries and other health impacts directly associated with trial procedures,
. staff views of the trial, particularly its efficacy and suggested modifications.

d) the law enforcement community (this would include police, corrective services staff and the judiciary):
. needle-stick injuries and other health impacts directly associated with trial procedures,
. staff views of the trial, especially effects on their own work, and suggested modifications.

ADDENDUM 2

Supplementary methods to be considered

There are essentially four strategies which may provide useful supplements to a randomised controlled trial. They are:

- comparing outcome measures for participants and the community during and at the end of the trial with measures taken at the beginning of the trial;
- comparing the trial participants with clients drawn from a current treatment population;
- comparing trial participants and the Canberra community with opioid users and the community in a different city;
- using the innate town centre structure* of Canberra to make the trial available to users in one town centre and compare them and the town centre community with users and the community in another town centre.

Some of the limitations listed earlier for the randomised controlled trial also hold for most of these supplementary methods.

Difficulties with each of these methods are outlined below.

The difficulties with comparing outcome measures for the same individuals before, during and after a trial are that the effects of changes impinging on outcomes but unrelated to the trial cannot be controlled for and that the collection of retrospective data (to obtain the 'before' measures) may be unreliable.

The difficulties with comparing the trial participants with clients of current treatment programs are that the outcomes may be affected by self-selection or referral bias and/or by program differences. For example, self-selection bias would result if the type of people who opted for inclusion on the trial (or were referred to it) were very different from those who opted for (or were referred to) other treatments. Program differences refer to differences in the way a trial was run, compared with the way other treatments were run. An example might be if the consequences of continuing to use other illegal drugs had no effect on inclusion on the trial but led to being excluded from other treatments.

The difficulties with comparing trial participants in Canberra with opioids users in another city are that there will always be important differences between two localities and it will never be clear if differences in outcomes result from the trial or from the differences in locations. This strategy is also likely to be the most expensive because of the need for liaison to overcome logistic problems.

The difficulties with using the innate town centre structure of Canberra to make the trial available to users in one town centre and compare them with users in another town centre are that users living in different town centres may not be completely comparable, users may not be evenly distributed across Canberra's town centres, and that users are likely to move to have access to trial drugs.

* Canberra has four town centres - Civic, Belconnen, Woden and Tuggeranong. Each has a major shopping centre and some other services are also specific for each town centre.