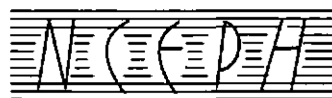
SEMINAR PROCEEDINGS

Heroin Treatment - New Alternatives

Ian Wark Theatre
Becker Building
Canberra

1 November 1991

NATIONAL CENTRE FOR EPIDEMIOLOGY AND POPULATION HEALTH



AUSTRALIAN INSTITUTE OF CRIMINOLOGY

HEROIN TREATMENT - NEW ALTERNATIVES

Proceedings of a Seminar held on 1 November 1991
Ian Wark Theatre, Becker House, Canberra

Edited by
Gabriele Bammer & Grayson Gerrard

IN COLLABORATION WITH

Heroin Treatment - New Alternatives

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Opening Address

Bob Douglas MBBS MA MD FRACP FRACGP FAFPM
Director, National Centre for Epidemiology and Population Health

Today's meeting is being co-hosted by the National Centre for Epidemiology and Population Health, the Australian Institute of Criminology and the National Drug and Alcohol Research Centre in Sydney. The meeting has been assisted by a grant from the ACT Government, which has a serious interest in the questions that we are exploring today. The theme of the meeting is Heroin Treatment - New Alternatives, and I want at the outset to give a particularly warm welcome to three overseas guests who have made the trip especially for today's discussions: Commander Bob Visser from the Municipal Police Force in Amsterdam; Commander Roy Penrose from New Scotland Yard; and Detective Constable Mike Lofts from the Cheshire Police. They have a particular contribution to make to this afternoon's discussions when we move from the health and medical issues to the social, law enforcement and legal issues.

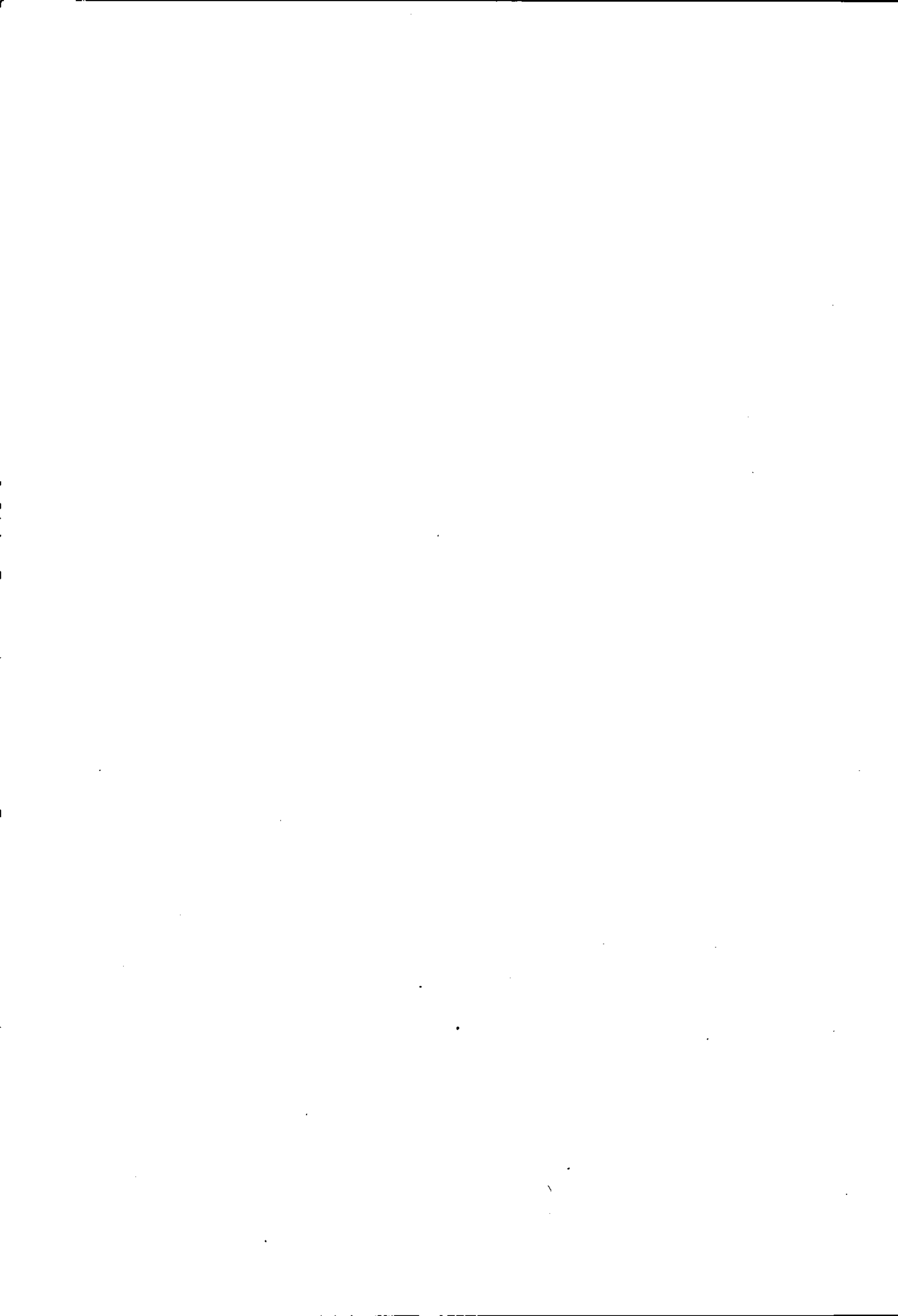
As a complete coincidence, our meeting is on at the same time as an international meeting on drug law enforcement in Canberra; we only discovered the coincidence this week. The two meetings obviously have issues in common: both are prompted by wide international concern that strategies for the treatment and control of substance abuse are failing and that we need to constantly reappraise what we are doing about a problem which costs societies in every part of the world enormous misery, massive dollars and wasted lives.

The meeting today grows out of a study conducted jointly by the National Centre for Epidemiology and Population Health and the Australian Institute of Criminology in the early part of this year. That study was prompted by an invitation from the Chairman of the ACT Legislative Assembly's Select Committee on HIV, Illegal Drugs and Prostitution - Mr Michael Moore - who invited us to examine the feasibility of a trial of the controlled availability of opioids in the ACT. Dr Gabriele Bammer, who directed that investigation, will be setting the scene for us by describing its conclusions at the outset of the day's discussions. We hope that from that baseline we can move forward in the course of the day to explore the implications of those conclusions and to discuss whether or not it is appropriate to extend the feasibility study to the next stage.

So our objective today is to explore the medical, health, social and law enforcement implications of evaluating, in the ACT, new approaches to the treatment of heroin dependent individuals. Drug policy is a highly political issue, any action to change the way we manage drug dependent people in the ACT has political implications for the ACT and for other parts of Australia as well. So I am delighted that we have representatives from drug and law enforcement agencies from most states of Australia here today and that many of the people who will frame attitudes to the proposed ACT trial will have an opportunity to discuss these issues in an open and uninhibited way.

The participants in today's discussion include a representative from the Australian Medical Association; the Chief Medical Officer of the Commonwealth Department of Health, Housing and Community Services; the Chairman of the Committee on AIDS Research; senior researchers in drug matters; police representatives from the UK and Amsterdam; a leading Australian criminologist; and a panel representing a broad range of interests who we believe have something important to say on the matters relating to such a trial.

I warmly welcome you once again and now invite Dr Gabriele Bammer, a Research Fellow at the National Centre, to outline for you the findings of the first stage of the feasibility study which was completed earlier this year.



Overview of Feasibility Research into the Controlled Availability of Opioids

Gabriele Bammer BSc BA PhD
Coordinator, Feasibility Research into the Controlled Availability of Opioids, National Centre for Epidemiology and Population Health

The work which I will be outlining this morning was carried out by a team which involved, for greater or lesser periods of time, 21 people (see Acknowledgements) and I had the privilege of coordinating their dedicated efforts. The research was conducted in collaboration with the Australian Institute of Criminology. It resulted in a two volume report (NCEPH, 1991) which I will briefly summarise. The topics covered included: an overview of illegal drug use in Canberra; a review of arguments for and against changing the availability of opioids; the political context of the Australian debates about drug policy; interest groups and social controversies; legal issues; possible options for a trial; ethical issues; attitudes to a trial; evaluation by a randomised controlled trial; and models of drug use. Valuable information was provided by a Reference Group of over 60 leaders in the field. A small Advisory Group had oversight of the whole process and provided expert guidance. The people involved in those two groups are also listed in the Acknowledgements.

We had two essential aims. The first was to determine if a trial to provide opioids, particularly heroin, in a controlled manner was feasible in principle. If we found that it was, the next aim was to develop a proposal for the structuring of such a trial.

We envisaged that this would be the first of a four stage process; a process where a decision to continue or stop would be made at the end of every stage. The second stage, which I will talk about at more length later, would involve thoroughly examining the logistic feasibility of the proposed trial. If it was found to be logistically feasible, the third stage would be a small pilot study and only if that was found to work would a trial be conducted.

IS A TRIAL TO PROVIDE OPIOIDS IN A CONTROLLED MANNER TO USERS FEASIBLE IN PRINCIPLE?

We began with a broad approach which allowed for a range of possibilities for a trial and essentially we did two things. First, we examined the potential benefits and costs of changing the controlled availability of opioids. Second, we examined closely the barriers and constraints which would determine whether or not a trial should go ahead and which would determine its shape if it did.

The potential benefits and costs were examined by working through the voluminous literature which has been written on this and associated topics. Commentators have suggested a range of potential benefits and a somewhat smaller number of potential costs (Table 1). However, some important cautions must be attached to this. First, much of what is listed on both sides of this table is based on what can best be called "armchair theorising" and is hotly disputed. Second, those challenging the status quo have been much more prolific commentators than those defending it and have put a stronger case. It may be that they in fact have a stronger case, or it may be that those supporting the status quo do not feel challenged enough to defend it as strongly.

Table 1. Potential Advantages and Disadvantages of a Trial of the Controlled Availability of Opioids

Potential advantages	Potential disadvantages
↓ spread of HIV	wrong message especially to children
↓ crime	↑ accidents - work and traffic
↓ dealing	no incentives for users to give up
↓ corruption	↑ number of users
↓ use	
improve health and well-being	
improve lifestyle	
alleviate overloading of courts and prisons	
↓ costs of policing	

There is a small amount of empirical evidence which has direct bearing on these questions and which essentially suggests that important benefits can result from treatment programs which involve controlled availability of opioids:

• research by Hartnoll and co-workers in London in the 1970s (Hartnoll et al, 1980). They compared people in treatment for heroin dependence, where one group received oral methadone and the other injectable heroin. Both treatments had advantages in some areas and disadvantages in others. Those users given oral methadone tended to polarise towards the extremes on a number of measures, whereas those given heroin tended to fall in intermediate categories. In particular, the users assigned to oral methadone were more likely to either be abstinent or nearly so, or to be injecting larger quantities of illicit opioids than people in the heroin group. There was a similar pattern for involvement in drug-related activities and in dependence on crime as a major source of income. The arrest rate in the methadone group was higher, as was drop-out from treatment (about half of the drop-outs did so because they had become abstinent). There were no differences between the groups in their consumption of non-opioid drugs, employment or health. For the heroin group there were few major improvements in their health or social conditions compared with those when they were dependent entirely on an illicit supply of drugs. This work was done before HIV/AIDS became an issue.

• evaluations of the Marks/Parry program in Mersey including the work conducted by Cindy Fazey. In the report of the Stage 1 study we compiled a range of evidence from this program that prescription of controlled substances (heroin, amphetamines, cocaine etc) has beneficial outcomes both for users and the community. However, on the whole, the evaluations have not been rigorous enough to be conclusive. We are very fortunate today to have with us DC Mike Lofts to give us the latest information on this program.

• the information we were able to gather about the policy in the Netherlands of normalisation. This is about reducing the stigma of dependence and helping users function better in society. Commander Bob Visser will be talking more about that this afternoon.

As well as that, we looked at a range of Australian government-sponsored enquiries into drug-related issues. While their considerations have been broad ranging, they have all come up with two basic conclusions. One was that we need a more informed debate in Australia (and that is partly what today's seminar is about) and the other is that we need a lot more empirical evidence on which to base that debate.

Next, we looked at the constraints on a trial, particularly legal, ethical and attitudinal issues.

On the legal side there are three important aspects. One is our international treaty obligations. They are not a barrier to the conduct of a trial but they pose significant constraints on how a trial might be structured. Australia would not be in breach of its international treaty obligations if a trial was conducted for medical or scientific purposes. A second aspect is the Commonwealth which controls the importation and manufacture of narcotic goods and has extensive powers in relation to therapeutic goods. There would need to be a number of licences and permissions granted and the Commonwealth would need to notify estimates of heroin importation to the International Narcotics Control Board. Again this need not be a significant barrier. Third, there would need to be legislative change in the Australian Capital Territory and probably in other states of Australia. In summary, a range of legal or related changes would need to be made for a trial to go ahead, but these changes are feasible if there is political will.

We found that there were a number of ethical considerations which affect the shape of a trial, but again no significant barriers. We would advocate that ethical monitoring needs to be on-going through Stage 2 and beyond.

As far as attitudes are concerned, we felt that it was very important to look at what we consider to be the four key players in the area, namely the community, the police, people who provide services and/or treatment to users, and users and ex-users. They were asked a very broad question:

Some people think there are so many problems caused by illegal drug use that something new urgently needs to be tried. They would say 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.

Do you think that a trial should go ahead or that a trial should not go ahead?

The results are shown in Table 2.

Table 2. Opinions on Whether or Not a Trial should Go Ahead from the General Community, Police, Service Providers and Users and Ex-users

	%General Community	% Police	% Service Providers	% Drug Users/Ex-Users
Should go ahead	66	31	71	76
Should not go ahead	27	63	19	14
Don't know	7	7	9	10
Number of Respondents	516	446	93	133
% Response Rates	77	40	38	25

A randomly selected sample of the community was surveyed by telephone and of the 500 people interviewed two-thirds thought that a trial should go ahead. We compared the demographic characteristics of our sample with what we know about the Canberra population from the Australian Bureau of Statistics and found that our sample was fairly representative, except that it was more highly educated.

Police, service providers and users/ex-users were surveyed using self-completion questionnaires. In all groups the response rates were much lower and we are less certain about how representative the samples are. We know that our police sample over-represented older people, men and sergeants (constables were under-represented) compared with all ACT-based police. The service providers who responded to our survey were younger than service providers as a whole and we have no idea about the representativeness of the user/ex-user sample. For each of these groups the response rate is calculated as the number of questionnaires returned over the number we know were handed out. The majority of police did not support a trial, but the majority of service providers and users/ex-users did.

We also asked these groups a number of questions about how a trial should be conducted. I do not have time to go into those issues now, but they also informed our considerations.

We decided that it is important to know if the ACT community is alone in being supportive of a trial. We have recently done a survey in Sydney and Queanbeyan, again by telephone and selecting a sample randomly. Of the Sydney population 58% supported the notion of a trial. The Queanbeyan population was rather more evenly divided between supporters and opponents (Table 3).

Table 3. Support for a Trial by the Sydney and Queanbeyan Communities

	% Sydney	% Queanbeyan
Should go ahead	58	43
Should not go ahead	34	46
Don't know	8	10
Number of Respondents	521	214
% Response Rates	61	74

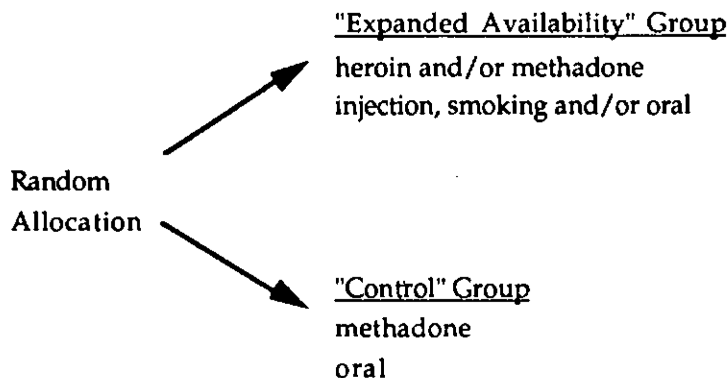
Overall, our conclusion was that a trial is feasible in principle. We recommended that a second stage of feasibility investigations, namely to examine logistic issues, should be undertaken. We developed a specific proposal as the starting point for those investigations and I want to discuss that briefly now. The underlying aims of a trial should be to improve treatment options for heroin dependent people.

HOW SHOULD A TRIAL BE STRUCTURED?

I want to emphasise that this is the first stage of a specific proposal which is being put up as a basis for further discussion and research. The final proposal may well look quite different. The other thing that it is important to make clear is that a move to Stage 2

would not involve the administration of heroin or other currently illicit opioids and it would not involve legislative change.

The key element of the proposal is that it would be a randomised controlled trial. People who meet eligibility criteria would be randomly allocated to one of two groups. One group we have called an expanded availability group, which would have a choice of heroin and/or methadone and three routes of administration - injection, smoking and/or oral. The second group would receive oral methadone only; that is "the gold standard" for treatment now. This is diagrammatically represented below.



The main questions to be tested with a trial such as this are:

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 stable 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?

We also recommended that methodologies should be developed to address a number of other questions:

• 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 than currently available programs? How satisfied are participants and workers with the program?

• Can such a treatment program have measurable 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?

• Can such a treatment program improve relationships and lifestyle from the point of view of family members and others close to trial participants?

• Would such a treatment program have a major impact on existing drug treatment services and on law enforcement?

We recommended that a trial should run for two years.

Our intial proposal, which we expect to be modified during Stage 2, is that:

• a trial should be restricted to dependent users

• there should be a register and some sort of identification system for trial participants

• the drugs should be administered at the distribution points and should not be allowed to be taken away

• trial participants should be allowed to have, at a maximum, three doses of heroin per day

• there should be a regular review process for people on the trial, where they would be encouraged to move to less dangerous practices. This means that they would be encouraged to use less dangerous drugs and to stop injecting and try using oral or smokable forms of administration

• trial participants should be encouraged to use counselling and other forms of treatment

• social functioning of trial participants should be regularly assessed and they should be referred to other services like housing and welfare as needed

• participants should not be required to pay for trial drugs

• there should be sanctions against the diversion of trial drugs

• continued use of street drugs should continue to be illegal but it should not be a barrier to participating in a trial

• at the end of the trial all participants should have oral methadone available to them.

Each of these suggestions has advantages and disadvantages which I do not have time to go into here. They are presented in some detail in Volume 1 of our report and need to be carefully researched and thought through as part of the Stage 2 process. It is likely to take 12 months to conduct Stage 2.

There is a significant amount of research which still needs to be conducted and I will outline that very briefly. In addition, there are a number of administrative issues and issues concerned with the day-to-day running of a trial that need to be looked at very carefully, but which I do not have time to go into here.

The research which needs to be conducted includes:

• a reliable estimate of the numbers likely to apply for trial participation (our preliminary investigations indicated that we might get as many as 600 people, but this needs to be looked at much more carefully)

• more reliable information about users' injecting behaviours

• the number and variety of drugs heroin users tend to use

• an evaluation of hair analysis as a way of monitoring drug use

• an examination of the effects of heroin and other opioids on driving

• an evaluation of naloxone eye drops as a way of assessing whether or not people are dependent opioid users

• examination of a range of issues concerning the smoking of heroin and other opioids

• more reliable information about the effects associated with the development of tolerance

• development of methodologies to measure outcomes, assess cost-effectiveness, measure incentive effects (ex-users starting to use again and non-dependent users becoming dependent in order to qualify for a place on a trial) and to be sensitive to unintended negative effects

• continuing assessment of community and key stakeholder attitudes, especially when a specific proposal is more fully developed.

CONCLUSIONS

In conclusion, it is clear that a trial such as the one proposed is not without problems. An attempt has been made to deal even-handedly with both the advantages and disadvantages of the strategy outlined, so that informed decisions can be made about the desirability of proceeding further. We believe there is a case for proceeding to the next stage.

The consequences of a decision not to proceed need to be considered carefully. The reasons which led to the enquiry remain and we have identified considerable community support for new approaches to the problems. Our study has unquestionably raised expectations in some quarters that change is a serious option.

Stage 1 has established a precedent for consultation with the community, police, relevant service providers and illegal drug users. For an issue as contentious as this, continuing consultation with all of these groups should be a central pillar for decision making.

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Discussion

BOB DOUGLAS, CHAIR

One of the important elements of today's meeting is the constitution of the audience, which in fact represents people from law enforcement, from legal, from medical, from health, from drug and alcohol services, and from academia. I invite you now to put questions to Dr Bammer and/or make comments about the current situation.

IAN WEBSTER
DRUG & ALCOHOL SERVICE, SOUTH WESTERN SYDNEY AREA HEALTH SERVICE

I'm involved in managing methadone programs, and actually it is very difficult. The day to day management of a methadone program is really a tough game, and the staff that get involved in it are nursing staff operating at the front line level with people who are sometimes quite difficult to handle. The question I'd like to ask is whether that group of people - the nurses, the actual providers at that point of contact with patients/clients - have been asked about the feasibility and the issues which might arise out of a program such as this?

GABRIELE BAMMER

The group that we've called service providers included a range of people who are involved in providing services to those who use drugs. That included nurses, counsellors and medical practitioners, the whole gamut of people.

PETER BAUME
SCHOOL OF COMMUNITY MEDICINE, UNIVERSITY OF NSW

What you're really trialling is a comparison of methadone treatment with the kind of treatment you've described - the controlled availability of opioids. It seems to me that many people would like to know whether what you are trialling is better than what exists for people in the community who don't have access to methadone. Obviously, you would have considered this. Was it just logistically and methodologically too difficult to do this? And will you get enough information from your comparison of methadone treatment and the controlled availability of opioids to draw some more general conclusions?

GABRIELE BAMMER

There is a large range of questions that it would be really nice to answer in a trial, but it is important that we focus more narrowly on something that we can get good conclusive answers to. One of the best methodologies we have available is a randomised controlled trial. To do that, it's important to have a standard to measure against. The best available treatment now for heroin dependent people is methadone, and what we want to see is whether this is better than the best that we can already provide. If it isn't, then there is probably no point in doing it. There are some subsidiary questions to that, one of which I think is important, and that is: is offering heroin a better way of bringing people into treatment, a better hook, and a bait that will keep them in treatment for longer?

KEITH POWELL
ALCOHOL & DRUG SERVICE, WODEN VALLEY HOSPITAL

When reading the Stage 1 report, there is reference in it frequently to the fact that certain issues will be further discussed and probed in Stage 2. Given that earlier on it was thought that Stage 2 might, if it goes ahead, take six months, and you're now referring to 12 months, do I take it that really any of the issues that are raised in the recommendations of Stage 1 are up for still further consideration in Stage 2?

GABRIELE BAMMER

The whole idea of Stage 1 was to see whether it was feasible, in principle, to do this, and if there were significant barriers around doing it, and what the constraints would be. We have identified that there are some real advantages to going ahead with the trial and that there are no major barriers that couldn't be overcome if there was a will to overcome them, but that there are a number of constraints. And those constraints have shaped the proposal that we've put forward. It's that side of it that needs a lot more investigation, and the logistics of doing it, and there's a whole lot of information that we don't have that needs to be gained before a trial design is actually set in concrete.

GREG WHELAN
ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS

One of the disadvantages, as I see it, of the trial as it's set out at the moment is that heroin is a relatively short acting drug, and I notice that you've built in a maximum of three injections per day. Was any consideration given to a longer acting drug? Maybe something like buprenorphine to get around that particular problem of people perhaps topping up because they aren't getting enough injections?

GABRIELE BAMMER

We did think about it, but heroin is really the "magic drug" as far as users are concerned and it's the one that's likely to bring people into treatment. One of the things that we think needs to be looked at much more carefully is how many times do users in fact inject? There is some information that says that most users only inject two or three times a day anyway. Is the information we've got good enough? And how do users deal with the short acting nature of heroin when they are using street drugs which are impure, not very high dosage, and all those sorts of considerations? And also how do they deal with the development of tolerance? What we've put forward is a proposal that is a starting point. There are a number of caveats around it. We have identified clear research issues that we need now to look at, clear administrative issues that we need to look at, and how we're going to structure a service if there is administration of drugs three times a day etc etc. It gives us the starting point that we can then build a whole lot of issues around, do some thorough investigation, and then decide exactly what it is that we're going to propose. That's the whole way that we've conceived Stage 2 working.

ADRIAN REYNOLDS
QUEENSLAND DEPARTMENT OF HEALTH

We have a fair experience with an intravenous methadone program - a small program, as you will be aware, in Queensland. One of the first issues that I think you will naturally need to look at in Stage 2 is the issue of resources. We have noted that many of our patients on the intravenous program take up to half an hour to find a vein, and often at least ten minutes to a quarter of an hour. Now having 600 patients will in itself present, I would suggest, considerable logistical problems. No doubt you will look at that, but have you considered it already, and what are your conclusions?

GABRIELE BAMMER

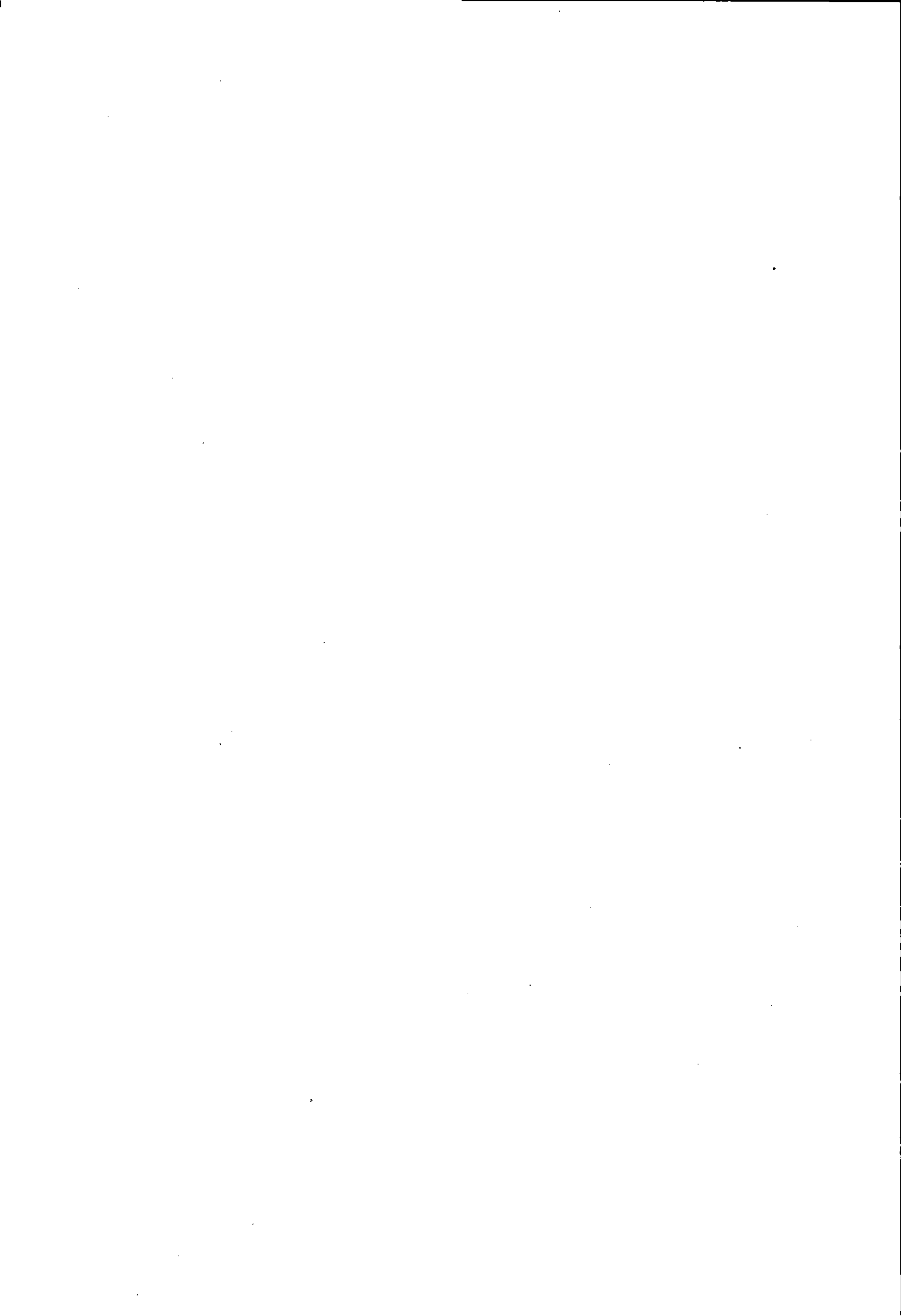
Again it's the same issue. The Stage 1 proposal gives us something to start with. OK, if we're going to work on a program that has 600 people, that leads - as you said - to certain administrative issues that need to be thought through clearly. It gives us a number to start with, and we might find that it's logistically impossible to deal with that many people, but it's much easier to figure out logistical issues if you've got something to start with, and then you can build out from that. The advantage of having lots of people on a trial is that it gives you much clearer outcome measures. The disadvantage, as you pointed out, is that there are a whole lot of administrative issues - people not being able to find veins, and so on - which make it difficult to process that number of people in a day. And those two things need to be balanced against each other, and you need to find the best solution to all of those particular concerns.

GAVAN CASHMAN
ACT ATTORNEY-GENERAL'S DEPARTMENT

My question in a way follows on from the one previously asked. Is 600 the estimated number of users in the Territory minus dependent users? And if the answer to that question is "yes", how do you distinguish dependent users from non dependent users? Is it feasible to do that?

GABRIELE BAMMER

It's rather difficult to get an accurate estimate of how many users there are in the ACT. The range is somewhere between 72 and 2,000 dependent users, and 720 and 8,000 non dependent users. The best estimate that we can come up with at this stage is that there are about 1,000 dependent users in the ACT, and we've assumed that maybe we could attract about 600 into treatment. That is the first part of your question. Distinguishing between dependent and non dependent is an interesting issue because they're not two concrete states, they're fluid states. Users move in and out of dependence, but it's an issue that methadone programs deal with all the time and there are some fairly well worked out standards that can be used to determine what sort of people you're going to admit on the trial. Clearly you wouldn't admit people who were only injecting on weekends, and one of the advantages of looking at things like hair analysis and naloxone eye drops is they might be able to give us some more criteria for assessing people.



Some AMA Views on Treatment of Heroin Dependence

Peter Wilkins BA MBBS MHP FRACMA FACOM FAFPHM
Australian Medical Association
(replacing Dr Bruce Shepherd)

I am Assistant Secretary General for the Australian Medical Association so I am one of its employees. Unlike the President, I am not in a position to express personal views on behalf of the AMA. I am constrained to report policy decisions taken by the AMA. My particular portfolio of interests with the Association reflects my background in medical administration and in occupational and public health.

While the AMA has a number of policies concerning drug related problems, it has not so far considered specifically the matter of opioid supply in the treatment of heroin addicted patients. However, on the basis of its extant, formal policies, it is possible to deduce the position I believe the Association would take on this.

The AMA is an extremely democratic organisation of almost 20,000 Australian doctors. It represents about half of all medically registered persons in Australia, and well over half of all those in present clinical practice. Its Federal Council is the AMA's supreme policy making body: the Federal Council itself is constituted of representatives from each of the eight Branches, representatives directly returned from six areas, representatives of ten Special Interest Groups (major specialties etc.) and an Executive elected at the Association's Annual Conference. Given its composition, the AMA believes it is the body most representative of the mainstream opinion of Australia's doctors.

Just on two years ago, because of its concern over illegal drugs and whether or not there were societal benefits to be gained from their legalisation, the AMA co-sponsored a summit with the Australian Doctors Fund. That summit - Drugs, the Law and Medicine - was held in Sydney and examined this matter over a period of two days. The summit, overall, did not favour legalisation including legalisation of heroin for the treatment of dependence. There was a very considerable proceedings of 150 or so pages published from that ADF/AMA meeting. I think probably the most significant thing that I found in reviewing those proceedings was the comment made by Dr Stephen Jurd, Director of the Drug and Alcohol Program at Royal North Shore Hospital in Sydney. In relation to the question of whether or not heroin substitutability should be allowed in methadone programs, Jurd pointed out to the Conference that "methadone, with its longer half-life, is pharmacologically superior and allows addicts a better lifestyle".

The AMA formally adopted policies in 1987 that bear on this matter. They are:

"The increasing misuse of and addiction to drugs other than tobacco and alcohol require flexible and comprehensive strategies directed at reducing demands for such drugs.

Law enforcement measures to combat illicit drug trafficking and other drug related crimes must be intensified and become more efficient.

Changing the attitudes of society to drug use through educating and influencing the young will be much more effective than law enforcement in the long term in controlling the growing problem of drug misuse.

Intravenous drug users require education emphasising the dangers of overdosage and disease transmission.

The quantity and quality of services provided for the victims of drug abuse must be improved.

A range of treatment and rehabilitation services should be readily accessible for drug abusers."

Thereafter the matter was considered again by the first National Conference of the Association held under its new constitution in 1989. A major forum discussion on "The Law and Drugs of Addiction" was sponsored by that conference, and a background briefing paper setting out the "for" and "against" cases was prepared for that forum by an independent body in Sydney, Diagnosis Pty Ltd, headed by Dr John Best. Dr Best is an authoritative and highly respected commentator on Australian public health matters. He was Foundation Editor of Australia's (and indeed probably the world's) leading magazine or periodical addressing medical quality assurance matters - the Australian Clinical Review, jointly published by the Hospital Standards Organisation and the AMA. Best gave up that editorship a year or so ago, after ten years, and has since been appointed Foundation Editor of *Snow's Field*, the magazine produced by the Australian Faculty of Public Health Medicine.

Dr Best dealt only tangentially in his briefing paper (as indeed did the National Conference) with the specific matter of treatment of heroin addiction as now proposed. Without too greatly compressing Dr Best's paper, I believe it fair that the balance of its discussion did not favour legalisation of drugs of addiction in Australia. I would like to quote several passages from that paper. These are as follows:

Addressing the situation in Sweden: "The Swedish programme of maintenance therapy for drug users introduced in 1965 lasted only two years. Overprescription by the medical profession resulted in registered addicts flooding the heroin market. Despite the availability of sterile needles and syringes, needle-sharing remained widespread and resulted in the frequent hospitalisation of addicts for hepatitis."

Reviewing the experience in the UK: "The Dangerous Drugs Act of 1967 encouraged maintenance on methadone as the preferred form of management and rehabilitation programmes were also included in the treatment protocol. By the end of the 1970s, injectable heroin was usually not provided by clinics for new patients."

Referring to a review in *The Economist* in 1989: "Drug users tend to ignore anti-AIDS advertising, in line with their socially marginal attitudes. There is no indication that self-help organizations will be formed to alleviate the situation. ... If the fight against AIDS is to be the main factor in its legalisation then the issue of syringes of heroin to registered users will not affect the hard-core users who do not want to break out of the drug environment, nor will it affect experimental or occasional users, who would presumably be unwilling to be registered for the purpose. It is a fallacy of the mainstream that heroin users want clean drugs; the sub-culture which produces drug dependency is not concerned with notions which derive from a concern with social health and stability."

And further: "To assume that present addicts will react conventionally to the availability of relatively free heroin is to misunderstand much of the rationale of the drug subculture. The majority of addicts use drugs as a way of coping with their problems and often belong to the less stable section of the population. At best, most of these people can expect marginal involvement in conventional society and they are unlikely to be anxious to return to the very situation from which they have escaped."

Referring again to the situation in the UK: "Since 1968 injectable heroin has been mainly available from Drug Dependency Clinics and by mid 1970's most were prescribing oral methadone only to new patients ... there are indications that many drug users actually prefer illicitly manufactured heroin, often because of the 'cutting agents' which can include stimulants, barbiturates, brickdust and glucose, and also because of the excitement of the danger in using illicit drugs with its potential for unexpected and harmful effects."

Best then concluded in this section of this paper as follows: "It is up to the opponents of heroin prohibition to put forward the decisive argument and rational projected outcome data before medical practitioners should be allowed and encouraged to distribute heroin."

Regarding the criminal aspects, he commented that: "The drug-crime connection, though significant, may be less specific for the addictive population at large and in fact, one study in Britain found no difference in the conviction rates of addicts before and after treatment at a London clinic."

The final quotation from Best's paper addresses the matter of polls. I imagine most people here would be familiar with the *Yes Prime Minister* episode in which Sir Humphrey Appleby explained to Jim Hacker how to produce the result one wants by asking the right questions. Regarding a somewhat earlier poll, Best commented: "An Irving Saulwick poll published in *The Sydney Morning Herald* on 5 July 1988 showed that 60% of respondents opposed the provision of free heroin to addicts under supervision, 35% agreed and 5% did not know."

As an aside, I should say that many of these polls are a bit like the ones for television. I have never been interviewed as to what I would like to see on television, and I don't know anyone else who admits to it either. In the short time I have had available I have spoken to a number of colleagues in general practice, some of whom have quite a large number of drug abusers on their books in the ACT, and they assured me that none of them had been approached either.

With that paper before them, our National Conference in 1989 resolved as follows:

"On the present evidence, Conference is opposed to heroin being made available within the law in Australia."

At a subsequent meeting, AMA Federal Council endorsed that resolution.

To conclude, I believe that the AMA would not countenance an unproven public health initiative such as a study of substitution of opioids for methadone in the the treatment of heroin addiction in the ACT, particularly in view of the Territory's other huge, unmet needs for health care.

