

**How could an influx of users be prevented if
Canberra introduces a trial of controlled
availability of heroin?**

**Gabriele Bammer, Deborah Tunnicliff and
Jennifer Chadwick–Masters**

Working Paper Number 9

**Feasibility Research into the Controlled Availability of
Opioids Stage 2**

**National Centre for Epidemiology and Population Health
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Executive summary

The potential problem of a trial of controlled availability of heroin attracting heroin users to Canberra has three dimensions: the number of people who might move in, the length of time they might stay and the consequences of their movement. Possible negative effects are an increase in visibility of the illicit drug 'scene', an increase in crime, an increased demand on drug-related and other services, and increased health problems.

These issues were investigated by examining factors that influence migration, so-called push-pull factors, and by analysing situations that provide analogies to what may happen in Canberra. These included migration to Brisbane and Canberra when there was an attempt to close down methadone programs in Sydney in 1978–85 and an investigation of factors causing open drug scenes in Zürich and Nimbin.

It seems that visibility of illicit drug users is more likely to result from an atmosphere of permissiveness towards illicit drug use than from immigration *per se*. Thus tackling permissiveness rather than immigration is central to avoiding this problem.

Preventing immigration is the best safeguard against the other potential problems of increased crime, increased demand on services and increased health problems. Attention to trial security and continuation of normal law enforcement against illicit drug use and associated crimes would also minimise possible effects on crime.

While there is some risk of an influx of users to Canberra if a trial of controlled availability of heroin proceeds, it is likely that this influx could be kept to a minimum by using residency criteria and a tightly controlled trial design with a limited number of participants. An influx of heroin users to Canberra would be minimal and should not constitute a barrier to a trial proceeding if the following conditions are adhered to:

- the final trial design should be one that discourages migration and, if possible, participants should be confined to an already identified group (for example, people currently on the methadone program);
- trial participants should have to prove residence in Canberra since at least 1993;
- a visible drug scene should be avoided by divorcing a trial of controlled availability of heroin from permissive attitudes to illicit drug use generally, stringently enforcing laws against the consumption and dealing of illicit drugs whenever this occurs in public places and locating the trial site(s) in an area(s) with physical attributes that discourage congregation;
- potential effects of immigration on crime should be avoided by maximising the security of the trial drugs and minimising opportunities to intimidate and rob trial participants. In line with divorcing a trial from permissiveness towards illicit drug use, normal policing should continue against crimes against drug laws and crimes to produce income for the purchase of drugs.

Finally, if a trial was to go ahead the Australian Capital Territory Drug Indicators Project should be recommenced to allow the evaluation of effects on immigration (as well as on drug use among people not participating in a trial and on the numbers of illicit heroin users). For the collection of baseline data, the project should be recommenced at least one year before a trial started.

Introduction: what are the problems?

There is widespread agreement that one of the potential disadvantages of a trial of controlled availability of heroin in Canberra would be that it could attract users from other parts of Australia. During Stage 1 of the feasibility study, a random sample of Canberra's general community and samples from each of three key groups (Canberra-based police, people providing treatment and support services to illegal drug users, and illegal drug users and ex-users) were asked how worried they were that heroin users would be attracted to the ACT¹ from elsewhere in Australia if a trial went ahead. Sixty-three percent of general community respondents, 91 percent of police respondents, 53 percent of service providers and 58 percent of drug users/ex-users said they were 'very worried' or 'somewhat worried' that a trial would attract heroin users (Crawford and Bammer, 1991).²

Controlled availability of heroin has long been possible in the United Kingdom (UK).³ Unfortunately there has been little documentation of any association between migrations of users and the controlled availability of heroin. However, it is known that, between 1958 and 1969, 91 dependent heroin users came to the UK from Canada to take advantage of the 'British system'⁴ (Spear & Glatt, 1971). In addition Leech, in his recollections of the 1960s London drug scene, reports 'a massive increase in the numbers of homeless young people from the north and from Scotland' (Leech 1991, p.52). While such congregations also occurred in cities outside the UK where heroin was not available on prescription, the availability (either legal or illegal) of drugs such as heroin was probably one determinant of which centres became focal points for congregation. More recently, when John Marks began prescribing heroin (and other drugs such as cocaine and amphetamines) in Widnes and Warrington in the 1980s, the resultant 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 became 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' (Lofts 1991, p.104).

Lofts makes it clear that these problems were associated with an unsettled period in the early days of the clinics. Unfortunately there is no information on the number of users attracted, the extent of problems caused or how the problems were resolved.⁵

This paper begins with an examination of potential problems which might be associated with opportunistic migration of heroin users to Canberra and then assesses how likely these problems are. Measures by which immigration could be discouraged are then discussed. If a trial eventuates, the effects on immigration should be evaluated and a strategy for doing this is outlined.

The potential problem of an influx of heroin users to Canberra has three dimensions: the number of people who might move in, the length of time they might stay and the consequences of their movement. Clearly there would be fewer problems associated with five employed heroin users living in a conventional family situation moving to Canberra than if the immigrants were 500 unemployed homeless heroin users. There would also be fewer problems with users who came to Canberra, tried to get a place on a trial, were unsuccessful and returned to their home town than with those who settled in Canberra and used illicit heroin, raising the necessary funds through illegal means.

The dimensions of number and length of stay are fairly clear-cut, but the dimension of consequences needs closer examination. There are four potential effects that are likely to be problematic:

- increased visibility of illicit drug users;
- increased crime;
- increased demand for drug-related and other services; and
- increased health problems.

Increased visibility

The image that comes to mind for many when concerns about an influx of illicit drug users are discussed is the open drug scene that occurs in many European cities. The visibility of drug users in Amsterdam is often cited, especially by police. Another potent image is that of 'Needle Park' in Zürich. Australian parallels,

albeit on a much smaller scale, are the visibility of drug users in the Kings Cross area of Sydney and in Nimbin in northern New South Wales.⁶

In Canberra, as far as the general community is concerned, there is currently little visible evidence of an illicit drug scene. There are no obvious congregations of users and no areas that ordinary citizens are advised to avoid.⁷ It is rare for discarded needles and syringes or other evidence of illicit drug use to be found in public places. In fact, in 1992 only 15 syringes were found on an annual community clean-up day that collected an estimated 10 tonnes of rubbish from public areas (*The Canberra Times* 2 March 1992, p.1. The ACT Needle and Syringe Exchange Program estimates that more than 130,000 needles and syringes are distributed each year⁸). Public health measures, such as disposal chutes for needles and syringes in some public toilets, a mobile bus that provides AIDS education, including free condoms and needle and syringe exchange, and various centres that provide information, advice, other services or treatment, are discreet and well tolerated. The concern therefore is that this equilibrium could be destroyed by an influx of illicit drug users to Canberra.

Increased crime

The link between illicit drug use and crime is not simple and the complexities have been well described by Wardlaw (1992). He argues that there needs to be differentiation first between crimes against the drug laws themselves (for example, offences such as use, possess or traffick in drugs) and drug-related crimes. This second set of crimes can be divided into three groups. First are crimes directly attributable to the pharmacological effects of the drug; these are relatively unimportant in the case of heroin.⁹ Second are crimes associated with the commission of drug offences, such as corruption of officials, violence in the drug distribution system and organised crime. Third are crimes committed to produce income for the purchase of drugs, for example burglaries and shoplifting.¹⁰

There are therefore two undesirable scenarios that could arise from an influx of heroin users to Canberra. The first is that the type of people who would be attracted would be those involved in crimes associated with the commission of drug offences. For example, in order to obtain heroin, they might attempt armed robberies against the trial site, attempt to corrupt trial staff or use violence against trial participants. The second is that immigrants to Canberra could commit both crimes against the drug laws and crimes to produce income for the purchase of drugs. This could nullify any beneficial effects of a trial on the community level and, in the worst case scenario, lead to an increase in such crimes.