Discussion

MARION WATSON
DRUG REFERRAL AND INFORMATION CENTRE, CANBERRA

I'm sorry, I can't let you go away leaving us with some of those comments so voluably quoted from somebody who sounds like they know nothing about people who use heroin but maybe has been in contact with them in a professional way, that is, perhaps through doctoring. I need to just tell you, I think, that the majority of the comments about heroin users are wrong. There are in fact user groups available, self organisation in Australia is now at quite a sophisticated level, given that it's about two years old. The big question that I suppose I would like to ask is: is the AMA in favour of the provision of heroin for those with chronic pain? And does the AMA see the two proposals - that is, that perhaps it might be available also for people with chronic pain and for those with heroin dependency problems - as two separate questions? Could they not be run together?

PETER WILKINS

My understanding of that issue is the last time the AMA formally examined it they concluded that there were no specific additional benefits available from the prescription of heroin over agents already legally available. And I can only conclude, on the basis of my research of the policy work that's gone on in this, that this is an omnibus resolution which still stands; that on the basis of present evidence, that is - up to July 1989 - the AMA is opposed to heroin being made available within the law.

IAN WEBSTER
DRUG & ALCOHOL SERVICE, SOUTH WESTERN SYDNEY AREA HEALTH SERVICE

Dr Wilkins, I want to reflect on some of the observations you made about people on methadone programs who are disinclined to adopt safe health practices. I don't have the documentary evidence before me for what I am going to say, but my experience is that they are surprisingly health conscious in safe sexual practices and in not sharing needles, and that's my direct experience with these people.

PETER WILKINS

Sir, obviously I bow to your greater experience.

ADRIAN BUSOLIC
QUEENSLAND DEPARTMENT OF HEALTH

I just wanted to clarify that you're actually drawing into question the sampling methodology of the study in the ACT, whether there was actually a random sample taken of service providers, and I wondered if Dr Bammer could answer that. But while I've got the floor I would also like to disagree with the comments that were made by the Best Report. From my experience with users and also from the Australian National AIDS and Injecting Drug Use Study.

GABRIELE BAMMER

We did in fact give all service providers who are directly involved in treating people who use illegal drugs a chance to participate in our survey. The way we did it was, we approached agencies, we dropped off questionnaires, we encouraged them to fill them out, and we followed them up after a week and two weeks to see if they had. Thirty-eight percent chose to do so. That 38% was a reasonably representative sample of service providers. They were a little younger than most service providers, but on all other characteristics they were pretty representative. And the AMA was also invited to give comments.

PETER WILKINS

I have seen the AMA branch comment, and as you know the AMA ACT branch came out against it.

KEITH POWELL
ALCOHOL & DRUG SERVICE, WODEN VALLEY HOSPITAL

I appreciate the very difficult task you had at such short notice in putting forward what might be seen as an AMA view, but I must comment that I think that it's an extraordinarily superficial account, and I would think the AMA, if it had time to give some thought to this question, would come up with a much more profound analysis than you've been able to give, given the short time and the information available to you, to this meeting this morning. I think that Best is an extraordinarily able person, but I don't think he is very experienced in the alcohol and drug field. I don't think he has had any direct experience in terms of methadone programs with regard to drug users, and I would take Marion Watson's point that he is not the best one to quote in this situation. I would think that the information that's been made available even at the Stage 1 level of this proposal would indicate that there's been a tremendous amount of research already done with regard to finding out, and labelling, and programming, and making public the issues that are to be addressed if we did go into Stage 2. And that there have been quite a number of people very experienced in the area - able and learned - who have been able to participate in the debate on the legalisation issue. And there would be a lot of other people, some of them at least within the AMA, who could have been quoted to give an alternative view to that of Best.

PETER WILKINS

As I mentioned, the AMA is a very democratic organisation and should our members or our committees wish to do so I'm sure that will happen.

RAY DONALDSON
DRUG ENFORCEMENT AGENCY, NSW POLICE SERVICE HEADQUARTERS

This question I think goes to Dr Bammer, but in the light of what's been related to us predominantly by Dr Wilkins, and based specifically on the UK experience where I understand heroin maintenance is being phased out, and particularly in the light of what happened in Sweden as I understand it, I wonder if Dr Bammer could enlighten us as to why, in view of those situations, it seems that perhaps the ACT study will provide any different results, any better results.

GABRIELE BAMMER

There's a lot of controversy about overseas experience. We hear that the British system works, that the British system doesn't work, that the Dutch system works, the Dutch system doesn't work. If you look at the literature, it depends very much on who's analysing it and exactly what they're looking at to see what conclusions they come to. One of the reasons we've invited three people from overseas to come today is that they can give us some current on-the-ground experience of what's happening, and we think that it's very important that they do so. I would like to leave the question on Mersey because we have someone specifically talking on that this afternoon.

BOB DOUGLAS, CHAIR

Can I just say that the discussion today, we hope, will not focus on the legalisation of heroin. We hope that today's discussion will focus on the possibility of exploring a new treatment for heroin dependent users. Now the two questions are clearly not totally divorced from each other but I think (and I take Dr Wilkins' point that the AMA is likely to take a fairly conservative stance about mass movement in social policy in the absence of evidence) what we're hoping today might focus on is the collection of evidence about the treatment of drug dependent people. Because until we resolve that question it surely is not appropriate for us to start talking in any serious way about the other one. And I think the views that the working group that prepared the report that Dr Bammer has been talking about were focused very clearly on the question: what are the research questions we need to ask in order to satisfy the very legitimate concerns that I believe Dr Wilkins has expressed? But I'm frankly pleased that the AMA is not locked into a fixed view on this matter. I believe the medical profession has been open to evidence and that it seems to me that one of the things we need to focus on in the coming discussion today is: what is the evidence and how can we make sure that the evidence is adequate, that we are applying the best available treatment to people and that we are producing the best possible result for Australian society as a whole?

BERNARD COLLAERY
RESIDENTS RALLY FOR CANBERRA, ACT LEGISLATIVE ASSEMBLY

I want to follow on from what Professor Douglas just said and ask the AMA: in view of the fact that you prefaced your conclusion with the words "on present evidence" I take it the AMA has cast an opinion on legalisation at this stage. What is your policy on a trial to gather further evidence?

PETER WILKINS

Clearly we don't have a formal policy on that, or I would have spoken to it. I had to deduce from the evidence available to me what I thought it might be. The AMA prides itself on considering issues on their merits, and I'm sure that as a result of this meeting and any other evidence put before it, if then it believes it appropriate the AMA would be very happy to consider altering its position or adopting a position that might favour such a trial. But it will make that decision on the basis of the evidence before it.

Treatment of Opioid Dependence: Government Policy

Tony Adams MBBS MPH FRACMA FAFPHM
Chief Medical Adviser, Department of Health, Housing and Community Services

I welcome the opportunity to take part in this seminar and to contribute the government's perspective on this important topic.

In the ongoing attempts to reduce the harm posed by drug abuse to the Australian community, which I appreciate is a fundamental concern of the organisers of this seminar, it is, I believe, important to bear in mind the perspective of both the National Campaign Against Drug Abuse (NCADA) and also the prevailing international consensus with respect to heroin use.

I would therefore like to cover briefly the rationale and direction of the NCADA and then to complete the picture by drawing your attention to a global perspective on the issue of heroin use.

THE NCADA PERSPECTIVE

NCADA was established as a result of the Special Premiers' Conference held in April 1985 to develop a national campaign to combat drug abuse.

The aim of the campaign is to minimise the harmful effects of drugs on Australian society through a major emphasis on prevention and including:

- 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 the quality and quantity of services provided for the casualties of drug abuse;
- directing firm and effective law enforcement efforts at combating drug trafficking;
- supporting international efforts to control the production and distribution of illegal drugs; and finally but importantly
- seeking to maintain a common approach throughout Australia to the control of drug use and abuse.

A notable strength of the NCADA is that it is a cooperative venture involving all Australian states and territories and that each jurisdiction plays an important and ongoing role through the Ministerial Council on Drug Strategy (MCDS) in shaping the nation's approach to drug abuse issues.

This reflects the constitutional position that the supply and use of drugs is a matter for states and territories while importation and manufacture of drugs of dependence is the responsibility of the Commonwealth.

The campaign has fostered preventive initiatives aimed at rendering drug abuse less attractive, empowering people to resist the perceived attractiveness of drugs, and promoting positive lifestyle models.

The media arm of the campaign, The Drug Offensive, has been pivotal in effectively raising the awareness of the Australian public with a demonstrated high recall of the underlying messages.

Treatment and rehabilitation initiatives have also formed an important aspect of the NCADA and, in relation to opioids, methadone programs have been upgraded and expanded to the point where over 10,000 clients are now in treatment.

From the outset of the campaign, it has been recognised that methadone is a legitimate form of managing heroin dependence and all states and territories with established programs agreed that national guidelines are important in developing a common set of standards for conducting methadone treatment programs in Australia.

The guidelines are intended for the use of states and territories in formulating their statewide programs and policies and methadone treatment in Australia is expected to be consistent with the guidelines.

The agreed objectives of methadone programs are:

- to reduce illegal drug use by clients;

- to reduce deaths associated with illicit opioid use;

- to decrease the spread of infectious diseases associated with illicit opioid use, in particular the spread of HIV and viral hepatitis;

- to improve the health of clients; and

- to improve the social functioning of clients and reduce the social costs of illicit opioid use.

The advantages of methadone include:

- its ease of administration, being orally active and long acting; and

- its ability to reduce opioid use and criminal behaviour and bring about improvements in health status, employment and other lifestyle factors.

It is recognised of course that methadone, even in optimal settings, is not the panacea for all opioid dependent people and that other options need also to be considered.

Moreover there is a view that despite considerable investment of resources into methadone maintenance in Australia, there has not been a corresponding attempt to evaluate its effectiveness.

Under the NCADA's funding for the Research into Drug Abuse Program (RIDAP), a treatment outcome index for comparing and evaluating opioid treatments has been developed but is still being "road tested" and is not yet in wide use.

In addition to that are suggestions that alternative pharmacological interventions should also be investigated for a possible role in treatment. This might include:

- opioid antagonist agents like naltrexone;

- mixed agonist/antagonist agents like buprenorphine;

- long acting agonist agents like levo-methadyl-acetate (formerly LAAM); and

- even non opioid agents like clonidine.

AN INTERNATIONAL PERSPECTIVE

UN conventions

Australia has signed and ratified two UN conventions on drugs: the Single Convention on Narcotic Drugs, 1961 and the Convention on Psychotropic Substances, 1971.

Australia has also signed (February 1989), but not yet ratified, the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

All three conventions aim to limit the use of narcotic and psychotropic drugs to medical and scientific purposes.

Under these conventions, parties who consider it to be in the national interest to prohibit the use of heroin are obliged to do so.

The conventions would probably not of themselves preclude a clinical trial, as envisaged in the NCEPH option, permitting prescription under medical supervision, provided that the trial could properly be characterised as having a medical or scientific purpose.

However, it must be remembered that Australia, along with most countries, has banned the importation or manufacture of heroin since the mid 1950's when it joined in an international consensus that heroin provides no therapeutic benefit that cannot be obtained from alternative drugs such as morphine and pethidine. This followed calls by the World Health Organisation in the 1950's for a ban on heroin use on the grounds that this would eliminate diversion without compromising treatment options.

This has been followed by several resolutions of the UN Commission on Narcotic Drugs that have urged nations that have not already prohibited the use of heroin for medical purposes to consider doing so.

In this light I would like to allude to the situation in the United Kingdom, the Netherlands and the United States of America.

United Kingdom

The UK is one of the few countries which continues to permit the use of heroin for severe pain and for the management of heroin addiction.

However, whereas in the 1960's prescription of heroin to addicts was widespread, this practice was severely limited when it became clear that much of the prescribed heroin was being diverted into the illicit market.

By 1990, only a small proportion of those registered heroin addicts who were receiving opioid maintenance were being prescribed heroin; the vast majority were being maintained on methadone.

The Netherlands

The Netherlands is widely perceived as having a liberal policy toward drug use. However, government authorities have clearly separated policy with respect to marijuana from that relating to heroin and other drugs which they label as 'high risk'.

Methadone is the opioid drug used to manage heroin addiction in the Netherlands.

United States of America

Again, methadone is the opioid drug used to manage heroin addiction in the USA.

THE NCEPH RESEARCH

I would like to come back now to the NCEPH research task of exploring the feasibility of a Canberra based trial to make opioid drugs available to users in a legal and carefully controlled manner.

I think it is important to remind ourselves just how broad were its original terms of reference. These included looking at all possibilities up to and including full legalisation of heroin provided that supply was under some form of control. That this was so is apparent from the early discussions held between NCEPH and officers of the Department.

From the published reports and recommendations however, I note that we now appear to be addressing ourselves only to the possibility of a trial to compare heroin with methadone, under medical supervision, as a prescribed treatment modality.

The proposed research project as I understand it is in four stages:

Stage 1 (Feasibility): which was an exploration of the issues surrounding the principles of a trial involving the supply of heroin to users. This stage has now been concluded and a report recommends that the ACT "cautiously proceed" to the second stage.

Stage 2 (Feasibility): would require "political and financial commitment on the part of the ACT Legislative Assembly" and would involve a detailed examination of the logistical issues to be overcome before proceeding to a pilot study. Stage 2 would require $60,000 of ACT government funds plus additional funding from other agencies and take about 8 months to complete.

Stage 3 (Pilot): would be a small scale study in which the procedures would be pre-tested on a limited number of dependent users. It would cost $250,000 and would require "firm political commitment from the ACT government".

Stage 4 (Trial): would be a full scale trial "designed to answer questions about the advantages and disadvantages of providing heroin as a treatment strategy". It would take about two years to complete.

The issues are thus complex and will require considerable debate. There are many unanswered questions, some of which I have already alluded to, namely the perceived needs to better evaluate existing methadone treatment programs and to explore the possible use of a range of alternative drugs and routes of administration.

I would also add that we do have from the NCADA workshop, which was held in Adelaide in February of this year, a statement on future research priorities for the Drug Offensive in Australia. This includes research into new ways of handling opioid addicts and people addicted to other drugs. And so the way is open to - carefully - look at research proposals for the future.

(I recall a recent television program which showed Iranian addicts, part of whose treatment included eating vast quantities of raw onions. Maybe that also needs to be evaluated!)

So I think it would be fair to say that the officials or the government in a broad sense are not closed in any way to suggestions for new ways of handling this vast problem of opioid addiction, and there is a need urgently to explore new ways of handling these situations.

At the end of the day, the practical reality would seem to be that the implications flowing from a heroin trial would need to be fully canvassed by the MCDS because drug laws are the mandate of all governments in Australia and ultimately it is Australia as a nation that will have to take responsibility for any changes that might be made to its current drugs policy.

Discussion

BOB DOUGLAS, CHAIR

Dr Adams has made it clear that the issue needs to be further considered by various federal bodies before it can be taken any further in the ACT. That really was why we saw the need to have a meeting of this calibre and type - so that there could be some open ventilation of the implications of the ACT going ahead with a trial. Mr Moore's committee, when it reviewed the issue, came to the conclusion that it would be sensible to proceed to a Stage 2. The ACT government has referred it to the federal committee system for further comment from other states, because it does not see the ACT as a totally independent group in this whole exercise.

MARION WATSON
DRUG REFERRAL AND INFORMATION CENTRE, CANBERRA

Just one point to clarify. Tasmania and the Northern Territory do not have methadone programs. And I wouldn't say that in Australia we could say so glibly that methadone is available widely and therefore available for open scrutiny. As to just exactly how effective it is, it's almost impossible, in fact, to get some countenance of the provision of methadone in Tasmania or the Northern Territory, and they seem to be very anti that. Perhaps someone from one of those states or territories might like to respond to that.

TONY ADAMS

If Wayne Hall is going to tell us after the break that methadone is effective, we need that sort of evidence to persuade - if persuasion is needed - the Northern Territory and Tasmania to take another look at whether methadone ought to be provided.

MONIKA ZANDER
TERRITORY USER FORUM, DARWIN

As far as the studies that you've been doing, I feel that the Northern Territory has been excluded in this area. And I think that you'd be surprised with the response and the size of the drug using population. There are a lot of opiate users up there, and I think they wouldn't have been approached at all.

BOB DOUGLAS, CHAIR

The studies that Dr Bammer was reporting on were studies in the ACT, and some studies of opinion in NSW. So there hasn't been any plumbing of opinion about an ACT trial outside those two states.

MONIKA ZANDER
TERRITORY USER FORUM, DARWIN

But don't you think it should be approached nationally?

BOB DOUGLAS, CHAIR

Well I think that's part of today's discussion, and I'm just trying to push you to be more specific about what you think the Northern Territory view might be.

MONIKA ZANDER
TERRITORY USER FORUM, DARWIN

I think it should be looked into and not neglected.

JAMES BELL
DRUG & ALCOHOL SERVICES, PRINCE OF WALES HOSPITAL

I apologise, Professor Douglas, I suspect I'm going to derail your attempt to focus on treatment. But listening to Tony Adams talk, particularly about Australia's international treaty obligations and the fact that opiates are to be restricted for medicinal research purposes reminded me very much of a film I saw as a child about a monastery that used to produce a very potent liqueur which none of the priests were allowed to drink unless it was for medicinal purposes. Needless to say, a lot of them were very sick a lot of the time.

I really think it is important that we recognise that drugs are being used - these are lifestyle drugs - and to medicalise people's social and emotional predicaments, which is what we are doing by focusing on drug use as a form of treatment for sickness, is really a bit of a distortion of the whole debate.

KAARINA SUTINEN
LIBERAL CANDIDATE FOR ACT LEGISLATIVE ASSEMBLY

I've worked in public health policy in this area for a number of years. Picking up on the previous speaker: Professor Douglas, you chose to take the position that heroin users are sick people - the medical model which has been around for ages - as opposed to seeing heroin use as a lifestyle choice. I feel that the vital components to make any program successful are the psychological counselling and the social support that go with them. I'd like to ask Dr Bammer whether that is part of the feasibility trial, and whether overseas research supports that?

GABRIELE BAMMER

There are two parts to your question, and if I can answer the second one first. Yes, we think that it's very important that people are encouraged to use counselling, that their social skills and a whole lot of other social factors are assessed, and that appropriate resources are offered and people are encouraged to try other forms of treatment. So they're encouraged to try a therapeutic community if that is appropriate, Narcotics Anonymous and things like that. And I think that our speakers on methadone will be reflecting on the importance of those sorts of things as well.

The first part of your question was about characterising people as sick. The whole rationale for treatment is also changing - the whole role of the medical profession is in the process of change. And it's possible to use medicine and medical skills to facilitate

wellbeing as well as to treat illness. I think that also relates to the point that James Bell was making. It's possible to conceptualise treating people who use drugs in a dependent fashion not as treating a sickness, but as a way of improving their wellbeing. And that's the way we would hope that a trial like this would be run.

OWEN DOWLING
ANGLICAN CHURCH OF AUSTRALIA

I just wanted to ask Dr Bammer, in the light of Dr Adams' comments, how much you actually explored the possibility of the use of other substances. It seems to me that the business of having to have people in three times a day for a program does stretch the imagination as to feasibility. I just wondered how much there had been a debate about the other substances that may be thought of as possible alternatives.

GABRIELE BAMMER

The study was called a Feasibility Study of Controlled Availability of Opioids. And the reason for that was to have a broad range of drugs available to us. It became very clear to us fairly quickly that the drug of choice for people who are dependent on opioids is heroin, and that heroin is likely to be the one that's going to attract people into treatment. There certainly is merit in also looking much more closely at other drugs, but there are many many things that could be done. This is the one that we've chosen to focus on - it's feasible in principle and it's worth looking further to see if it's feasible in other ways.

MARK FINDLAY
INSTITUTE OF CRIMINOLOGY, SYDNEY

I think that coming out of the last reference to drug of choice there's another useful side to this debate that we should consider when we are looking at whether the study is an appropriate one or whether there are attractive benefits to the formulation of government policy. I know this afternoon we'll be talking about law enforcement issues, but is there a potential way for measuring, at least at the pilot stage, the influence on other areas of the system? The structuring of a market for drugs of choice when they are restricted through legal prohibitions has important ramifications for law enforcement, not only in terms of the efficiency and effectiveness of law enforcement but the deleterious effects on law enforcement, as we know, through police corruption and the supporting of the illegitimate market which exists through police controls over narcotic use and narcotic distribution. I think that it's very exciting actually that there is a potential within this let's say limited study, within a very small jurisdiction with perhaps a manageable law enforcement sample, that we could examine to see whether in fact this sort of freeing up of the market has positive effects not only for the user in a treatment sense but significant positive effects on law enforcement, both from its potential to effectively control drug abuse and also to minimise the deleterious effects on the law enforcement agency itself.

ALEX WODAK
ALCOHOL & DRUG SERVICE, ST VINCENT'S HOSPITAL

My question is addressed to Dr Adams. As I understand it, the principal aim of Australia's drug policy as declared at the Special Premiers' Conference that you referred to and as enshrined in the National Campaign Against Drug Abuse has been the minimisation of harm resulting from drug abuse. I'm quoting specifically from the communique of that meeting and from the documents that have appeared repeatedly. One of the principal

components of the National Campaign Against Drug Abuse was a very much needed, and I think a very beneficial, expansion and improvement in Australia's research capability in this field. That's the second point. The third point, as you have quite accurately quoted, is that at a national meeting in Adelaide earlier in February this year it was agreed that one of the further things that needed to be done in research over the next three or five years was to look at areas of innovative research that needed to be done.

Putting all that together, and Dr Bammer's evidence, which presented the grounds for believing that the careful collection of information related to the effectiveness of this approach was highly plausible (in that there were many things in favour of it and relatively few things against it) it seems to me extraordinary that this day is really necessary, that this issue is so controversial. It seems to me that if raw onions were as plausible as heroin we should certainly be compelled to evaluate raw onions. But as to the plausibility of legal provision of heroin under medical conditions, which satisfies our international treaty obligations, it seems to me that is so plausible that there can be no argument against allowing this to proceed.

TONY ADAMS

Well I think that you've answered your own question, Alex. It's just there are no UN conventions on raw onions.

BERNARD COLLAERY
RESIDENTS RALLY FOR CANBERRA, ACT LEGISLATIVE ASSEMBLY

I was at the Ministers' Conference last March, and that followed by a few weeks a letter from the then rotating chair of the Police and Other Health Ministers Council - Ted Pickering from NSW - asking all governments whether they could come up with innovative ideas as part of the formation of a national drug strategy. I was therefore most surprised and astounded when Mr Pickering came to Queanbeyan a few weeks later and absolutely in the most controversial terms bagged the suggestion from Mr Moore's committee. It was totally inconsistent with what we ministers had discussed in March.

What I would like to put to Dr Adams is that there is a confusion in the debate between decriminalisation and legalisation. I'd like you to confirm, if it's possible, that the South Australian decriminalisation of one of the narcotic drugs - marijuana - but not the rendering of it legal, does not offend any of the three conventions you have mentioned, including the non-ratified one. And I wonder, Dr Adams, if you could comment as to whether the United States government has already approached the Commonwealth government in regard to the proposal of the Moore committee. As I understand it the United States government is already expressing concern and is bringing its own speakers out to add to what the last speaker suggested was a wholly unnecessary controversy.

TONY ADAMS

Mr Collaery, I'm not able to answer either of those questions. I'm not aware of anything that the United States government has said on this issue. One of our legal people in the audience might be able to comment on the South Australian marijuana laws.

BARRY ENGLAND
DRUG SQUAD, SA POLICE DEPARTMENT

On the question of marijuana laws in South Australia it's incorrect to say that it's been decriminalised. What the government has done is to de-emphasise the criminality, and there's a slight difference in the interpretation. The possession of minor amounts of marijuana is subject to an infringement notice on which a penalty is payable, and if that penalty is not paid then the matter can be heard and determined in court.

KEL GLARE
VICTORIA POLICE

I have some difficulty with the idea that a trial such as this is going to somehow be a magical way to overcome problems such as police corruption. It seems to me that if there is to be a trial it needs to be available to anyone who wants it. Otherwise we still have the same problem of people becoming addicted in the illegal market, with all of the problems of potential corruption and so on that that entails. I'm not expressing my view one way or the other at this stage on whether I think a trial ought to go ahead. But I don't believe that the trial is going to affect those kinds of issues.

GABRIELE BAMMER

One of the things that we have to realise is that there is no magic trial that is going to have no problems attached. What has to happen is that there has to be a weighing up of costs and benefits, advantages and disadvantages. This trial would be to look at whether things might be better than they are currently, whether it could produce better circumstances. It's certainly not going to do things like wipe out corruption. But I'd like to give you an example of what it might do. Many dependent users supply to maintain their own dependence. Non-dependent users obtain their supplies from them. If the supply dries up because dependent users no longer have to deal in drugs there is much less availability of drugs to non-dependent users and potential new users. And it's possible that a trial might have that sort of an effect, and that's the sort of thing that one would want to measure.

RENE POLS
NATIONAL CENTRE FOR EDUCATION & TRAINING ON ADDICTION, FLINDERS UNIVERSITY

Whilst my position would be very similar to Dr Wodak's, and I would agree that it is obvious that the proposals before us should proceed to Stage 2, I'd like to congratulate the National Centre on the process that is being used to involve so many people. Because quite clearly here this morning, as there is within the community, there is really a wide range of opinions about this. And the anxiety and hysteria as it's been described is something that needs to be dealt with, and appropriately so. Because many of these things are enshrined in law, there are just so many prejudices and perceptions that are incorrect, and there's so much misinformation around. It seems to me that the process that we're using is a very important one and I think it is wise and it should continue. I'm sure that if we do this then we as a group will reach the sort of conclusion that is sensible, reasonable and appropriate for this time.

Study on Controlled Availability of Opioids - The HIV/AIDS Perspective

Peter McDonald MBBS MRACP FRACP FRCPA MASM FASM
Director, Department of Clinical Microbiology, Flinders Medical Centre
Chair, Commonwealth AIDS Research Grants Committee

First, I would like to congratulate the organisers and the ACT on the inspired process that they are following in coming to decisions about a difficult topic. If only all policy was determined by such logical processes. Second, I must acknowledge that I am going to talk mostly about data that others have generated and I want to pay special tribute to my colleagues on the Commonwealth AIDS Research Grants Committee and other key researchers in Australia.

HIV/AIDS is a complication of drug utilisation that introduces an important new element into the imperative to reduce the harm to individuals and society that arises from current drug utilisation patterns.

However, in Australia at present there is no spread, of any real significance, of HIV through drug usage per se. High-risk sex in Australia, which is predominantly unprotected homosexual contacts, is the principle mode of spread. I think what we are now seeing, though, is that drugs, and not just intravenous drugs, are contributing to high-risk sex behaviour and the notion of bringing drug users, and not just intravenous drug users, into some sort of program appears to be providing an effective opportunity for education that reduces the incidence of high-risk sex.

Hence the rationale for embarking on a drug treatment program to reduce AIDS ought to be to bring people into a program that can modify their high-risk practices that might not be directly related to needle sharing.

DRUG USE AND TRANSMISSION OF HIV

There is no doubt that drug use can be associated with the spread of HIV/AIDS. Injecting drug users (IDU) in particular, are seen to be in a high-risk category for transmission. IDU are currently being analysed as a possible bridge for HIV between sections of the gay community who are known to be reservoirs of virus and other groups within the community.

What is the evidence that drug taking is a risk factor in HIV transmission? The evidence arises out of the following:

1. epidemiological studies on the incidence and prevalence of HIV amongst drug users, IDU in particular.

2. data which demonstrates that injecting equipment (needles) is a vehicle for HIV.

3. that high-risk sexual practices are associated with certain aspects of drug taking (eg. intoxication). These associations are not confined to IDU but they are best documented amongst IDU.

4. anecdotal evidence where HIV is spread between partners at least one of whom is a drug user. Other important anecdotal evidence is where the unsuspecting blood donor is identified as HIV positive, and subsequently shown to be the sexual partner of a drug user whose drug use and HIV status were unknown to the partner.

Epidemiological studies

There is an epidemiological basis for concluding that IDU are associated with HIV transmission. It is based mainly on disease notification data for AIDS in certain European countries (Italy, Spain) and in specific areas such as Edinburgh in UK and New Jersey in USA. In these places injecting drug use is cited as the most common risk factor for AIDS (ie. greater than 50%) at the time of notification. This does not take account of multiple risk factors with reported individuals.

Another body of evidence that is cited to support injecting drug use as a risk factor are the sero-prevalence studies undertaken amongst IDU. HIV seropositivity rates amongst 601 IDU attending 17 narcotic clinics in Bangkok were recently reported (Kachit et al 1990) as being 34%. Similarly high prevalence rates are reported from certain drug treatment centres in the USA and Europe.

In Australia, the HIV seropositivity amongst IDU is relatively low, being reported as 0.6-0.7% amongst IDU attending a Melbourne STD clinic (Denham & Hayes 1990) and up to 14% for IDU attending Albion Street Clinic (Morlet et al 1990). These small studies however are quite likely to be biased in favour of HIV positivity because the subjects were seeking HIV related services.

These data arising out of disease notification and sero-prevalence studies formed the epidemiological basis for concluding that injecting drug use is a risk factor for HIV transmission.

On these data it was predicted that HIV would spread amongst IDU and it was therefore considered to be important to modify drug taking behaviour in order to prevent HIV transmission. I believe these data are a component of the justifiction for undertaking the ACT trial. Many centres embarked on studies based on the above rationale and we are now in a position to assess some outcomes.

In Australia, two major cohort studies were established initially with a view to assessing the specific risk factors associated with an anticipated increase of HIV amongst IDU. The ANAIDUS project has sampled over 1200 IDU over 2 years and demonstrated a stable low prevalence of HIV seropositivity (1.9% with a range of 1.3% to 2.5%). The risk factors associated with seropositivity have been high-risk sex as much as needle sharing. This is inferred from the Crofts & Hay study (1991) which concluded that IDU males who have a history of homosexual contact are at highest risk of HIV. A recently reported study of 500 IDU in Glasgow over 3 - 4 years (Haw et al 1991) indicated an HIV seropositive incidence of only 2.2% ± 1.6% despite a high incidence (66%) of injection sharing and unprotected vaginal sex (77% with regular partner). This Scottish report indicated that HIV entered this IDU population in 1985.

My conclusion from these reports is that the risk to IDU of HIV transmission in Australia is quite low and the factors required for spread amongst IDU have yet to be fully identified. In the presence of such low prevalence rates it is very difficult to study factors associated with HIV transmission. Drug culture and behaviour in Australia is moving towards HIV risk reduction strategies. There is some evidence of success with education and needle exchange programs. Thus the HIV risk factors associated with drug taking may be the promotion of high-risk sexual practices rather than needle sharing. Such drug related high-risk sex is not the sole province of IDU - alcohol for example is clearly associated.

Thus a trial of opioids which promotes a transfer from injectable to non-injectable drugs may not achieve maximum success in preventing HIV transmission unless it is associated with strategies that diminish sexual risk factors i.e. sexual counselling.

Virological studies

Several studies have demonstrated HIV antibody in discarded needles and this is an indirect method of confirming the presence of HIV infection amongst IDU. However, the presence of antibody does not indicate directly the presence of infectious particles. This is also a somewhat discredited epidemiological approach because of the unselected nature of the sampling.

So far, the number of HIV virus particles required to establish infection has not been confirmed: there must be a threshold for infection. It is generally agreed that a small quantity of blood (0.2 ml) from an HIV positive individual contains sufficient virus to establish infection. This need for at least a small amount of blood to be "transferred" can be deduced from blood accidents to staff in the course of treating HIV positive patients. Accidents associated with transmission involve significant blood transfer i.e. serious accident.

Sexual practices

As cited above, there is considerable evidence that the drug users with HIV are more likely to be those who have engaged in high-risk sexual activities, especially unprotected homosexual contacts. The evidence in Australia indicates that drug-associated sexual practices may be a more prominent vehicle for transmission of HIV amongst IDU than needle sharing. This differs from many other countries, eg. Italy and Spain, which attribute more than 50% of their AIDS to injecting drug use behaviours.

Anecdotal reports

All clinicians involved with HIV care will have seen evidence of HIV transmission between partners.

STUDY ENDPOINTS - EFFICACY CRITERIA

Given the low sero-prevalence of HIV in the ACT drug using population it is unlikely that HIV sero-conversion will be a useful endpoint for the proposed ACT study. A list of suggested efficacy criteria to determine whether controlled opioid use diminishes AIDS risk is provided in Table 1. Modification of risk behaviours can only be expected if appropriate education and counselling accompanies drug administration.

Table 1. Efficacy Criteria for Opioid Study

HIV sero-conversion
Acquisition of infections associated with HIV transmission - hepatitis C and B, sexually transmitted diseases
Modification of direct IDU risk behaviours - needle sharing, blood contamination
Modification of high-risk sexual behaviours

ARGUMENTS IN FAVOUR OF OPIOID STUDY FROM THE HIV/AIDS VIEWPOINT

The benefits of this study would arise out of evidence that controlled opioid use reduces HIV risk behaviour. The arguments in favour have largely been accepted and they consitute the rationale for embarking on the study.

ARGUMENTS AGAINST THE OPIOID STUDY

The arguments against the study from the HIV/AIDS perspective are that the small numbers of available subjects, the low HIV sero-prevalence and the difficulties in validating questionnaire/interview data constitute insuperable barriers to satisfactory completion of the study in so far as HIV transmission is concerned.

RECOMMENDATION

I am in favour of exploring the feasibility of such a study - to a limited extent. From the HIV/AIDS perspective I believe that a feasibility study which focuses on the study endpoints, problems of numbers of subjects and validity of data could be conducted quickly and at limited cost. There should be an analysis of those associated factors that are predictors for the spread of HIV, namely the high-risk sex factors and associated practices with drug use, not merely injecting drug use. I would be prepared to recommend to CARG that funds be provided for such an analysis.

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Discussion

TIMOTHY MOORE
NEW SOUTH WALES USERS AND AIDS ASSOCIATION

Given that the Australian National AIDS and Injecting Drug Users Project showed that 25% of gay men in the inner city area of Sydney had injected drugs, and given the situation of an HIV positive gay man - that it's much more useful to identify as a gay man than as an injecting drug user because of the discrimination they're likely to face - do you think that the evidence that you presented earlier might bring some of that injection transfer into question?

PETER McDONALD

They may do, and you've identified a difficult area. One could say the reverse about some of the European data where maybe the injecting drug user group are overrepresented and they may include many whose dominant contact has been sexual.

HAYDON RAYSMITH
HEALTH DEPARTMENT, VICTORIA

Peter, you may wish to take this on notice, but I'd be interested, based on the premise that you've put to us, and that is that the study will be one component in addressing the possible spread of HIV between needle using drug users: if you had an open go, what would be the three steps that you might take to tackle the problem of intravenous drug use and the potential spread of HIV?

PETER McDONALD

I think I will take that on notice, and I'm looking at Alex Wodak and other people that I always look at for advice in those sorts of circumstances. Perhaps I will just make a comment, and that is that the AIDS initiative has put a lot of resources into the injecting drug use area because of some of the early data I presented. In fact I was surprised yesterday - we calculated that about 10% of the research funds have in fact been allocated to injecting drug use studies. So that is clear evidence of commitment.

I think that many of the community groups and the processes needed to come to grips with the enormous problems of drug use in the community have been set in train by the AIDS initiative, if you like. Now we're faced with the situation where we have a low seroprevalence, but I think perhaps this is because of the AIDS initiative opening up avenues to doing things that have previously not been available.

ALEX WODAK
ALCOHOL & DRUG SERVICE, ST VINCENT'S HOSPITAL

I hope I'll be able to keep it down to three things. First, to raise and maintain a high level of awareness in the community, which has been achieved in the past but which is not currently the state of play. Unless the community, including the policy advisers and the ministers really know the potential of the problems we could face and are aware of what

our colleagues in Spain and Italy and unfortunately many other parts of the world now, are going through we don't have a hope of doing anything in this area at all. So that would be my first point.

In terms of what we should actually do, I think we should be doing all the things that we're doing now but more vigorously. Now I know that's a cheat, but it's an important part of the answer because the things we are doing are very important. We are providing lots of needles and syringes. I think we need to do more in that area, and we certainly need to expand some of the orthodox treatments that we've got, including most particularly methadone and liberalise it.

The third area that I think that we need to go into, and these are now new initiatives and I'll just mention two as part of the new initiatives' third bracket.

That really is the whole range of things that were mentioned at the Prisons Conference that the Australian Institute of Criminology and NCEPH organised almost 12 months ago, and I think that shamefully we have to say that splendid though that communication was, wonderful though the ideas were which were presented in the communique, progress has been appallingly slow. And I think if we are going to have a conference in ten years to say what went wrong, why did Australia go that way after such a wonderful first decade where we contained the epidemic, why did it escape out of control I think the answer will be, if it does escape out of control, that we didn't stop the spread in prisons.

I think that the next new initiative is that we really haven't done anything about sexually transmitted diseases in the injecting drug using populations. We don't have good evidence that it's much higher than in other populations but the evidence we have got points in that direction. And as an important co-factor for a behavioural practice - namely sexual behaviour - that we have such great difficulty in changing in all heterosexual populations, it's something that we ought to be doing something about. So those would be the answers.

PETER McDONALD

Thanks Alex, I guess I was not wanting to get into a "how to control HIV" debate today but the prisons are really something that have to be tackled. I found it interesting that the Thai studies of injecting drug users looking at what their associated risk factors were in terms of being HIV positive, are different from ours. Unlike our population, where they turn out to be high risk sexual contacts, in Thailand it's being in gaol that is your major risk factor.

ADRIAN BUSOLIC
QUEENSLAND DEPARTMENT OF HEALTH

One thing that's worrying at the moment is that we seem to be becoming victims of our own success to date. There may be some danger in overlooking the importance of potential, and so I was particularly worried when you were saying about Glasgow that there may be some evidence that there's a lot of needle sharing going on but not transmission through that vector.

I'd be interested to know exactly what are the measures of needle sharing, plus the patterns of partner change for needle sharing. Because I think that we may be running the risk of neglecting potential spread, because obviously it *is* potential. Perhaps we are underestimating the potential now, simply to explain the fact that the rapid increase hasn't occurred in this country yet. And for studies like this I think it's important to stress that we are trying to prevent the potential.

PETER McDONALD

Thank you for making that point. I am conscious of the fact that in a sense there is a negative or down side in saying we have a low seroprevalence amongst drug users therefore we can soften up in analysing the situation. I think there is the potential for an explosion of HIV amongst drug users, and I think it's important to refocus on the critical factors associated with it. It seems to me that we need to refocus on the sexual practices associated with the drug using group, perhaps to a greater extent than has been done. And those initiatives are underway.

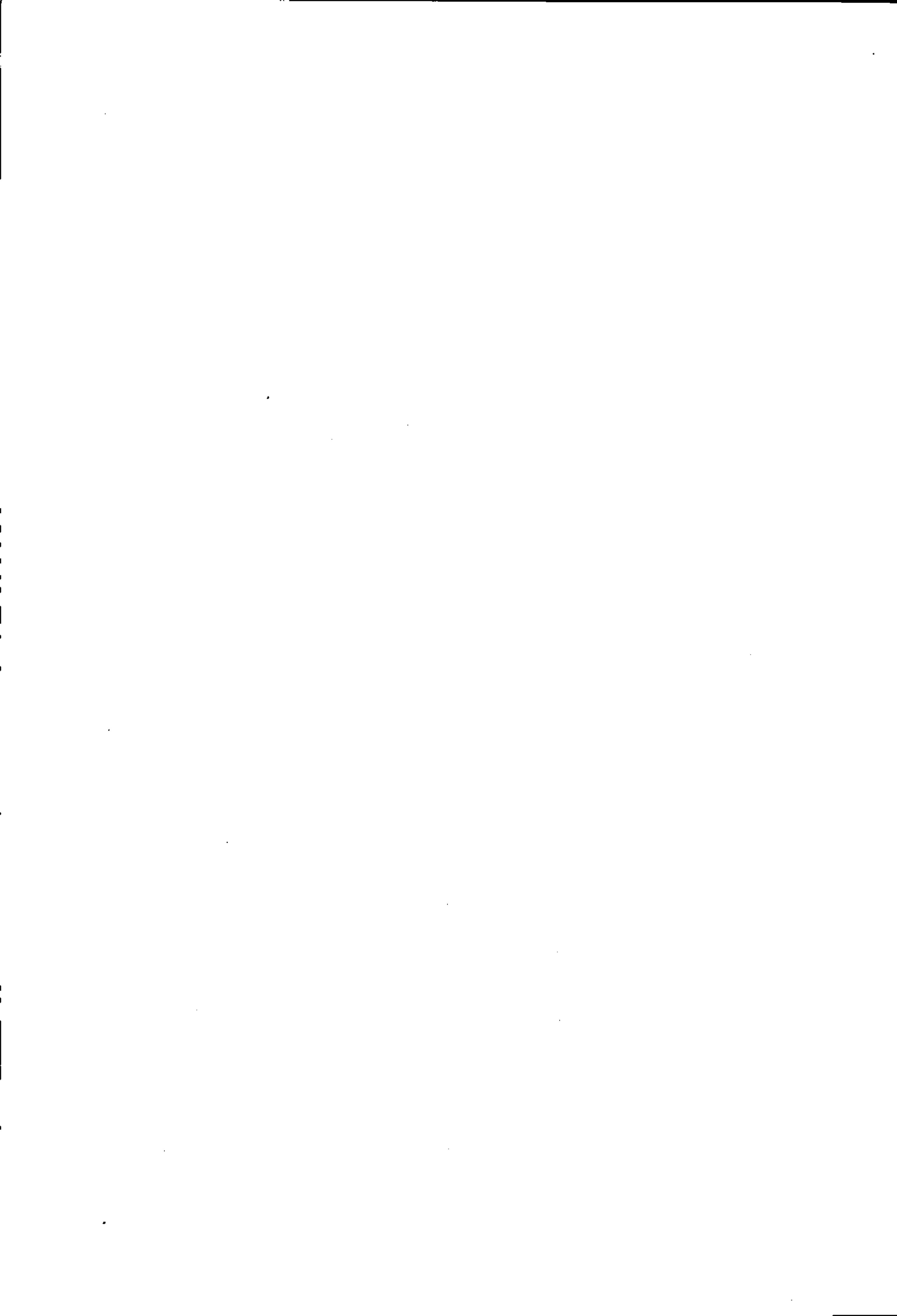
IAN WEBSTER
DRUG & ALCOHOL SERVICE, SOUTH WESTERN SYDNEY AREA HEALTH SERVICE

Peter, you said that the sampling of the antibody from the needles had been discredited as an epidemiological technique. But reflecting on your last response, and thinking about the low level of prevalence of HIV infection (as it seems to be) amongst intravenous drug users, how does that compare with hepatitis B prevalence? I did studies back in 1974 where 75% of intravenous drug users had evidence of past or current hepatitis B infection and it seems that they both had the same sort of risk factors. And I wonder how the current prevalence rate of hepatitis B now correlates with HIV.

PETER McDONALD

Clearly hepatitis B transmission correlates with needle sharing. Hepatitis B has come under some measure of control because of vaccination. Hepatitis C, however, is perhaps a slightly better marker, and there is clear evidence that it is an association of injecting drug use and needle sharing. I wouldn't want to make the point that needle sharing is not an HIV risk factor. If I said that or if it was interpreted that way, I want to recant that.

I guess what I think is coming through is that the actual risks of needle sharing or the extent of risk associated with needle sharing may not be as great as we might have thought. That's based more on the occupational health accidental exposures and rates of circumstances of transmission than it is on analysis of needles. I don't know that I'd say that that's an absolutely discredited epidemiologic tool, it's just one that's very difficult to do well epidemiologically.



The Effectiveness of Methadone Treatment: Implications for a Trial of Injectable Heroin

Wayne Hall BSc PhD, Jeff Ward BA, Julie Hando BA
Associate Professor and Deputy Director, Senior Research Assistant, Research Assistant, National Drug and Alcohol Research Centre

(The paper was presented by Wayne Hall)

The aims of this paper are: to discuss the competing rationales and goals of the variants of methadone treatment used in Australia; to outline the research evidence on the average efficacy of methadone treatment and the factors that may explain variations in outcome between different methadone programs; and to discuss some of the issues that research on methadone raises for the proposed trial of the controlled availability of heroin and other opioids (which in the interests of brevity will be abbreviated as the "trial of injectable heroin").

The effectiveness of methadone treatment is relevant to the proposed trial for several reasons. First, it is a type of drug substitution treatment which differs from the controlled availability of opioids in providing an oral opioid rather than injectable heroin. Second, it has been a controversial treatment modality since its introduction, and because of this it has been the most intensively studied treatment for opioid dependent persons. Third, some of the issues raised by the literature on the outcome of methadone treatment have direct implications for the design of the proposed trial of injectable heroin.

The paper is based on a review of the research literature on methadone conducted as part of two projects at the National Drug and Alcohol Research Centre, namely, the Quality Assurance Project funded by the Research into Drug Abuse Program, and a Policy Review of Methadone which was commissioned by the New South Wales Directorate of Alcohol and Drugs, both of which are directed by Richard Mattick. These literature reviews have been substantially improved by the critical commentary of expert practitioners and by the deliberations of a consensus conference of Australian experts in the treatment of opioid and polydrug dependence. The views expressed in this paper are, nonetheless, those of the authors and do not necessarily reflect the views of other project staff, the clinical experts consulted, or the funding agencies.

METHADONE TREATMENT

The rationale of methadone

The original Dole and Nyswander model (1965, 1967) was of methadone maintenance in which injectable heroin was replaced by a legally available, orally administered opioid drug which had a sufficiently long half-life to allow for daily dosing. The assumption was that the underlying cause of heroin addiction was a metabolic disease which produced a craving for heroin and other opioid drugs. The craving, which in turn motivated the addict's involvement in crime to procure supplies of heroin, would be eliminated by the provision of methadone which, when given in sufficiently high doses, would also reduce the rewarding effects of injected heroin because of cross-tolerance.

The duration of methadone maintenance was to be indefinite on the hypothesis that the underlying metabolic disorder of addiction was analogous to that of insulin-dependent diabetes which required the daily provision of insulin for life. The major goals of treatment were the reduction and eventual elimination of illicit drug use and of the criminal activity engaged in to finance drug use. A secondary goal of treatment was social

rehabilitation, which was to be accomplished by the provision of vocational and other rehabilitation services within methadone programs.

After its introduction in the early 1960s, methadone maintenance rapidly proliferated in the United States. It was introduced into Australia in the late 1960s by Dr Stella Dalton and gradually expanded during the 1970s. In the early 1980s the scale of methadone provision in Australia contracted largely because the treatment failed to live up to the high expectations that some had of it as a "cure" for heroin addiction (Burgess et al 1990). The reasons for the disenchantment with methadone continue to be contentious; its critics regarding it as a consequence of the failure of methadone to deliver on the promises of its proponents; its defenders attributing it to a failure to implement methadone maintenance as described by Dole and Nyswander.

Methadone treatment regained popularity in Australia during the middle 1980s, largely in response to fears about an epidemic of HIV among injecting drug users. There was a rapid expansion of program places after the National Drug Summit endorsed methadone as part of the strategy for treating heroin dependence in 1985. This accelerated throughout the late 1980s with an increase in the number of persons on methadone from 2,203 in February 1985 to 6,597 in June 1989 (Commonwealth Department of Community Services and Health 1989). The expansion of programs was accompanied by a change in their goals to harm-reduction by reducing drug use and transmission of HIV.

Inevitably, the rapid expansion of methadone programs led to a proliferation of competing models, rationales and goals of methadone treatment. There are probably few workers today who embrace the metabolic disease model of Dole and Nyswander, although there are a small number of programs which implement something like the original model of methadone. Survey data of methadone agency staff (Baillie et al 1991) suggest that many more staff operate within a therapeutic model, according to which the goal of methadone treatment is abstinence from all opioid drugs, including methadone, within a period of several years.

One consequence of the adoption of such a therapeutic approach has been a move towards time-limited treatment with abstinence as a goal, and a reduction in average doses of methadone from the levels originally used by Dole and Nyswander. These trends have been observed in both the United States and Australia (Gerstein & Harwood 1990). The reasons for the change have been a combination of economics - the scarcity of places on methadone encouraging staff to create vacancies for new patients by discharging old ones - and the incorporation of methadone into the more traditional abstinence-oriented therapeutic ideology of practitioners in the drug and alcohol field.

Pluralism in program rationales and goals makes it difficult to evaluate the efficacy of methadone treatment. Nonetheless, it is still necessary to ask the question: does the average heroin dependent person who enters an Australian methadone program have a reasonable chance of benefiting from the experience?

The efficacy of methadone treatment

In the best of all possible worlds, the efficacy of all treatments for drug and alcohol dependence would be evaluated by well-conducted randomised controlled trials (RCTs). That is, clinical experiments would be conducted in which large representative samples of patients were randomly assigned to receive either a specified treatment or some ethically defensible minimal form of treatment (eg. advice to stop drug use and referral to Narcotics Anonymous). This rarely happened when methadone treatment was first introduced, and nearly thirty years later it is practically, politically or ethically unacceptable to do so.

Only a very few randomised controlled trials were carried out at the time of methadone's introduction. These involved small numbers of patients, short follow up periods, and rudimentary measures of outcome (Dole et al 1969; Newman & Whitehill 1979; Gunne & Grönbladh 1981). Although all produced positive results, despite small sample sizes, three trials are too few to provide an adequate basis for the evaluation of the efficacy of methadone. Such evaluation therefore depends upon the corroborative results of prospective observational studies in which statistical methods of control have been used to deal with the major threats to the validity of inferences which are dealt with by randomisation in controlled trials.

Observational studies of methadone efficacy

The most convincing observational studies of treatment efficacy are controlled studies in which persons who select themselves into treatment are followed prospectively, and their outcomes compared with the outcomes of persons who select other forms of treatment (eg. therapeutic communities or drug-free counselling). The major problem with the interpretation of comparative observational studies is that, in the absence of random assignment of patients to treatment, it is uncertain whether people receiving different forms of treatment were comparable prior to treatment. It is accordingly difficult to rule out the possibility that apparent differences in treatment outcome are a consequence of differences in patient prognosis prior to treatment.

The strategy of quasi-experimentation (Cook & Campbell 1979) provides a way of making cautious causal inferences about treatment efficacy. Plausible rival hypotheses are generated to explain any apparent differences between treatments in outcome. Patients are then measured on relevant variables and statistical methods of control (eg. stratification and covariate adjustment) are used to decide whether the rival hypotheses explain the differences in outcomes between treatments.

The most plausible rival hypothesis of any difference in outcome between methadone and other forms of treatment is that people receiving each of the treatments differed in their likely outcome before treatment. In order to test this hypothesis, the relevant prognostic characteristics of patients in each treatment are assessed (eg. age, sex, severity of dependence, pre-treatment criminality and motivation to discontinue drug use) and covariate adjustment is used to discover whether the difference in outcome persists after adjustment for differences between patients in each treatment. If the differences in outcome persist after statistical adjustment, the analysts' confidence in a treatment effect is increased.

There are three major American studies which come closest to meeting these criteria: the studies of Bale and his colleagues (1980); the Treatment Outcome Program Study (TOPS) (Hubbard et al 1989); and the recent Three Cities study, the detailed results of which are reported by Ball and Ross (1991). Because of time and space considerations only the studies of Bale and colleagues and Ball and Ross are reviewed here. A more comprehensive review of all the major controlled observational studies is provided in Hall et al (1991).

a) Bale and colleagues 1980

Bale and his colleagues (1980) planned to conduct a RCT of methadone maintenance, therapeutic communities and simple detoxification. Ethical and practical problems compromised the integrity of random assignment to treatment, resulting in a study in which subjects selected their own treatment. The outcomes of patients selecting methadone treatment, therapeutic communities, and detoxification only were compared at 12 months post-treatment.

There were several distinctive features of this study. First, subjects who entered methadone and therapeutic communities were very nearly comparable, as indicated by a comprehensive pre-treatment assessment. The main reasons for this were that subjects were recruited from a common pool of potential patients (opioid-addicted veterans in the Veterans' Administration treatment system), and that staff from each of the treatment programs competed for the patients on conditions of near equality. All had access to the potential subjects while they were in hospital, and subjects were encouraged to spend three weeks in the program to which they were assigned before they could change to the program of their choice.

Second, a number of different programs were represented within each treatment modality. Three therapeutic communities with a variety of orientations, and two low dose methadone programs were compared with simple detoxification provided in the main treatment centre from which all subjects for the study were recruited.

Third, 93% of patients were followed up at 6 and 12 months. Unlike many other studies, the results of treatment were available for almost all who entered treatment, regardless of how long they stayed, and not just for the treatment successes. Moreover, outcome was assessed by an independent interviewer who was unaware of which treatment the subject had received, and efforts were made to validate self-reports of drug use and criminal activity.

The major results which are relevant to the purposes of this review are those which compare the outcomes of methadone maintenance with those of simple detoxification; the comparison between methadone treatment and therapeutic communities, which failed to find any difference in average effectiveness, will not be discussed. The results indicate that the two methadone maintenance programs produced better outcomes than did detoxification when measured by reductions in opioid drug use during the past month and the number of convictions recorded during the past year. The differences between methadone maintenance and detoxification persisted after adjustment for 10 covariates which had been shown to predict outcome.

A number of caveats need to be considered in interpreting this study. First, the type of methadone maintenance provided in this study differed in several ways from that recommended by Dole and Nyswander. Both programs prescribed low doses of methadone (see Ward et al 1991) and they encouraged their patients to become abstinent. Second, the combination of a small sample size for methadone and the use of crude dichotomous measures of outcome reduced statistical power and hence the sensitivity of the study to detect differences in outcome between treatment modalities. Third, persons who received detoxification only were entirely self-selected in that they consisted of persons who declined any other form of treatment.

Even allowing for these qualifications, the study by Bale and colleagues provided evidence of the efficacy of methadone maintenance which supported that obtained in the three RCTs. The methadone programs produced better outcomes in terms of drug use and criminality than detoxification, and this difference in treatment outcome was not explained by the covariates that Bale and colleagues measured. In terms of the quasi-experimental strategy outlined above, this study provides qualified support for the conclusion that the differences in outcome between methadone maintenance and detoxification were caused by the difference in treatment.

b) Ball and colleagues

Ball and his colleagues (Ball et al 1988; Ball & Ross 1991) have recently reported the results of a large scale outcome study of methadone treatment involving six methadone programs (two each in Baltimore, Philadelphia and New York City) over a three year period between 1985 and 1987. Six hundred and thirty-three male patients were interviewed during the winter of 1985-86, and 506 were reinterviewed a year later about

their drug use history, their last period of injecting drug use and their past and current criminal activity.

The initial sample consisted of 113 new admissions and 520 patients who had been in treatment for at least six months. At follow-up 388 had remained in treatment throughout the follow-up period and 107 had left treatment at some time during the intervening year. The characteristics of the methadone programs were also extensively assessed to determine if there was any relationship between program characteristics and outcome.

The findings showed that methadone maintenance had a dramatic impact on injecting drug use and crime among the 388 patients who remained in treatment during the follow up year: 36% had not injected since the first month on methadone maintenance, 22% had not injected for a year or more, and 13% had not injected in the past 1-11 months. In all, 71% had not injected in the month prior to interview, and the rate of injection among the 29% who had injected in the past month was substantially less than before treatment. The results also showed that some programs were more effective at eliminating drug use than others: four of the programs reduced drug use by between 75% and 90%, whereas in the other two programs around 56% of patients were still injecting.

Among the 107 patients who had left treatment by the time of follow up, 68% had relapsed to injecting drug use. The relapse rate increased over time, reaching a maximum of 82% among patients who had been out of treatment for more than ten months. Those patients who had been in the less successful programs had higher relapse rates than those who had been in the more successful programs. Overall, these results suggested that methadone maintenance substantially reduced injecting drug use among the majority of patients, and that some methadone programs were more effective than others in achieving this goal.

The reduction of crime associated with retention in methadone maintenance was also impressive. The study sample had an extensive criminal history prior to entering methadone: a total of 4,723 arrests, with a mean of 9 arrests for the 86% of the sample who had been arrested. Sixty-six per cent of the group had spent some time in gaol, 36% having been incarcerated for two or more years. The sample as a whole admitted to 293,308 offences per year during their last period of addiction. Among those who admitted committing criminal acts, each person committed an average of 601 crimes per year (range 1 to 3,588) and had committed criminal offences on an average of 304 days per year during their last addiction period.

After entry to methadone, the number of self-reported offences declined to 50,103 crimes per year and the mean number of "crime days" per year decreased from 238 in the year prior to entry to 69 crime days during the early months of methadone maintenance. The number of crime days continued to decline with the number of years spent in treatment. In terms of the number of crimes committed, the reduction during methadone maintenance was 192,000 offences per year. As Ball and Ross (1991) remark, such a substantial reduction in criminal activity has only ever been achieved within the heroin-using population by incarceration. As might be expected given the relationship between drug use and crime, some programs were more successful than others in reducing crime.

The more effective programs in the study by Ball and colleagues had the following features: they prescribed higher doses of methadone and had as their goal of treatment maintenance rather abstinence; they offered better quality and more intensive counselling services and provided more medical services; they retained their patients in treatment and managed to achieve compliance in terms of regular clinic attendance; they also had close, long-term relationships with their patients and had low staff turnover rates.

Two important points emerged from this study. The first was that different types of methadone treatment programs differed in their level of effectiveness. The second was that, on average, methadone treatment was effective for the majority of patients but only while they were maintained on methadone; they relapsed to drug use once they left

treatment. The fact that the sample in this study was restricted to inner-city males with long histories of dependence (mean = 11.2 years) and long-standing criminal involvement provided a stringent test of the efficacy of methadone treatment. It is reasonable to assume that if methadone treatment was effective in this difficult population, then it would also be effective with a less troubled group.

The relevance of US studies to Australia

There have been no controlled clinical trials and no large scale prospective studies of methadone maintenance in Australia which are comparable to the TOPS or the study by Ball and colleagues. 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. This situation reflects the lack of funding for such research in the past rather than the competence of researchers, many of whom have managed to conduct creditable studies with a minimum of support.

Given the absence of Australian research, assessments of the efficacy of methadone maintenance in Australia have depended upon the assumption that the results of American research are applicable here. Is this a reasonable assumption?

We believe that, on the whole, it is. The characteristics of methadone patient populations reported in American studies are primarily of unemployed males, aged around 25-35 years, who have a long history of opioid dependence and extensive criminal backgrounds. Surveys of Australian methadone patients reveal a similar population, although there have been changes since the introduction of methadone treatment (Bell et al 1990; Reynolds et al 1976). Methadone patients have been getting older, more females are applying for treatment, the patients' history of dependence is longer, and more patients are appearing with histories of criminal activity and polydrug use. The major difference between American and Australian treatment populations is in ethnic composition, the importance of which is diminished by the consistent findings of controlled clinical trials in three different cultural contexts (New York, Hong Kong, and Stockholm).

The variations in goals and policies between Australian methadone programs is probably within the range observed in the major American multi-centre studies. In addition, the relationship observed between program characteristics and treatment outcome has been similar in both America and Australia. There is suggestive evidence that the length of time spent in Australian methadone programs is associated with a reduction in opiate use (Dalton & Duncan 1979; Reynolds & Magro 1976) and criminality (Bell & Hall 1991). Methadone dosage is an important predictor of retention in treatment (Caplehorn & Bell 1991; Reynolds et al 1976).

There is clearly a need for good quality Australian research on methadone treatment programs, which documents not only patient characteristics and program retention, but looks at longer term outcome and examines the relationships between outcome and program characteristics. Until such time as these studies have been done, it is defensible to assume that the American results can be cautiously extrapolated to Australia.

An overall appraisal of efficacy

In arriving at an overall evaluation of the efficacy of methadone maintenance we have examined the degree to which the observational and experimental evidence satisfied a modified set of criteria suggested by Bradford Hill (1977) for making causal inferences from observational data. Although none of these criteria are necessary for the establishment of a causal connection between treatment and outcome, the more of them that are satisfied the greater our confidence in a causal relationship.

Strength of association: Relationships which are strong, indicating a high degree of predictability of outcome in the event of treatment, are more deserving of trust than those based on a weak relationship. This is in part because the latter are more easily explained in terms of assessment bias or selection (Bross 1967; Schlesselman 1978).

The relationship between methadone maintenance and a reduction in illicit opioid use and criminal behaviour is on average a reasonably strong one. The rate of each approximately halves with each year that a patient remains in treatment. The relationship between methadone and outcome is strongest in the small number of randomised controlled trials which compare its efficacy with little or no treatment.

Consistency: A relationship is consistent if it is observed in studies conducted by different investigators, using different study methods, in different populations. Relationships which are consistent are less likely to be explained in terms of chance, sampling idiosyncrasies and methods of study.

A relationship between methadone treatment and reduced drug use and criminal behaviour has been consistently observed in controlled trials, quasi-experimental studies, comparative studies, and pre-post studies in the United States, Sweden and Hong Kong. The same relationship has been observed in a limited number of studies in Australia.

Specificity: Specificity exists when the relationship between the occurrence of treatment and outcome is such that if treatment is given, the outcome occurs, and if the outcome is observed, then one can confidently infer that treatment has been given. This criterion is desirable in that, if it exists, it suggests that there is a strong relationship between treatment and outcome. But it is not necessary in that its absence does not exclude the possibility that treatment makes a contribution to a good outcome.

A degree of specificity is evident in the relationship between methadone treatment and outcome. Its effects are most evident on those outcomes it has been designed to affect: opioid use and criminal behaviour motivated by the need to finance illicit opioid use. Its effects are less marked on outcomes other than illicit opioid use, namely, other illicit drug use and vocational adjustment (unless this is specifically addressed, as in the original Dole and Nyswander program and in the Swedish methadone program).

A dose-response relationship: A dose-response relationship between exposure to treatment and outcome (eg. the longer the time in treatment, the more intensive the treatment) is desirable. Such a relationship increases confidence that there are some specific treatment components which are responsible for the benefits of treatment.

A dose-response relationship between methadone maintenance and reduced opioid use and criminality is shown in three ways. First, there is a relationship between the dose of methadone received and treatment retention and outcome. Both within individual programs and between programs, the higher the dose of methadone the longer the retention in treatment, and the better the outcome (see Ward et al 1991). Second, there is a relationship between treatment duration and benefit: the longer patients remain in treatment, the better the outcome, and this relationship is apparently not explained by a higher retention rate among patients who have a good prognosis. Third, there is suggestive evidence that the strength of the relationship between methadone treatment and outcome also varies with the fidelity with which the Dole and Nyswander model of treatment has been implemented. That is, demonstrated effectiveness decreases to the degree that methadone moves away from the high dose maintenance treatment with extensive ancillary services initiated by Dole and Nyswander towards low dose programs which aim to achieve abstinence.

Plausibility: A relationship is plausible if it is consistent with other relevant knowledge (eg. about the mechanisms of addiction). The consonance of a relationship with such mechanisms enhances our confidence in it.

The rationale for the effectiveness of methadone maintenance is plausible. Opioid dependence is characterised by an overweening preoccupation with the procurement of illicit opioid drugs to the detriment of the user's health and well-being. The provision of methadone in sufficiently high doses to avert withdrawal and reduce the positive effects of illicit drug use, reduces the salience of opioid use and the necessity for users to spend most of their daily existence in the pursuit of opioid drugs.

Coherence: A relationship is coherent if it makes sense of other information about the natural history of the condition.

The evidence on the effects of methadone maintenance coheres with what is known about the natural history of opioid drug use, namely, that it is a chronic relapsing condition with a high mortality rate. It accordingly takes time for methadone maintenance to achieve its benefits because of the long-standing nature of opioid use prior to the initiation of treatment, and its effects only last while people remain in treatment because of the high rate of relapse to drug use.

Experiment: Although there is limited experimental evidence of the effectiveness of methadone maintenance it is consistently positive. There have been only three controlled trials (Dole et al 1969; Newman & Whitehill 1979; Gunne & Grönbladh 1981), all involving small numbers of patients in three very different cultural settings, but all provide evidence of substantial differences in outcome on opioid drug use and crime, which favour methadone.

"On average": Some caveats

Taken as a whole, we believe that the available evidence provides good reasons for believing that, on average, methadone maintenance is an effective form of treatment for opioid dependence. The phrase "on average" implies a number of caveats, which need to be spelt out.

First, there is considerable heterogeneity in the characteristics of methadone programs, and in their effectiveness in reducing drug use and criminal acts. The factors responsible for this variability are not well understood, although they include the clientele of the programs, the dose of methadone given, the duration of treatment, the quality of the therapeutic relationships, and perhaps the intensiveness of ancillary services.

Second, the most effective programs are those which most closely resemble the model introduced by Dole and Nyswander, namely those which provide higher doses of methadone in the context of a comprehensive treatment program with maintenance, rather than abstinence as a treatment goal. The efficacy of programs which depart from this model, by reducing methadone dose, by eliminating ancillary services, by imposing abstinence from methadone as a treatment goal, or by reducing the therapeutic demands on methadone patients in the interests of preventing needle sharing and the transmission of HIV, is much less certain.

Third, the benefits of methadone maintenance only continue as long as patients remain in treatment. Patients who discontinue treatment seem to relapse to opioid use at a high rate. There have been too few studies of people who successfully "graduate" from methadone programs to say whether planned attempts at withdrawal and rehabilitation will succeed. This suggests that some individuals now entering treatment will be maintained on methadone for life. If the community believes that this is an acceptable option, then the economic consequences of this will need to be faced. Perhaps the intensity of programs for long-term stable maintenance patients can be reduced and efforts made to improve the post-methadone outcome of persons who may wish to stop taking the drug after many years of stable maintenance, or both.

Fourth, even though methadone is effective "on average" it is not a panacea for heroin dependence. About half of those who enter treatment will leave treatment or be discharged for continued illicit drug use within 12 months, and a substantial but variable proportion of those who stay in treatment will continue to use heroin and other illicit drugs, even if much less frequently, than before their entry to methadone.

When judged by the high standard of 100% of patients achieving enduring abstinence from all opioid drugs, the effects of methadone are "poor". But in the treatment of heroin dependence, as in most things, we must not let "the best be the enemy of the good" (Simon 1991). If instead, we compare the outcome of methadone treatment with what would have happened in its absence (Gerstein & Harwood 1990), the evidence suggests that other forms of treatment attract and retain fewer patients, and do not produce superior outcomes to methadone among those who complete treatment, while failure to provide any treatment carries a high risk of premature mortality and serious morbidity for users and high social costs for the commmunity.

ISSUES FOR THE PROPOSED HEROIN TRIAL

What is to be compared with what?

A central theme of this paper is that a variety of competing models of methadone treatment have evolved over time. The original model of methadone maintenance has been supplanted by a treatment which aims to achieve abstinence from all opioid drugs. More recently, abstinence-oriented methadone programs have been challenged by the development of programs with harm-reduction as their goal. One can foresee a similar evolution if the controlled availability of heroin were to be introduced.

The variety of possible treatment approaches raises the following questions: what type of controlled availability program will be compared with what type of methadone program?

What will be the major goal of the controlled availability of heroin in the proposed trial? Will it be maintenance of the status quo with heroin use while reducing the harm caused by illicit opioid use? Or will it be a means to the therapeutic end of transferring the person to oral methadone, with either the aim of eventual abstinence from all opioid drugs, or of indefinite methadone maintenance?

What is the appropriate form of methadone treatment against which to compare injectable heroin maintenance? Is it the Dole and Nyswander model, an abstinence-oriented treatment, or the newer harm-reduction programs?

The answer to each question will depend upon the aims of the trial. Do we want to know whether the provision of injectable opioids produces a socially and clinically meaningful improvement in outcome over and above existing forms of methadone? Are we interested in trying to tease out the specific contribution made to outcome by the use of injectable heroin as against oral methadone?

Whatever forms and goals of treatment and control conditions are eventually included in the trial, explicit guidelines will need to be developed for staff in both treatment programs. Care will also need to be taken to select staff whose therapeutic ideologies are consistent with the goals of the treatments. And the quality of treatment will have to be monitored throughout the trial to ensure reasonable fidelity to program goals and policies.

Will randomisation succeed?

In the study by Bale and his colleagues the researchers' best intentions to conduct a randomised controlled trial were subverted by staff and patients. Practitioners in the treatment service believed that it was unethical to randomly assign patients to treatment and so resisted this happening. The patients who did not like the treatment condition to which they had been assigned sought treatment elsewhere.

Given the special virtues of randomization in the evaluation of treatment outcome, efforts should be made to ensure its success. The experience of Bale and his colleagues suggests that the researchers will need to be vigilant to ensure that the same processes do not happen in the proposed trial. The integrity of random assignment will need to be monitored, and contingency plans developed to salvage the trial if its integrity is threatened.

How big a difference?

There are good reasons why we should not expect a large difference in outcome between the controlled availability of heroin and methadone treatment.

First, heroin dependent persons are difficult to treat. Most users have a 5 to 10 year history of illicit drug use and a thorough socialisation in the illicit drug culture before they are prompted to seek help. When they do present, they often enter treatment under legal or other duress and are usually ambivalent about discontinuing their drug use. Under these conditions it is not surprising that heroin dependence is a chronic relapsing condition which is often resistant to the best therapeutic efforts of treatment staff.

Second, these difficulties may be compounded by the incentives to participate in the trial. If one of the advantages of injectable opioid maintenance is that it attracts into treatment users who have proved resistant to the lure of existing services, then an even tougher therapeutic task may be faced. If so, the benefits of such treatment may be lower still. The results of the single randomised controlled study of heroin and methadone maintenance (Hartnoll et al 1980) were consistent with this expectation. It produced an equivocal result: heroin retained more users in treatment while having little effect on their drug use and criminality; methadone retained fewer people in treatment but produced a higher rate of abstinence.

For all these reasons, any benefits of controlled availability of heroin additional to those of methadone treatment are likely to be modest. This is not a reason for abandoning the trial because even a modest improvement in outcome would still be of substantial public health importance. The study design, however, will need to be sufficiently sensitive to detect differences in outcome of, at most, moderate magnitude between heroin and methadone treatment. Since design sensitivity is most reliably achieved by using a large sample, the study will take considerable time and money to accrue, treat and follow up a large sample for a sufficient period of time to provide a fair test of the comparative efficacy of the two forms of treatment.

Opportunity costs

The costs of the proposed trial are likely to be substantial for the reasons indicated. At a guess, it will probably cost a substantial fraction of a million Australian dollars, a very large sum by the standards of Australian research on drug treatment but petty cash by American standards. Providing a more credible estimate of the trial costs will be an important task of Stage 2 of the feasibility study.

Whatever the final cost of the trial proves to be we need to ask: what opportunities will be foregone in conducting it?

The answer depends upon on whom any opportunity cost will fall. There will inevitably be some opportunity cost to the community as a whole. The amount involved, it needs to be stressed, is small by comparison with the funds currently expended on law enforcement programs aimed at preventing drug use, or the judicial and penal systems which process and punish drug users, none of which have been adequately evaluated.

What will be the opportunity costs to the drug and alcohol treatment or research sector? Hard-pressed treatment staff will no doubt point out how many staff positions the amount of money required for the trial would buy. Researchers, with their own interests to promote, could argue that the money for the proposed trial could be better spent in other ways, such as investigating existing methadone programs with the aim of improving their outcome, or evaluating other under-studied forms of treatment such as therapeutic communities, residential programs, and self-help groups.

There are several things to be said in defence of expenditure on the proposed trial. First, it is by no means certain that the money required for the trial is transferable; that is, that if it were not spent on such a trial it would still be spent in the drug and alcohol field on either treatment or research. Controversial initiatives like heroin maintenance often attract funds that would not be forthcoming otherwise.

Second, in the course of conducting such a trial much useful knowledge could be gained about opioid dependence and its treatment, including information on the effectiveness of methadone treatment. Good researchers are opportunists who take whatever chances they can to improve their knowledge and it is likely that this would happen during such a trial.

Third, the proposed trial provides an opportunity for Australian drug and alcohol workers and researchers to make a unique contribution to research into the treatment of heroin dependent persons. If such a trial is not undertaken in Australia it is unlikely to be undertaken elsewhere. It is extremely unlikely, for example, that the National Institute of Drug Abuse in the USA, which has funded major research into methadone treatment, would countenance such a study, given their hostility to harm-reduction programs such as needle and syringe exchanges.

CONCLUDING HOMILIES

None of the issues we have raised are new to the team who have undertaken the feasibility study, as anyone who has read their comprehensive two volume report will know (National Centre for Epidemiology and Population Health 1991). These are the issues that seemed the most important from our reading of the methadone outcome literature. None of them are necessarily insurmountable obstacles to the conduct of a trial; they are the kind of challenges that imaginative researchers relish the opportunity to solve, and their investigation would be among the major tasks to be undertaken during the second stage of the feasibility study.

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Discussion

BOB DOUGLAS, CHAIR

Dr Bammer, do you want to make any comments?

GABRIELE BAMMER

I think a number of important issues were raised by that paper which some of you have taken up with me during the morning break, and we can continue on in some of the other breaks. There are real issues in all of those caveats and problems that you have raised that need to be looked at very carefully and that is also part of what Stage 2 is all about. But I think there is also the feeling that we have an opportunity here to learn some things that will have valuable spin offs in a whole range of areas.

MARION WATSON
DRUG REFERRAL AND INFORMATION CENTRE, CANBERRA

One of the important questions that seems to be emerging from this for me (and I still do have some questions left about the provision of heroin) is the loss of people from programs and under what circumstances that's occurring. For my money, what is coming out now and has just come out of Wayne Hall's talk is "why do people leave methadone programs?" I think I know why, because we often see them when we are re-recruiting them to contact through needle exchange, through the IV Leagues and through the need for drug information. What is absent from the talk just given is the client's perspective on these things. Somehow looking at client perspectives is considered to be not 'objective'. They don't seem to be considered very highly; there is a some kind of a perception that clients do not have a useful input into the programs.