Increased demand for drug-related and other services

Clearly immigrants to Canberra would place an increased demand on the trial itself. Even if strict residency criteria were enforced, a large volume of applications for a place on a trial would place stresses on trial staff and other resources. Immigrants could also place an increased demand on other drug-related services, including other treatment services, advice and advocacy services, and needle and syringe exchanges.

Immigrants in general place a demand on services such as employment agencies, housing services and welfare services and this is likely to hold true for immigrant illicit drug users as well.

Problems will arise if the demand is such that agencies cannot cope.

Increased health problems

The concern here is that an influx of illicit drug users may lead to a more rapid spread of infectious diseases, particularly HIV and hepatitis B and C, both in the illicit drug using community and into the general community.

How likely are these problems?

The picture painted above focuses on the worst that could happen. To get some idea of how likely these problems are, we need to address the following questions:

- What will encourage heroin users from elsewhere in Australia to move to Canberra?
- What will encourage them to stay in Canberra?
- What will promote the development of increased visibility of illicit drug users, of increased crime, of problems associated with increased demand for services and of health problems?

There is no strong empirical evidence on which answers to these questions can be based, as there has been no previous identical situation. However, there are some analogous situations from which lessons can be learnt.

What will encourage heroin users from elsewhere in Australia to move to Canberra?¹¹

One useful way of thinking about migration is in terms of “push” and “pull” factors. Push factors are a combination of unfavourable forces that make continued residence in a place undesirable, while pull factors are the attractions of a new location. The provision of heroin will become a significant new pull factor for Canberra, but it is useful to see this in the context of other push and pull factors (Appendix 1). Thus factors such as having established contacts in Canberra, the possibility of employment and housing and even the distance of Canberra from beaches¹² will influence people’s decisions about whether or not to move to Canberra in order to try to obtain a place on a heroin trial. The vast majority of push and pull factors will be outside the control of the heroin trial, but those responsible for the implementation of a trial need to be aware of them and of their potential effects on immigration. Where possible, cooperation with other agencies to minimise push and pull factors should be sought.

The pull effect of a trial will be determined, at least in part, by the trial structure (and perceptions about its structure). A small trial with tightly defined eligibility criteria will be less likely to attract users than a large trial open to all comers. In addition, tightly enforced residency criteria, which mean that all or almost all immigrants are refused a place on a trial, will also discourage ongoing immigration. Evidence to support this comes from an analogous situation where there were disparities in the availability of methadone maintenance treatment in Australia. In 1978 the New South Wales (NSW) Government moved to abandon methadone maintenance¹³. Until this policy was reversed in 1985, there was closure of services and shrinkage of available places (Caplehorn and Batey 1992). Substantial numbers of NSW heroin users moved to Brisbane where an expanding program aimed to meet their needs (Appendix 2); few moved to the ACT where a small tightly controlled program discouraged immigrants (Appendix 3).

What will encourage heroin users from elsewhere in Australia to stay in Canberra?

An examination of push and pull factors is also useful for determining what might encourage users to stay in Canberra and what might encourage them to return to their home city (see Appendix 1). Apart from being refused a place on a trial, other factors that would discourage users from staying are beyond the control of those responsible for a trial.

There is some overseas experience with active intervention to encourage immigrant illicit drug users to return to their home base. In Amsterdam, authorities have been involved in returning immigrants to their home country (Visser 1992, see Appendix 1) and in Zürich immigrants are transported back to their home city inside Switzerland (personal communications made to GB). It is not clear how effective these strategies are; indeed some scepticism was reported regarding the Zürich strategy. In Amsterdam, immigrants from other countries have only restricted access to treatment and other services, as the free and easy access that had originally been available was thought to add to the pull factors. In the Australian context, where most immigration is likely to be from interstate, doubts could be raised about the legality of such actions and many would see them as unethical. Restricting access to treatment and other services might also have undesirable public health consequences.

Overall, the best strategy is likely to be to discourage users from moving to Canberra in the first place. As we discuss below, actions might also be taken to minimise the negative effects resulting from immigration.

What will promote the development of increased visibility of illicit drug users, of increased crime, of problems associated with increased demand for services and of health problems?

a. Increased visibility

It seems that open or visible drug scenes are a function of a liberal or permissive attitude to illegal drug use, rather than resulting from immigration *per se*. Certainly immigration may contribute to the magnitude of an open drug scene and an open drug scene may encourage immigration,¹⁴ but immigration without permissiveness is unlikely to result in an open drug scene. Analyses of the open drug scenes in Zürich and Nimbin are presented in Appendix 4. It should be reiterated that none of the existing open drug scenes result from legal or controlled availability of heroin.¹⁵

Lessons can also be learnt from the United Kingdom, where controlled availability of heroin is practised on a small scale. In Widnes and Warrington there is no visible drug scene. Detective–Constable Mike Lofts from the local drug squad reports that the physical location of the clinics is a deterrent to congregation. In both cases they are on major roads in the town centre and close to police stations (Lofts 1991). In addition, there is no large area outside the clinics where congregation could occur (observation by GB).

Thus the ways to discourage a visible drug scene are to:

- divorce a trial of controlled availability of heroin from permissive attitudes to illicit drug use generally;
- stringently enforce laws against the consumption and dealing of illicit drugs whenever this occurs in public places; and
- locate the trial site(s) in an area(s) which has physical attributes that discourage congregation.

b. Increased crime

There are few parallels that indicate the likely effects on crime of immigration associated with controlled availability. The best evidence comes from Widnes and Warrington. As reported in the introduction, in the early days of these programs publicity attracted dependent users to the area and ‘[i]ntimidation and occasional robberies became the order of the day outside or near to the chemist shops where the addicts picked up their drugs’ (Lofts 1991, p.104). This no longer occurs, but there is no evidence on how it was halted.

Lofts (1991) also reports that the crime rates of Widnes and Warrington are comparable to those of surrounding areas where there is no controlled availability of heroin, although there is a clear reduction in crime among those receiving prescriptions. Lofts argues that if larger numbers received scripts,¹⁶ a more pronounced effect on crime at the community level might be seen. Further, Lofts reports that

‘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”’. (p.105)

In many ways this information raises more questions than it answers. Few dependent users from other parts of the UK seem to have relocated to Widnes or Warrington and those who did were accepted by the clinic.¹⁷ Thus the situation described does not parallel potential problems that might occur in Canberra, where it is possible that dependent users who relocated to Canberra but were unable to obtain a place on a trial would fill the crime ‘niches’ vacated by Canberra residents who had obtained a trial place.

It is difficult to predict what the effects of immigration on crime might be. Again the best prevention is to discourage immigration in the first place. The trial design will need to maximise the security of the trial drugs¹⁸ and to minimise opportunities to intimidate and rob trial participants. In line with divorcing a trial from permissive attitudes to illicit drug use, normal policing should continue against crimes against the drug laws and crimes to produce income for the purchase of drugs. Clearly law enforcement will have a major role

to play in minimising the effects of immigration on crime and contingency plans should be developed for worst case scenarios.

c. Problems associated with increased demand for drug-related and other services and health problems

There is even less evidence about what might happen in these areas than there is about crime. In general, among Australian intravenous drug users HIV infection rates are low and hepatitis B and C infection rates are high and there seem to be no major differences in rates between different areas of Australia.¹⁹ In addition the Australian population, including the illicit drug using population, is quite mobile,²⁰ so it is unlikely that additional migration associated with a heroin trial would lead to an increase in infectious diseases.²¹ Immigration is most likely to cause problems for drug-related and other services if there are not enough resources to meet demand.²² From the current situation in the ACT, some services—like needle and syringe exchange, for example—are more likely to be able to cope with an increased demand than others like counselling.