WAYNE HALL

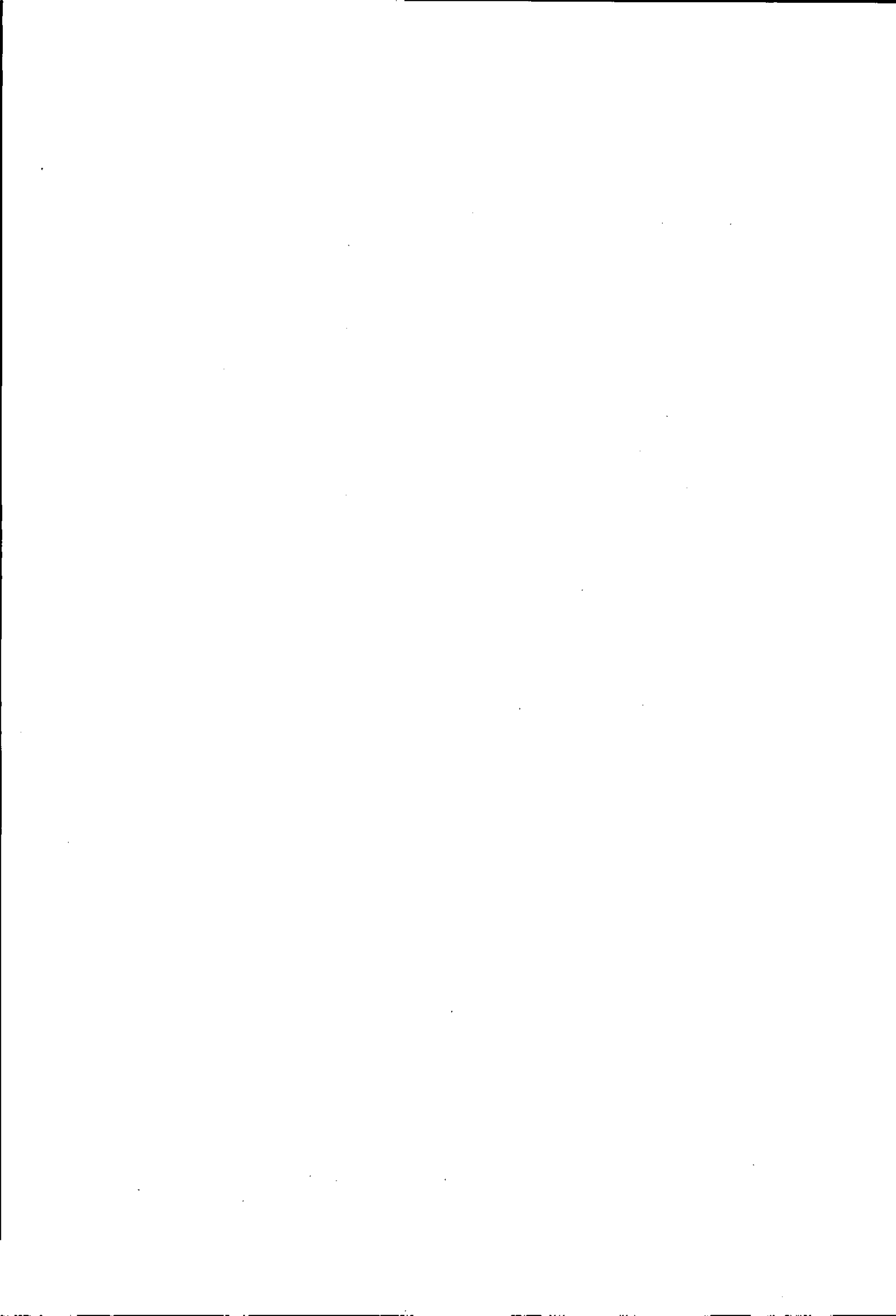
I think you're right. I would agree that it would be highly desirable to get more information on what goes on in programs, to get the points of view of the participants - the consumers. We need to know a great deal more about what goes on in existing programs, and if I was to "put a plug in" for anything else independently, then that's something that ought to be done.

LYNNE BLATCH
KARRILIKA - ALCOHOL AND DRUG FOUNDATION OF THE ACT

I'm not sure whether mine is really a question or whether it is a comment, but some of the statistics you used, Professor Hall, compared methadone with therapeutic communities, and you showed that they were about equal, which was one of the bases for showing that methadone was perhaps a good idea. I guess what I am saying is that it can just as easily show that therapeutic communities are just as efficient. So my concern around this is that, in looking at the drug substitution places which we'll be offering in the ACT, that with heroin plus methadone, we're looking at perhaps around 700 places. In terms of the drug free places that we offer to clients, it is less than one hundred. Could you comment on that in terms of the fact they are are about equal after all?

WAYNE HALL

Yes, I wasn't wanting to imply that methadone was the sole form of treatment that was effective and that we ought to invest all our bucks in methadone at the expense of drug free treatment approaches. They certainly do have a role, and they ought to be supported. I would not say anything to the contrary on that, and your interpretation of the Bale studies is reasonable.



Why Does Methadone Maintenance "Work" and What are the Implications for Heroin Maintenance?

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INTRODUCTION

Wayne Hall has presented evidence that methadone programs "work". I would like to ask the question "Why?" Why is giving drugs to addicts of benefit to the addicts and of benefit to the community? Why is it that in methadone maintenance programs benefits can be demonstrated? These are extraordinarily controversial and confused questions.

The basic gist of what I want to argue is that methadone is poorly understood by the community and by those people who work in it. There is such an extraordinary diversity in what the aims and intentions of methadone maintenance are among staff working in the clinics, that it is no surprise that the efficacy of programs is somewhat variable. In fact I would suggest that if this is the gold standard for narcotic addiction treatment it is a tarnished standard. There was a program introduced by Dole and Nyswander over 25 years ago which by most accounts is accepted to have been extraordinarily effective and it has been downhill ever since.

In 1983, the National Institute of Drug Abuse (NIDA) staged a seminal conference on the treatment of narcotic addiction. One topic listed for discussion was the efficacy of maintaining addicts with their drug of addiction as opposed to using methadone as a maintenance drug. Significantly, there was insufficient research literature on this topic to warrant reviewing. Discussants concurred that "methadone should be the only narcotic used in maintenance and detoxification from street addiction because of its ease of administration (oral), duration of action, and safety and efficacy" (Cooper et al 1983). At that time, there was no support for research on this topic.

Eight years later, there is still little research literature, but there is interest in new approaches to treating addiction. The importance of containing the spread of HIV has led to a reordering of priorities, in the community and in drug abuse treatment programs (Stimson 1990). Recognition that infection with HIV is a more serious predicament than is addiction to opioids has led many people to ask the question with which Vincent Dole began his research in the early 1960's - "What is so bad about narcotics?" (quoted in Courtwright et al 1989). One question now being raised is whether heroin addicts should be offered heroin maintenance in an attempt to attract more addicts into treatment and reduce the harm associated with using street drugs (Caplehorn 1990). In other words, can the whole principle of maintenance therapy and substitution therapy be improved by giving a drug that the addicts like better? Because addicts don't much like methadone; they regard it as a boring drug. Its street value is something like a dollar a milligram.

In order to explore whether heroin maintenance might be preferable to methadone maintenance, and how to frame this question into a research study, it is helpful to analyse how and why methadone programs are beneficial to those in treatment.

METHADONE MAINTENANCE

Methadone maintenance is modestly effective - and may have the potential to be quite effective - in reducing the harm associated with heroin use. However, despite two decades of research and discussion, methadone maintenance remains a poorly understood modality of treatment. Despite greater consensus over the goals of treatment, there remains little

agreement over how best to achieve these goals. Programs differ markedly in their policies and procedures and differ markedly in their capacity to retain addicts in treatment (Caplehorn & Bell 1991) and to reduce intravenous drug use (Ball et al 1988).

Despite a large number of published studies, research has contributed less than might be expected to treatment practices. From the many published studies, some consistent findings have emerged. Two findings in particular stand out. Firstly, there is consistent evidence that higher doses of methadone are associated with longer retention in treatment and with less heroin use. The studies demonstrating this were elegantly reviewed in 1983 (Hargreaves 1983). Subsequently published research (eg. Ball et al 1988) provides further confirmation of the importance of dose. The second reasonably consistent finding is that longer periods of treatment are associated with better treatment outcomes (Hubbard et al 1989; Simpson 1981; Ball et al 1988) and that few addicts are able to withdraw from treatment and remain drug-free. Despite the consistency of these two findings, there has been an increasing tendency in the USA towards prescribing lower doses of methadone (Hubbard et al 1989) and towards encouraging addicts to detoxify from treatment (Milby 1988). These policies appear to have been adopted in spite of research findings rather than being based on them.

This gulf between research and practice is also reflected in the lack of consensus over what is optimal care in methadone clinics. Different authors have emphasized the pharmacological properties of methadone, the place of support services and program rules, the role of counselling, or the clinic as a therapeutic environment. There have been a variety of approaches to treatment based on intuition and feeling rather than empirical findings. One author, describing the development of methadone programs in the USA, commented "Program directors and enthusiasts of each model became zealots for their particular approach, leading to considerable friction, a comparable loss in clarity of purpose, and goal displacement. Program type became more important than client status" (D'Amanda 1983:637). Methadone programs are guided by regulations concerning staffing levels, security, frequency of urine tests, and other primarily bureaucratic rules, but these are no substitutes for widely accepted standards of practice.

Evaluation studies suggest that methadone maintenance "works" but there is little agreement over why or how it does so. Without such a rationale for treatment, it is difficult to reach agreement on standards of clinical care. Several quite different explanations for why maintenance treatment is effective have been advanced, without any consensus. A recent Institute of Medicine report suggests that the evidence supporting the efficacy of methadone maintenance provides an adequate rationale for these programs (Gerstein & Harwood 1990). This pragmatic justification for the existence of programs offers little help in trying to interpret the results of research and develop more effective approaches to treatment.

In interpreting the results of research, what is needed is a framework of hypotheses which holds together and accommodates the observed phenomena - a scientific paradigm, in the sense defined by Kuhn (1970). Many theories about addiction and treatment have been advanced, yet none has had the explanatory power to gain widespread acceptance. In the absence of a paradigm of addiction there will continue to be difficulties in reaching any agreement over what constitutes optimal clinical management in methadone programs. Similar problems will plague any discussion of heroin maintenance.

In this paper I will review some of the mechanisms which have been proposed to explain why methadone maintenance is an effective treatment of addiction. Each of the therapeutic rationales which has been proposed emphasises a particular aspect of narcotic addiction. The divergent views about why methadone is effective illustrate the complexity of the problem.

RATIONALES FOR TREATMENT

Addiction as a metabolic disease

The rationale for methadone maintenance advanced by Vincent Dole, the pioneer of this form of treatment, is that the drug was being administered to correct a metabolic disease - a disease caused by prolonged exposure to opioids, which led to craving for narcotic drugs (Dole 1980). This account of addiction provided a powerful rationale for methadone maintenance - it was replacement therapy, analogous to the administration of insulin to a diabetic (Dole & Nyswander 1967). The measure of whether the dose of methadone was adequate was whether it suppressed craving for opioids - "drug hunger" (Dole & Nyswander 1965). In the light of recent research on the relationship between maintenance dose and in-treatment heroin use, he has recently restated this position (Dole 1988). Once this metabolic problem was corrected and the craving for drugs abolished, the patient could start leading a more normal life.

Central to Dole's theory was the claim that methadone differed significantly from other opioids in its ability to satisfy drug craving. He reported that in laboratory experiments the use of short-acting opioids as maintenance therapy led to persistent intoxication and seeking for more drug rather than to stabilisation (Courtwright et al 1989). In contrast, once an adequate dose of methadone was used patients ceased being preoccupied with drugs and began to turn their attention to more normal interests.

He explained these observations as being due to methadone's slow absorption and slowly declining blood levels between doses, which avoided the cycle of intoxication and withdrawal experienced by addicts using short-acting drugs such as heroin (Dole 1980).

It is important to note that Dole explicitly rejected the notion that treatment was merely pharmacological. He recognised the influence of sociological factors in addiction, but emphasised that recognising the "metabolic" aspect of addiction was essential to effective treatment. An adequate dose of methadone was necessary, but not sufficient, for effective methadone maintenance.

As an aside, I would like to comment here that the assumption that heroin is a short acting drug is based on studies using acute administration. The majority of intravenous drug users in NSW who regard themselves as addicted only inject twice a day, yet most of them are physically dependent. The explanation for this may well be that with repeated use there is an altered pattern of metabolism of heroin. Normally in the acute dosage it is metabolised to an inactive metabolite, morphine-3-glucuronide, which is fairly rapidly excreted. In chronic administration there appears to be induction of hepatic enzymes that produce a new metabolite, morphine-6-glucuronide. This is an extremely potent new agonist. In some studies it has been found to be 45 times as potent as morphine itself, and has at least in some situations a much longer half life. So it may well be that it is possible to achieve pharmacological stability with heroin maintenance and I would commend to the pharmacologists running this proposed trial that they might investigate that possibility.

Addiction as learned behaviour to be extinguished

While in his writings Dole placed little emphasis on psychological factors in the genesis of addiction, his theory of methadone "blockade" implicitly acknowledges the role of learning in maintaining addiction. He claimed that methadone in adequate doses produced blockade of opioid receptors, abolishing the effect of other opioids. Although not described in these terms, he was implicitly advancing a learning theory basis of methadone treatment: that by abolishing the reinforcing properties of heroin, methadone maintenance could help extinguish this learned behaviour.

This rationale is quite complementary to the notion of addiction as a metabolic disease - maintenance therapy with methadone not only abolishes the craving, but extinguishes the habit.

Dole's theories remain influential today. Most people working in methadone clinics believe the pharmacological stability achieved with methadone is central to treatment. Most addicts in treatment believe that there is a dose of methadone which will "hold" them and which will suppress their desire to use other drugs (Bell et al 1988).

Both these theories rest heavily on the specific pharmacological properties of methadone as being the key to its effectiveness. If Dole's theories are correct, heroin maintenance would not be effective in the rehabilitation of addicts.

Addiction as self-medication

"Disease" theories of addiction, like disease theories of alcoholism, emphasise that the primary problem for the addict is addiction and that other problems of psychosocial dysfunction result from this. On this view, "addiction" is the result of exposure to drugs in constitutionally predisposed individuals. It may be that there is some therapeutic benefit from this approach, and that focusing on drug use as the cause of the addicts' problems enhances their capacity to recover from their addiction.

However useful this conventional approach may be in treatment, it sits uncomfortably with the observation that many addicts exhibit problems of adjustment independent of their use of drugs (McClelland et al 1984). This has led to the alternative theory that addicts may use drugs as an adaptive mechanism, as self-medication to control dysphoric moods (Martin et al 1973; Khantzian 1985). The reason opioid addicts are prone to "relapse" to drug use is their need, particularly during periods of adversity, to control moods of rage and pain. It is not the patient's drug use which is "out of control", but their mood states, and drug use is in fact an attempt to regain control.

As pointed out in a recent authoritative review of drug abuse treatment, drugs "work" for addicts, and this is the major reason why drug users are reluctant to enter treatment (Gerstein & Harwood 1990). It answers the question: if drugs are so bad for people, why on earth do they use them? On this view of addiction, the use of methadone may be seen as an attempt to medicate people, to alleviate intense anger and psychic pain. The value of methadone in medicating addicts may be one reason for the greater therapeutic effectiveness of doses of methadone much higher than are needed merely to block withdrawal. Whether methadone is superior to long term use of heroin in controlling mood states is unknown. One study (Martin et al 1973) suggests methadone may not be particularly effective long term, and may even exacerbate dysphoria.

Drug use may "work" for addicts in more than pharmacological ways. For many young people lacking a sense of identity and purpose in the "straight" world, addiction provides meaning and a sense of belonging within a subculture. By relieving both dysphoric moods and the lack of identity experienced by alienated young people, drug addiction is an adaptation to a difficult world. Methadone maintenance stabilises this adaptation, while redefining the addict's identity - a redefinition elegantly described in the title of one of Marie Nyswander's papers "From drug addict to patient".

Methadone maintenance as a psychological treatment

While Dole emphasized the importance of methadone as a pharmacological treatment of addiction, he also observed that merely giving methadone was not in itself treatment. It is a commonly held view that the real "treatment" in methadone maintenance programs is not the drug itself but contact with clinic staff. Recent studies have confirmed that clinic

policies do influence the outcome of treatment (Ball et al 1988; Caplehorn & Bell 1991), over and above the marked effect of different policies regarding methadone dose. Such therapeutic effects may occur in a number of ways. It is convenient to summarize them under three broad mechanisms - individual and group counselling, behavioural approaches such as contingency management and treatment contracts, and the notion of the methadone clinic as a "therapeutic milieu" - a miniature society which allows the addict, through the support and structure offered by staff, to develop self respect and autonomy.

There has been considerable research into various approaches to counselling. Two broad approaches to counselling may be identified: psychotherapy and advice or information giving such as vocational counselling. It appears that many patients, particularly the more severely disturbed, can benefit from psychotherapy (Woody et al 1983). However, the most common finding in almost all structured investigations of counselling, either psychotherapeutic or skill based, has been that patients seldom continue to attend (Hall 1983) and there appears to be little demand for structured counselling sessions. This reflects the belief of most addicts that they do not have a psychological problem (Ball et al 1974). A recent report from the Treatment Outcome Prospective Study indicates that programs offering ancillary services, such as vocational and social work support, were not discernibly more effective than programs without these services (Joe et al 1991). It thus appears that while counselling may be of value in individual cases, there is little evidence that it is integral to the effectiveness of programs.

In many cases the treatment is presented as some form of contract that clients enter into; they come and get drugs in return for which they obey certain rules. The commonest rule is that once a week they have to go and urinate under supervision to see whether they are using drugs. And in a sense this is the almost religious significance of methadone; that people come and take the sacrament daily at the temple of "done" and once a week they are referred to the confessional. This is a urinal, where you get the dirt on them. And where, instead of relying on some vague mumbo jumbo from a priest, you get thin layer chromatography to determine how exactly this person has erred in the preceding few days. And, of course, associated with this approach there is penance. Contingency management, as it is known, is a system of rewards and punishments so that if you are a bad person you lose privileges or get dealt with harshly, and if you are good you may get weekend takeaways or something like that. This sort of carrot and stick approach is almost universal in methadone programs.

Many clinic policies are based on behavioural approaches, particularly contingency management. Contingency management policies are usually aimed to reduce illicit drug use (for example by removal of take-home dose privileges if urine testing indicates heroin use). Despite the widespread use of such approaches, structured trials of contingency management have not in general demonstrated any benefits. This may be due to the limitations of research design, but quite probably indicates that contingency management is not integral to the effectiveness of treatment.

Seeing the clinic as a therapeutic milieu assumes that the clinic is experienced by the addict as an expression of society and authority. The addict's non-methadone experience is that society responds to drug use with disapproval and punishment; other forms of treatment reflect these anti-drug attitudes. In contrast, methadone maintenance provides validation of the addict's experience that he or she needs drugs. Through demonstrating acceptance of his or her need for drugs (by giving methadone in adequate doses and by accepting that some patients will continue to use heroin and other illicit drugs), maintenance programs can define a new relationship between the addict and society. They allow the addict to re-integrate into society without abandoning drug use - something which he or she experiences, however ambivalently, as necessary. Where the addict previously experienced rejection and punishment, through the clinic he or she experiences acceptance and support.

The clinic must provide more - it must also provide structure to contain the anger and acting-out which features in the lives of many addicts before and during treatment. The clinic, by virtue of dispensing methadone, has the precious capacity to soothe distress and sustain the addict in a sense of well-being. The dependency experienced in the relationship between clinic and patient means that the clinic is also the target of the primitive rage aroused by unmet or delayed dependency needs. In reacting to anger and rule infractions, the therapeutic challenge is to avoid reacting with the fear, loathing and punishment that has been the addict's more usual experience of authority. It can be difficult to run a clinic in which both staff and patients feel safe with the patients' destructive impulses.

On this view, how staff members relate to patients - the total interaction between clinic and patient - is the key to the effectiveness of treatment. Staff members who are punitive and rejecting, or who believe that addicts "shouldn't need methadone", presumably undermine the effectiveness of treatment. This view of how programs work also explains why active attempts to "treat" patients - to change their behaviour through counselling or contingency management - do not achieve their expected benefits, as they run counter to the essential aspect of methadone maintenance, which is acceptance of the addict's validity as he or she is.

Giving heroin is a far more validating form of treatment than giving methadone and may be the implicit assumption behind proposing a heroin maintenance program. It may therefore well be more effective in that regard.

Methadone maintenance as a response to a social predicament

The dominant community understanding of addiction is that it is essentially a moral problem, a foolish and tragic act of rebellion by young people who experience alienation, frustration and a lack of identity in the "straight" world. The addict lifestyle, revolving around intoxication, illicit activities to support their drug use, and risks to health, is an eloquent rejection of conventional values. The spectacle of young people adopting heroin use despite the punishments, wretchedness and emptiness of life as an addict is one which has etched its way into the consciousness of the western world. It is not only tragic, it is wrong. It is sufficiently threatening to society that one influential nation has gone to the remarkable lengths of declaring war on drugs. Most western nations have adopted a similarly bellicose attitude towards drugs and drug use.

As with all aspects of methadone maintenance, Vincent Dole well understood the sociological implications of addiction. In 1973 he commented "The despair and anger of sensitive people stem from deteriorating neighbourhoods. Many underprivileged young people today avoid heroin to keep themselves fit to be militant, and to assert themselves in a repressive society. Let us therefore see the urban drug problem in the context that created the epidemic, and recognise the social conditions that breed addiction" (Dole & Nyswander 1973).

From a sociological perspective, the rationale for methadone maintenance is that it offers a way out of the impasse between a society committed to a war on drugs and individuals expressing their disaffection through addiction to opioids. This largely symbolic struggle - between a society promoting order and sobriety, and some of its most disadvantaged citizens expressing their alienation - is mutually destructive. By giving drugs to addicts and calling it a form of treatment, the impasse can be resolved.

This view of methadone programs has treatment implications. It suggests that the therapeutic efficacy of treatment rests on calling a truce between society and the addict. In so far as treatment is based on behavioural contracts, punishments and rewards aimed at making the addict behave in certain ways, programs may be undermining this truce and reducing their own efficacy in achieving the very changes they seek to bring about. In

contrast, more tolerant programs which do not seek to push patients towards socially acceptable behaviours may be more effective in achieving such goals because they promote patient autonomy.

INTEGRATING DIFFERING PERSPECTIVES ON METHADONE MAINTENANCE

These explanations for the effectiveness of methadone treatment variously emphasize the drug's pharmacological and symbolic role. Each provides a plausible explanation for at least aspects of the efficacy of maintenance programs. Integrating the biological, psychological and sociological perspectives on addiction and its treatment is intellectually and emotionally challenging. However, these mechanisms are not mutually exclusive, and it seems likely that all are operative and important in treatment programs. Taken together, they provide a picture of how treatment should operate - adequate doses of methadone administered by staff who are able to provide the individual support and structure needed to meet the dependency needs of clients while protecting the safety of staff and clients.

However, there is considerable resistance to acknowledging both the pharmacological and symbolic importance of giving enough methadone. Instead, there is marked ambivalence about validating addicts and addiction. This is apparent in the policies of many methadone clinics, which favour low doses of methadone and use rewards, punishments and exhortation in attempting to control patients' behaviour. It is particularly apparent in the way urine testing is used, and the collective preoccupation with how many "dirty" urines patients put in. Far from accepting and validating drug users, the belief that drugs and drug users are bad or dirty permeates many methadone programs.

This is no surprise, for programs reflect the society that funds them. Drug use is widely seen as a moral fault - a modern day "fall of man" through tasting of forbidden fruit. This powerful image has contributed to community ambivalence towards methadone maintenance, an ambivalence shared by staff working in methadone clinics (Hubbard et al 1989), and by clients in treatment. Many clinicians (and clients) retain an essentially moral view of drug use, and these attitudes compromise the effectiveness of treatment. An emphasis on personal responsibility and the wrongness of drug use may be appropriate as a prevention strategy, and has been argued to be highly effective (Peele 1988). Such emphasis may also be of value in drug-free therapeutic communities and in self-help groups. However, emphasis on the wrongness of drug use is misplaced in methadone programs; integral to giving methadone is validation of the addict's need for drugs.

Addiction has been invested with quite extraordinary symbolic significance in the contemporary world, with drug abuse being identified as "Public Enemy Number 1" by successive American presidents. In this emotionally charged atmosphere, dealing factually with drug abuse is difficult and threatening. The difficulty of reconciling moral and empirical views of drug use is the major obstacle towards effective treatment being given in methadone programs. It is also the major impediment to any community consensus over the nature of drug addiction.

Neurath likened the task of the philosopher to that of a mariner trying to rebuild his boat in open sea. Clinicians trying to implement a different understanding of addiction are in a similar predicament. Treatment cannot be insulated from its social context, and every change to treatment is actually a change to society.

WHAT ARE THE IMPLICATIONS FOR HEROIN MAINTENANCE?

1. Drug abuse treatment does not exist in isolation from social forces and community values. Any decision to conduct a trial of heroin maintenance will impact on methadone programs everywhere - just as the existence of methadone programs impacts on therapeutic

communities. It not only challenges the often unconscious assumption that heroin is "bad", but implies by its very existence that the preferences of drug users should be taken into acount in treatment. For people who run "strict" programs aimed at controlling drug use, the idea of allowing the right of addicts to have preferences in treatment is highly threatening. Indeed, it may even be that calls for heroin maintenance programs are motivated more by a concern to alter attitudes of staff in methadone clinics than by a belief that heroin would be a more effective maintenance drug. Whatever the findings of such a trial, merely proposing to stage it probably changes treatment practices.

Actually staging it may cause problems. Knowing that heroin maintenance is available to some, addicts receiving methadone may feel that they are receiving second class treatment, being denied the drug they want through timorousness and bureaucratic delay.

2. For similar reasons, it will be difficult, probably meaningless, to conduct a conventional, randomized trial comparing heroin and methadone maintenance. If prospective clients know that heroin is available, would prefer it, and are randomized to receive methadone, they are likely to experience this as rejection - and to do poorly in treatment. In the only previous study comparing heroin and methadone as maintenance drugs (Hartnoll et al 1980), the dropout rate in the methadone group was very high. One alternative is to employ a quasi-factorial design, by establishing a methadone clinic at a remote location (i.e. in another city) which employs policies as close as possible to that of the heroin maintenance clinic, and to control for client variables in the analysis of outcome predictors. This type of trial is also difficult to stage because, as indicated above, most methadone clinics fall short of the optimal clinic needed for such a trial.

3. No-one knows how important to the therapeutic efficacy of maintenance treatment is the pharmacological stability achieved with methadone. It may be that it is critical, and in a well conducted trial methadone would be demonstrably superior to heroin as a maintenance drug. It may be relatively unimportant, and that the greater attractiveness to addicts of heroin maintenance makes this a much more effective approach to reducing the harm associated with illicit intravenous drug use. A trial which gave information on this would not only contribute to a better understanding of the nature of addiction, but might enable a more effective community response to a significant social problem.

I will finish with a warning against what I think has dominated the whole drugs debate: fundamentalism. This is the recourse to simple principles that can be held inviolate, and protect the believer against confusion and complexity. The issues of drug use in society, of what is going on for addicts and for the community, are enormously complex and may be viewed on a number of levels, and retreat from complexity is enormously common and dangerous.

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Discussion

RENE POLS
NATIONAL CENTRE FOR EDUCATION & TRAINING ON ADDICTION, FLINDERS UNIVERSITY

James, I thought I heard you saying very loudly and very clearly that one of the implications from your review is that program characteristics, both in objective and in subjective terms, in terms of the degree of acceptance, unconditional positive regard, and perhaps empathy that there seems to be between clients and staff, is perhaps one of the characteristics that you think ought to be measured both in the methadone programs and in the heroin program alternatives.

JAMES BELL

I did. The loudest message was: avoid fundamentalism and avoid dualism and don't distinguish objective and subjective. You're absolutely right, the way in which the treatment is given is essential to the structuring of any trial. There's a grave danger, for example, if a heroin maintenance trial is set up, that the enthusiasm, interest and dedication of reasonably highly trained and intelligent research staff would make this a stunningly effective treatment which could never be replicated when it was actually put out to grass in the clinics around the country. That is just a little warning; that's certainly what happened with methadone maintenance, where the wisdom of Vincent Dole in running his own program resulted in a highly effective program which could not be replicated when people with their own particular burning agendas and need to save souls got out there and started working.

DAVID MCDONALD
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James, you would have seen the recent article by Bob Newman in *Drug and Alcohol Review*, two issues ago I think. And if I read it correctly he was trying to think 'now why is it we still have such opposition to methadone programs in many parts of the world and in parts of Australia?' And I think his conclusion was one which shocked him. He said 'look, could it be that people don't understand what tolerance is and what the effect of tolerance is, and are really thinking that people receiving methadone are becoming intoxicated and are getting euphoric experiences?' He concluded that that underlies the objection to methadone, although it is not often expressed in those terms. Any implications there for the proposed heroin trial?

JAMES BELL

There are several implications. I would remind you at one stage Bob Newman was threatened with imprisonment for not handing his records over to the police, who were harassing him and who considered that a methadone treatment clinic should hand its records over to the Narcotics Bureau in order that they could investigate people in treatment. So he's been through a lot in the early days.

I think the point that he's making is it's unacceptable to think that you might be making people feel good. And this was in a sense the question I was asking earlier that Gabriele answered superbly, which is that medical treatment can validly be seen as promoting

wellbeing. I don't agree with Bob Newman about tolerance; it may well be that tolerance is partial. I have no trouble with making people feel good, I think that's a wonderful thing to do, as long as it works. And the fact is that it is regarded as unacceptable, that many of the strident criticisms of methadone maintenance are about "subliminal euphoria". What on earth is that? I really don't know. There's a fear, I think, that if everyone gets on to this it'll be so good that no-one will do any work.

We're dealing with fundamental issues of values. Bob Newman tried to take refuge in a pharmacological explanation and say 'because of tolerance they don't feel anything'. I don't know whether that's true. I suspect that it's not particularly true, I really don't know. That's a very hard thing to interpret, but it raises the issue that we're dealing with fundamental assumptions about the nature of life when we're giving drugs to people.

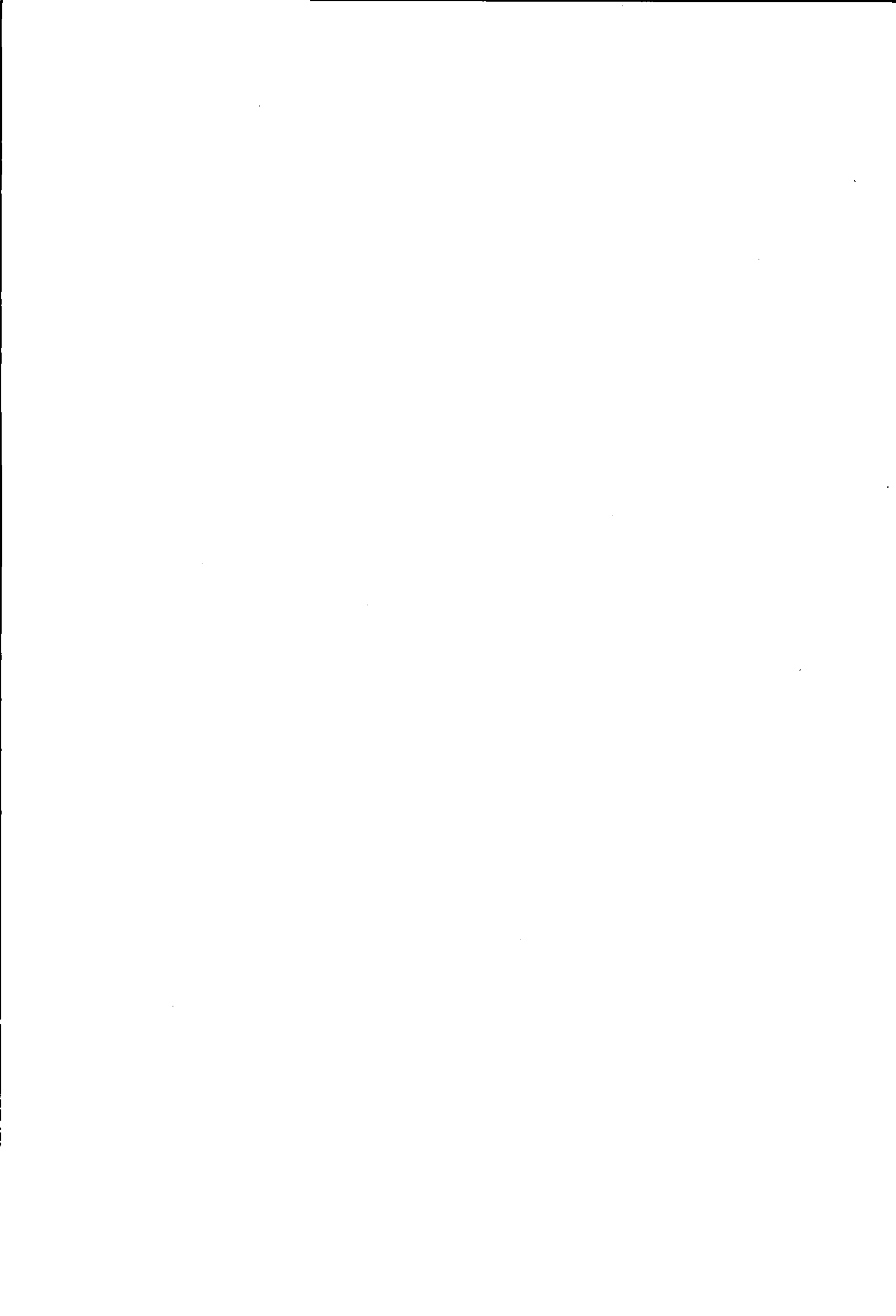
Introduction to Part 2

Duncan Chappell BA LLB PhD
Director, Australian Institute of Criminology

The Australian Institute of Criminology is delighted to be one of the co-organisers of this seminar, as well as to be a collaborator with NCEPH on the feasibility study. The Institute is a national independent statutory body which is involved in criminological research and policy advice to all governments in the country. We also have an affiliation with the United Nations, and we very much believe that the issues that we are looking at in this seminar are ones that are of both national and international significance, and therefore very much within the mandate that the Institute has.

This afternoon's session is going to turn away from the medical, pharmacological, and similar aspects of the proposed trial, and look rather more at some of the social aspects of alternative methods of treating heroin dependence, and especially those that link in with criminological questions such as impact on crime and impact on law enforcement agencies. And it is also going to focus very much on comparative experience - overseas experience - in these areas. We have already had some hints this morning in some of the questions of interest in this comparative experience. We had a reference to the United Kingdom and to Sweden.

I very much welcome our three overseas speakers who will tell us about drug policies in the UK and the Netherlands.



In Search of a Balance between Repression (Enforcement) and Normalisation

Bob Visser
Head, Criminal Investigation Office, Municipal Police Force, Amsterdam

I have divided my contribution to this seminar into the following sections:

1. general information on Dutch drug policy;
2. specific information about the situation in Amsterdam;
3. the role of the Amsterdam Municipal Police; and
4. an evaluation.

GENERAL INFORMATION ON DUTCH DRUG POLICY

Drug policy in the Netherlands has been developed from the viewpoint of the safeguarding of health. It moves along two lines, namely:

- enforcement of the Opium Act; and
- prevention and assistance or treatment policy.

The main purpose is to limit, as much as possible, the risks related to the use of drugs for users, for their immediate surroundings, and for society (harm reduction).

The approach chosen to implement the policy is pragmatic and realistic and starts out from the principle that only cohesive, balanced and multidisciplinary measures can help to keep the problem under control. It has been found that an objective, problem-solving approach yields better results than one that is dogmatic and emotional.

Other essential points in Dutch policy are:

- discouragement of the use of drugs;
- stimulating social control;
- cost/benefit evaluation in relation to the effectiveness of the policy instruments;
- striking a balance between the measures in the different fields;
- reducing the appeal of Amsterdam to foreign addicts.

Besides this, the Dutch Opium Act distinguishes between drugs which offer an unacceptable risk, and other drugs. This, in fact, implies a distinction between hard drugs and soft drugs, to which different penal systems apply. The Dutch police are pragmatic in that a strict distinction is made between the ways in which drug users and drug dealers are dealt with. The Minister of Welfare, of Health and for Cultural Affairs is responsible, together with the Minister of Justice, for the implementation of the Opium Act.

Essential for the implementation of the law is the so-called expediency principle within the Dutch criminal law system. This implies that the Public Prosecutor has the discretion to refrain from prosecuting punishable offences on grounds deriving from the general good when there are weighty public interests at stake. Guidelines have therefore been established for the detection and prosecution of punishable offences contrary to the Opium Act, just as there are guidelines with respect to offences contrary to other laws.

The essential points of these guidelines are as follows:

• in common with the international approach, high priority is given to countering the production, importation, exportation and large-scale trafficking of drugs;

• specific police investigations, provisional detention and, in principle, prosecution do not take place when there is only a small quantity of hard drugs for personal use;

• this also applies to trafficking in and possession of quantities of less than 30 grams of marijuana.

The aims of the guidelines are:

• to separate the market for drugs with unacceptable risks from that for hemp products;

• to keep the traffic in hashish as far away as possible from the sphere of serious crime and so to de-mythologise drug use and reduce the appeal of drugs;

• de-criminalisation of drug-taking.

The key points of the assistance policy are:

• multi-functional networks of medical and welfare services on a local level;

• easy access to the assistance services ("low threshold", few conditions);

• furtherance of social re-integration of (former) addicts;

• bringing the largest possible number of addicts into contact with assistance services (the more contact made and maintained with the addict, the bigger the chance of affecting their conduct and of reducing the harm/hazards for society and themselves).

Specific information about the situation in Amsterdam

There are around 6,000 drug addicts in Amsterdam, a city with an estimated 700,000 residents. A large majority of the addicts have had a long history as users of mainly heroin, although they have gradually also turned to other substances. Heroin, however, has been their principal drug. They use it for long periods of time and spend most heavily on it. Some 70% of the addicts are involved in a treatment program (Figure 1). Of the addicts in Amsterdam around 35% are intravenous users. About 8% of all drug users are HIV positive.

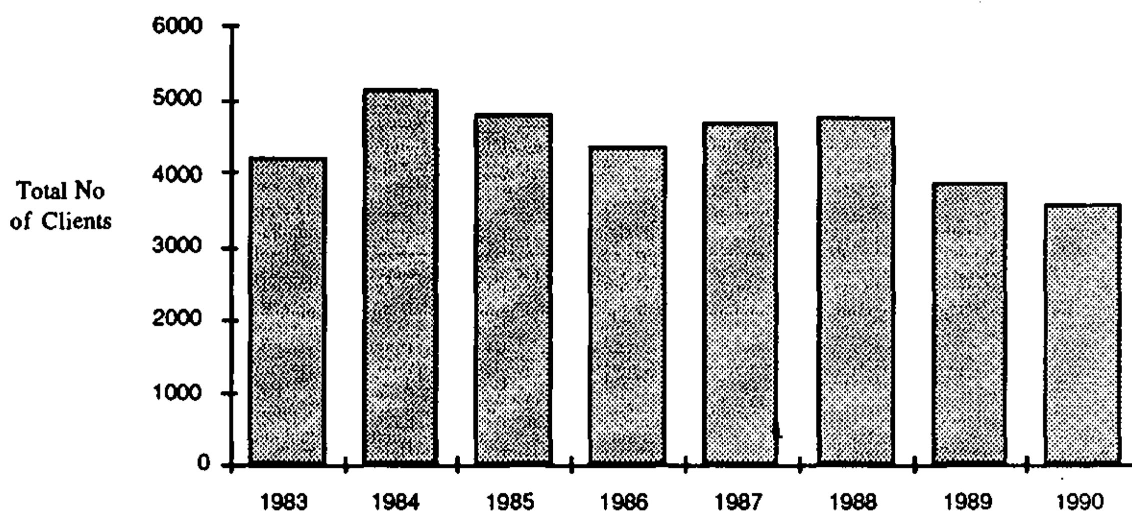


Figure 1. Total Number of Clients in Treatment (Municipal Health Department Figures)

About 3,500 addicts take part in the scheme where methadone is given (for 23 weeks on average). The methadone is taken orally. The total number of addicts and the number of addicts in this scheme are slowly decreasing.