Again the best way to cope with potential problems would be to limit migration in the first place. However, in the event that large scale migration did occur, there should be contingency plans. The social and health consequences of immigration are likely to be minimised if immigrants have access to services. Thus restriction of access to services should not be one of the measures used to deter immigration.²³

How can immigration be deterred?

It is clear from the above discussion that deterring immigration would be an important component of a trial of controlled availability of heroin. Two strategies will be fundamental: the strict implementation of residency criteria and the design of the trial.

Residency criteria

There are a number of possibilities for proof of residency, including:

- bank, credit union or building society membership;
- driver's licence;
- evidence of receipt of social security payments;
- proof of employment;
- Medicare registration;
- medical treatment records;
- registration on the electoral roll;
- land or water rates notices;
- electricity, gas or telephone accounts;

- rent receipts or leases;
- education course enrolment records.

Many are not foolproof and obtaining some would rely on the cooperation of other agencies (see Appendix 5).

The results of a survey investigating how likely people who might be candidates for a trial would be to have various proofs of residency are shown in Table 1. It is unlikely to be difficult to obtain proofs of residency. Seventy-two percent of those interviewed had seven or more of the potential proofs. The smallest number of potential proofs was four, which was reported by five percent of respondents. Eight respondents suggested additional proofs, including motor vehicle registration (six respondents), bail papers (one respondent), probation and parole records (one respondent) and children's school records (one respondent). (A number of respondents suggested other proofs that would be readily open to falsification.) For a high percentage of respondents, proofs of residency covered periods of more than two years. Men and women were generally equally likely to be able to produce each of these proofs; the one exception was that women were more likely to have pensioner benefits cards.

Table 1: Percentage of Survey Respondents with various proofs of Residency^a

Have	Never in treatment group ^b n=12	Treatment drop-out group ^c n=11	Methadone treatment group ^d n=43	Total n=66
Bank, credit union or building society account	100	91	93	94 (81) ^e
Driver's licence	67	64	63	64 (95)
Pensioner benefits card (eg. transport concession or pharmaceutical benefits card)	82*	82	65	71* (50)
Proof of employment (eg. group certificate, taxation records)	75	73	72	73 (79)
Medicare card	92	82	93	91 (87)
Medical records (eg. drug treatment, GP)	82*	82	98	92* (83)
Electoral enrolment	67	45	76*	69 ⁺ (66)
Land or water rates notices	9*	18	9	11* (57)
Electricity, gas, or telephone accounts	75	55	69 ⁺	68* (66)
Rent receipts/leases	67	55	70	67 (66)
Education course enrolment records	100	82	77	82 (85)
	*n=11		*n=41	*n=65
			⁺ n=42	⁺ n=64

^a Data taken from surveys of heroin users in the ACT. Other results will be published in future working papers. Results for those resident in the Canberra/Queanbeyan for more than two years only were used here.

^b Dependent heroin users who have never been in treatment. Two cases were excluded because they had been resident in Canberra for less than two years; there were no missing cases.

^c People who have been dependent heroin users who have dropped out of treatment in the last 2 years. Six cases were excluded; one had been resident in Canberra for less than two years and there were 5 cases where either length of residency in Canberra/Queanbeyan was missing or the responses to the questions were missing.

^d People currently in methadone treatment. Six cases were excluded as they had been resident in Canberra for less than two years; there are an additional 16 missing cases.

^e The figure in brackets is the percentage of respondents with each proof of residency who had that proof for more than 2 years.

Thus it would be possible to screen trial applicants according to residency criteria.²⁴ The most foolproof way of screening would be to use methods that rely on the cooperation of other agencies, for example letters from social security or Telecom (see Appendix 5). However, this may be too expensive. It would also be possible to screen applicants with a combination of proofs that applicants are able to produce (for example bank statements, lease agreements) and some questioning to produce evidence of local knowledge (see Appendix 3).²⁵

Trial design

The ideal trial design from the point of view of deterring immigration is a small trial with fixed numbers. If eligible participants were to be drawn from people who are already known to be Canberra residents (for example clients of the methadone program²⁶) there would be even less attraction for outsiders.

However, the deterrence of immigration is only one factor in determining the final trial design. The most important determinants will relate to the evaluation of the trial. Analysis is still in progress to determine the final trial design.²⁷

In the interim, the following can be said about deterring immigration. There will be residency criteria and they will show not only that Canberra is the current place of abode, but also some long-term links to Canberra.

If a trial eventuates, it is likely that there will be some delay between the announcement of a trial and its implementation. Some people may consider moving to Canberra in that interval in the hope of establishing proofs of residency. To deter this and any immigration that may be occasioned by the publication of this report, long-term links to Canberra should go back at least to 1993.²⁸

Monitoring immigration if a trial eventuates²⁹

It would be desirable to monitor immigration if a trial eventuates,³⁰ but this would not be easy to do.³¹ A workable strategy would be to reinstitute the ACT Drug Indicators Project³² and thus use contacts by illicit drug users at treatment agencies and with police as the information source.

Migration data could be included on the contact sheet and/or could be studied by independently surveying individuals approaching service providers. Ideally, a drug indicators project should be recommenced some time before a heroin trial to allow the gathering of baseline data.

Such a drug indicators project would also be valuable in monitoring other aspects of a trial, particularly changes in drug use among people not on a trial and the size of the illicit heroin using population (see Larson 1992). It should therefore be given high priority if a trial eventuates.

Conclusions

The final question which needs to be asked is:

Is the risk worth taking?

This question can only be answered when all the evidence from Stage 2 of the feasibility research is to hand.

Nevertheless, what this paper has shown is that the problem of immigration resulting from a trial of controlled availability of heroin is one which must be taken seriously. It is impossible to determine what the extent of such migration might be, but previous experience in analogous situations does point the way to minimising both immigration and problems that might be associated with it.

Thus our analysis indicates that migration of heroin users to Canberra would be minimal and should not constitute a barrier to a trial proceeding if the following conditions were adhered to:

- the final trial design should be one that discourages migration and, if possible, participants should be confined to an already identified group (for example, people currently on the methadone program);
- trial participants should have to prove residence in Canberra since at least 1993;

- a visible drug scene should be avoided by divorcing a trial of controlled availability of heroin from permissive attitudes to illicit drug use generally, stringently enforcing laws against the consumption and dealing of illicit drugs whenever this occurs in public places and locating the trial site(s) in an area(s) which has physical attributes that discourage congregation;
- potential effects of immigration on crime should be avoided by maximising the security of the trial drugs and by minimising opportunities to intimidate and rob trial participants and staff. In line with divorcing a trial from permissiveness towards illicit drug use, normal policing should continue against crimes against the drug laws and crimes to produce income for the purchase of drugs.

Finally, if a trial was to go ahead the Australian Capital Territory Drug Indicators Project should be recommenced to allow the evaluation of effects on immigration, as well as on drug use among people not participating in a trial and on the number of illicit heroin users. For the collection of baseline data, the project should be recommenced at least one year before a trial started.

APPENDIX 1

Push and pull factors that could be associated with attracting heroin users to Canberra

The concept of push and pull factors is a useful way of describing and explaining the migration of illicit drug users.¹ Visser (1992) has described the push and pull factors that attracted and continue to attract illicit drug users to Amsterdam. The most important ‘pull’ factors are a general atmosphere of permissiveness towards illicit drug use and that there were no serious attempts to prevent the influx in the early stages. In addition, in the early stages foreign immigrants had free access to assistance and treatment facilities. The most important ‘push’ factor was an atmosphere of repression in neighbouring countries, especially Germany. For example, as well as having a more repressive police and judicial system, there is also no wide acceptance of some forms of treatment, particularly methadone substitution therapies.² Measures are now being taken in Amsterdam to return dependent users to their country of origin through counselling and contacts with and transfer of dependent users to assistance services in their home country. Foreigners only have free access to assistance and treatment services in emergencies and to tide over crises.

Lanz and colleagues (1992) assessed the push and pull factors for users moving to Zürich. Fifty percent reported they did not like living in Zürich. Negative factors were seen to relate to general living conditions and to the drug scene. Fifty-three percent of those who did not like living in Zürich referred to accommodation shortages, high cost of living, pollution, and a negative atmosphere (stress, the big city lifestyle, cold weather, lack of ‘life’, unfriendliness). Twenty-one percent said that the drug scene too readily provided access to drugs, which they saw as a dangerous temptation too hard to resist. They said this made it difficult for them to cease dependent drug use. Seventy-three percent of respondents, however, saw the drug scene as one of Zürich’s attractions. Fifty-four percent of those not resident in the city of Zürich gave drugs as the reason for coming to Zürich. Lanz and colleagues did not discuss push factors from Germany, but these are also thought to be important (personal communications to GB, 1992), although illicit drug users from Germany make up only a small percentage of people in the open drug scene.³

Lanz and colleagues (1992) presented a theoretical model of push and pull factors that could be used to explain the migration of illicit drug users to Zürich. A modified version relating to Canberra is presented as Table A1.1 and describes factors that could push heroin users out of their current location, attract them to Canberra and, thirdly, push them out of Canberra. Different factors will be important for different people, hence some mutually contradictory factors are listed. For example, some people will be attracted to Canberra because they have family and/or friends there, others will not want to stay in Canberra because they lack social contacts. The aim of this list is to illustrate the kinds of factors, apart from the ‘heroin trial’, that might encourage and discourage people to move to the ACT.

Table A1.1: Possible push and pull factors that could influence migration to Canberra and that could encourage people to leave again

Push factors (out of 'X')	Pull factors (into Canberra)	Push factors (out of Canberra)
unemployment	employment ⁴	no suitable work
long public housing waiting lists	perception that public housing waiting lists are shorter ⁵	no suitable housing
	more generous rental assistance ⁶	
	lower cost of private rental or house purchase ⁷	
lack of social contact		lack of social contact
	no slum areas; nice for families	
	family or friends here	homesickness
personal problems, eg. debt, domestic conflict		personal problems
legal/police problems	new place, so not so known to police	legal/police problems
too dangerous, high crime rate	less dangerous, lower crime rate	
want to get away from drug contacts	new place, so can undertake treatment without old influences ⁸	
		city too small
	good support services for users	
		weather (cold in winter)
		too far from the beach
		high cost, poor quality and low availability of illicit drugs ⁹

Overall, there are factors that will act in conjunction with a heroin trial to attract some people to Canberra. For others, these additional factors will mitigate against movement to Canberra. Under present circumstances, it is likely that the overriding factor in encouraging or discouraging migration will be the structure and conditions of the trial. Nevertheless, an eye needs to be kept on differences between Canberra and the rest of Australia, so other factors that might encourage immigration are recognised and, where possible, kept to a minimum.

APPENDIX 2

Effects of NSW policy change in 1978–85 on the Brisbane Methadone Program¹⁰

In 1979 there was one government run methadone clinic in Queensland, located in Brisbane, which catered for 220 clients. In response to the tightening of NSW policy between 1978 and 1985, Lynne Biggs, Michael Bolton and Adrian Reynolds¹¹ recalled that a significant number of people dependent on opioids migrated to Queensland specifically to obtain a place on the methadone program. This is reflected in unpublished official statistics that show a rise in the numbers registered on the programs to 1985 and then a dramatic fall (Table A2.1; source Lynne Biggs 1993). Lynne Biggs estimated that by 1984–5 around 50 percent of clients were originally from New South Wales.

Table A2.1: Total number of clients registered on the Queensland Methadone Maintenance Program, 1979–1987

Year	Number Registered
1979	220
1980	360
1981	351
1982	570
1983	651
1984	748
1985	1064
1986	692
1987	781

It appears that the primary reason people moved to Queensland rather than elsewhere in Australia was that the public methadone maintenance program in Queensland held what we would call today a ‘harm minimisation’ philosophy, in that it was conceived as a public health initiative.¹² In accordance with this philosophy there were no restrictions on the number of people permitted to receive treatment, nor was there a waiting time. People would present at the clinic and, provided they met dependency criteria, could commence treatment that same day.

It appears that Queensland’s ‘open’ policy quickly became common knowledge within the NSW illicit drug using community and that this was achieved mainly through word of mouth between users. In addition, NSW program staff, unable to place people on a methadone program within NSW, were also said to suggest Queensland as a treatment alternative.

The Brisbane program was, and still is, based on a pharmacy distribution system, whereby scripts for the client are mailed to a nominated pharmacy to allow daily methadone pick-up. Clients attended the clinic for initial and regular ongoing assessment. The pharmacy distribution system permitted these additional clients to be absorbed more easily than would have been the case if a ‘clinic dosing’ system, which was standard in many other centres, had been used.

Nevertheless, the increase to 1985 in the number of people requiring treatment placed strain on the staff and on the actual service that could be provided to clients. Ancillary services and regular counselling dropped to minimal levels. The overall management of the service became considerably more difficult.

Under this pressure, the Queensland program managers considered implementing some form of residency criteria. They resisted because it went against the philosophy that treatment should be readily

accessible. However, if NSW programs had not begun to expand in 1985, some action to limit migration would probably have been taken.

One response to the increasing numbers was to open a second clinic. Because of the lead time involved, this did not come about until 1985.

Apart from housing needs, there was no recollection of major pressures being placed on other agencies. There was a particular need for accommodation, especially when people first arrived in Brisbane. Lynne Biggs recalled

‘We had numbers of people who used to arrive ... straight off the bus or the train, with their luggage, their children, their dogs – you name it. And they used to come straight from arriving in Brisbane into the methadone clinic.’

The interviewees recalled that clinic staff maintained regular contact with the Housing Commission and the Commonwealth Employment Service, particularly in the late 1970s.

The influx of people seeking treatment did not become a media or political issue. There was also little recollection of untoward difficulties with police. The setting up of formal liaison with the police in around 1985, as a National Campaign Against Drug Abuse funded initiative, was seen as a positive step.

As shown in Table A2.1, there was a significant decrease in the number of people registered after 1985. This was attributed to initiatives of the National Campaign Against Drug Abuse, which provided funds for the expansion of the NSW methadone maintenance program. As a consequence, fewer people moved from NSW to Queensland. The movement of people back to NSW, once they were assured of entry onto a program in their state of origin, also contributed to this trend.

APPENDIX 3

Comments on the experience of Woden Valley Hospital Methadone Program staff resisting unwanted migration

Keith Powell¹³

During 1982–85, the NSW Health Authority placed a moratorium on admission to their methadone programs. Very few were admitted during those years. Would-be applicants sought admission to programs in other states. As Queensland had an ‘open’ program, most sought admission to it. A few sought entry to the ACT program, especially from the Liverpool area, Wollongong and the South Coast of NSW. There was never a great influx and we were not swamped in any way with requests. Most applicants knew that we had a ceiling on the intake. They usually knew that we preferred to admit local clients—those from the ACT and immediate surrounds. The issue never became a big problem. We had many phone inquirers who accepted our explanations and reasons for not having an open program. The reason for restricting admissions was that money and facilities limited our numbers. We could not diversify and use private pharmacies and private medical practitioners.

Criteria for admission to Methadone Maintenance Program (MMP)

1. Established illicit drug use.
2. Above the age of 18.
3. Must be a local resident for at least six months, or have a local residency basis (for example, parents).