Last year one million needles and syringes were provided (Figure 2), 96% of which were returned.

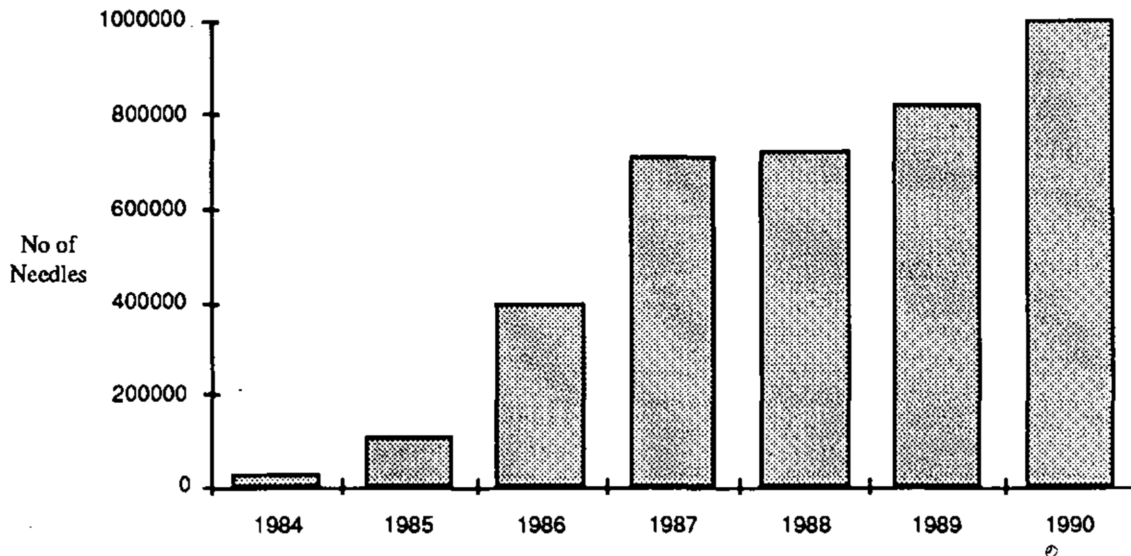


Figure 2. Number of Needles Distributed in Amsterdam Needle Exchange Schemes

The Amsterdam drug policy has not been introduced overnight. It has developed over a number of years and success and failure have taken turns. The policy was preceded by a series of private initiatives and slowly it developed from a phase of acceptance and permissiveness into a comprehensive drug policy along the aforementioned three lines, namely:

- normalisation of use;
- prevention and reduction of the inconvenience caused by users; and
- discouragement of new users and the arrival of users from outside Amsterdam.

The most significant trend has been the shift of attention which was at first focused on the drug user (assistance) and later on society (inconvenience). Where society was at first considered to be the cause (underprivileged young people), now it is seen predominantly as the victim (inconvenience).

The broad approach to the problem lies in front line assistance (primary care), which is aimed at reaching as many addicts as possible in order to prevent their being futher cast out from society. They can be especially found through streetcorner work and the police. The effort is aimed at getting in touch with as many addicts as possible, providing them with methadone and affecting their conduct through counselling.

There are two mobile methadone supply stations (coaches), four permanent stations in the city districts (outpatient methadone clinics) and general practitioners. The supply in the special coaches, where liquid methadone is given for immediate use, is within easy reach for addicts. A minimum of conditions must be fulfilled. At the same time, however, little extra is offered there. The doses are on the whole relatively low. There are more stringent requirements for the more extensive assistance and care at the permanent stations in the city districts (among other things regular checks of urine). Lastly, general practitioners

take over. Of the 200, half take part in the scheme. Their aim is the adoption by addicts of as normal a lifestyle as possible. Patients are given tablets for a maximum period of one week. We refer to it as the graduation model.

The supply of injectable methadone has come up in discussions. It would fit in better with the habits of the intravenous users, however, politically support for a general supply of other substances is still small.

Second-line care is made up of institutions assisting drug users to kick the habit. There are specific services for special groups, such as prostitutes, extremely problematic addicts, ethnic minority groups, etc.

Lastly there are the auxiliary services in the field of prevention, drug education, housing, protection of interests, family therapy, etc.

For an assessment of your planned experiment, I think it is relevant to mention that several projects and efforts to bring the drug problem under control have proved unsuccessful in Amsterdam in recent years.

One of the projects was to permit users to take their illicitly obtained drugs on a so-called "junky boat" and in some special houses in the districts. As it caused lots of inconvenience for neighbours and attracted drug-related crime, like drug dealing and handling stolen property, the project was ended.

In the early stages the drug problem was approached by strictly separated services, namely:

- assistance stations and medical services (doctors, primary health care);
- welfare services (social services, job centre, rehabilitation services, Salvation Army);
- enforcement services (police and justice agencies, detention centre).

Initially the approach to the drug problem suffered unnecessarily from a widespread mistrust and lack of cooperation.

Amsterdam has always had a large number of foreign drug addicts. We can distinguish between pull and push factors. One of the pull factors has certainly been the liberal climate in the Netherlands. On the other hand a suppressive police and judicial apparatus in the countries of origin has been a push factor for addicts to go to Amsterdam.

Initially, foreigners had free access to the assistance and treatment facilities. Some years ago, however, this came to an end. At present a successful appeal can only be made on the services in emergency cases and for the sake of tiding over a crisis situation. The purpose is to make it unattractive for addicts to settle in Amsterdam. Their return to their own country is stimulated by counselling, contacts with and transfer of addicts to assistance services in the countries of origin.

The present situation is characterised by a widespread network of assistance services and a strong and growing repression of the inconvenience and problems caused by addicts.

THE ROLE OF THE AMSTERDAM MUNICIPAL POLICE

I would like to move on now and tell you something about the role of the Amsterdam Municipal Police. I will first briefly give you an overview of the specific problems faced by the Amsterdam Municipal Police when they are executing police duties with respect to drugs.

Transit and trafficking

The population of Amsterdam is multi-racial, 25% of its residents being of ethnic origin. This percentage is 49% for children under the age of 12.

The Netherlands - a transit country in the field of commerce - has an infrastructure geared to the transportation of large quantities of goods to its hinterland (Holland: gateway to Europe). Together, these factors make it attractive for criminal organisations to use the Netherlands as a transit country and Amsterdam as a transit city. The extensive contacts with foreign police colleagues who end up in Amsterdam for enquiries are an indication of this, as are the frequently occurring murders within criminal groups, with drugs as the underlying reason. The principal role is played by South American and Turkish groups. The cocaine connections with Italy and the heroin connections with Spain are partly operated through the Netherlands. In Amsterdam the Turkish community has a dense network of coffee shops where contacts are made and maintained. People from Surinam, which in the past was a Dutch colony, are mostly engaged in the local traffic in (particularly) hard drugs. Pakistani groups are mostly engaged in trafficking hemp products. The part and role of Chinese persons in hard-drug trafficking is diminishing.

The market share of cocaine has risen sharply in the last few years. Apart from heroin, an increasing number of addicts have started using cocaine. With the considerable growth of cocaine on the market, increasing quantities of cocaine are being confiscated. Meanwhile, the quantities of heroin and cocaine seized are almost the same (over 500 kilos of each substance in 1988).

Foreign addicts

From any place in the Netherlands it is possible to reach Germany or Belgium by car within two hours. In anticipation of the European unification in 1992, when the inner borders between most European countries will be lifted, border traffic has already become quite unrestricted. One can cross borders almost without checks. Many, mostly German, addicts are seeking refuge in the Netherlands.

About half the heroin deaths in Amsterdam are German. Other foreign addicts that we frequently come across are Italians, Frenchmen and Britons.

Trouble and degradation

The inner city of Amsterdam is characterised by an old city centre with many old houses, small streets and alleys. It is also the shopping and entertainment centre. In one area both the "red light district" (where prostitutes solicit from behind their windows) and a number of meeting places and assistance facilities for addicts can be found. Much trouble is caused in this area by groups of addicts who gather, molest passers-by, and are responsible for a lot of unsightliness and unsanitary conditions, for instance by urinating in halls and disposing of used syringes. Heroin-addicted prostitutes, some of them infected with the AIDS virus, solicit and service their customers in the street, and are not only a hazard for public health, but also cause trouble in the densely populated inner city through the sort of people they attract.

As a result of dropping sales, many shopkeepers have sold or closed down their businesses, which has led to a further degradation of the neighbourhoods. A knock-on effect has been decay and dilapidation of premises. These premises, in turn, are used by addicts as meeting places.

Crime

In houses, pubs and on the street, professional dealers and addicted peddlers try to supply their customers. These traffickers attract large numbers of addicts. Their presence, in turn, causes other peripheral phenomena. Acquisition-related crime, such as theft of car stereos, muggings, shoplifting, and receiving and handling of stolen property, occurs frequently. This is one of the reasons why addicts go to the inner city. Most criminal activities take place without violence. Where violence has been used, the perpetrators are mostly from other than addict groups, for instance North Africans. A study has shown that only a small part of the income an addict makes is the proceeds of crime. Addicts should not be held responsible for all forms of crime. In many cases, other groups, for example youths, are responsible.

Disturbing public order

In certain places in the inner city the trouble caused has led to disturbances of public order, when residents proceeded to take action against the trouble they experienced by taking the law into their own hands and holding demonstrations (eg. blocking traffic tunnels). In the absence of adequate legal solutions, the police have, for an extended period of time, maintained order by frequently making baton charges to disperse them. Experience taught us that here too the effects were short-lived.

Aggression between police and addicts has risen. It has also occurred that large numbers of addicts have collectively put up resistance against the police when arrests were made. In one such incident in 1986 a policeman was stabbed to death by a resisting addict.

Difficulties within the judiciary in dealing with certain groups of drug users

The increase in the number of suspects arrested and prosecuted for drug-related crimes has put the processing capacity of both the Public Prosecution Service and the prisons under great pressure.

Approximately 75% of the suspects arrested in Amsterdam are directly or indirectly involved in drugs; about 50% of the persons detained in prisons are users of hard drugs.

Police spend an increasing amount of their time writing reports, which leaves them less time for actual policing on the streets.

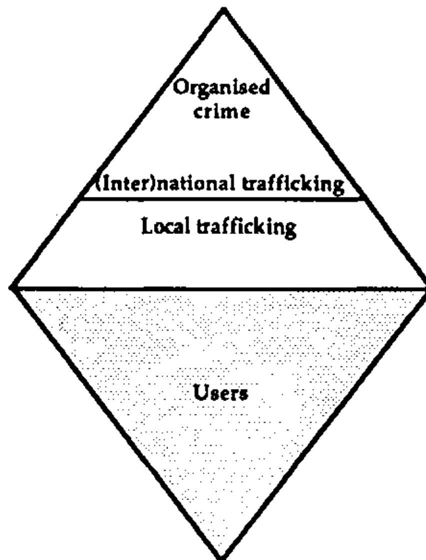
Besides, certain drug addicts have deteriorated to such an extent that (the threat of) penalty and assistance hardly has a positive result, whereas they are responsible for a large part of drug-related crime. A study has shown that only 250 of these - what we call "extremely problematic" - addicts were responsible for well over 6,000 crimes over a period of one year. This renders them to a considerable degree responsible for clogging up the judicial circuit, because they take up a disproportionate part of the capacity, while the results are meagre.

Before I discuss the way in which the approximately 4,000 executives in the Amsterdam police force tackle the problem and try to keep it under control, I would like to make an initial remark about the attitude in the force. In the past decade there has been quite a change in culture and line of thinking in the force. The focus has shifted from thinking in terms of legality (enforcement of the law where illegal acts are committed) to thinking in terms of effectiveness (which police activities have the greatest impact on the smooth functioning of society).

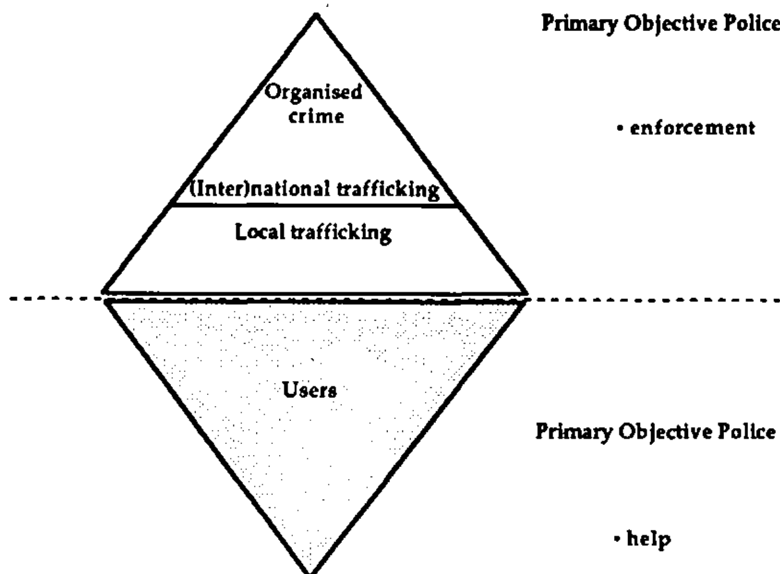
It is our experience that the sequence of arresting, detaining and setting free addicts is of little use. High crime rates, large numbers of arrested addicts, too few cells and the absence

of alternatives have led to a vicious circle, which has been broken by a joint search for alternative approaches and possible solutions.

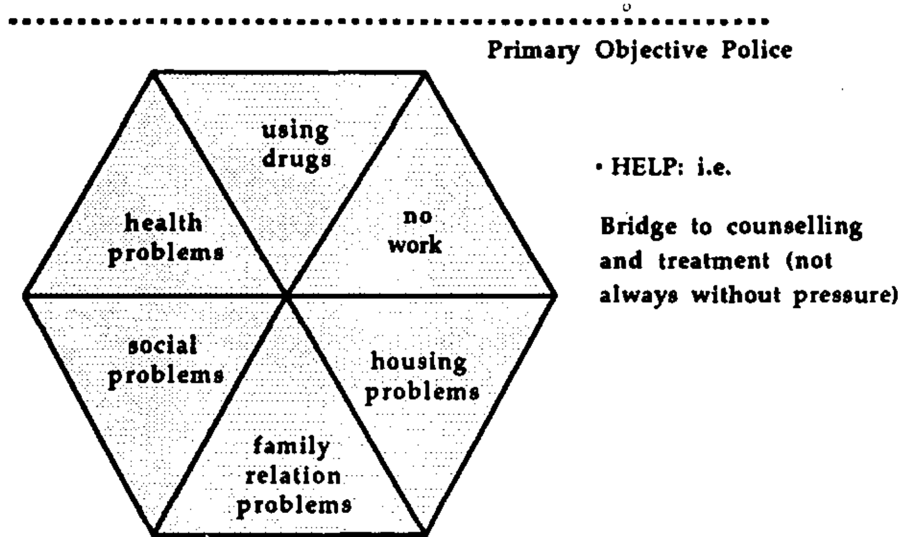
We have divided the drug problem into organised crime (international drug trafficking), local trafficking and the user problem.



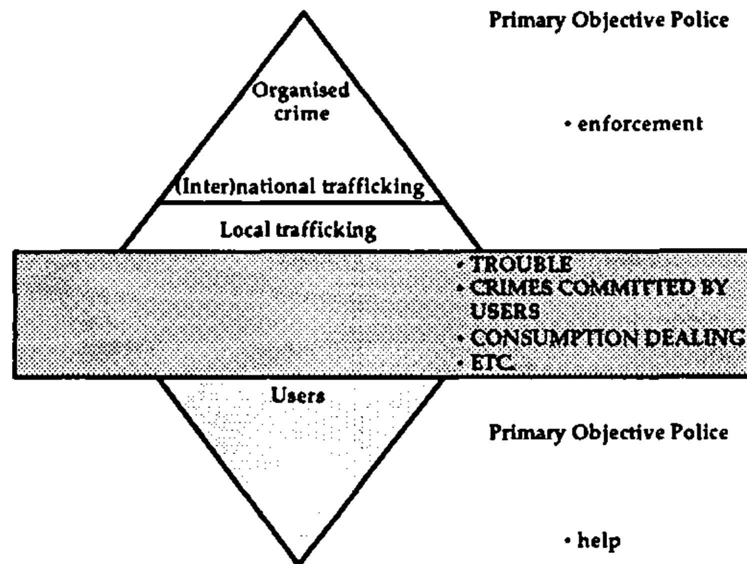
We approach the first two fields in a police manner and the last field from the view of rendering assistance and searching for alternatives.



Addicts are no longer seen as criminal offenders but as people who have lots of problems, their addiction included.

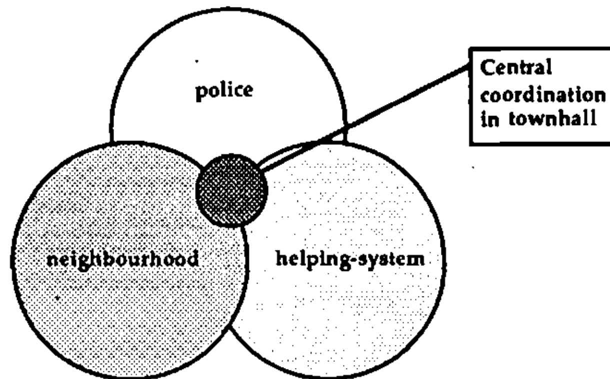


In the transition zone between those fields we try to find a balance.



The police are not able to solve the user problem on their own but only in multi-disciplinary cooperation with others.

Integrated drug policy



Our staff have begun to understand and accept that. They reap the fruit of such a multi-disciplinary approach because it provides them with alternative solutions for the treatment of problematic cases, where criminal justice does not have any.

I will now give you an overview of our activities in the framework of the comprehensive approach.

Outlines of the approach

• Multidisciplinary teams are increasingly deployed in the suppression of organised crime. Their objectives are: identification of the "big shots" of organisations; gathering of evidence against them; tracking down money flows and confiscation of criminally gained money.

The high priority that this has been given should lead to effective elimination of distribution lines and organisations.

• The (inter)national traffic and transit of drugs are combated in Amsterdam by a special Drug Squad, which is made up of 60 detectives. By means of selection criteria, the priority of cases to be tackled is established. There is close cooperation with liaison officers from other countries and frequently use is made of undercover agents, controlled deliveries, wiretapping, etc.

• Local drug trafficking is combated by special task forces which are directly aimed at dealing with (local) dealers. The priorities, which determine the order in which cases are handled, are set according to the degree of trouble and the hazards involved, for instance where drug dealing occurs in the direct vicinity of schools.

By means of books containing photographs of suspects, incriminating statements from addicted users are gathered against (sub)dealers. Eight such statements suffice to have dealers prosecuted, even when they are not found in possession of drugs.

• Upon a well-founded proposal by the police, the mayor can order that houses and pubs where drugs are sold be closed down for an unspecified period of time. This enables the

police to rapidly and effectively harm dealers financially, because they will lose their earnings. Re-opening will not take place until after the police have given positive advice.

• Crime in Amsterdam is often combated by taskforces. There is ongoing monitoring of the effect of identifying and countering offences which stand out in a negative sense in terms of scene, size or seriousness. This makes it possible to react adequately to the effects of drug scenes that move to other locations after preceding police action. The aim is to prevent certain forms of crime from settling elsewhere.

• For the sake of maintaining public order, the mayor has introduced measures in that section of the inner city where the problem is greatest. The police have been vested with the authority to apply these measures. They include: a ban on the use of alcohol in public, which is otherwise permitted; a ban on gatherings of more than five persons; a ban on carrying knives, which is otherwise permitted; an 8-hour ban on entering a certain area; a ban on entering a certain area for a period of a fortnight.

Legal penalties are imposed for violation of these measures. A special public order unit, supported by mounted police and motor police, is charged with enforcing the measures.

• Shops within the area are ordered to remove articles which addicts use to cut or take drugs (lawyers of the shopkeepers have taken legal action against this measure).

• In order to avoid unnecessary work and loss of effective time, addicts stopped in the street with a quantity for personal use are questioned on the spot, the fix is seized and the addict is subsequently sent off. Incidents of this sort are recorded in brief police reports. This possibility exists because the policy is not aimed at arresting and judicially prosecuting this group.

• At the police station, a doctor examines arrested addicts and gives them methadone if they wish.

• At police stations, arrested addicts can get early care. About 50% of the addicts in custody are seen at the police stations by social workers, who are often volunteers. By means of counselling they try to move addicts to safe drug use, safe sex, and, if such is not yet the case, to active participation in regular assistance programs. These programs are easily accessible: there are no pre-conditions and the aim is not detoxification. Besides, early care is orientated towards facilitating social rehabilitation by contacting the municipal social services, the housing department, job centres, etc.

• At all police stations, it is possible to exchange syringes.

• Arrested foreign suspects are either deported from the Netherlands by the police or handed over to the local judicial authorities or assistance organisations. Where possible, the prosecution of punishable offences takes place in the home country of a suspect. In view of transfers to welfare organisations, branches of such organisations from Germany have been established in Amsterdam. Foreign addicts cannot apply for treatment in residential assistance programs, which reduces the appeal of Amsterdam.

• The group of extremely problematic addicts (about 250) who are known by name receives special treatment owing to the fact that this relatively small group is responsible for a large number of relatively minor offences. This special treatment is twofold:

they have a treatment status as if they had committed a major, not a minor crime, which causes them to be imprisoned sooner than others committing similar crimes;

they can either opt for a prison sentence or receive detoxification treatment, to which end accommodation is available at rehabilitation centres. The police, the judiciary and the assistance services jointly design the relevant programs. Absconders from detoxification

centres are made to serve their prison sentences when they are apprehended. Incidentally, this approach was initiated by the police. The figures for 1989-1990 show an increasing number of addicts who have been given the choice of imprisonment or treatment. A growing number has chosen treatment. Thirty-five percent follow the treatment program successfully (Figure 3).

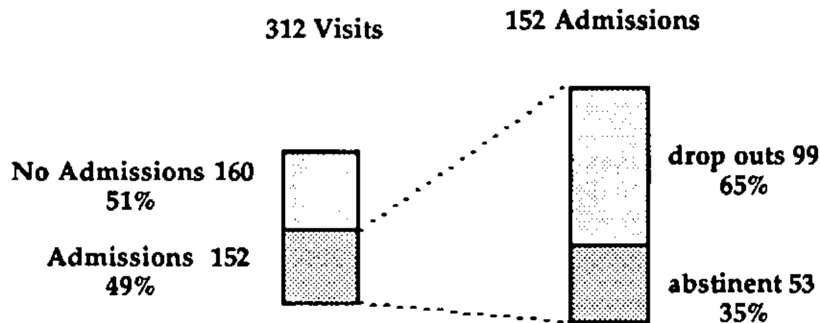


Figure 3. Outcomes for Addicts Give a Choice between Imprisonment (No Admissions) and Treatment (Admissions) in 1989 and 1990

• In order to counter the degradation of the inner city and enhance the quality of life, the police maintain direct contact with municipal services. This makes it possible to actually put a halt to undesirable situations in the short term. In this respect I mention: street cleaning; extra lights in the streets; unclogging syringe-filled sewers; closure of alleys; upkeep of roads; etc.

• Groups of police from the inner city stations, which use the team policing method, frequently meet with groups of residents from the areas with drug-related trouble. The purpose of the meetings is to come to understand their respective situations and to reach agreements on a joint approach.

One particular policeman has developed a project where pupils are invited to a police station to visit an arrested addict, who, on a voluntary basis, tells them about his or her addict life. These meetings are made by small groups in the cell block of the police station. Parental permission is required. Preparation and follow-up at schools are carried out by teachers. So far, this project has been introduced at more than 50% of the schools in Amsterdam. Evaluation after 12 months indicated that 89% of the pupils recalled the project. All remembered visiting the police station. All of the 80 pupils interviewed declared that they neither used nor were going to use drugs.

This approach must be considered in the perspective of other municipal measures, such as: the regular supply of methadone to addicts from special municipal healthcare coaches; community centres; night supply; centres for extremely problematic addicts; and assistance from a large number of doctors, given that 70% of the addicts receive some sort of assistance.

The city of Amsterdam has set up a joint venture with business organisations to stimulate economic recovery in the inner city. In strongly affected areas, premises are purchased, reconstructed and sold with promotion premiums and measures. The objective is to stop the degradation of the city.

EVALUATION

While reading your report, it became clear to me that the ACT police did not beg you for an experiment in which controlled supply of opiates takes place. It has, in addition, been established that the enforcement of prohibition is not effective. I would nevertheless plead for the support of police executives in Canberra for your activities, not so much for your experiment, but particularly for a comprehensive multi-disciplinary approach, which includes the police.

It is my view that the experiment you favour is worth that support, but I must add that it is not without dangers.

It is of the essence that the assistance offered is intensive, offering addicts the opportunity to lead a dignified life, as normal members of society, whose crisis situations can be tided over.

On the other hand there is the danger of the pull effect on the surrounding region. The experiment could change into a driving force of the problem. If, in the ACT, drug policy and the available facilities differ too much from those in the surroundings, there will be a pull of addicts to the ACT, whereas an emphasis on the enforcement model will lead to a push. With this in mind, I would take great care not to make the experiment too attractive, which would be the case if many sorts of opiates were supplied on easy terms and in large doses to a great number of addicts. The supply should make it possible to live with the addiction but I think it should also be ultimately aimed at reduction (in the long term and as soon as possible).

By not setting a maximum to the number of participants, the question also arises whether it will still be possible to stop it after two years. Can you all of a sudden tell addicts that the intensive supply program they have enjoyed for two years is over?

The supply stations are another question. On the one hand you wish to take them out of a suspect atmosphere by locating them in busy places in town. On the other hand, your plan is apparently considering supplying liquid methadone and two injections a day. It is to be expected that this can hardly be combined with a return to work, school or family. It is to be foreseen that participants will be hanging around the supply stations the entire day.

The subcultural elements of the lifestyle are very dominant. The program should be adapted to this (it will be a day filler for the addicts).

It is an empirical fact that peripheral phenomena, such as handling stolen property, drug dealing and health hazards and unsightliness, come up in places where large groups of addicts get together. The question is whether (and how much) of this visible inconvenience is socially acceptable.

Not only are the Amsterdam methadone coaches an inexpensive (and therefore perhaps typically Dutch!) facility, which cover several locations, they are also an effective means of supplying methadone - in spite of their poor acceptance in the neighbourhoods. They cause little inconvenience and the locations are outside the residential areas.

Where there is no public acceptance of special places where addicts can take illicit drugs, the supervision and cooperation of the police will be required. A condition for the implementation of the program is a basis for trust between social workers, officials, police and, if possible, addicts. Because the police now only give limited support, much effort has to be made to bring these groups together.

An illegal or grey circuit of drugs will have to be reckoned with, because there will always be addicts who either do not want to be registered, who have adverse feelings towards assistance, or who have not been enrolled in the scheme. The development of an overlap between these two areas in the actual situation should be avoided.

An underlying purpose of the supply scheme will have to be that the addict ultimately ends up in some sort of individual counselling program (therapy) so as to make a bridge to a normal life.

Not only should the graduation from first line supply to individual counselling schemes be possible, it should also be encouraged. The development of this secondary line and the specific facilities should be on par.

The obvious thing to do is to attach medical care and medical facilities to the experiment. Yet too much care can lead to a diminished sense of responsibility on the part of the addict. When, for example, a doctor is always available to resuscitate in cases of acute respiratory difficulties, the drug user will be less motivated to take care of him or herself.

With these questions I hope that it has also become clear why I have entitled this introduction "In Search of a Balance between Enforcement and Normalisation".

The American Arnold Trebach wrote that "success" in the context of drug policy is always composed of "a bagful of advantages and disadvantages".

This statement appears to apply well to the situation that we have in the Netherlands and Amsterdam in respect to the formulated drug policy.

There is no cure-all for the Amsterdam situation. In itself it is quite possible to define and combat addiction as a crime issue. However if, in this approach, aspects such as cause, surroundings, and follow-up are not taken into account, it would be an offence to the intelligence of average police to think that this gives them the feeling of being useful. Usefulness and results activate people, uselessness does not.

The approach to the above-mentioned problem adopted by the Amsterdam Municipal Police has not been restricted to being purely repressive and judicial. The police take part in a variety of social activities and assistance programs, believing that in this way they are doing a really useful job.

There is, however, something paradoxical in what is expected of the police. On the one hand we have the vigorous, committed combat against hard drug trafficking and drug-related crime and on the other hand there is the cooperation in the implementation of a two-track policy, where users of these very drugs are preferably not dealt with judicially.

The everyday situation in particular demands that a balance be struck within the measures taken. Time and again police must determine what can or cannot be tolerated. Some cases in this respect are the following:

• In reaction to the restricted detection policy regarding soft drugs, someone decided to open up a museum, where hashish was displayed and offered for testing. Action was taken.

• A commercially talented individual conceived a plan to start a business, named Blow-away, with couriers to deliver orders of hashish and marijuana at home. This business was not tolerated and therefore put an end to.

• Police are not after junkies because they are addicted (decriminalisation of drug taking), but they are after them for the trouble they cause and the criminal activities they undertake. However, the inconvenience is countered so rigorously that it can jeopardise the balance that exists with the assistance.

• Soliciting on the street by heroin addicts is not permitted. However, police do not take action against it at some locations in the city unless there are complaints. As a consequence, we operate in a zone between two extremes, namely suppressing and permitting. The policy makers have to date not taken a final decision, so it is up to the police to face up to this dilemma.

• Action will be taken against those who supply to hashish-selling coffee shops and youth centres. However, no action is taken against the owners of coffee shops and in-house dealers at youth centres.

• It is generally difficult to see the difference between an addict who carries a fix for his or her own use and an addict who as a (sub)dealer tries to find customers, who is a cashier, or who supplies fixes.

In short, the drug problem and drug policy require a continuous process of decision making as to what measures should be taken, what their aim should be and what they should solve.

The two-track policy in the Amsterdam situation has contributed to practical and pragmatic solutions. The entire problem has not been solved, but it has become controllable to such an extent that, compared with other countries in Europe, it is now at an acceptable level and will remain that way.

The main question is whether we will be able to keep the problem under control. As far as Amsterdam is concerned, we believe that the situation is reasonably stable, considering that:

• the number of addicts has been at the same level for years;

• the crime rates have been stable for a number of years (Figure 4);

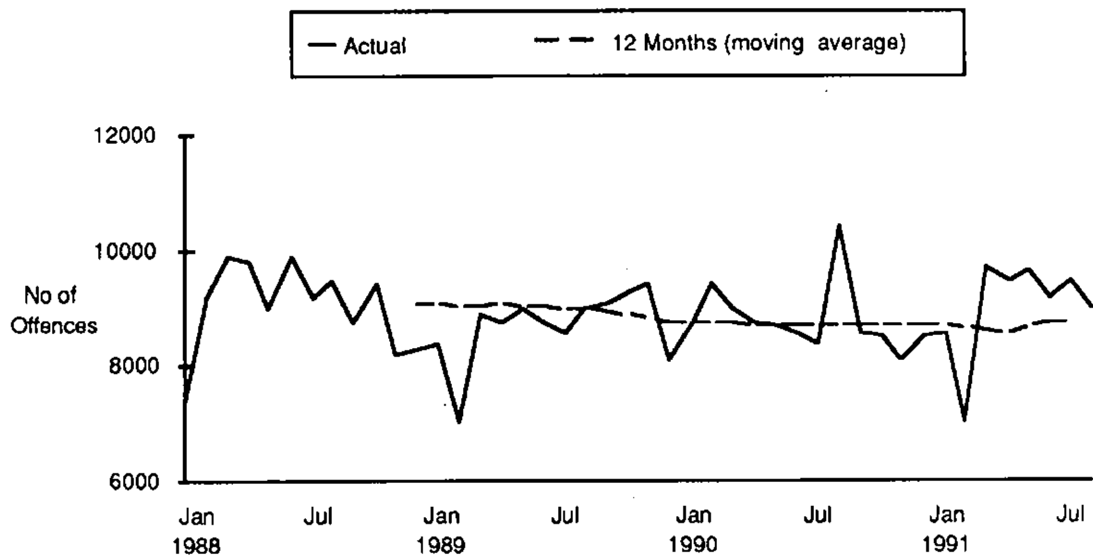


Figure 4. All Criminal Offences in Amsterdam (Traffic Excluded) January 1988 - August 1991

• the number of deaths caused by drugs has remained at the same low level (Figure 5);

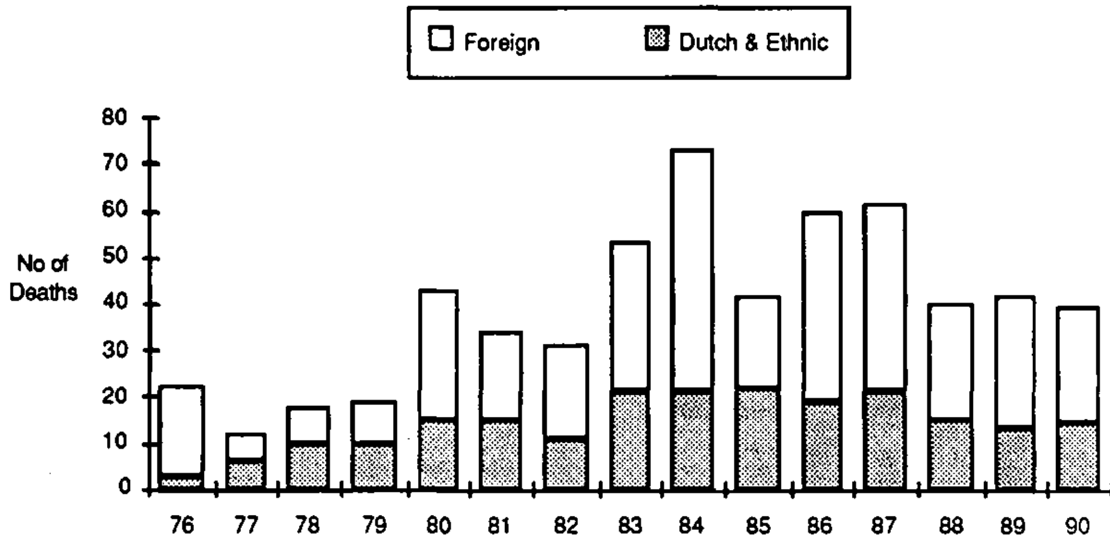


Figure 5. Death after Overdose in Amsterdam

• the average age of addicts has risen (Figure 6) and the percentage of addicts under 22 has decreased (Figure 7);

• the inconvenience they cause has diminished.

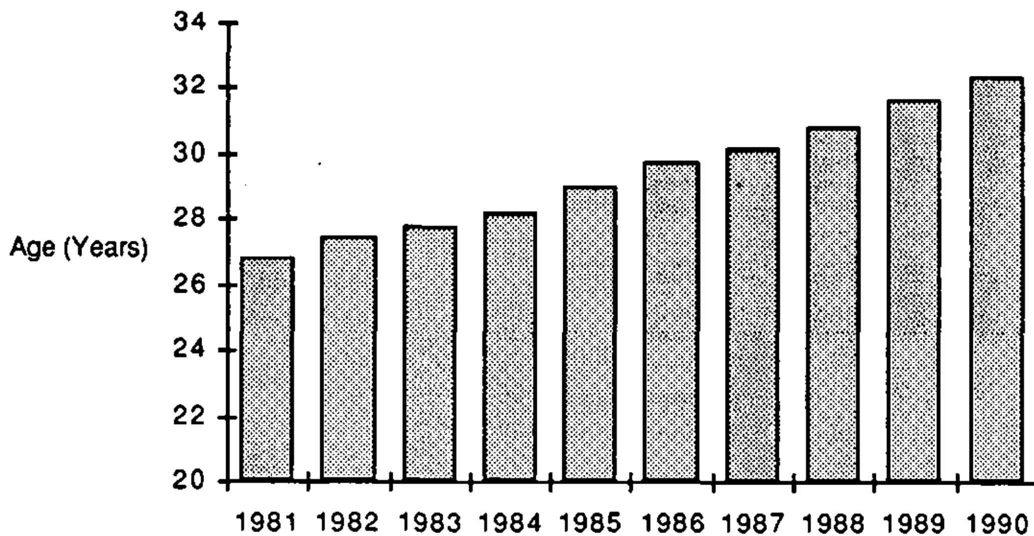


Figure 6. Average Age of Clients (Municipal Health Department Figures)

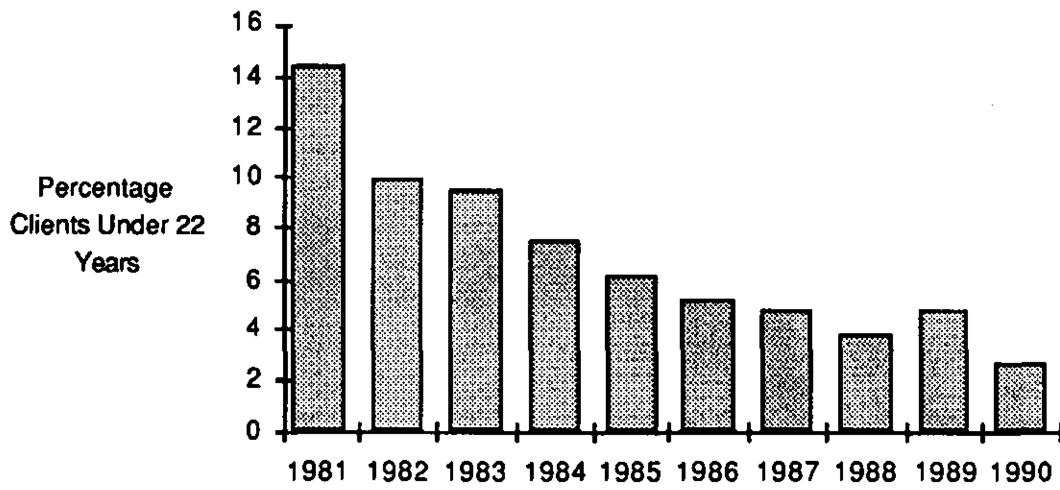


Figure 7. Percentage of Clients Aged Under 22 Years

As far as the future is concerned, I expect that we will have to aim at establishing a fine balance.

Experiences and Developments of the Drug Misuse Strategy within the "British System"

Roy Penrose
Coordinator, Regional Crime Squad, New Scotland Yard

I represent a country which some commentators may say has a patchy, almost reactive history to the subject of drug abuse and addiction. History does however demonstrate that we, the British, do tend to listen, to assess the situation, and then try to do something about it as things appear to us at the time. Whether we get it right is a matter for others to judge, which they often do - although always with the benefit of that exact science, hindsight!

I shall briefly describe the current UK drug scene to indicate the backcloth against which we operate and against which the British government have set their strategy. I shall then touch upon the history of our treatment strategy before speaking of the UK police involvement in the various treatment and diversion efforts.

UK DRUG SCENE

The broad picture is that there is no shortage of illicit drugs in the UK, especially in London which accounts for about 75% of the national police seizures (Figure 1).

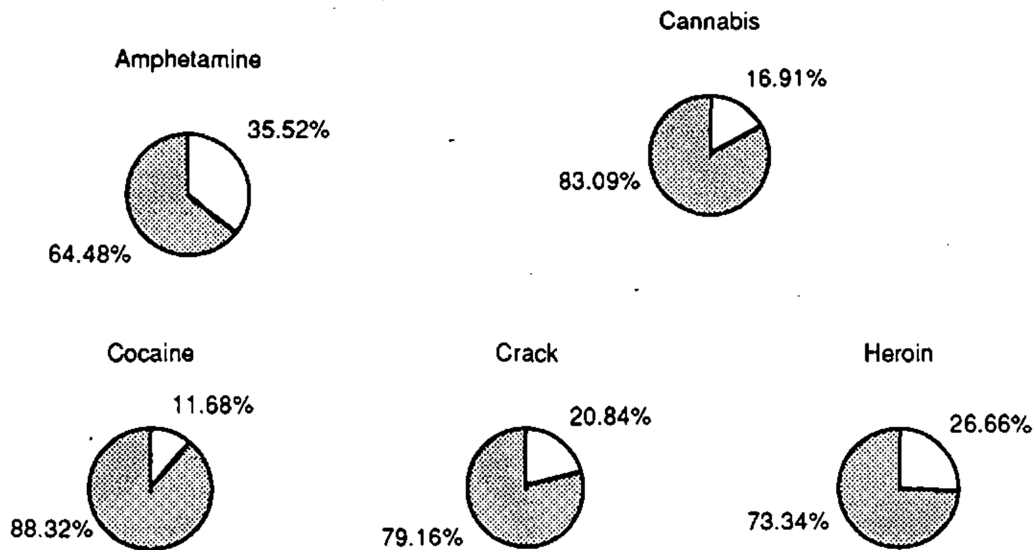


Figure 1. Drug Seizures by Police 1990. Shaded areas represent seizures made in London

Cannabis

Cannabis (Figure 2) remains plentiful and is by far the major drug of abuse. Calls for its legalisation, or at least decriminalisation, continue to ebb and flow. I do not intend to consider it further when the crux of this debate relates to major drugs of addiction and principally to opiates.

In the figures which follow, CRSE refers to Home Office Central Research and Support Establishment, and HMCE refers to Her Majesty's Customs and Excise.

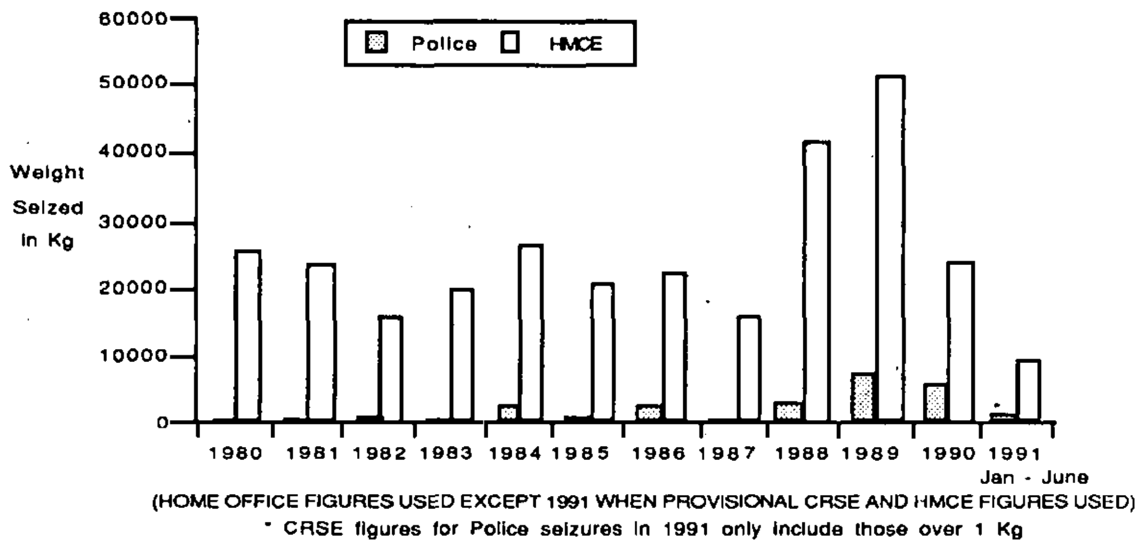


Figure 2. Amount of Cannabis Seized by Agency 1980 - June 1991

Cocaine

In the last 10 years the amount of cocaine seized in the UK has increased more than 14-fold (Figure 3). Last year 611 kg was seized and already 645 kg have been seized in the first 6 months of 1991. Its greatest availablity and use is in London although many of the bigger towns and cities outside have general availability and increased use. Cocaine is however almost completely absent from Scotland.

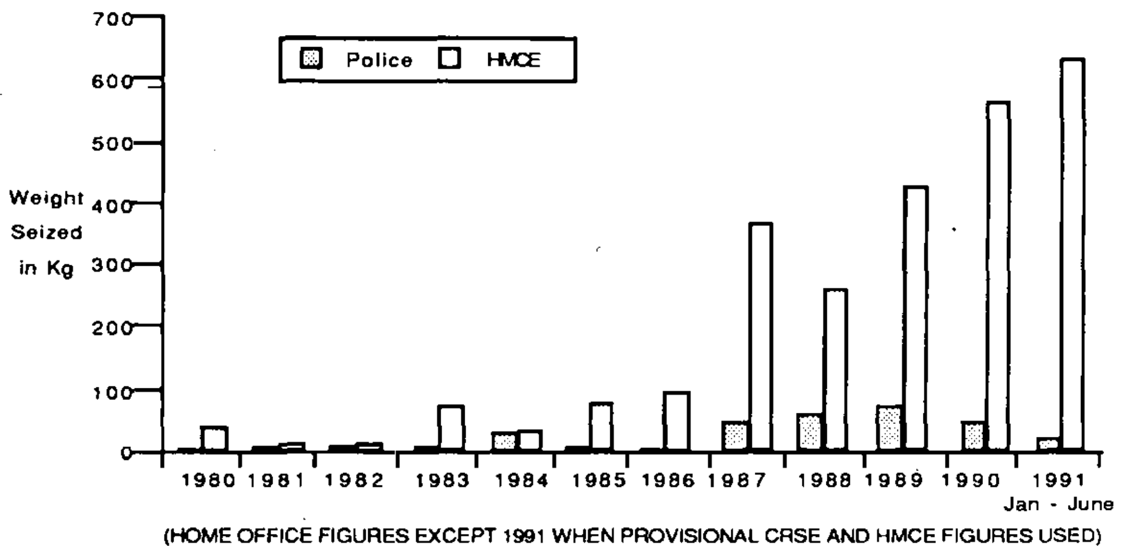


Figure 3. Amount of Cocaine (Including Crack) Seized by Agency 1980 - June 1991

Crack

Conversion to crack continues to increase from 12 seizures in 1987 to 352 in 1990 (Figure 4). It is centred mainly on the inner city housing estates in London and is driven almost exclusively by those of Caribbean origin who have forged direct links with their counterparts in the US and Jamaica. Other major conurbations are beginning to see its emergence, but much more slowly than London.

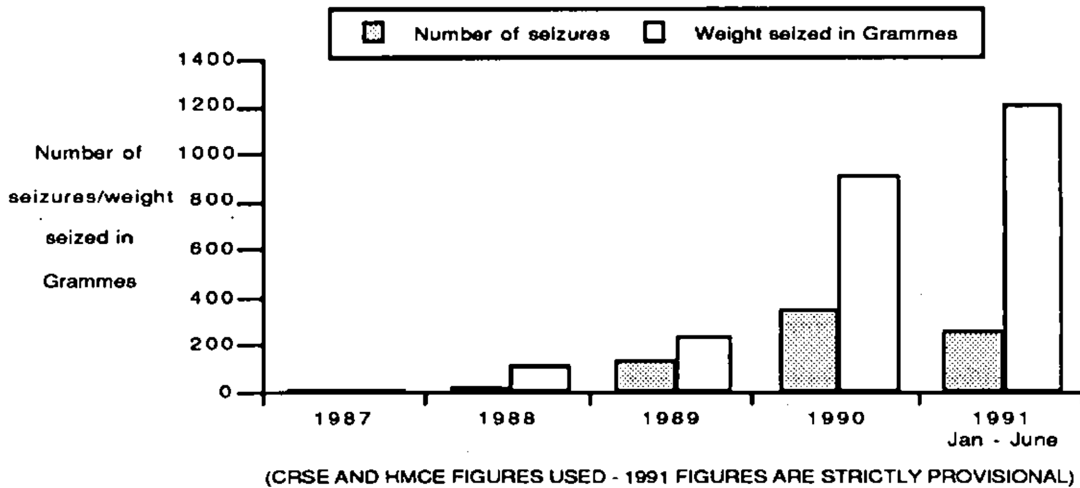


Figure 4. Crack Seizures 1987 - June 1991

Amphetamines

Amphetamine seizures are shown in Figure 5. Up to about 1987 amphetamine sulphate was largely home produced. However, enforcement successes linked to an effective voluntary program of precursor chemical monitoring have created a general reduction in availability which has attracted production from north-west Europe, predominantly from Holland, as evidenced by the increase in customs seizures in 1990 and 1991.

The demand for amphetamines continues to increase across the country although at a low level of purity. Methamphetamine, in its base form of ICE, has started to appear in London and there are reports of its availability in other parts of the country.

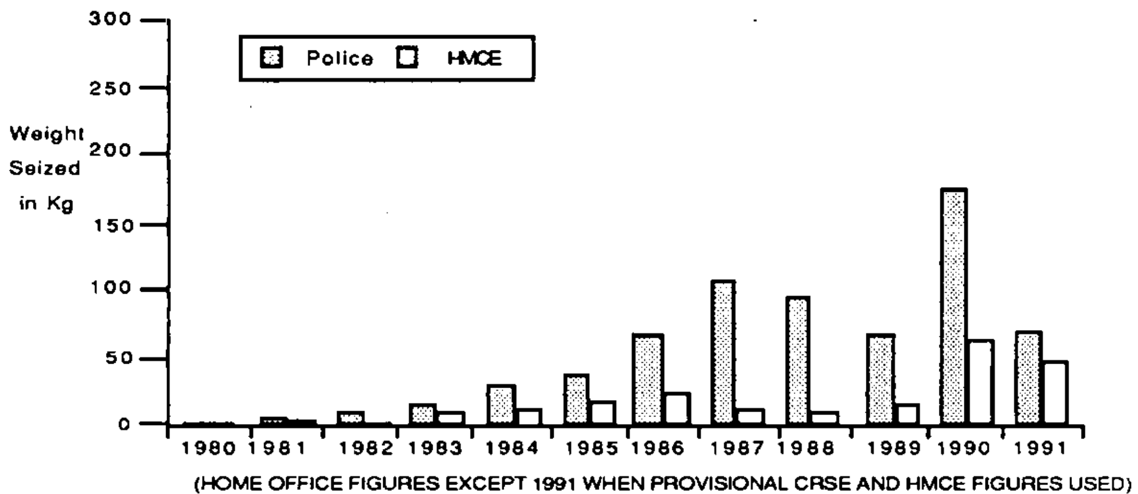
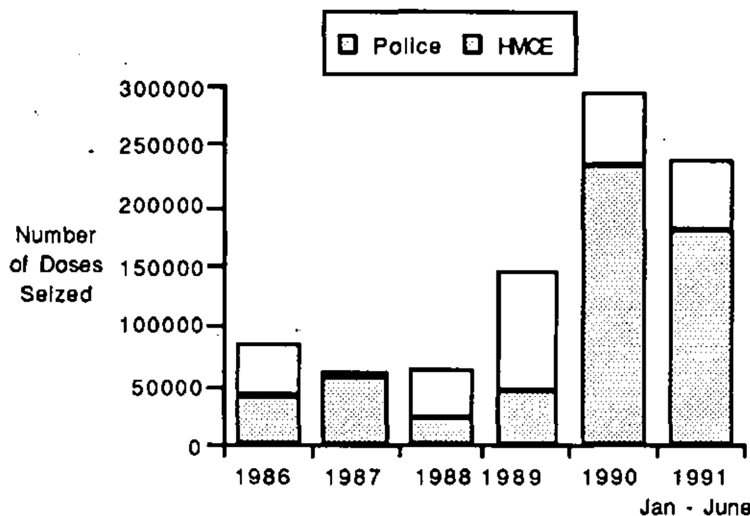


Figure 5. Amount of Amphetamines Seized by Agency 1980 - June 1991

LSD/MDMA

The main upsurge in misuse has been with LSD, particularly amongst younger misusers (Figure 6). In some areas LSD is marketed with amphetamine as ecstasy. MDMA is still around the club and disco scene especially in the recent phenomenon of acid house or pay parties.



(CRSE AND HMCE FIGURES USED - 1991 FIGURES STRICTLY PROVISIONAL)

Figure 6. Total Amount of LSD Seized 1980 - June 1991

Pharmaceuticals

Benzodiazepines are probably the most misused pharmaceutical drug, with temazepan popularity continuing unabated despite its re-formation into a gel in what has proved to be a fruitless attempt to prevent injection. Several other pharmaceuticals remain in great demand such as temgesic (noteably in Scotland) and DF118 tablets which are the standard substitute if more favoured opiates are unavailable. Most of the availability of pharmaceuticals is thought to come from prescriptions written for alleged therapeutic conditions either through patient diversion or over-prescribing.

Heroin

There was an increase in heroin seizures in the first half of the 1980s which peaked in 1985 but for some reason seizures dropped dramatically in 1986 and remained almost constant until 1989 when they rose alarmingly and continued to rise rapidly in 1990 (Figure 7). Evidence of the lack of availability in 1986 can be seen from a significant drop in the number of drug offenders that year (Figure 8). Incidentally note the steep rise, shown in Figure 8, of the 17-20 age group and that of the 21-24 age group. Also worrying is the upward trend of 10-16 year olds.

The availability of heroin is generally spread around the country, although there are reports that supplies are patchy and intermittent in some rural areas. In London there is no shortage of supply with street purity levels at around 30% or more, which is generally higher than elsewhere in the country. As you would expect the preponderant use is by injection although smoking is reported to be equally popular amongst ethnic groups.

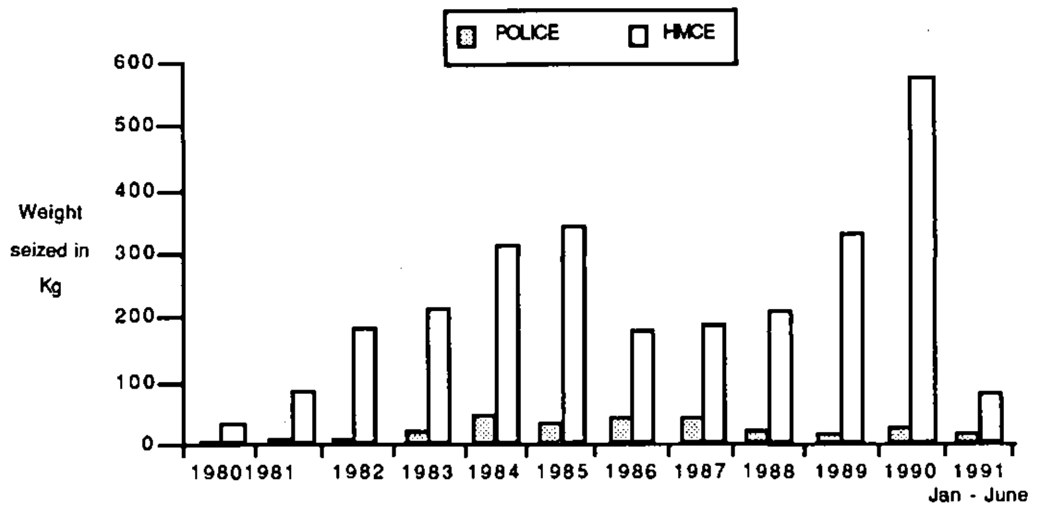


Figure 7. Amount of Heroin Seized by Agency 1980 - June 1991

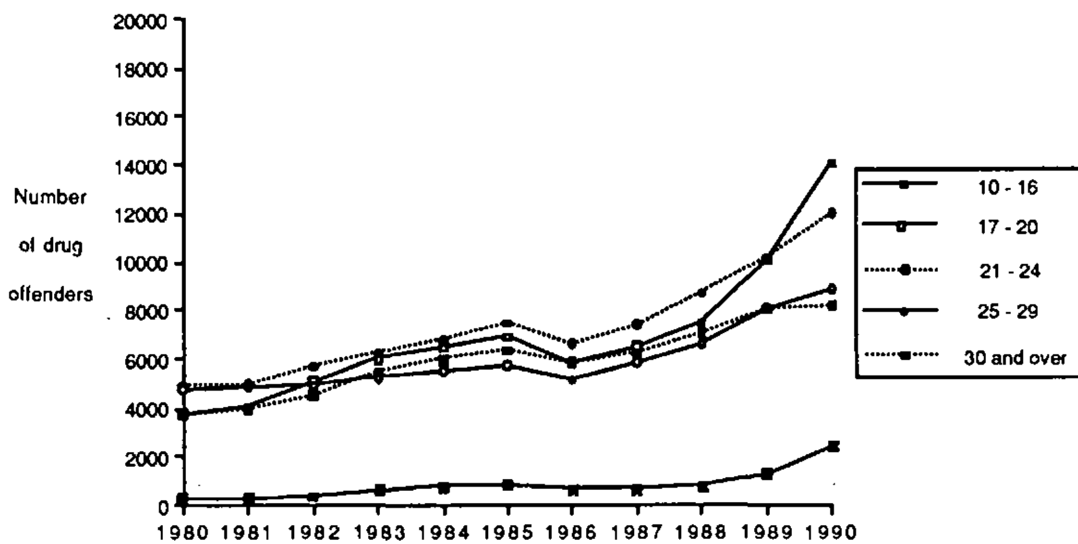


Figure 8. Drug Offenders by Age Group 1980 - 1990

ADDICTS

Statutory regulations in the UK require doctors to notify the Chief Medical Officer at the Home Office of cases of opiate or cocaine addiction. Many addicts have not sought treatment and will not therefore be notified. Researchers have demonstrated that there are considerable local variations in the extent to which the number of notified addicts underestimates the number of regular users of notifiable drugs. Some would suggest that the number notified is a shortfall to a 5-fold degree whilst others suggest it is twice that. However, despite the limitation of statistics, I suggest they do give an indication of trends on the number dependent on notifiable drugs.

The total number of addicts notified in 1990 was almost 18,000 which is a 20% increase on the previous year and a 66% increase since 1987. Of those, 82% were addicted to heroin, 28% were addicted to methadone and 6% were addicted to cocaine. Those proportions have remained fairly constant over the last four years. However, 1990 saw a 66% increase over the previous year of those addicted to methadone, which may be indicative of increased numbers in treatment.

In 1987, because of its importance in the transmission of HIV infection, doctors were asked to indicate whether their addict patients injected any drugs. Whilst there is no statutory requirement for them to provide this information, it was noted in 1990 that it was provided for just over 80% of notified addicts which showed that over two-thirds of them were injecting - similar to the proportions in 1988 and 1989.

If we accept that a large proportion of the expenditure is realised from crime it could be argued that prescribing pharmaceutical heroin in controlled conditions and at no cost to the user would bring about a reduction in crime and be much safer for the user. On the other hand if the user of the prescribed heroin did not administer under supervision then there is a danger that some prescribed heroin could be diverted onto the illicit market.

UK GOVERNMENT STRATEGY

In March 1985 the British government first published their strategy entitled "Tackling Drug Misuse". That initial document has twice been revised and there are indications that a further revision would be timely. Its objective is to attack the drug problem on five different fronts:

1. to **reduce supplies from abroad** through international cooperation, by using the United Nations and its conventions and by aid to producer countries;

2. to **ensure effective enforcement** through close cooperation between police and customs to reduce the amount of drugs entering the country and therefore reaching the streets;

3. through the **tightening of domestic controls** by stricter supervision of the legitimate production and distribution of controlled drugs and by strengthening legislative deterrents [a point of note is that whilst a specific criminal offence has been created to cover the possession of drug paraphernalia, hypodermic syringes were specifically excluded in recognition of the AIDS problem];

4. through the **promotion of prevention measures** in the health, education, and training fields;

5. through **improved and expanded treatment and rehabilitation** services especially in those areas related to curbing the spread of HIV infection among injecting drug misusers.

TREATMENT

The UK introduced controls over drugs of addiction in 1920 which preserved the right of doctors to prescribe controlled drugs to addicts. This principle was soon questioned and subjected to a review in 1926 by the Rolleston Committee. It concluded the following: addiction to morphine and heroin was a rare occurrence chiefly confined to people having access to drugs for professional reasons; addiction should be regarded as an illness; and, whilst favouring some form of institutional treatment towards withdrawal, there was a valid argument for treatment by general practitioners. The Committee's formulated guidelines were accepted by the government of the day and by the medical profession and ultimately became known as the "British System".

The policy of Rolleston was later reviewed by the Brain Committee which reported in 1960 that although there had been some changes in the situation since Rolleston it did not warrant a change in policy.

By 1964 however there had been a significant rise in the number of people known to be addicted to drugs, especially to heroin, and concern was heightened by the fact that these new addicts were younger and had not originally taken the drug for therapeutic purposes but had been introduced to heroin in other ways. The Brain Committee was therefore reconvened with a remit to review its advice in relation to the prescribing of addictive drugs by doctors.

The Committee concluded in 1965 that the main source of concern was over-prescribing by a small number of doctors and it made extensive proposals to limit the number of doctors authorised to supply heroin and cocaine. The Committee stated:

> "If there is insufficient control, it may lead to the spread of addiction - as is happening at present. If, on the other hand, the restrictions are so severe as to seriously discourage the addict from obtaining any supplies from legitimate sources it may lead to the development of an organised illict traffic. The absence hitherto of such an organised illicit traffic has been attributable largely to the fact that an addict has been able to obtain supplies of drugs legally. But this facility has now been abused with the result that addiction has now been increased."

Some would argue that that was an invitation to create an illicit drug market.

These proposals were accepted by Government and led to: the establishment of treatment centres; the licensing by the Home Secretary of doctors who wanted to prescribe heroin and cocaine and; a system of notification of those addicted to certain controlled drugs.

In recent years, in response to an increased awareness of the extent of problem drug use and the unprecedented threat to health posed by AIDS there has been an expansion of services in drug dependency clinics and a range of new approaches to treatment. In effect the necessary development in treatment practices in recognition of the AIDS threat has opened up the present prescribing debate.

In the mid 1970's a controlled trial was carried out at University College Hospital in London in which heroin addicts seeking prescriptions were randomly allocated into two groups, one being prescribed injectable heroin, the other only oral methadone (Hartnoll et al 1980). It was reported after 12 months that many more of the heroin group were still in treatment but more were injecting and using heavily though there was less crime, whereas the methadone group tended to polarise into "very good" or "very bad" outcomes in terms of drug use and criminality.

John Strang, in reviewing the "British System" in 1989 in the light of the increasing significance of HIV infection amongst injecting drug users, stated that the potential benefits of prescribing were being re-examined and 'harm reduction' approaches were being incorporated

into the clinical practices of established drug clinics, newer community drug teams, and recent syringe exchange schemes. Strang concluded that an area of new development of the "British System" may need to be the development of combined HIV/drug care in which attention should be paid to the possible value of opiate prescribing as a means of enhancing compliance with anti-HIV treatment.

The Advisory Council on the Misuse of Drugs, in their first report on "AIDS and Drug Misuse", recognised that the practice of prescribing injectable drugs did occur in some clinics but commented in terms that it should be seen as the exception rather than the rule. In their second report on the same subject they appeared to endorse their earlier views, adding that the principle of prescribing should never be undertaken without an identifiable goal, and that a range of goals should be considered.

POLICE INVOLVEMENT

The success of the illicit drug trade is driven by the laws of supply, demand, and profit. Anyone who thinks they can neutralise any one of those elements in isolation is, I suggest, living in a fool's paradise. To have any impact it requires the combined efforts of prevention through education, law enforcement, and treatment and rehabilitation. Law enforcement not only has a wide role in its own area but also has a significant and important support role to play in both education and treatment.

In the education field, drug education coordinators have been appointed in all local education authority areas in the UK to develop a curriculum of drug education in schools which caters for the structured involvement of police and other agencies.

In pure law enforcement it is my firm belief that strong interdiction and enforcement measures with realistic sentences on conviction are absolutely justified against importers and major drug traffickers just as legislation to trace, freeze and confiscate assets derived from drug trafficking is equally appropriate. It is in relation to the demand market and its nexus to treatment and rehabilitation where law enforcement in the UK has to recognise that it represents a service to the community and must be prepared to enter willingly into a partnership approach with other agencies aimed at improving the overall quality of life. Our duty to protect, help and reassure people is not always achieved by enforcing sanctions. Whilst we must always be seen to act with integrity, common sense and sound judgement we have a duty to reflect the priorities of the public in the action we take and as those priorities change so must we show a willingness to change.

There is no doubt in my mind that the UK police service has clearly shown a willingness to change from its earlier enforcement led position but there is room for further improvement. By entering into a partnership with other agencies we have publicly demonstrated our flexibility and our concern for the quality of life.

In recognising that the spread of AIDS has been severely heightened by drug abusers sharing needles we freely entered into an agreement to facilitate needle exchange schemes by giving an undertaking not to target those premises designated for the schemes. Since their commencement in 1987 they appear to be working well.

One of the principles of the UK policing system is the discretion an officer has on the outcome of an arrested person: whether to charge and take before a court; whether to caution; or whether to release without either. In so far as drugs are concerned all, or certainly nearly all, police forces in the country have adopted at least a cautioning policy in respect of those persons arrested in possession of small amounts of drugs for personal use. Some Forces relate this only to those arrested for the first time and some relate it only to the possession of cannabis. In London we are not so restricted and, whilst each case will be judged on its circumstances, we do caution in some instances for second and third arrests and for the possession of small amounts of heroin and cocaine. The national trend towards greater use of

cautioning can clearly be seen in Figure 9. It has been used in many cases to informally persuade and allow individuals to at least touch base with, if not fully enter into, local treatment and rehabilitation facilities.

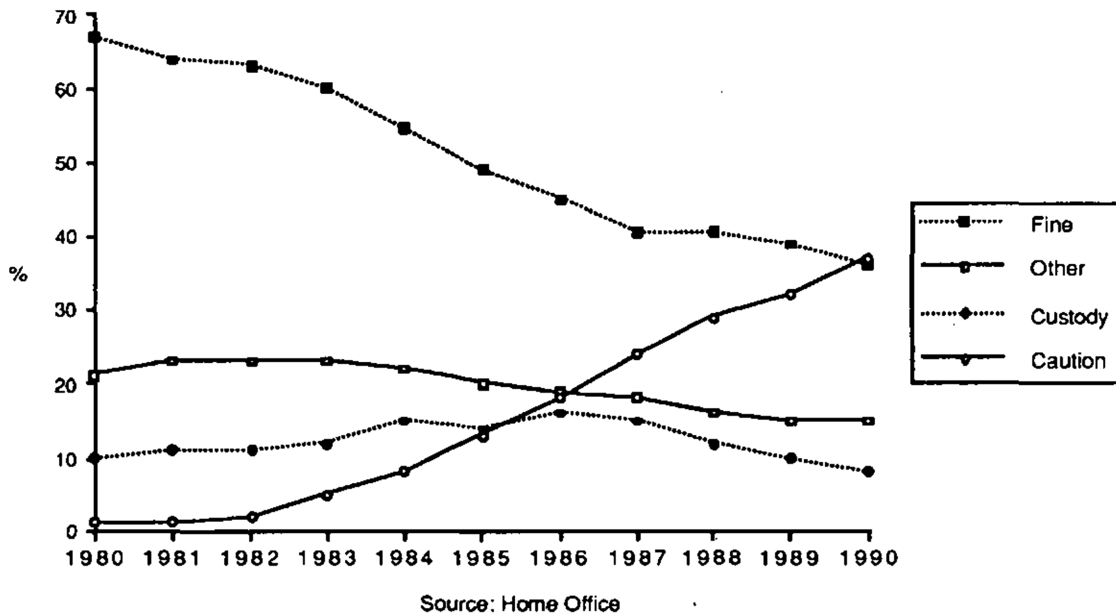


Figure 9. Trends in Action Taken Against Drug Offenders 1980-90

An extension of this informal process has been the piloting of formal arrest referral projects at designated locations throughout the UK, of which three are in London. The principal aim is to determine whether arrests can provide an effective and positive point of intervention for the purposes of providing information, advice and referral for those who would like help in tackling their problem drug use. Its aims and objectives are set out and subsequently monitored through the cooperative efforts of local police and specialist agencies in a true multi-disciplined partnership approach.

Everyone arrested at designated police stations, irrespective of the nature of the offence, is given a card (Figure 10) offering support and medical aid to those who feel they have a drug problem. Those who choose to take up the offer can themselves, or through a police officer and whilst still at the station or following release, contact the Scheme Worker. Even detainees are offered this facility. The scheme does not, however, include any formal provision for diverting people out of the criminal justice system; it is not designed as an alternative to arrest or charge; nor is it a negotiating factor in the application of police discretionary options such as cautioning.

DO
YOU
THINK
YOU
HAVE
A
PROBLEM

Ask the police to call us and we can arrange for someone to come and meet you when you are released. Or you can call us yourself.

Drugs

we can help you now

This is a special service, set up to help drug users who have been arrested, run by independent drugs workers. You can talk freely - nothing you say can be used in criminal proceedings.

Free
advice
support
and
medical
help

Telephone 071-708 5888 ask for Simon

Figure 10. Card Given to Drug Users by Police

One of the London schemes has recently reported on its first 27 months of operation and whilst the take-up rate may be seen as disappointing it is encouraging that 40% of those who elected to seek help had not previously done so, and 65% of those presenting for help through the scheme had been arrested for non-drug offences. It clearly demonstrated the inter-dependence of police and drug worker roles in encouraging arrestees to take up the offer of help which was enhanced by the efforts of officers in encouraging interest in the scheme. Not all officers were attracted to it - some were sceptical and others suspicious - but the more senior and middle management demonstrated their commitment to, and ownership of, the scheme, the quicker that scepticism and suspicion began to wane.

CONCLUSION

In conclusion I have to say that there is increased willingness of police in the UK to support treatment efforts in drug misuse to reduce the threat of the spread of AIDS and HIV infection. I do not see this trend as a soft option. Any environmental scan will identify the spread of AIDS as a major threat to our wellbeing and to the quality of life. We cannot, in the UK, support the notion that any one agency can achieve any degree of success in this area on their own. It has to be a partnership where police are but a member, albeit an important member, of a true multi-disciplined team with sufficient status that they can make decisions and influence local policy. That relates to the UK. It is no part of my brief to suggest that what is happening in the UK should happen here. What works in one country may not work in another.

I suspect, however, that the success of your pilot scheme will depend on the support of all agencies, on the support of government, on the support of the criminal justice system, and more especially it will depend on the support of the client group and the community at large. I suspect it will not be without its hurdles but, having read the report and recommendations, I would say you are right to have consulted widely and proceeded incrementally using a cautious approach. The adage of "united we stand, divided we fall" might just have a relevance in this context. That having been said, it is your decision both individually and collectively and I sincerely wish you well in your endeavours. Thank you for inviting me and for the opportunity to present the UK perspective from the police point of view. I hope it has been helpful.

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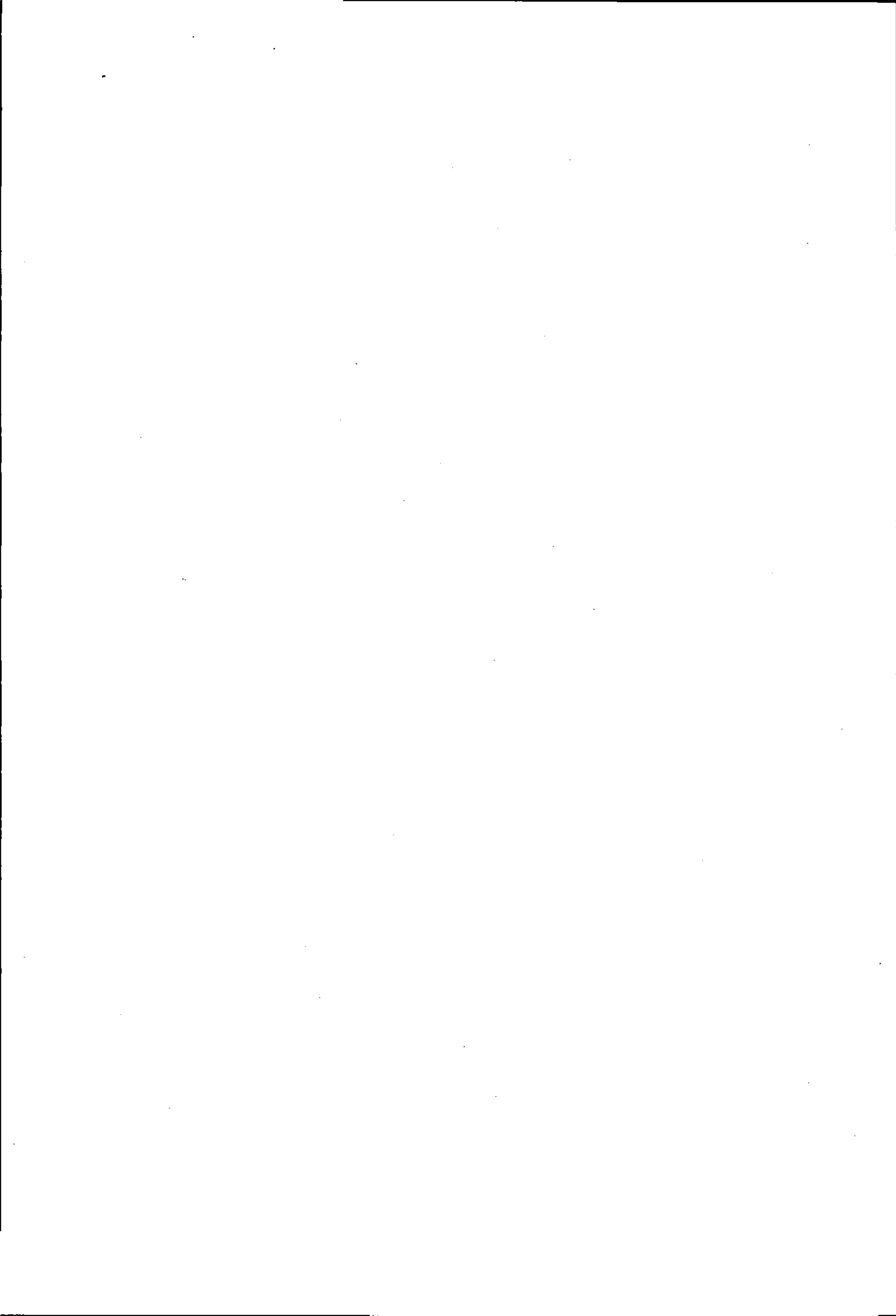

Policing the Merseyside Drug Treatment Program: "The Cheshire Experience"

Mike Lofts
Drug Squad, Cheshire Police

INTRODUCTION

Cheshire is predominantly a rural county with an area of 850 square miles and a population of 955,800. It is situated in the north west of England and is bordered by the counties of Merseyside to the north, Greater Manchester to the north east, with Shropshire, Staffordshire to the south and North Wales to the west.

It is dissected by 200 miles of motorways which give access to all areas of the British Isles. As a county it demonstrates a dramatic contrast demographically from the foothills and valleys bordering the Peak District to the rural villages of the Cheshire Plain, the industrial towns of Warrington and Widnes, to the tourist mecca of Chester, the county town. This demands a complete range of policing methods.