Difficulties experienced

1. Many clients were adept at giving false information. The history taking proved to be a good screening device. It was difficult for them to recite events demanding some knowledge of the local geography when they were from outside the local region. If their criminal record did not include ACT court experience they were suspect.
2. Simple questions about features of the local environment near their address were useful. Some gave street names that did not exist in the ACT.
3. A schooling record was important. Many simply said they came to Canberra post school, a fact that was true for many genuinely living in the ACT. Not all were consistent.
4. Some had genuinely enrolled years ago at TAFE/CCA/E/ANU,¹⁴ but had never seriously participated in courses. There were applicants to the MMP who advanced the idea that they were returning and this was not easy to disprove.
5. The address of parents was given, but we were told that they did not want their parents to know they were street users. This was not easy to circumvent.

General comments

People slipped through the net. Many tried and were refused, and raised only minor objection to being refused. They knew that other facilities were limited. We did not have any unpleasant confrontations on this issue. There was the occasional tense scene.

APPENDIX 4

Open drug scenes

In this section two open, or visible, drug scenes are described to illuminate factors that lead to high visibility of drug users and hence to suggest ways that open drug scenes can be prevented. The descriptions are of ZŸrich in Switzerland and Nimbin in northern New South Wales. These have been chosen because there is some documentation available about them.

The open drug scene in ZŸrich¹

Eisner (1992) contends that the origins of the open drug scene date from the 1970s counter-culture, particularly the hippy movement. As he describes it, groups of people congregated in parks and other public places, made and listened to music, bought and sold a range of 'alternative' products and made a point of exhibiting a life of indolence. The open consumption of hashish and other illegal drugs was an integral part of this diverse youth subculture. In ZŸrich, the main area of congregation was a large set of steps on the banks of the River Limmat, the so-called 'Riviera'. The second half of the '70s saw the development of a distinct and geographically separate subgroup that specialised in the dealing and consumption of 'hard' drugs. Further developments occurred with youth unrest in the 1980s, especially with the opening of the 'Autonome Jugendzentrum' (Autonomous Youth Centre). The view of the police and the original users of this centre was that it was increasingly being taken over by a socially marginalised, politically inactive drug scene, supplied by organised groups of dealers. This was associated with the first reported 'FixerstŸbli' (fixing room). With the closure of the Autonome Jugendzentrum (after two periods of operation in June to September 1980 and April 1981 to March 1982), the scene moved back to the 'Riviera'. It was tolerated for a year; then from 1983 to 1987 the policy was to break up the scene (presumably by police action), which resulted in it moving in rapid succession from location to location. At the end of 1987 the scene moved to a park called Platzspitz, where it remained for the next four years. The location became known world-wide as 'Needle Park'. While none of the publications give figures, it seems that the number of people involved in the open drug scene at this time was in the tens, not the hundreds or thousands (personal communications to GB, 1992). In fact KŸnzler (1992) reports that in 1986 intensive police action meant that the open scene had effectively disappeared.

Eisner argues that the cessation of the policy to break up the scene and its toleration at Platzspitz was the result of political compromise. On the one hand, the distribution of clean needles and syringes and the provision of other assistance directed at harm minimisation was a response that recognised the dangers of HIV/AIDS and reacted to criticism of repressive drug policy. (This marked change in policy to emphasise harm minimisation is also described by others, for example, Lanz et al. 1992.) On the other hand, more radical change in drug policy, such as controlled distribution of currently illicit drugs, was not possible because of federal laws and the political composition of the city of ZŸrich. KŸnzler (no date) contends that another reason for tolerating the scene at Platzspitz was that, unlike other European cities, ZŸrich has few empty spaces such as deserted building sites and areas under freeways where drug users could congregate and be tolerated. This view is also commonly expressed by locals who have familiarity with the ZŸrich drug scene (personal communications to GB, 1992).

Platzspitz is a V-shaped parcel of land bounded by two branches of the River Limmat and a museum. It is therefore relatively out of the way, although it is across the road from the central railway station. It seems that before the drug scene moved there, the park was part of the gay men's beat and this also contributed to the policy makers' toleration of the establishment of the scene there (personal communications to GB, 1992).

In the winter of 1988–89 the scene at the Platzspitz grew massively. An estimated 2,500 people visited the park each day in early 1990 and it was calculated that 15,000–23,000 different people visited it annually (KŸnzler, no date). In the summer and autumn of 1989 there were continual police raids (Eisner 1992). In 1990 the ZŸrich City Council issued ten principles governing drug politics (10 Drogenpolitische

Grundsätze des Stadtrates von Zürich, Informationstelle der Stadt Zürich, 18 Juli 1990; see also Scholz et al. 1991). The ninth principle stated that:

‘The city council is governed by the principle that an open controlled drug scene in the city of Zürich must be tolerated for the time being. In the meantime the following measures have been decided on to lessen the attractions both of moving into and of staying in the drug scene at Platzspitz:

- a) enforcement of the prohibition on camping;
- b) removal of stalls;
- c) reducing the quantity of food hand-outs and shortening the times in which hand-outs take place;
- d) increased presence of uniformed police with a stricter system of checking people.’

In August 1990 the closure of Platzspitz began. This was a gradual process with final closure (sealing the park with iron fences and locked gates) in January 1992 (Eisner 1992). Sempach and coworkers (1992) argue that the main factors leading to the closure of the Platzspitz were the brutality of the dealers, the growing rate of drug-related crime and the resulting harassment and threats to the general public.

There continues to be an open drug scene on the streets of Zürich and it was observed by GB during fieldwork in 1992. Relatively few people were visible during the day, but in the evenings there were gatherings of several hundred people and both the dealing and injection of heroin and cocaine were openly conducted.² There was police action to prevent the scene from taking root in any one place and to keep users on the move. The trials of controlled availability of heroin currently being introduced in Switzerland³ have partly been introduced in response to the open drug scene and aim to contribute to its demise.

The open drug scene in Nimbin

The situation in Nimbin is very different, particularly in scale. With regard to heroin, concerns about the visible drug scene were highlighted by nine non-fatal overdoses that occurred in January 1993⁴ (*The Lismore Echo*, 22 January 1993 p.1–2 and 5 February p.2) and discarded needles and syringes found in the local primary school (*The Lismore Echo*, 19 February 1993 p.2 and 26 February p.22). Concerns about congregation usually result from small clusters of people gathering for a very short time to buy drugs (*The Lismore Echo*, 22 January 1993 p.1–2). The congregation of young homeless people, who were not locals, who looked like they might be drug users (even if they were not) and who were seen as harassing passers-by also added to this concern.

There is a somewhat larger visible drug scene relating to marijuana use. There is public consumption of marijuana, mainly centred around a cafe in the main street. Many shops in Nimbin sell articles linking Nimbin and marijuana, including T-shirts, jewellery, postcards, imitation marijuana plants and bongs (Helliwell⁵ 1992). The availability of marijuana has become a drawcard for tourists and visitors are often approached on the street to ask if they would like to buy marijuana. Indeed, Helliwell maintains that marijuana can be smoked and sold in Nimbin with less risk of legal sanction than in the rest of Australia.⁶

There are thought to be links between marijuana use and production and the use of heroin and other illicit drugs. For example, Helliwell and colleagues (1992) reported that increased law enforcement directed at marijuana growers in the late 1980s reduced supply and increased prices. This coincided with increasing numbers of individuals using injectable drugs, particularly heroin and amphetamines. More recently, in a report to a mayoral think tank, Helliwell (1992) argued that ‘people dependent on opiates fund this dependency by the sale of marijuana to both locals and tourists’ (p.5). Further, he maintained that

‘With the expansion of tourism in Nimbin, and the increase in the price of marijuana, there is a greater availability of opiates and other injectable drugs in Nimbin as more money enters the illicit drug market. For people selling opiates and other injectable drugs, the profit/risk ratio becomes attractive enough for them to set up business in Nimbin. In turn, this has led to people visiting Nimbin from other areas to purchase injectable drugs.’ (p.5)

He reports that increasingly people from outside Nimbin are selling marijuana on the streets, attending the needle and syringe exchange and appearing in hospital after heroin overdoses.