Cheshire Constabulary, the police force responsible for this area, has a strength of 1,868 officers and together with their civilian administrators they manage a £50 million business employing over 2,500 people in 210 different buildings.

Easy motorway access to the county has made Cheshire's affluent housing belts a prime target for professional criminals travelling from neighbouring conurbations.

Throughout the ten years ending 1987, crime soared by an annual average of 8% and the Force has faced every category of major offence, including terrorism, murders and riot. Crime figures for 1989 and 1990 are shown in Table 1. Widnes and Warrington are well within the general increase throughout the county area.

Table 1. Cheshire Constabulary: Cumulative Reported Crime Totals

	1989	*1990*	*+/-*	*+/-%*
CHESTER	7214	7768	554	7.7%
ELLESEMERE PORT	4071	4439	368	9.0%
NORTHWICH	3690	4340	650	17.6%
WESTERN DIVISION	14975	16547	1572	10.5%
WIDNES	**3821**	**4406**	**585**	**15.3%**
WARRINGTON WEST	**6685**	**7417**	**732**	**10.9%**
WARRINGTON EAST	**4324**	**4928**	**604**	**14.0%**
RUNCORN	4094	4624	530	12.9%
NORTHERN DIVISION	18924	21375	2451	13.0%
MACCLESFIELD	3909	5024	1115	28.5%
WILMSLOW	2857	3645	788	27.6%
CREWE	5112	6163	1051	20.6%
EASTERN DIVISION	11878	14832	2954	24.9%
FORCE	45777	52754	6977	15.2%

The number and type of drug-related crimes for the period 1989 and 1990 are shown in Tables 2a and 2b. During 1989, 72% of all offenders arrested on drug charges were found to have other convictions including shoplifting, fraud, robbery and prostitution.

Under the supervision of the Serious Crime Squad, Cheshire's Drug Squad coordinates the Force's operations against trafficking and misuse. The Drug Squad consists of 17 officers (15 operational) all based at Northwich, a town central to the county. To supplement the work of the Drug Squad, each division and sub-division has a uniformed sergeant as a Drug Liaison Officer, collating relevant information from all officers within his sub-division. Apart from operational duties, Drug Squad officers also liaise with public, professional and social bodies and other agencies in an attempt to increase awareness and stem the tide of drug abuse.

Table 2a. Force Drugs Summary for Class A Drugs: January 1989 to December 1990

	HEROIN		*LSD*		*COCAINE*		*OTHER CLASS 'A'*	
	89	*90*	*89*	*90*	*89*	*90*	*89*	*90*
POSSESSION	85	30	18	54	2	2	1	17
SUPPLY	9	1	9	4	-	-	4	-
INCITE TO SUPPLY	-	-	-	-	-	-	-	-
POSSESSION w/i TO SUPPLY	8	6	6	36	2	-	-	3
CONSPIRACY TO SUPPLY	-	-	-	-	-	-	-	-
CONCERNED IN SUPPLY	1	-	-	-	1	-	-	-
CULTIVATE	-	-	-	-	-	-	-	-
IMPORTATION	-	-	-	-	-	-	-	-
CONCERNED IN IMPORTATION	-	2	-	-	-	-	-	-
ALLOW PREMISES TO BE USED	3	-	-	-	-	-	-	-
OBSTRUCTION	-	1	-	-	-	-	-	-
TOTAL	106	40	33	94	5	2	5	20

Table 2b. Force Drugs Summary for Class B and C Drugs: January 1989 to December 1990

	CANNABIS		*AMPHETAMINE*		*OTHER CLASSES B/C*		*ALL DRUGS**	
	89	*90*	*89*	*90*	*89*	*90*	*89*	*90*
POSSESSION	813	869	65	51	8	4	992	1027
SUPPLY	77	42	13	13	1	-	113	60
INCITE TO SUPPLY	-	-	-	-	-	-	-	-
POSSESSION w/i TO SUPPLY	93	66	13	35	-	1	122	147
CONSPIRACY TO SUPPLY	11	4	3	11	1	1	15	16
CONCERNED IN SUPPLY	-	-	-	-	-	-	2	-
CULTIVATE	8	1	-	-	-	-	8	1
IMPORTATION	5	5	-	-	-	-	5	5
CONCERNED IN IMPORTATION	-	-	-	-	-	-	-	2
ALLOW PREMISES TO BE USED	12	11	1	-	-	-	16	11
OBSTRUCTION	23	2	-	-	-	-	23	3
TOTAL	1042	1000	95	110	10	6	1296	1272

* *ALL DRUGS* calculated from Tables 2a and 2b

THE PHILOSOPHY

In 1983, Dr John Marks presented us with the following philosophy on which he based his drug treatment program. (John Marks is the clinical psychiatrist who is responsible for the Widnes and Warrington clinics.)

Drug addiction is unfortunately a chronic relapsing problem. However it need not be life threatening, nor, if it is properly managed, need it affect the general health and functioning of the addict.

The overall goal of treatment is to return the addict to a drug-free lifestyle. However it is recognised that for some addicts this will be a very long-term goal, whereas for others it will be a practical option.

Having assessed that a client is opiate drug dependent, the first goal is for that client to become drug free. This may be done via a "methadone detoxification program". If the extent or length of dependency and attitude of the client does not indicate this course of treatment, then the stability of the client's drug taking must be an initial goal. Illegal drug use often leads to wide fluctuation in the amount consumed, and so the maintenance program must begin at the least amount possible which will prevent discomfort and the onset of the withdrawal syndrome. Other indications of success will include improved physical health, keeping someone from a criminal lifestyle (as measured by fewer criminal convictions), a reduction in the amount of drugs being prescribed, a change in the means of administration of the drug - from intravenous use to oral use - and greater stability of social circumstances.

There is no known single treatment modality which has proved successful for all clients. After years upon years of research and experiments with various treatments, it has been found that a variety of treatments needs to be offered and that different clients may respond to different approaches.

It is recognised that there are always people who obtain services and treatment which are inappropriate. Through mimicking symptoms there will be patients who come forward for treatment and manage to deceive their general practitioner and/or the clinic staff even after an in-depth interview. Such people might receive a prescription when they should not.

Table 3 breaks down regular opiate users by area. Cheshire is part of the Merseyside Regional Health Authority and has approximately 2,000 regular opiate users.

Table 3. Regular Opiate Users by Area

Liverpool	5,000
Wirral	5,000
Sefton	5,000
St Helens & Knowsley	3,000
Cheshire	2,000
Mersey Region	20,000

Table 4 shows estimates of the prevalence of the use of illicit drugs in the Mersey region of which Cheshire is part. There are an estimated 12,000 injecting drug users. Twenty thousand people use opiates. In addition to injecting, a popular way of taking heroin is called "chasing the dragon". The heroin is simply mixed with water, heated from underneath and a straw is used to inhale the black smoke which is given off.

Table 4. Estimates of the Prevalence of Use of Illicit Drugs in the Mersey Region in 1989

	NUMBER OF USERS	*APPROX. RATE PER 1000 OF 15-39 YEAR OLD POPULATION*
Injecting drug use	12,000	14
Opiates	20,000	23
Hypnosedatives	5,000	6
Amphetamines	10,000	12
Cocaine	2,000	2
LSD	10,000	12
MDMA	10,000	12
Psilocybe	15,000	17
Solvents	15,000	17
Cannabis	50,000	57

In the Mersey Region, drugs are prescribed on an indefinite basis to drug users in order to eliminate the necessity to commit acquisitive crime to buy drugs. There is no need to sell drugs to others to finance one's own use. There is no need to risk one's (and others') health and possibly life with adulterated drugs.

An important side-effect is the removal from criminals of a lucrative source of revenue.

Provision of a state-controlled supply of drugs through responsible drug dependency clinics rapidly brings into contact with authorities a large majority of the most serious drug problems that other agencies never see because they do not prescribe drugs.

THE CLINICS

Marks' philosophy together with a Department of Health initiative in 1983 (which suggested that there may be a place for the prescribing of heroin to addicts in the fight against the spread of HIV and AIDS) culminated in the setting up of the Widnes and Warrington clinics.

The Widnes Clinic

Funded by the Halton Health Authority and serving a local population of 150,000, this clinic is now situated in new premises close to the police station and the town centre. It has several facilities including counselling offices, clinic, needle exchange room, gymnasium, group therapy room and a large basement which is currently being converted into a "fixing room" where clients can call in and use their prescribed drugs.

The clinic is staffed during office hours Monday to Friday and outreach workers operate until 10 pm on Tuesdays and Thursdays offering counselling, advice/information and needle/syringe exchange.

It is staffed full time by a coordinator, three drugs workers, two outreach workers and a secretary. Sessional input is given by a consultant psychiatrist, a general practitioner (who acts as a clinical assistant), a probation officer and a representative of the Social Services.

It currently has 50 maintained drug users who attend weekly, 40 on reduction regimes and 20 who are maintaining abstinence with clinic support. About 10 are in treatment (hospital/rehabilitation), about 10 are in prison and about 10 merely attend for needle and syringe exchange (Table 5). Overall clients seen by the clinic are approximately 130-140. The outreach team has made initial contact with 100 to 150 other drug users including LSD and cannabis users. These are "black market" drug users.

The Warrington Clinic

Funded by the Warrington Health Authority and serving a local population of 185,980, this clinic is a three storey building located near the local police station and became fully operational in 1985.

It has several facilities including a counselling room, examination room, needle exchange room and a room with facilities for urine analysis for the presence of drug misuse. It does not have a "fixing room".

The clinic is staffed during office hours Monday to Friday and has an answer phone for weekend enquiries.

It is staffed by a full time clinic coordinator, a full time assistant coordinator, a peripatetic worker and two part time secretaries. Sessional input is by a consultant psychiatrist and two general practitioners who are clinical assistants.

It currently has 51 maintained drug users who attend weekly, 31 on reduction regimes and an undisclosed number of ad hoc clients who include clients attending for needle exchange, advice etc (Table 5).

It has a full time outreach worker.

Table 5. Clients of the Warrington and Widnes Clinics

	WIDNES	*WARRINGTON*
Maintained addicts	50	51
On reduction regime	40	31
Maintaining abstinence	20	-
Hospitalised	10	8
In prison	10	not known
Attending for needle exchange only	10	20-30

Assessment of Clients

The assessment of clients is common to both clinics. Addicts will be offered treatment as an in-patient, if necessary by detoxification. If appropriate a reducing regime of withdrawal from opiates may be prescribed. For those who do not wish treatment but continue to use drugs, a maintenance supply of opiates may be prescribed.

Addicts dependent upon controlled drugs are referred by their general practitioner to the consultant psychiatrist. A multi-disciplinary team comprising a consultant psychiatrist, the clinic coordinator, a clinical assistant and a drug counsellor will assess the client.

Prescriptions for drugs are given on the basis of a clinical judgement, the foundation of which is that the client is drug dependent, physically and psychologically.

The condition of such a prescription is that the client attends a weekly group therapy session with a monthly review. Examinations are carried out for intravenous use and urinalysis (random testing). The total yearly attendance statistics at weekly group therapy sessions are shown in Figure 1.

Script negotiations (between doctor and client) are followed by either a reduction or increase in the prescribed amount or a change from intravenous use to oral or smokable use.

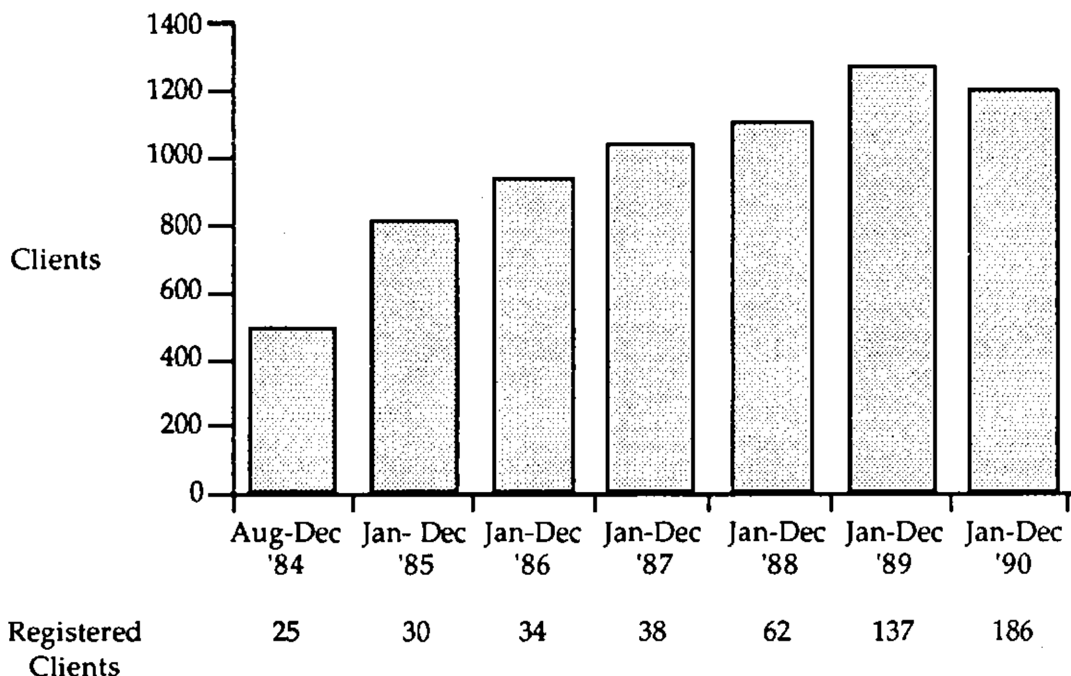

Figure 1. Total Yearly Attendance Statistics at Weekly Group Therapy Sessions

POLICING OF THE CLINICS

Implementation of the Scheme

From the very outset of the clinics a close collaboration has been kept between them and the police service.

Before they opened, meetings were held with the health services, probation service, general practitioners, chemists and the police (local and drug squad).

Guidelines were written into the conditions to be observed by clients and it was agreed that any criminal activity by the clients would be reported to the police. The clinic teams reserve the right to refuse to prescribe drugs to anyone who abuses the service.

Physical policing of the clinics is carried out by regular but discreet visits by plain clothes or drug squad officers. A good relationship exists between the staff and police.

The chemist inspector makes regular visits to the chemist shops where the prescriptions issued by the clinics are dispensed. This it to ensure that:

1. the drugs are being dispensed correctly;

2. a record of the names/numbers of addicts can be recorded and forwarded to the Home Office (Drugs Branch);

3. any overprescribing by the doctor can be detected and again reported to the Home Office;

4. the security of the drugs on the chemist shop premises can be checked;

5. any antisocial or untoward behaviour by the addict can be discussed with the chemist and reported back to the clinic for appropriate action to be taken.

The types of drugs offered on prescription by the clinics include heroin, cyclimorph, diconal, amphetamine and cocaine, all in either oral, injectable or smokable form. Consequently the chemist shops carry large stocks of these controlled drugs and the physical security of the shops and staff is reviewed. The types of prescriptions given at the Widnes clinic are shown in Figure 2.

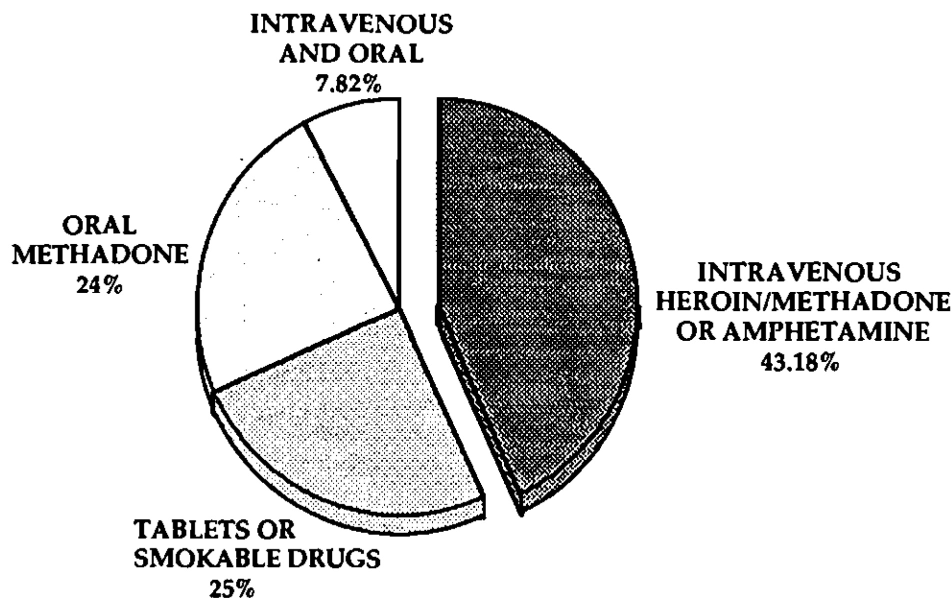

Figure 2. Type of Prescription (Widnes Only)

In order that new addicts are encouraged to attend the clinics a certain amount of leeway has to be given in and around the area of the clinics and so stop checks, surveillances etc are discouraged. However, if the clinic features in an ongoing enquiry involving drug abuse then the full force of the Misuse of Drugs Act will be brought to bear.

Regular meetings of Drug Advisory Committees are held in both Warrington and Widnes and are attended by all the statutory bodies (including police) involved in the running of the clinics. These are an open forum where any changes in policy, staffing, financing, philosophy or practical matters are discussed with the clinic staff and views are exchanged.

Early Problems of the Maintenance Programs

In the beginning the clinics went through an unsettled period. This was due to several factors. Firstly ignorance of the local communities about the clinics. Fear and prejudice resulted in labelling of the clinics as "drug super-markets". There was also a certain amount of anger on the part of local ratepayers, who appeared to be footing the bill for some "junkie's habit". This brought about unwanted publicity. The publicity attracted addicts from many surrounding areas who came to the clinics because they were unable to receive maintenance in their own area. Intimidation and occasional robberies become the order of the day outside or near to the chemist shops where the addicts picked up their drugs; the addicts were often reluctant to report such offences.

Many offences were committed by the existing "black market" heroin dealers who saw a possible threat to their business.

A certain amount of swapping, borrowing and lending of the prescription-issued drugs went on amongst the registered addicts (and still does today). A self-help group of a kind started to form.

Temporary local and false addresses were often given by "outside" addicts attempting to be "taken on" at the clinics. Because of national and international interest shown in the clinics they were constantly given a high profile in the media with addicts and staff persistently being interviewed on television and radio programs, thus destroying their anonymity. Some acquired "celebrity" status, which did little to help the cause.

Financial considerations loomed large and with local authority spending cutbacks the inevitable high cost of prescribed controlled drugs soon became an issue.

The needle exchange scheme was introduced in June 1987 and operates from the clinics. This has been fairly successful but we are still recovering used needles and syringes from places of public resort. Records show that approximately three quarters of the amount of needles and syringes dispensed are returned.

Figures for needles and syringes are shown below.

1989	1990
Syringes Dispensed 13,677	Syringes Dispensed 19,947
Needles Dispensed 22,903	Needles Dispensed 18,323

EVALUATION - HEALTH WISE

Undoubtedly the main achievement of the program, healthwise, is the zero HIV positive results discovered by testing 90% of the maintained clients at the clinics in 1988-89.

Many clients' chaotic lifestyles have been stabilised and their health has improved, with many being re-united with their families and a few returning to full time employment.

EVALUATION - CRIME WISE

Drug-related crime, other than actual offences, supply, importation etc, has always been difficult to record and indeed if we look at reported crime figures for 1980 (pre-clinic days), 1985 (beginning of clinics) and 1990 (clinics fully operational) it appears the maintenance program has had little or no effect (Table 6).

Table 6. Crimes Recorded for 1980 (Pre-Clinic Days), 1985 (Beginning of the Clinics) and 1990 (Clinics Fully Operational)

	1980	*1985*	*1990*
Chester	5,488	7,101	7,633
Warrington	6,139	8,283	12,121
Widnes	3,121	3,638	4,329
Cheshire	32,390	42,995	51,676

However because of the relatively small numbers of maintained users in relation to the criminal population of the two clinics' catchment areas it is not surprising that they have made little impact on the overall crime figures.

A more accurate picture can be seen by an eighteen month joint study carried out at the Widnes Clinic.

Between July 1988 and January 1990, all new clients, whilst being assessed, had the number of their previous two years' criminal convictions recorded. These were validated against the criminal records system. One hundred and forty-two clients took part and after 18 months of maintenance treatment their convictions for that period were again recorded. This study showed the following:

July 1988 - 142 Clients - 6.88 convictions per person

Jan 1990 - 112 Clients - 0.44 convictions per person

This demonstrates roughly a 15-fold reduction in criminal convictions amongst the participating clients.

It is also true to say that since the clinics opened, the street heroin dealer has slowly but surely abandoned the streets of Warrington and Widnes and convictions for possession of street heroin have dwindled along with him. We still have heroin problems in other parts of the county, where the drug dependency clinics practice predominantly "methadone reduction regimes".

THE REEFER SCHEME

The "diamorphine (heroin) reefer scheme" introduced in July 1989 has been both controversial and difficult to police.

The success rate of the reefer scheme is shown by the clinic reduction of clients injecting heroin intravenously (Figure 3).

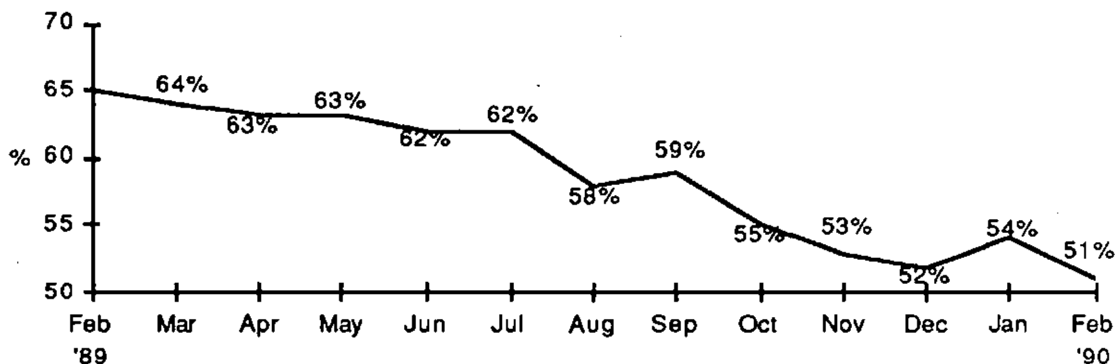

Figure 3. Percentage of Clients on Intravenous Prescriptions (Widnes DDU)

The ethos behind the reefer scheme is admirable but nevertheless the endproduct is a tailor-made "black-market" saleable commodity.

The diamorphine, cocaine and methadone reefers dispensed in the Warrington and Widnes areas are practically indistinguishable from normal cigarettes save for a small slight discolouration at the end and as such are being sold on the streets at a cost of £10 per cigarette. The pharmaceutical cost of producing 72 diamorphine reefers is £54.

These facts together with the "passive smoking debate" have been the main reason for non-adoption of the reefer program in other areas of the United Kingdom. A residential psychiatrist, influenced by John Marks, wanted to start a prescribing clinic in Bradford and to use diamorphine reefers as part of the treatment. A public meeting was held and a strong wave of public opinion (including local police opinion) out-voted the idea. The idea was subsequently abandoned, and methadone treatment continued. (Items covered by the local newspaper *Bradford Argos* in 1990.)

CONCLUSIONS

There is evidence that in Warrington and Widnes drug-related street crime, usually committed by heroin addicts, has been reduced since the opening of the clinics.

It is felt that the philosophy of the clinics' consultant and staff have had much to do with this.

This philosophy could also be a factor in the low incidence of HIV amongst the drug addicts.

After a shaky start and problems with bad publicity the clinics appear to have "got their acts together".

The type of work is too emotionally charged to expect unqualified social acceptability and so the service offered to the community must be reliable, consistent and of the highest quality.

In any Drug Dependency Clinic it is felt that the following aims and objectives must be strived for.

Aims

To minimise the damage caused by drug addiction to the community.

To minimise the damage caused by drug addiction to the individual.

To prevent drug addiction wherever possible.

Objectives

To provide adequate counselling, clinical examination and assessment so as to choose the most appropriate management of each individual's case.

To protect from withdrawal symptoms those drug addicts who do not yet wish to give up their habit.

To prevent ill-health due to drug-related activities and self-neglect.

To remove the need for criminal activity to fund drug habits.

These can only be achieved by close liaison with the health authority, other disciplines and the police. Close control, management and supervision over the dispensing of the drugs is essential to prevent a "subculture" of dealing in pharmaceutical drugs springing up. A "liberal" attitude to the "swapping" and "borrowing" of clients' scripts amongst each other had to be adopted by the authorities. Personal ambition of anyone working on a drug scheme must never be an element and "reputation-building" avoided at all costs.

TRIAL AVAILABILITY OF OPIOIDS

Finally turning to your proposed trial of controlled availability of opioids.

It appears from reading the method of your proposed approach that you will have eliminated many of the problems encountered by the Cheshire Police before you begin.

For example much of the possible black market distribution of your opioids will be greatly reduced by "on site" administration, both injecting and smoking. Most of the doubt, uncertainty, suspicion and uninformed rumour has already been eliminated because of your multi-disciplinary consultations prior to commencement.

Finally the proposed scientifically based evaluation and research techniques which will accurately record the whole trial will eliminate much of the "hit and miss" techniques originally tried by the Warrington and Widnes clinics.

The road you intend to take is controversial, unpredictable, frightening and at times heart-breaking. But with the rapid proliferation of HIV and AIDS throughout the world and the growing problem of drug abuse something has to be done. Many schemes have been tried and failed; the one you are embarking upon may hold at least some of the answers.

We wish you the Best of British Luck.

ACKNOWLEDGEMENTS

Sue Taylor, Warrington Clinic; Andy Palombella, Widnes Clinic; Dr John Marks, Widnes and Warrington Clinics; The Chief Constable, Mr D. Graham, Cheshire Constabulary; The Assistant Chief Constable, Mr B. Baister, Cheshire Constabulary; Detective Chief Superintendent G. Jones, Cheshire Constabulary; Inspector P.L. Williams, Cheshire Drug Squad; Detective Constable D. Bowdler, Cheshire Drug Squad; Diane Clegg, Cheshire Drug Squad

Discussion

JOHN JOHNSON
TASMANIAN POLICE

Mike Lofts - does your program have any particular policy in respect to children or people who work in what might be described as dangerous occupations such as our colleagues (police officers), people who work in manufacturing and building industries or airline pilots?

MIKE LOFTS

I think I know why you're asking this. We did actually have an airline pilot on the scheme at the beginning. He was quickly notified to the civil aviation authority, and he's now flying kites on Clapham Common. In respect of children, the minimum age of anyone going onto any heroin maintenance program at the clinic is 18. Educationally, we go into schools as a police service and talk about drug addiction etc, and each clinic has outreach workers to talk to parents and friends or whatever around children in the privacy of their own homes.

RAY DONALDSON
DRUG ENFORCEMENT AGENCY, NSW POLICE SERVICE HEADQUARTERS

Mike Lofts - it's rumoured here that as the tolerance builds with the people that have been maintained on heroin that they virtually lie about in the streets in the vicinity of the clinic waiting for their next shot. Can you comment on that?

MIKE LOFTS

All I can say is that I've never seen anyone lying around in the street waiting to go into the clinics. Part of my job as a chemist inspector is to check the pharmacy register. This shows every single dispensation of heroin throughout the county, and I've not noticed any increase in the amount, the level. Most average levels are 60 ml of heroin and it's very rare that anything ever goes above that.

As far as congregating etc outside the clinics, both clinics are on a major road in the town centre and it would be very noticeable if they started to congregate. You would imagine they would congregate, but what we find is that it's quite the opposite. They tend to dart in, get their gear, get the business over with and dart out again so as not to draw much attention to this facility.

MARGARET HAMILTON
DEPARTMENT OF COMMUNITY MEDICINE, UNIVERSITY OF MELBOURNE

I'm very interested in the fact that the three presenters in this session, all representing in their various guises law enforcement, present us with a picture that is the sort of picture we'd expect from someone who runs a treatment clinic. And while I take the point of the great importance of positive collaborative efforts between law enforcement, health and welfare personnel in actually managing this, and see this as one of the major thrusts of

NCADA here in Australia - to actually bring together these previously competitive and sometimes antagonistic sectors - I would be interested in having a little more Australian input from the law enforcement personnel here. Because as I heard the end of this morning's session I felt that we were in a sense "geed up" for the positive attributes of the proposal that's before us and its scientific legitimacy (which I commend) and all the good reasons why we should do it.

I'm conscious that there are other people in the audience who are probably far more pessimistic and negative about it, and I'm just concerned that the one hour that will be left this afternoon might not allow sufficient of that view to be expressed and enough of that debate to actually be heard.

So I would ask to hear from other people in the audience who might in fact be somewhat opposed to the possibility of the trial, or the feasibility component of the trial, going ahead, so that those issues might be flushed out. Because I think the three representatives we have just heard from are from systems where a lot of those attitudes have some differences to the ones we still currently have.

DUNCAN CHAPPELL, CHAIR

It sounds something like a challenge rather than a question, but I would point out that there is at least one senior law enforcement representative on the panel discussion that will follow.

KEL GLARE
VICTORIA POLICE

I can't speak for my colleagues or other forces around the country, but as far as Victoria is concerned we're not antagonistic at all to this. All I can say is that I'm absolutely delighted that it's being tried in the ACT!

I think the fact of the matter is that all of the law enforcement agencies - all the police forces anyway - understand that law enforcement of itself isn't the answer to the problem, that the law enforcement agencies don't have the capacity to solve this problem on behalf of society. I'm here, like a lot of other people, to listen to what is being said and to try to evaluate whether in fact, if this kind program is introduced in Victoria, I ought to lend support.

Now I don't know what the outcome is yet. I had some reservations about the way in which it would work - for example people darting in for their shot and darting out again worries me because if they're darting in and out from their motor cars then I'm terrified of the consequences of that. But I have to say that as far as Victoria is concerned anyway, we have an enormous problem at the moment with prescription drugs - tranquillizers - and people driving their motor cars absolutely stoned out of their minds on legal drugs, so it's not just a problem with illicit drugs.

I think law enforcement agencies, so far as I can gather the mood of my colleagues around the country, simply are looking for some way to improve the quality of life in the various jurisdictions, and if that means changing the attitude of the law enforcement agencies to what we now do, then we're all willing to jump in and have a go. Better to do something and fail, than not to do anything at all.

LLOYD WORTHY
AUSTRALIAN FEDERAL POLICE

Just a couple of things, having spoken to Mike Lofts and Roy Penrose earlier. Raising the point about people lying around the street and so forth, is it true, Mike, that the majority of people who come and get the drugs take them away and use them at home?

MIKE LOFTS

Yes, that is in fact part of the treatment - the trust that they place in the addict to go away and do it in the privacy of their own homes. And in fact that mostly happens, but obviously some of them don't, they go to parks and back of schools and things like that.

LLOYD WORTHY
AUSTRALIAN FEDERAL POLICE

Well that raises one of the problems that we envisage in the ACT with the scheme in the early stages. Admittedly, Stage 2 is to look more closely at these issues, but the original scheme is to have drugs that are administered on the premises. Two shots a day, and there we see the risk of people waiting for their second shot lying around outside. And what do you do with the people who are in the park outside waiting for the place to open? The second thing is that we plan they should be residents of the ACT. I'm sure we'll have a dramatic rise in the population - they don't really care where they live - if we make it too attractive, and I think we have to caution about that.

The second question I was going to ask is for Bob Visser. I noticed, Bob, that you talked about a number of measures as to whether there can be a ban on people with knives, meetings of more than 5 people, 8 hour "no go" areas, and 2 week "no go" areas, and in fact the mayor has the ability to close down premises indefinitely. Could your scheme work without those additional enforcement measures?

BOB VISSER

When we see drug addicts gather we don't chase them because they are addicted, but when they gather and try to offend people who are passing by, and cause a lot of damage to the environment we need the power of the mayor to prevent that. If we didn't have that power then it would be very difficult to maintain an acceptable situation in the city centre.

This musn't be confused with our methadone program and with the fact that we want addicts to be helped. But it is a fact that addicts look for each other and concentrate at certain places (especially the ethnic drug users) and that the moment they concentrate they cause trouble and degradation. We don't accept that because we think they have their own responsibilities. We don't want harm for society, so we make it clear to them that they can live with their addiction as long as they don't cause trouble. This hasn't got anything to do with their addiction but just with the way they want to behave. And we think that the measures taken are very necessary to keep things under control in a city centre.

LLOYD WORTHY
AUSTRALIAN FEDERAL POLICE

The reason I raised that is that we've had a heated debate in recent times to have a "move on" power in the ACT, which is looked on by many as a draconian power, and for those law makers who would consider a trial of this type, we may need to amend the law in terms of some Netherlands measures for us to be able to deal with those things.

The last question is addressed to all three speakers, and that is: there seems to be an illusion here in Australia that legalising or decriminalising or making available drugs to addicts will somehow magically reduce the overall crime figures. And it's a very emotive issue that the drug-related crime is all brought about because of the drug addiction of certain people, without reference to the point that the majority, or a lot, of criminals who take drugs were criminals before they started to take them. Is it true that in your various jurisdictions the actual crime rate and the level of crime has not dropped as a result of these treatment centres?

MIKE LOFTS

Well certainly in Cheshire it hasn't dropped at all, but I think that's because we were looking at such small numbers of addicts on the scheme. We don't know, but maybe if we had 2,000 of the addicts on the scheme it may have some impression. But at the moment because it is 50 at one clinic and 51 at the other it has not significantly affected the crime figures at all.

ROY PENROSE

Generally for the UK, Lloyd, the answer is no. Crime is rising, there's no doubt about that. And it would be ridiculous to presume that part of that crime wasn't being committed by people who are trying to finance an illicit drug habit. But what I'd like to get away from is this idea of legalising heroin. Under the treaties - the UN conventions, the '61, the '71 and the '88 - we would be in breach of that if we had legalised. Heroin is not legal in the United Kingdom. It is licensed to be prescribed by general medical practitioners by the Home Office, and that doesn't offend the three conventions. I would have difficulty with just the moral issues of legalising heroin and allowing it to be on the streets, generally speaking.

But on this occasion I think where we come from is from the point of the knowledge of harm reduction and the threat of AIDS, which we see as quite severe. And we need to try to do what we can. Those treatment centres where heroin is being prescribed throughout the United Kingdom are increasing because we have always had the ability of doctors to prescribe opioids as treatment. It's being tried, and if it isn't working after a good time of trying I hope that somebody at the end of the day (which includes us) is honest enough to say so. But at the moment we're in a position where we think that the maintenance of this might just assist the quality of life, and that hopefully as a spin off there'll be a drop in the amount of crime committed by those seeking to support their habit.

BOB VISSER

I would agree with Roy. According to our figures in Amsterdam the crime rates have been stable for some years. When I look at the rest of the Netherlands I see they are still increasing. We used to have a yearly increase of crime in our city. Critics say "you have a stable level of crime but you have a high level. We haven't reached that plateau yet." So you can look at the figures in more than one way. We think that we have found a balance,

and we are certainly not influenced by the program to start worrying about crime. We think that the result of the methadone program is that, in that group, less crime is committed. And there was a survey held about how drug addicts get their money, and 25% of their money they get by consumption dealing - dealing within the group to supply their own drugs - and only 30% of their income comes from crime, and the rest comes from welfare and other things. We don't have evidence that the program is a great risk for crime. We think it has a very positive effect against crime.

IAN WILLIAMSON
DRUG SQUAD, MELBOURNE

Perhaps I'll take up on the point that Margaret Hamilton mentioned before. The reason that I'm up here with Mr Glare is to listen to some of the overseas experiences and, as was said before, to perhaps take some of the better points that you've got and see if we can put them into practice here.

But perhaps to take Margaret's point a bit further. We in Australia, and I talk for quite a few of the people here whom I've sat on many committees with, have been doing something on our own, fighting the supply side. We've now come to realise, and the people up the front have just told us, that it's a coordinated, cooperative effort. We have got to work in with health, the treatment agencies or whatever, and this is what we are now starting to do. Whether - and it's a big thing - whether we can convince fellow members further down the line that this is the way to go, is going to be one of the biggest tasks. And I make no bones about it. I've been in law enforcement - the drug side of it - for over 20 years, and it's taken me a long time to sit up, and I'm now starting to realise that we're not doing it perhaps the way we should and that we can't do it on our own.

One of the most recent things that we've undertaken is to get policemen to change their attitudes in regard to needle exchange. If that is one way we are going to stop the spread of AIDS, well we're making good progress. What we're going to do in the future is we're going to work closely and it's going to be a cooperative area effort. We've listened to you today, and no doubt I'll go back with my boss and we'll talk about things and perhaps pick the eyes out of the best of it. As he said, if the ACT wants to run this pilot program, well let them run it here first.

Crime Control and Heroin Treatment Programs

Grant Wardlaw BA MA PhD GradDipInt'lLaw
Consultant

(Because of time constraints this paper was not presented at the seminar)

In seeking to predict the impact on criminal behaviour of any drug treatment program we need to be careful to distinguish different types of drug-crime connections, to address problems in the inference of causality and to be aware of the use of inappropriate or misleading comparisons which give inaccurate impressions of the relationships between heroin use and the incidence and types of crime in our community.

Failure to be careful about these issues is, unfortunately, a hallmark of the drug debate and has been characteristic of many of the public comments both supportive of and in opposition to the proposal to trial and evaluate a system of controlled availability of heroin for established users. Since the issues of drug use and crime control are both such emotional ones, it is not unexpected that debate about them - and especially about their convergence - should stir considerable passion. The community is done a disservice, however, if arguments on any side of the debate are founded on or supported by a deliberate misuse or deliberately careless use of scientific evidence and argument or of, for example, crime statistics.

So before talking about the crime impacts of heroin use and of various ways of attempting to curb use, it is necessary to make some general comments about association, causality and crime statistics.