The descriptions of the problem provided by Helliwell (1992 and personal communication 1993) and the media are consistent with visibility of illicit drug use stemming primarily from permissiveness. In addition, there is an interaction between permissiveness, visibility and the attraction of outsiders, each feeding on the other to promote increasing problems.

APPENDIX 5

Residency criteria

A discussion of some potential ways of proving residency is presented below.

Bank, credit union or building society account

Many banks, credit unions and building societies would provide copies of statements containing the address statements were posted to. There would generally be a fee involved.

Driver's license

It is possible to obtain a 'statement of licence details' from the Registrar of Motor Vehicles for \$13. This includes date of first issue and any matters such as cancellations. However, it is possible to hold an ACT license without necessarily remaining resident in the ACT. (This is also a drawback of using motor vehicle registration as a proof of residency.)

Social security

It seems that two options are available to recipients of all social security benefits including unemployment benefits, family allowance, supporting parent benefits and sickness benefits.

1. Establishing a history of receipt of social security from a particular regional office is possible through a Freedom of Information (FOI) request by the client. Such a request would have to be lodged at the applicant's usual regional office and would then be sent on to the central office along with files. It would take about 30 days and a fee would be charged if the applicant's benefit history was complicated.
2. It may be possible to make arrangements with local regional office managers to provide, on request by the person applying to the trial, a written and signed statement detailing the time the person had been receiving social security payments from that regional office. Depending on the regional managers and the willingness of applicants to collect the letter, this may take as little as a week. Negotiations with regional managers would be required to establish procedures.

Medicare records

Although Medicare records do contain addresses, the general policy of the Health Insurance Commission is to refuse to provide this type of information.

Electoral rolls

When a person first enrolls, or when they change their enrolment, they are sent an acknowledgment card, which shows date and place of enrolment. A person can re-enrol at any time and consequently receive one of these cards. However, the card would only carry that re-enrolment date. Only the original card would give a 'length of time enrolled' and would not indicate if there had been re-enrolments.

Trial staff could request that applicants for a place on a trial provide a certified photocopy of the relevant page of the past electoral rolls, however this would involve the applicant taking a Commissioner of Declarations or a Justice of the Peace with them to the Divisional Electoral Office. Again it would not indicate if there had been subsequent re-enrolments.

Trial staff could try to organise a search and certified copy service by divisional office staff. This would have to be organised through the central office in consultation with the divisional office director. It would most likely involve a fee.

However, whether electoral roll registration is always indicative of place of residence is debatable. Some people maintain registration at addresses at which they are no longer resident, for example parental homes.

Electricity, gas and telephone accounts

The appropriate agencies can all provide either account statements or can verify that accounts were sent to particular addresses.

Rent receipts or leases

It would be possible to confirm tenancy and length of tenancy through the ACT Housing Trust. This would require a written request from the trial applicant. Depending on the availability of the records, such a request could take anywhere between two weeks and a month to process, but it may be possible to negotiate special arrangements with the branch head.

Real estate agents report that they keep rental records under the name of the person renting the premises and that photocopies could be easily obtained.

If agency-provided information was used to establish residency, there would need to be negotiations with the agencies about the added workloads obtaining these proofs would entail. If it is left to trial applicants to obtain proofs, the role of agencies in potentially biasing the trial sample also needs to be considered. For example, some agencies may be more able to help than others and as a consequence some applicants may be favoured over others. Another possibility is that there may be differences within agencies, so that some staff may be more helpful than others or that staff may be more helpful towards applicants who have a history of being 'cooperative'.

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Feasibility Research into the Controlled Availability of Opioids

The Feasibility Research into the Controlled Availability of Opioids arose from a request to the National Centre for Epidemiology and Population Health (NCEPH) from the Select Committee on HIV, Illegal Drugs and Prostitution established by the Australian Capital Territory (ACT) Legislative Assembly.

A first stage of research, conducted in collaboration with the Australian Institute of Criminology (AIC), found that a trial to provide opioids, including heroin, to dependent users was feasible in principle. It was recommended that a second stage of feasibility investigations to examine logistic issues be conducted.

The first stage investigations examined illegal drug use in the ACT, the arguments for and against the controlled availability of opioids as reviewed in the literature, the current Australian political context for a trial, the role of interest groups in social controversies, legal issues, possible options for a trial, ethical issues, attitudes to a trial in the general community and among key interest groups (police, service providers, and illegal drug users and ex-users), and evaluation by a randomised controlled trial.

In addition, a proposal for a trial was developed as the starting point for the Stage 2 investigations.

The research which needs to be conducted to determine Stage 2 logistic feasibility can be divided into five areas:

- core information (for example, estimating numbers of users, determining relevant characteristics of ACT-based users, documenting the known information about the psychopharmacological and toxicological effects of opioids);
- information relevant to trial design and evaluation;
- information relevant to service provision;
- information about relevant legal, law enforcement and criminological matters;
- community and key stakeholder acceptability of a specific trial proposal.

The Stage 2 research is also governed by the following principles:

- the research should have intrinsic value so that, regardless of whether or not a trial goes ahead, the research should be of value to treatment services or to drug policy generally;
- research should be conducted in all relevant disciplines and the disciplinary findings should be integrated to address the central problem;
- the process should involve to the greatest extent possible the key interest groups—illicit drug users, ex-users, service providers, police, policy makers and the community.

Stage 2 of the feasibility research into the controlled availability of opioids has many components. As significant advances are made in each particular substudy, we publish the results as a working paper, so that the information is available for discussion in the public arena.

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Newsletters

- # Newsletters reporting project results are also published from time to time.

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¹ Canberra is the major population centre in the Australian Capital Territory (ACT), thus the terms Canberra and ACT are often used interchangeably.

² A number of assumptions underlie this paper, but time prevents us from considering them in depth. One is that fears about immigration are well-founded. We have taken concerns about immigration and its potential negative effects as a given, although these could be debated. We also take as a given that immigration should be prevented rather than accommodated. Some potential negative effects of immigration could be prevented by opening a trial to all comers and appropriately resourcing other services and treatment programs that cater for illicit drug users. We also do not consider the ethical implications of using residency criteria to select trial participants. These are touched on in Ostini and Bammer 1991 and Ostini et al. 1993.

³ For a history, see Stimson and Oppenheimer 1982; and Strang 1989. Prescribing was relatively common during the 1960s, corresponding with the growth in numbers of so-called 'non-therapeutic addicts'. ('Therapeutic addicts' had become dependent on heroin after being prescribed it for therapeutic reasons; 'non-therapeutic addicts' had become dependent for other reasons.) There were a few hundred dependent heroin users in the early 1960s and a few thousand by the end of the decade (Spear 1969). In the 1970s the prescribing of methadone rapidly replaced heroin, so that today there are only a few programs where heroin is still prescribed. The best documented are those in Widnes and Warrington in the Mersey region of Cheshire.

⁴ Spear and Glatt (1971) suggest that other factors that influenced the movement of the Canadians were 'discussion in Canada to provide for indeterminate prison sentences for convicted addicts' (p.144),

articles in the Canadian press by dependent users who had moved to Britain, a conference in Ontario in early 1963 at which a paper was presented by the doctor who was treating most of the Canadian dependent users in London, and the introduction of the Commonwealth Immigrants Act, 1962, under which for the first time Commonwealth citizens could be refused entry to the UK or deported if they got into trouble. Spear and Glatt suggest that news of the impending passage of the Act may have contributed to the rush of immigrants in 1961 and 1962. After its passage it was used to refuse entry to people and to deport them. Less than half of the 91 Canadian dependent heroin users known to authorities remained in the UK; 30 left the country voluntarily, 10 were deported and 10 died.