First, we should note that the quality of data available in both the drug use and crime fields is very poor. Since both involve trying to measure behaviour which those who indulge in it seek to hide, there are obviously considerable problems simply in measurement and in knowing how accurate or comprehensive the measurements are. As we really do not know with any accuracy how many people use illegal drugs or how many crimes are committed, it is not surprising that there is plenty of room for disagreement about numbers and plenty of room for partisan manipulation of them (intentional or otherwise). Indeed, one of the major contributions of a feasibility study would be the development and refinement of measures of drug use and of crime. For example, building on overseas studies and on the ACT Drug Indicators Study conducted by the Australian Institute of Criminology, the project would need to undertake further work on estimating the size of the illegal drug using population. Similarly, I would hope that in association with the Institute and the Australian Federal Police, NCEPH would examine the commissioning of crime victim surveys as part of its monitoring of the crime impacts of the study.

A second major point is that in looking for information on the crime impacts of drug use and distribution, there are two sorts of police statistics which need to be examined - those involved with the administration of the drug laws themselves (for example, offences such as use, possess or traffick in drugs) and those which attempt to measure "drug-related" crime (crimes committed under the influence of drugs or in order to produce the money to buy them, for example).

The first type of data is of limited value if it is used principally to attempt to measure the actual incidence of (or changes in the incidence of) either illegal drug use or offences against the drug laws. The problem is that such statistics are significantly influenced by police effort - they are activity or productivity measures - and may bear no consistent relationship to the underlying phenomenon. Thus, for example, it is quite possible for drug arrest figures to go up substantially at a time of declining drug use, and vice versa. If the police double the strength of the drug squad or issue an instruction to be more or less vigorous in attempting

to uncover one kind of drug offence or another, the statistics will reflect these changes. They will not necessarily, though, tell us much about the real incidence of the offences. Especially since almost all drug offences are detected by, rather than reported to, police, drug arrest figures are particularly susceptible to significant changes occasioned only by changes in police practice. This simply means that care must be taken in using and interpreting them.

A second type of statistic - drug-related crime figures - is also problematic. It is especially so because people tend to confuse drug-crime categories. Essentially there are three classes of drug-related crime (apart from those offences, such as possession or sale of drugs, which are created by the drug laws themselves). These are:

1. Crimes directly attributable to the pharmacological effects of a particular drug, i.e. some drugs directly produce physiological or psychological changes in some individuals which lead them to commit criminal acts, often of a violent or destructive nature.

2. Crimes associated with commission of drug offences, eg. corruption of officials, violence in the drug distribution scheme, organised crime activity.

3. Crimes committed to produce income to be used to purchase drugs for consumption, eg. burglaries, shoplifting, prostitution.

In attempting to measure the amount of drug-related crime or the impact on it of any anti-drug program, including treatment or controlled availability options, it is important to examine each type of drug-crime connection separately.

For the case of heroin, what is the nature of these connections? For most practical purposes, the first category (crimes directly attributable to the pharmacological effects of the drug) is irrelevant for heroin. Heroin is a depressant and is therefore not the type of drug likely to be associated with violence as a result of its administration. There is, of course, violence potential associated with the anxiety and irritability associated with withdrawal in heavy users.

There is clearly a considerable amount of crime associated with the commission of drug offences involving the buying and selling of heroin. Attempts to corrupt those responsible for administering the laws, violence associated with disputes over sales territories or lack of payment for drugs or theft of drugs from dealers are not uncommon, although they are difficult to quantify because they are not reported by the victims.

Probably the clearest and most pervasive link between heroin and crime, however, is the commission of income-producing offences such as burglary, theft, prostitution and credit card fraud, with the income being used to purchase heroin. Although the nature and extent of this relationship has often been overstated, there is now such a volume of research about it internationally that nobody can deny that property and street crime rates are linked to heroin use rates where there are significant numbers of heroin users. Further, the data clearly show that during periods of heavy use of heroin, regular users commit crimes at a consistently higher rate than they do during periods of low or no use. (Note, however, that for most of these people crime is a part of their way of life and continues at some level even during periods of abstinence).

In discussing the income-producing crime and heroin use association, though, we must be realistic about the extent of the relationship. Remember that there have been very high rates of property crime even when there has been no evidence of significant amounts of regular heroin use. We must not leap to the conclusion, therefore, that a rise in property crime is always linked to an increase in heroin use. It is, in fact, very difficult to measure the precise association between heroin use and crime and even large-scale, carefully conducted studies have found contradictory results, with some cities showing increased crime rates with increasing heroin use rates, some showing decreased crime rates with

increasing heroin use, and some finding no change in crime with increasing heroin use. Therefore, put baldly, anyone who tells you that any particular percentage of crime is heroin related is expressing a personal and usually unverifiable opinion and is usually using the figures to make a rhetorical, rather than a scientific point. A careful scientific study of the relationship between crime rates (as measured by both crime reported to police and by victim surveys) and heroin use rates could well be one of the major contributions of the proposed trial if it goes ahead.

What then are the likely effects on crime in the ACT of a controlled availability of heroin scheme? Clearly it is difficult to be precise, because some of the predictions, at least in terms of magnitude, will be critically dependent on the detailed implementation of the scheme. Such matters as the number of participants, the entry criteria and the conditions under which the drugs are administered will greatly influence the extent of the impact of the scheme on the pattern of crime. I would expect that these are matters which would be addressed squarely in Stage 2 of the project if it eventuates.

Nevertheless, it is possible to draw some sensible general conclusions which may help to dampen the enthusiasm of those who expect too much of the scheme (or who oversell its virtues) and calm the fears of those whose emotional reactions or philosophical objections to the proposal have caused them to expect the direst consequences to follow its implementation.

First there is the impact on drug offences themselves. I would expect there to be very little impact here, although that may depend on the reaction of the Australian Federal Police in their ACT policing role. The reality is that heroin offences have always played a relatively minor role in the total number of arrests (the majority relate to possession of cannabis). For example, in 1988, charges in the ACT (including Queanbeyan) on heroin related matters amounted to only 12.6 percent of all drug charges and involved only 40 out of 299 persons arrested that year (Stevens et al 1989).

Second, there is the pharmacologically-induced form of crime. As noted earlier, this is relatively unimportant in the case of heroin and it is difficult to see how the proposed trial would change this.

Third, we have crimes associated with the trade in heroin. Here there is a potential for some impact, although the final outcome is uncertain. On the one hand, it is possible that removing the hard core of users from the scene would decrease supply and hence the crime associated with it. This outcome would need to be predicated on the assumption that a significant proportion of the heavier users enter the trial, that they seek no heroin outside the scheme, that they divert no prescribed drugs and that there is not a pool of users currently at lower habit levels who are only held there by the relative unavailability of heroin caused by the uptake of regular users. How realistic these assumptions are will depend on the precise configuration and extent of the scheme.

A potential negative impact in this area is the possibility that if the scheme does succeed in capturing the heaviest users there may be more competition than at present among sellers for the remaining market. This competition may take the form of marketing to make the product attractive to new or existing low volume users or it may result in violence between sellers over market share. At present we know nothing in detail about the structure and dynamics of the heroin market in Canberra which would allow us to make detailed predictions. This is clearly an area which would have to be monitored by the evaluation of any such scheme. My tentative overall assessment, however, based on what we know, is that the trial as envisaged would have little impact on the total amount of this type of crime, although it may alter its distribution or form.

The final form of crime to consider, and potentially the most important, is that committed to finance the purchase of drugs. If the scheme were able to attract and hold a substantial majority of the most active heroin users in Canberra the impact on some forms of crime could

be substantial. There would have to be no concomitant replacement of heavy users for this to occur (eg. by users coming to the ACT in hope of getting on the program, failing to do so, and staying; or by currently less frequent users moving into a heavy use pattern).

It also needs to be pointed out that false expectations can be created for substantial and permanent falls in crime which, when they fail to materialise, could do great damage to the viability of the program. Remember that the majority of heavy drug users were criminals before they became drug users (see Wardlaw 1978 for Australian data, and Chaiken & Chaiken 1990 for a general review) and that a proportion of them will continue to commit income-producing crimes even when they do not need to spend the money on drugs.

Further, the rather simplistic way in which claims are made either for more or less crime in the wake of a controlled availability scheme ignore the more complicated realities which confront us. For example, without getting overly technical, it is worth considering some of the dynamics of property crime. There is reason to believe from some economic analyses that decreasing the number of addict-thieves may not have as great a long term effect as we might hope.

For example Gould (1974) suggests that the classical economic factors of supply and demand apply to criminal markets. In this case, the market is the black market upon which stolen goods are sold to realise cash. Theoretically, a large number of thieves selling their stolen goods quickly in order to raise cash for drugs should drive down the price of goods, thus making each act of theft less profitable. Thieves, therefore, must steal more to maintain the same income or turn to other sources (including legitimate ones). Non-users may be less compelled to stay in this criminal market and as theft becomes less profitable may leave or turn to other forms of crime. If addict-criminals are taken from the market, for example by the proposed program, the rate of return on stolen property may rise again, thus attracting back the non-user criminals. In other words, the level of property crime may not change significantly, only the labour pool of thieves.

We have no way of knowing at present if this analysis is relevant to our situation in the ACT, but it is this level of sophistication we need to get to if our discussions and evaluations are to be more than promotion or condemnation of the proposed trial.

Again, on the basis of what we know now about drug use and crime, and about the numbers likely to be admitted to the trial, it is unlikely to have any serious negative impact on crime rates and may have a modest positive one (which may not be long term).

In conclusion, it seems to me that not too much should be expected of the trial in terms of crime reduction. It may be moderately useful in that regard, but I cannot see crime control as being a major aim of the scheme. On the other hand, I can see no reason to expect any significant negative impacts either for the community generally or the police specifically. Those that are possible should be able to be minimised with careful planning and program implementation.

We might expect that the crime reduction virtues of a heroin maintenance scheme would have a substantial impact on the lives of the users involved, even if this is not reflected in overall substantial decreases in crime rates. Certainly, the proposed research has the potential for significant contributions to our knowlege about both methodological and substantive issues. Of prime importance, it will provide a knowledge base which currently exists nowhere in the world to enable a national debate about the issue of heroin maintenance. As this is such a prominent part of many suggestions for reform of drug strategy it is important to be able to decide about its usefulness once and for all. For this reason alone, I support continuation of this project into Stage 2.

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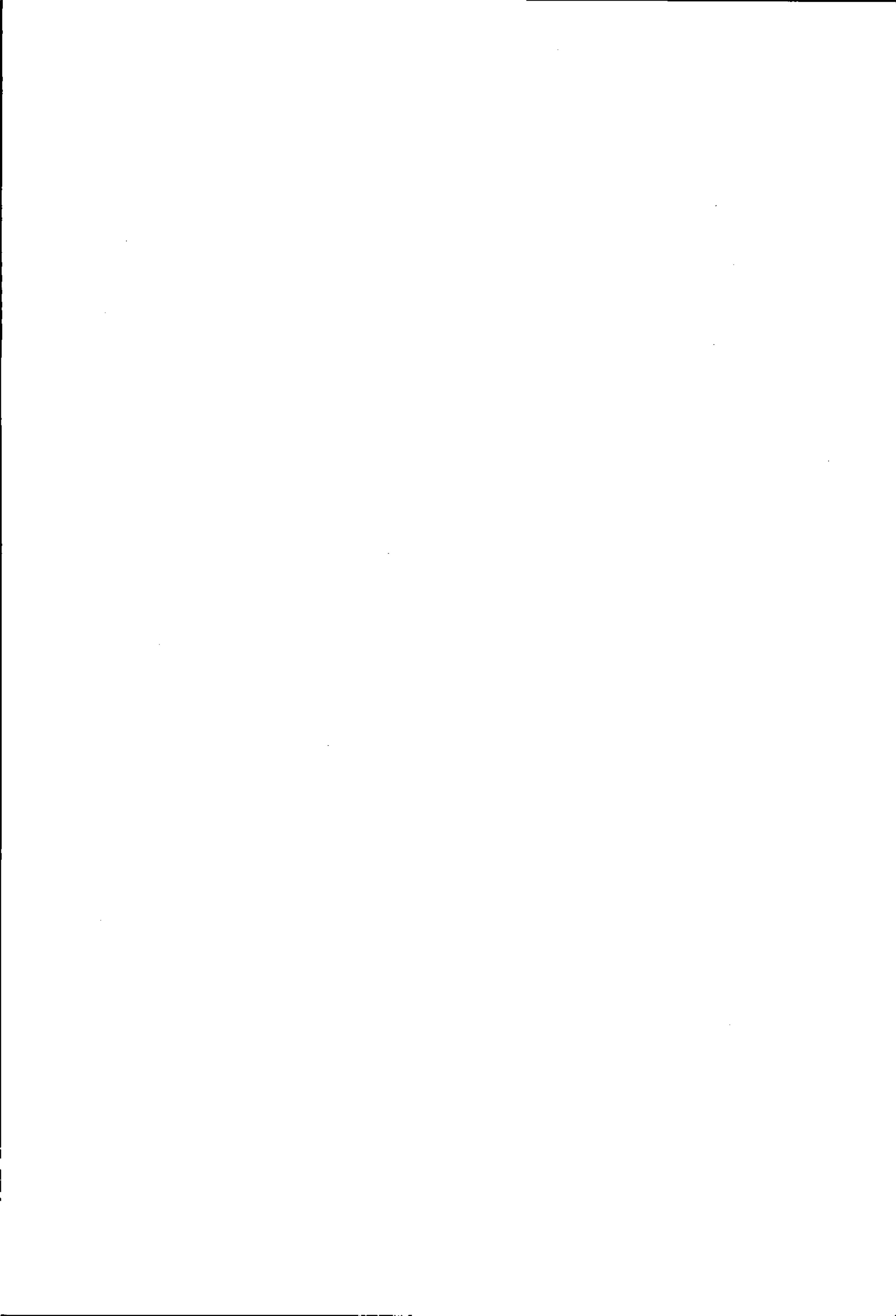


Panel: Costs and Benefits of an ACT Trial

BOB DOUGLAS, CHAIR

The purpose of today has been to review the costs and benefits of a trial in the ACT. We have on the panel the multidisciplinary group that we believe is going to be critical to a study of the kind that has been outlined for the ACT. Each panelist will now reflect for a short time on the issues they see to be pertinent.

MAGISTRATE JOHN BURNS
LAW COURTS OF THE AUSTRALIAN CAPITAL TERRITORY

It would be improper of me to purport in any way to state any position by the Magistrates Court or any other court in this Territory. As to whether a pilot study or eventually a full scale study should take place, obviously the courts cannot and do not have any policy in relation to that at all. However, as a person who has been both a prosecuting and defending counsel in this Territory over a period of years and now has some experience on a bench that regularly deals with people with drug dependency problems, I think it is appropriate that we as a community ask ourselves whether the crime control or enforcement model of dealing with drug offenders is really working.

Can we really say that increasing penalties and increasing funding to law enforcement bodies has dramatically eased the community's drug-related problems? And if, as I subjectively feel to be the case, the present system is not working to effectively reduce drug-related offences, then surely it is encumbent upon us as a community to try to find some more effective alternative.

Before any informed decision can be made, the community must be given full details of any proposal. In that respect I note that the current proposal is merely that the logistics and mechanics of the proposed trial be investigated and that a further and fuller debate takes place before any change in drug law or policy occurs in the Territory.

If we are to be intellectually honest as a community we must be prepared to at least consider options that challenge our preconceptions and hopefully to make pragmatic decisions based upon evidence. It is in that respect that I perceive the discussion which has taken place here today and the proposed logistical study to be positive steps in seeking to enable this community to make educated decisions in this field.

BISHOP OWEN DOWLING
ANGLICAN CHURCH OF AUSTRALIA

I came here very much with an open mind today, and I must say that even after listening to it all I haven't come to firm conclusions. I do believe, however, that there could be value in a controlled trial whereby results can be assessed. I wouldn't like to have anything set up which works against having people making good decisions about their lives. Sometimes people can get into one of a range of therapeutic programs and can make some very good steps, and it would be a pity if they got siphoned off into just having continuing heroin rather than dealing with the problem. So I would hope that there would be encouragement still towards those counselling or therapeutic programs; that they would not be cut down. It would also seem to me a pity to steer people off even the methadone program into this, if methadone is, as we are told, superior from the pharmacological point of view.

However, I recognise the fact that there are a number of addicts who perhaps wouldn't be drawn in in those other ways and that this may be a way of helping them through. There seems to be some evidence to suggest that with regular provision of heroin they may improve in their health and therefore improve in their decision making abilities. If that is possible, then that should be our goal - to help people make responsible decisions about themselves.

I am concerned about the fact that others are saying "oh well, try it in the ACT and ha ha ha we're glad that it's you!" It seems to me that we can perhaps draw positively on the fact that the different states are represented here today. Maybe they should continue to be represented on the controlling body that considers the results. Why should we be isolated? I would encourage continuing cooperation, because the more we can tackle these problems at a national, rather than a state and territory level, the better.

COMMISSIONER JOHN JOHNSON
TASMANIAN POLICE

When I came here today, like Bishop Dowling and Kel Glare, my colleague from Victoria, I came with an open mind. I must say that as the day has progressed I have been more and more impressed by the speakers that we have had on the dais and also by the other contributors to the discussions. I've been impressed to such an extent that I will leave here as an enthusiastic supporter of the project.

Innovative public policy such as the program we've been talking about today - which has the potential to improve the life of addicts while at the same time reducing crime and the incidence of AIDS and hepatitis infections in our community - must have my support. If the best scientific and medical advice is that the controlled provision of opioids to addicts will assist in stabilising their lives and removing their dependence on illicit drug supply, then I - as a senior police officer - must agree to the proposed trial. Should the scientific advice prove the benefits outweigh the costs, particularly if those benefits involve a significant reduction in crime, then my enthusiasm will multiply significantly.

One matter though, that has my exercised my mind today, is that the program that we're looking at is really an attempt to attack one of the symptoms of a very complex social problem in Australia. I link the problem we've been looking at to what I think is a related problem: the very high rate of youth suicide in Australia. I and my colleagues believe that the most productive dollar spent in this area - the drug dependence area - is the one that's spent on persuading some young Australian today not to give him- or herself that first injection. This is the preventative side that is part of police thinking at the moment - that police should be involved more in crime prevention and in the prevention of this sort of behaviour, than in the reactive role that we've played in the past. The cost of drug abuse to my jurisdiction is significant, not just to my budget, which has its problems, but also in terms of human misery and social disruption. If this program will help reduce these costs then let's give it the green light.

EMERITUS PROFESSOR PETER KARMEL
CHAIR, AUSTRALIAN NATIONAL COUNCIL ON AIDS

One of the main reasons given for the evolution of this particular proposal was that it would contribute to the prevention of transmission of HIV among injecting drug users. It is important to recognise that the existence of the HIV epidemic has had a profound impact on the approach to drug policy. Harm minimisation, including the avoidance of transmission of HIV, has increasingly been emphasised as against the alternative of simply preventing drug use. In specific terms this has resulted in the development of major

needle exchange schemes which appear to have been relatively successful in Australia in containing the transmission of HIV among injecting drug users.

As Peter McDonald pointed out, the apparent prevalence of HIV among injecting drug users may be as low as two percent. With figures as low as that, this trial is unlikely to produce very convincing scientific evidence as to whether a heroin maintenance program would have a positive effect on the transmission of HIV. It might have many other positive effects, but if we are dealing with six hundred individuals, three hundred on the methadone program, three hundred on heroin, and assuming that about half of those remained in the program, we will only have probably two or three cases of HIV. The likelihood of getting statistically significant results over a 1 or 2 year period is fairly small.

Having said that, I wouldn't want that to be taken as a reason for not going ahead with the proposal, because the fact that we have a relatively low instance at present among injecting drug users may lull us into a sense of false security. It doesn't mean that there could not be a blow-out in a fairly short time, particularly as the evidence of transmission may occur some years after the actual transmission, and one may not realise that the epidemic is expanding until it is well on the way. It does seem to me that the present drug policies are not uniformly successful, that we must try a wider menu of options, and that this option is worthwhile as a scientific piece of research on a short term experimental basis. We ought to be prepared to try this and other means of sorting out the best way of minimising the harm that comes to individuals and to society from the increasing use of drugs.

DR MICHAEL MACAVOY
DIRECTOR, DRUG AND ALCOHOL DIRECTORATE, NSW HEALTH DEPARTMENT

In summing up comments from speakers and from the audience today I've come to the conclusion that there are two important points that have been made and I would like to raise these and to suggest a way forward.

Firstly, drugs are capable of arousing considerable emotion. Secondly, however rational and logical our arguments may be, the reality is that - apart from a very few of us in the audience today - we are not the decision makers.

These two factors are to me so important that unless they are well managed any prospect of a wider informed debate, and indeed the future viability of the feasibility study, may well stumble. As an adviser to the NSW government, I can't comment on the policies of that government, whose views have I think been clearly made known. However, I am firmly of the belief that Stage 2 of the feasibility study should proceed. The loss of the opportunity to expand the process begun by Dr Bammer and her team would I think be unforgivable. However, I believe that in parallel to Stage 2, at least as it is currently espoused, a strategy ought to be developed for progressing the rationale - the costs and benefits of the trial - into the community and into the political process.

It seems to me that only at the end of the Stage 2 process should the strategy be put into action. For example, as a tactic I do not believe that the material today should be presented to the Ministerial Council on Drug Strategy. There are far too many methodological considerations and logistical questions which are unanswered. These matters would need to be provided with convincing answers to satisfy both politicians and their advisers, and indeed the community.

NSW has experienced a considerable growth in drug treatment programs and the methadone program in particular, with close to six thousand persons currently on the program. Our growth rate is between fifteen and twenty percent a year. The size of such a program has resulted in a community backlash and in political sensitivity which is proving

to be a nightmare for the likes of me. This backlash is largely the result of a disease called "NIMBY" which means "not in my backyard". The reaction is very effective and vocal and belies all our carefully construed surveys that continue to demonstrate considerable public support for methadone programs. Therefore, in managing this aspect, I believe NSW has a lot to offer the ACT.

DR GREG WHELAN
ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS

The College of Physicians represents consultant physicians in internal medicine and its subspecialties and, as such, only a small percentage of our fellows are actually directly responsible for drug treatment programs. But a larger percentage are obviously involved in treating illnesses, such as hepatitis and AIDS, which result from drug problems. I would like to start by congratulating the organisers on the process that we have gone through to get this far, and the wide consultation that has so far occurred. The issues from a health viewpoint are pretty straightforward: current treatment programs for drug dependent individuals do not attract the number of individuals that we would like to see, and a trial such as this will give us a lot more information about those particular issues. Support for such a trial from the College would be based on evidence of practical feasibility, the rigour of the trial design, the evidence that ethical issues would be adequately covered, and the belief that a better understanding of many of the health issues would come as a spin-off from such a study.

Having been involved in controlled trials I am well aware that they can't answer more than a limited number of questions. But I do have some concerns about the fact that we are focusing on a single drug - heroin - whereas intravenous drug users often use a wide variety of drugs. I'm concerned logistically about the use of a drug which needs to be given many times during the day and I raised the issue earlier about the use of a longer acting drug. I hope that perhaps in the pilot study we could look at some of these issues of drug metabolism raised by Dr Bell's comments that may perhaps explain why it need not be used quite so frequently.

I would recommend to our colleagues that we give, in principle, support for the next stage of this trial. I need to point out, as another speaker has, that this doesn't supply support for legalisation of heroin. I think, however, that this is not predominantly a problem with getting agreement on the health issues but on the social, political and community issues, and I wonder whether we need perhaps a bigger input from many members of the community to see whether this trial is actually a goer.

Discussion

MICHAEL MOORE
SELECT COMMITTEE ON HIV, ILLEGAL DRUGS AND PROSTITUTION, ACT LEGISLATIVE ASSEMBLY

I have a question to the panel and it is something that we are really going to have to consider which hasn't been raised today. As this proposal goes ahead to the next feasibility stage, one of the things we must consider is the possibility of introducing sunset clauses into the legislation that facilitates it in the ACT. I wonder if in fact we have been talking about a time limited trial - some two years - and whether the community would therefore feel much more secure if we introduced sunset legislation. That gets around, for example, the problems with the Drugs of Dependence Act. I wonder therefore if we could have a comment particularly from Professor Karmel, who used the term "short term" trial in his response and perhaps from a couple of other members of the panel.

PETER KARMEL

I think that from the point of view of community acceptability a time limited trial is desirable. The only problem is that if it is too short a period it won't be long enough to obtain valid scientific results. But the original proposal was a two year proposal, and it certainly, I believe, would be much more acceptable from the community point of view to have a sunset clause in any enabling legislation. But after further consideration of the feasibility it might turn out that a three year period is necessary to obtain a sufficiently large sample for scientific purposes.

JEFF BROWN
AUSTRALIAN FEDERAL POLICE ASSOCIATION

Thirty one percent of my members support a trial going ahead in the ACT, which is pretty high. Sixty one percent oppose. All of us are crying out for some new initiatives, however. Not a trial - some enhanced methadone program, community orders, or something else. But I'm surprised that some of you people here are prepared to mislead the international community by pretending that this trial is for medical and scientific purposes, when from what I have heard it is all about law and order. I'm also surprised that you are prepared to give a misleading message to our youth that drugs must be OK because governments and other important people are prepared to issue them free to addicts. I'm disappointed in those among you who will support a proposal to send your addicts to the Australian Capital Territory. It is not for law enforcement to suddenly advocate legislation which would convey a confusing message to children and young adults, who count on law enforcement to protect them from the ills of civilisation, and, it seems, also from misguided researchers and doctors.

MARION WATSON
DRUG REFERRAL AND INFORMATION CENTRE, CANBERRA

There are two points that were raised during the break which, after hearing from three erudite and very supportive speakers from overseas (though with very pragmatic warnings, I thought, about the processes that had to be gone through in Cheshire and in Amsterdam before they got to where they got to) that we should look out for. There was very little

that came out in questioning the police officers, though I would have thought it an important issue, on the matter of security of the drugs, which was hinted at but not commented on. The bus that Commander Bob Visser displayed on the slide (it's a reinforced and beautifully armoured bus now) was introduced in 1990. Prior to 1990 an old ex-municipal transport system bus was used, with no reinforcement apart from a piece of sliding glass between the nurses and the clients who came to pick up their methadone dose. That bus was never, to my knowledge, the subject of an armed robbery or of any kind of hold-up. That may be important for the police. However, the needle exchange program that I visited in the Netherlands is highly fortified, with counters four feet high and three feet wide and reinforced glass separating the needle exchange customers from the suppliers. The difference, I think, is in the wide availability and accessibility of methadone, and what has been a fairly restricted accessibility of needles and syringes.

The second point is costing, and I think that this may have some bearing on your comments. I talked to Mike Lofts in the break and asked him to what extent the Cheshire police force had been penalised financially because of the introduction of a cooperative approach to drug use in the area. He said that in no way has the police force in Cheshire been directly financially penalised. I think that is a very important point, given that everywhere people are being penalised financially because of the recession. It's important for us to make that knowledge available to our local police.

JAMES BELL
DRUG AND ALCOHOL SERVICES, PRINCE OF WALES HOSPITAL

I'd like to make two comments. First of all I think the emphasis today has been very much on this as a treatment issue, and we have also had a very large emphasis on social benefits in terms of reduced crime. It really should be made clear that neither law enforcement nor drug abuse treatment impact particularly on crime. The social factors that give rise to epidemics of crime or increases in crime also give rise to increases in addiction and it's just crazy to think that either intensive policing or intensive treatment is actually going to reduce the underlying factors that are setting up a situation which we are merely attempting to contain. More specifically, we are attempting to help those who wish to avail themselves of treatment. The option of a heroin maintenance trial is making treatment more accessible to people by offering them something which is, in their experience, what makes them feel good.

ALEX WODAK
ALCOHOL & DRUG SERVICE, ST VINCENT'S HOSPITAL

I would like to ask two very brief questions, the first one to Detective Constable Lofts. Many of the commentators speaking today have been concerned about the possibility of inadvertently attracting drug users from many other states and territories to the ACT. Have you been able in Cheshire to restrict recruits to Dr Marks' program to residents of a particular area and have you been able to do that effectively?

The second question is to Dr MacAvoy. If we're summarising, in one brief phrase, what today's proceedings are about, to me the question is: should the question be put? I don't see how we can answer that question unless we get the green light to start answering some of the preliminary questions. You're saying you can't ask that question unless you've answered the preliminary questions. It seems to me we have a circular problem there.

MIKE LOFTS
DRUG SQUAD, CHESHIRE POLICE

When our scheme started initially, the area was bombarded with people from all over the country. In fact I would say between a third and a quarter of all the clients were from elsewhere other than Widnes. The point about it was they simply came down for the day, did their hours of obligatory counselling, received the script, and then went back home again to where they came from. So it was never a problem of residents or temporary residents staying in and around the area of Widnes. I'd like to add to that if anybody has ever actually been to Widnes, neither would you. It is in fact the northwest centre of bonemeal manufacture and the factory that makes it operates 24 hours a day.

MIKE MACAVOY

In response to your question I think it's a matter of managing how this proceeds. Stage 2 is about investigating the logistics of a sample trial, a feasibility. There are simply too many unanswered questions at the moment. I would hate to think that this project ran the risk of being wrong simply because there were no answers to some of the fundamental questions which I think will be posed. Questions such as: what is wrong with our current system? And questions that Peter Baume raised this morning: what if we improve the current system? why do we need to go any further? Unless those answers are ready I think there is a real risk of being wrong. But then I am not a politician, and maybe Michael Moore would like to follow me.

MICHAEL MOORE
SELECT COMMITTEE ON HIV, ILLEGAL DRUGS AND PROSTITUTION, ACT LEGISLATIVE ASSEMBLY

I agree with Mike that we have to go through this feasibility stage so that we can have the answers ready before such a proposal goes to the Ministerial Council on Drug Strategy. It would be a very strange thing to take a half-baked proposal to that Council, and it would be entirely inappropriate.

I would also like to comment on Jeff Brown's point about mixed messages, because I hear the argument often - that we do not want to send mixed messages to our kids. I have very young children - my youngest is eight - and I do not want to send them mixed messages at all. What I want to do is to send them a message of compassion. I want to send them a message that when we deal with people who, as far as *my* personal judgement is concerned, have made the wrong decisions, we don't have to deal with them in any other way than by showing compassion and understanding, and perhaps by trying to provide them with some dignity.

ROBERT ALI
TREATMENT SERVICES, DRUG & ALCOHOL SERVICES COUNCIL, SA

I would like to make two points: the first one relates to mixed messages. In South Australia, when the expiation system for cannabis was introduced, there was a fair degree of concern in our community about what that was going to say. We've just released a major review of the system and two things emerged. The first one was that there hasn't been a massive increase in the use of cannabis in our state amongst the group where it was thought

that would occur, principally among school kids. The second thing that has occurred is that in fact the community attitude has probably marginally hardened. It certainly hasn't moved towards a view of softening towards drugs, so the prophets of doom got it wrong on both counts.

The second thing that I would like to talk about is the fact that drug treatment is in flux. When I first came into the area we had a very rigid view of what was acceptable. That has changed over time. The treatment options have expanded, and not the least of that has been in the methadone area. When I first came to methadone, methadone was one "brand". There are now several types of methadone program, and I think James Bell has clearly illustrated how they are influenced by the players in the game both on the treatment side and on the consumer side. I suspect that within the next two years methadone in Australia is going to advance even further. In my state we are expanding programs at a rapid rate because we are now providing a service that is a bit more accessible and a bit more acceptable to the population. But the point I want to make is that we reach a small fraction of the in need population that uses injectable opioids. We do not reach the majority; we reach the minority. I think we need to be creative at looking at ways to open that gate, to extend the hand. This may be one of the solutions. I think it deserves a chance.

LLOYD WORTHY
NATIONAL OPERATIONS DIVISION, AUSTRALIAN FEDERAL POLICE

I think everyone should recognise and remember that the ACT is a small and insular society and that we are also talking about people. We're not just talking about a few addicted people, we're talking about 300,000 people who live here in a society well protected by its own systems of law and order, education and health. It therefore becomes a perfect place to conduct such an experiment.

When we look at the cost, let's not just talk about the financial cost. If we have an influx of people, as they did into Cheshire, would we be able to get rid of them? The ACT is not like Widnes where they would only stay for a day, it's a lovely place, and they'd stay forever. How do we get rid of them when they stay after two years and we say "well, we were only joking, you don't have to come"? We really need then the powers that Bob Visser was talking about. "To discourage foreign addicts", I think were his words. We can't even discourage our people off the bus stop when they're drinking and giving a hard time to the commuters.

So think about the laws that we would require, think about the mopping up procedures that we would require. Don't throw this away as a bad idea, because the next stage is very important, but when it's in that next stage let's not commit ourselves to Stage 3, let's not fool ourselves that we're heading straight to Stage 4. Because the next stage is a time when each and every one of these questions has to be examined in depth and then a rational decision made on how it would affect this community.

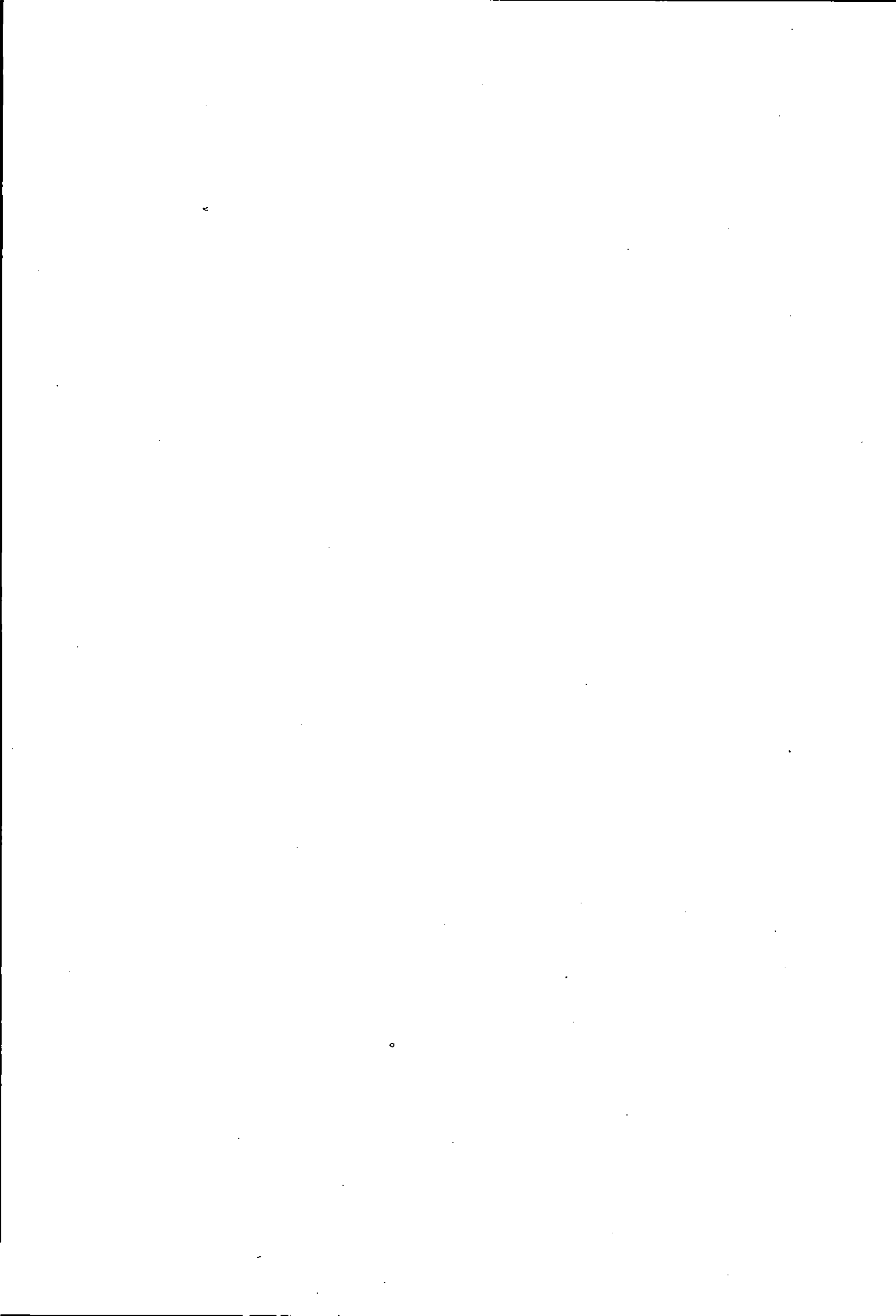
BOB DOUGLAS, CHAIR

The situation now, it seems to me, is that there has been a substantial degree of interest and support expressed at today's meeting from around the states for us to very cautiously proceed to the second stage. I'm hearing people saying that it seems worth getting more data before it is put to the test, and that was our conclusion at the end of Dr Bammer's study. The politicians in the ACT have, I think very wisely and appropriately, felt the need to have input from their interstate colleagues before they moved further. Perhaps inappropriately, they have also asked that it go to the Ministerial Council on Drug

Strategy at this stage. What Mike MacAvoy has suggested is that perhaps it is too early to go to that committee.

I think I sense a fairly strong groundswell of support for moving to Stage 2, in this theatre at any rate (whether it extends much beyond this theatre at this point remains to be seen). We need more facts before we can decide whether it is important to go to Stage 3. It will be important in this next two or three weeks that our overseas visitors interact with the police forces not only in the ACT but also in other states. I believe there is good representation from ACT government here today so that the very legitimate concerns that have been voiced can be brought to bear on the decisions that would need to be made by the Standing Committee officials and by the Ministerial Council on Drug Strategy.

I thank all participants very much for their contributions, and particularly express my warm thanks to Gabriele Bammer and the staff from the Institute of Criminology and NCEPH, who have made a major contribution to getting you together, and I thank you all for making the trip.



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