⁵ Dependent heroin users who lived outside Widnes and Warrington were admitted to these programs. In 1991 Marks estimated that about 100 new clients were seen each year and that 20 of these came from outlying districts (personal communication). With the exception of a few cases, they seem to have commuted rather than physically relocated to Widnes or Warrington. This was possible because clients from outlying areas remain in the care of their local general practitioner and pick up prescriptions from the local pharmacist. The initial assessment, prescribing and ongoing supervision are conducted by the consultant psychiatrist at Widnes or Warrington (Marks 1991, personal communication). A description of the Marks/Parry program in Widnes and Warrington can be found in Bammer et al. 1991.

⁶ It should be noted that none of these visible drug scenes has occurred because of liberalisation in laws about heroin use; in all cases heroin use is illegal. The reasons for these open drug scenes and the lessons that can be learnt from them are discussed in the next section and in Appendix 4.

⁷ There are, however, some areas of public housing that are seen to be undesirable and an association with illicit drug use is one reason for this.

⁸ Unpublished statistics (Fran Hill, personal communication 1994). The ACT Needle and Syringe Exchange Program does not operate on a strict *exchange* basis; their unpublished statistics show that around 40 percent of distributed needles and syringes are returned (Fran Hill, personal communication 1994).

⁹ '[S]ome drugs directly produce physiological or psychological changes in some individuals which lead them to commit criminal acts, often of a violent or destructive nature. ...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 anxiety and irritability associated with withdrawal in heavy users.' (Wardlaw 1992, p.116)

¹⁰ As Wardlaw (1992) points out '[p]robably the clearest and most pervasive link between heroin and crime, however, is the commission of income producing offenses 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 part of their way of life and continues at some level even during periods of abstinence.)' (p.116)

¹¹ The issue of immigration from other countries is not dealt with in depth here. Given the distances involved and Australian restrictions on migrants from other countries, this is unlikely to be a big issue. A possible exception may be migration from New Zealand, as the Trans-Tasman arrangement means that visas are not required. The only restriction placed on New Zealanders seems to be a six-month Australian residency period before they are eligible for unemployment benefits. In the financial year 1991-2, more than half a million New Zealanders arrived in Australia; however figures from the 1986 census showed that only 3,000 New Zealanders were residing in the ACT. In addition, the proportion of New Zealanders in drug treatment services seems to be low. Figures from a 1990 one-day Australia-wide census of clients of drug and alcohol treatment service agencies show that two percent were born in New Zealand (Webster et al. 1992). ACT figures for 1988 show that three percent of those who were drug-treatment clients and/or arrested on drug-related charges were born in New Zealand (Stevens et al. 1989). Certainly, if a heroin trial eventuates immigration of dependent heroin users from New Zealand (and elsewhere) should be monitored. It is likely that the same measures that would deter immigration from elsewhere in Australia would also deter immigration from New Zealand.

¹² For many Australians, living near the ocean for recreational purposes is important; Canberra is about two hours by car from the nearest beach.

¹³ A useful history of methadone maintenance in NSW is given in Caplehorn and Batey (1992). The first methadone maintenance program in Australia was established in 1970 by Dr Stella Dalton at a specialist drug and alcohol unit in Sydney. In the first two years 82 heroin users received methadone maintenance. In 1972 the New South Wales Health Commission decided to expand methadone treatment services through

both specialist and community health clinics. In less than five years more than 2,200 dependent heroin users were admitted to methadone treatment, with 700 in treatment in 1976. The NSW policy of abandoning methadone maintenance in 1978 was implemented by placing a freeze on the recruitment and replacement of community health staff. 'As there was high staff turnover, the freeze caused the rapid deterioration and closure of services.' (p.666) In 1981 Dr Dalton's program was responsible for around 430 of the 500 people in maintenance in NSW. In early 1986, soon after the reversal of the policy, there were 980 people receiving methadone maintenance from public units and 1,000 in treatment with private practitioners.

¹⁴ An open drug scene may encourage immigration both because of the message it gives about permissive attitudes and because of the easy access to illicit drugs.

¹⁵ Controlled availability of heroin has recently been introduced in Switzerland as one measure to reduce the open drug scene.

¹⁶ Only 50 or so people receive scripts for heroin at each clinic.

¹⁷ This experience suggests that controlled availability of heroin does not necessarily have such a strong pull effect that the migration of users leads to overwhelming problems. This may be influenced by the history of heroin prescribing in the UK and by the medical system. People from outside who use the clinics in Widnes or Warrington are paid for by their home health district. This may restrict the numbers who seek entry to the Widnes and Warrington programs. In addition, they may fear that this costing arrangement means that they will be forced to resume the more restricted treatment in their home district after a few months (Marks, personal communication 1991). Although strong pull effects do not seem to occur in the UK, it would be wrong to assume that they would not occur here.

¹⁸ Potential weak points include the security of drugs when transported to the trial site(s), security of the trial site(s) from robbery and accounting procedures that prevent misappropriation by trial staff.

¹⁹ The Australian National AIDS and Injecting Drug Use Study (Ross et al. 1993), which surveyed intravenous illicit drug users in Sydney, Brisbane, Melbourne and Perth, found that the seroprevalence of HIV infection was less than two percent in all centres except Sydney, where the prevalence was under five percent. A Victorian snowball based study of 303 injecting drug users found that 68 percent were seropositive for Hepatitis C virus (Crofts et al. 1993) and this percentage is only a little lower than that found in a clinic population of 172 in Sydney (86 percent, Bell et al. 1990). The study by Bell and colleagues also showed that 89 percent of the sample had been exposed to Hepatitis B.

²⁰ Using census data for the period 1981–86, Martin Bell's (1992) study of internal migration concludes that Australians are a very mobile population. During the five year period reviewed, some 41 percent of the population changed their usual place of residence. Of these 13 percent (717,000 people) moved interstate. Approximately 55 percent of this interstate migration took place in the eastern states of Australia.

²¹ This assumes that those with HIV, in particular, are not more likely to migrate than those without and that preventive measures such as needle and syringe exchange will still be readily available.

²² A description of ACT agencies providing services to drug users is given in Stevens et al. (1991).

²³ Such restrictions would also have untoward consequences for people who were attempting to stop dependent heroin use. Relocating to another area and using services there is often part of the process of successfully becoming an ex-user (Bammer and Weekes 1992).

²⁴ There is an additional problem that residency criteria that are too tight may exclude people who should be eligible. In our survey, we also asked respondents if they had lived outside Canberra for substantial periods of time in the last 12 months. Twenty-six percent of those who said they had lived in Canberra for more than the last two years had spent periods away in the last 12 months (n=76; missing data for an additional six cases. Of those who had been away, two did not report the length of time). For two-thirds this totalled less than 10 weeks and included time away for holidays, visiting friends or travelling, work, treatment and returning to live with parents. The remaining third (eight percent of the total) had substantial periods away that might interfere with their ability to prove residency. Periods away ranged from 18 to 45 weeks and included time away for holidays, visiting friends or travelling, work and escaping a domestic situation. Ideally, residency criteria should not exclude such people.

²⁵ A potential disadvantage of using residency criteria is the administrative burden it could place on trial staff. This would need to be taken into consideration in the budget for the start-up phase of a trial.

²⁶ Participants at a June 1993 workshop that considered trial design argued that restricting a trial to volunteers who were currently in a methadone program had advantages for generalisability of the results (Bammer and McDonald 1994). However, this would not allow a trial to evaluate whether or not controlled availability of heroin would attract into treatment people who would not otherwise come to treatment.

²⁷ For more information, see National Centre for Epidemiology and Population Health and Australian Institute of Criminology (1994).

²⁸ While these are not long-term links now, they will be if a trial eventuates.

²⁹ Dr Ann Larson, Tropical Health Program, University of Queensland, provided useful input to this section.

³⁰ Such data would also be useful for putting rumours about migration in context. There are already rumours that illicit drug users are moving to Canberra. One rumour variously linked this movement with the proposed 'heroin trial' or with the expansion of the methadone program, depending on who relayed it. We believe that we have traced this rumour back to its original source—an off-the-cuff remark by a treatment provider who doubted the motivations of *one* new applicant for a place on the methadone program. While this rumour did not become the focus of public attention (it mainly circulated among service providers), the potential use of untrue or exaggerated rumours to discredit a heroin trial is obvious, particularly if such rumours are picked up by the media.

³¹ Census data as used by Bell (1992) would not be useful as they are confined to the single year or five year period immediately preceding the most recent census. Not only are the data unlikely to be timely, but they are also likely to underestimate short-term migration. However, census data can give a very general indication of the background levels of migration on which immigration to gain a place on a trial would be overlaid.

³² The ACT Drug Indicators Project was a three year program of research (1987–89) that aimed to 'develop and refine methodologies for estimating the incidence, prevalence and character of illegal drug use, to construct and monitor indicators of relative changes in drug use levels and patterns over time, and to assess how best to integrate information from different agencies and sources to provide a broader and more accurate picture of illegal drug use than is currently available' (Stevens et al. 1989, background information). All major drug treatment and criminal justice agencies in the ACT area collected demographic, drug use, treatment and criminal record information from new contacts according to a standard format. Data from this project were used by Larson (1992) to estimate numbers of heroin users in the ACT.

¹ However, demographers and geographers generally agree that the concept of push and pull factors is an oversimplification of the complex processes involved in migration and has little value apart from description (for example, Bogue 1977; Lewis 1982).

² This is now slowly changing.

³ A study of people entering Needle Park in March 1990 (Křnzler, no publication date) found that 39 percent said their place of residence was the city of Zřrich, 26 percent lived elsewhere in the canton of Zřrich, 31 percent lived in other Swiss cantons and four percent lived in other German-speaking countries. Eighteen percent could be classed as homeless. Similar results were also found by others (Lanz et al. 1992; Mřller and Grob 1992). Lanz and colleagues also found that 24 percent of those interviewed said they would only stay in Zřrich for a few weeks or days. Further, while most of the people in their study were living in Switzerland, with only one percent living in Germany and 12 percent with no fixed residence, the nationality of 15 percent was from adjoining European countries (Austria, Germany, and Italy) and three percent were from the then Yugoslavia.

⁴ Compared with NSW (10.6 percent) and Victoria (12.0 percent), the ACT (7.1 percent) has the lowest unemployment rate (Australian Bureau of Statistics, December 1993) This may provide an incentive for some people to move to the ACT. It should be noted that this and the other comparisons between Canberra, Sydney and Melbourne (or the ACT, NSW and Victoria) need to be treated with caution because they do not present the whole picture. For example, while there are unemployment differences between the three locations, the types of employment available are also very different. Canberra, for example, has no substantial industrial base, so that jobs in that sector would be quite difficult to come by. The material is presented to be illustrative of the ways in which immigration to Canberra may be influenced. In depth discussion of these issues and calculation of possible effects of these state/territory and city differences is beyond the scope of this paper. If a heroin trial eventuates, it may be possible to collaborate with some agencies to reduce locational differences and hence possible push and pull factors.

⁵ In November 1992 there were 7,000 people on the waiting list for public housing in the ACT (personal communication, ACT Housing Trust). This compared with 50,000 on waiting lists in Victoria (personal communication, Victorian Department of Planning and Housing, November 1992) and 71,000 in New South Wales (NSW Department of Housing Annual Report 1991/92). Waiting times were around three to four years in the ACT, five years in Victoria and two to eight years (depending on location) in NSW. While the proportion of people on waiting lists to the population in the ACT was double that of Victoria or NSW (3.1 percent in the ACT, 1.4 percent in Victoria, and 1.5 percent in NSW; population data for those aged 15 years and over taken from Australian Bureau of Statistics, November 1992), the waiting lists in Victoria and New South Wales were publically stated to represent a crisis in public housing, which was not the stated perception in the ACT. It is possible that illicit drug users who have public housing in NSW or

Victoria may be reluctant to relinquish it to gamble on a place on a Canberra-based heroin trial. For those on waiting lists, however, a move to the ACT may be an attractive option.

⁶ Compared to NSW and Victoria, the ACT is significantly more generous in the provision of rent relief, although there is a six month residency requirement for eligibility.

⁷ In late 1992, according to the Real Estate Institute of Australia, the private rental market in Canberra was cheaper than in Sydney, but more expensive than in Melbourne and this was also true for home purchases. However, Canberra had the lowest moving annual vacancy rate, which meant that accommodation was most difficult to obtain in Canberra.

⁸ Geographical and social distancing from the drug scene is an important contributor to successfully stopping illicit drug use (see Bammer and Weekes 1992).

⁹ This seems to be the case when Canberra is compared with Sydney and Melbourne (Bammer and Sengoz, working paper #10 forthcoming).

¹⁰ The Brisbane situation was assessed from telephone interviews conducted with Ms Lynne Biggs, Dr Michael Bolton and Dr Adrian Reynolds.

¹¹ Ms Biggs, currently a Senior Policy Officer at the Alcohol and Drug Branch of Queensland Health Department, was involved in the methadone program during 1978 to 1990 in the capacities of nurse, senior nurse therapist and team leader. Dr Bolton, currently the Assistant Regional Director (Community Clinical Services), Brisbane North Regional Health Authority, worked as a medical officer at the Drug Dependence Clinic (methadone program) in 1978 and in 1981 became Director of Alcohol and Drug Dependence Services, Queensland. Dr Reynolds, currently Director, Brisbane North Alcohol and Drug Services, was a medical officer at the clinic from 1983 until he became Deputy, Director Alcohol and Drug Dependence Services, Queensland in 1987.

¹² Descriptions of the policy are available in Bolton (1984) and in the Department of Health, Queensland Methadone Program, Policies and Procedures Manual (unpublished, no date but circa 1983).

¹³ Dr Keith Powell was Senior Physician of the ACT methadone program from its inception in early 1979 until he retired in 1992. This piece was written by him after discussion with the only two members of the staff who were present when people from Sydney and Wollongong sought admission to the ACT Methadone Maintenance Program. More information about the program is available in Powell and colleagues (1984).

¹⁴ TAFE (Technical and Further Education), CCAE (Canberra College of Advanced Education, now the University of Canberra), ANU (Australian National University).

¹ Open drug scenes also occurred in other Swiss cities, but the one in Zürich was and is the largest and best studied. The city of Zürich has a population of just under 350,000, with just over a million living in the canton of Zürich (1989 figures, source Embassy of Switzerland).

² There is also an open scene for cannabis dealing and use, but this is much smaller and in a separate location.

³ Two of the trials, based in Zürich, started in early 1994. Three more will commence in other areas of Switzerland later in 1994 (personal communication to GB).

⁴ Four occurred on one day with *The Lismore Echo* reporting 'four people were carried down the [main] street needing hospital treatment for heroin overdoses' (22 January 22 1993 p.1). All were apparently visitors to the area (Helliwell, personal communication 1993).

⁵ David Helliwell is a local general practitioner.

⁶ The association between Nimbin and marijuana use began with the 1973 'Aquarius Festival'. This was organised by the National Union of Students and was the forerunner to the alternative society/counter culture movement in Australia (Helliwell et al. 1992). Thereafter Nimbin and surrounds became a centre for people seeking to live alternative lifestyles, incorporating various levels of marijuana and other illicit drug use (Helliwell 1992). The population of Nimbin itself is around 300, but the town services between 5,000 and 10,000 people living in a 20 km radius (Helliwell et al. 1992; Helliwell, personal communication 1993). The growth and sale of marijuana, the so-called green economy, has been an important contributor to the prosperity of the area (Helliwell, personal communication 1993).