

**Becoming an ex-user:
Would the controlled availability of
heroin make a difference?**

Gabriele Bammer and Sue Weekes

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

Working Paper Number 4

**National Centre for Epidemiology and Population Health
The Australian National University**

Australian Institute of Criminology

AUGUST 1993

**ISBN 0 7315 1818 7
ISSN 1039-088X**

ACKNOWLEDGEMENTS

Our biggest debt is to the participants who shared their stories with us.

Beverly Sibthorpe and Kate Elliott contributed to the conceptualisation of this study and Charlie Blatch, Lynne Magor-Blatch, Joy Murdoch, Jacqui Pearce, Liz Skinner and Adele Stevens contributed useful ideas.

Lynne Magor-Blatch, Joy Murdoch, Jacqui Pearce, Lyn Enright, Liz Skinner, Marion Watson, David Rogerson, Kate Lundy, and Peter Edwards played an important role in the recruitment of participants.

Useful feedback on the draft report was received from the respondents and from David McDonald and Beverly Sibthorpe.

Pat Goodall minded the phone when needed, Kaye Devlin provided administrative assistance, Jodie Rickett helped with the layout of Appendix C and Belinda Richardson helped in the production of the report.

This study was supported by a grant from the Australian National University's Strategic Development Fund and by NCEPH.

Becoming an ex-user: Would the controlled availability of heroin make a difference?

Feasibility Research into the Controlled Availability of Opioids Stage 2

Working Paper Number 4

ISBN 0 7315 1818 7

ISSN 1039-088X

© National Centre for Epidemiology and Population Health

Published by the National Centre for Epidemiology and Population Health

The Australian National University

ACT 0200

August 1993

Cover designed by Fran Smith, ANU Graphic Design, The Australian National University, ACT 0200. Based on an original design for the Feasibility Research Project by Kathie Griffiths.

Publications Officer: Belinda Richardson, NCEPH

CONTENTS

Executive Summary	v
Introduction	1
Methods	3
Description of the participants	4
Views on a 'heroin trial'	7
Understanding of the proposal for a heroin trial.....	7
Arguments in favour of a trial.....	8
Arguments against a trial.....	10
Would respondents be tempted to start using again so that they would qualify for a place on a trial?	13
Effect on decision to stop.....	14
Alternatives to a trial.....	16
Pathways out of heroin dependence: The decision to stop	18
No or minimal treatment group	18
Detoxification program group	19
Methadone program group.....	20
Therapeutic community group.....	21
Summary and discussion	24
Pathways out of heroin dependence: The role of treatment and other services	26
Methadone programs.....	26
Therapeutic communities.....	28
Narcotics Anonymous (NA) and Alcoholics Anonymous (AA)	31
Counselling	32
Doctors.....	32
Suggestions for expanded and new services	33
Barriers to treatment.....	34
Summary	34
Pathways out of dependence: Maintaining abstinence	36
Relocation and avoiding old haunts	36
Supportive close relationships.....	36
Professional and peer support.....	37
Dealing with past personal issues.....	37
Remembering the past life	38
Learning a new way of living.....	39
The rewards of a conventional lifestyle	39
Work	39
Using other drugs.....	40
Spiritual influences	40
Summary and discussion	40
Conclusions	42
Feasibility study.....	42
Comments on existing treatments.....	43

Further work	44
References	45
Appendix A: Interview Schedule	46
Appendix B: Recruitment Strategies	52
Appendix C: Results from a survey of ex-users conducted during Stage 1.....	56
Appendix D: Heroin use and pregnancy.....	68
Feasibility Research into the Controlled Availability of Opioids.....	70
Publications	71

EXECUTIVE SUMMARY

The primary aim of this study was to gain some insight into what the effects might be on stopping dependent heroin use if heroin was made available in a controlled manner through a 'heroin trial'. To do this, we documented the 'stories' of a diverse group of people who have been dependent on heroin in the recent past. We explored how the participants had come to give up heroin. They were also questioned on their views about the proposal to conduct a 'heroin trial'.

For some of the analysis, participants were divided into four groups: those who had given up with minimal or no formal treatment; those who had used detoxification; those who had used methadone; and those who had been in a therapeutic community.

Of the 18 people interviewed, 17 were asked their views about a heroin trial. Forty-seven percent were in favour of a trial; 41 percent were not in favour; and 12 percent were undecided. In each of the four groups into which participants were allocated, there were people who were in favour and people who were against a trial. Of 12 respondents, 11 would have participated in a heroin trial if that option had been available to them at the time. Of 14 respondents, 5 indicated that they may be tempted to start using again if a trial were to go ahead. A survey of 45 ex-users conducted during Stage 1 of the Feasibility Research found that 62 percent were in favour of a trial going ahead; 22 percent were against; and 16 percent did not know. Only 2 percent thought they might start using again to get on a trial; 19 percent were unsure.

The views of the participants and information which can be drawn from their stories highlight a number of potential benefits and problems of a trial. The potential benefits include providing a new treatment option that could allow some people to 'stabilise' their lives. It might also reduce crime and health problems and provide a drug that was easier to withdraw from than methadone.

The potential problems include that there would be people who would 'rip off' a trial and others for whom it would not be a helpful alternative. There are likely to be people whose lives would be 'stabilised', but who would not find the motivation to deal with underlying problems or become drug free. A number of participants were opposed to a trial because they thought it would work against dependent users being helped to lead 'normal' lives. There are people who may start using again. The particular design of a trial might also lead to logistic problems.

These potential advantages and disadvantages of a trial need to be weighed up along with the results of all the other components of the feasibility study before a final decision about the controlled availability of heroin can be made.

Participants were also asked about how they had made the decision to stop using; what the role of treatment had been; and how they had maintained their decision to be abstinent.

A diversity of experiences was reported about how the decision to stop using was made. For most participants a range of factors was involved. Many were consistent with factors identified in previous studies and included 'hitting rock bottom'; change because the situation or environment changed; maturing out; fear of the law; and the influence of family and friends.

Advantages and disadvantages of a range of treatment services were reported, with a focus on methadone programs, therapeutic communities and Narcotics and Alcoholics Anonymous. The results highlight that different treatments and services work for different people at different times. Not only do a range of treatments need to be available, but there also need to be various supports for people who want to stop dependent use without formal treatment.

Key factors in maintaining abstinence were reported to be relocation and avoiding old haunts; supportive close relationships; professional and peer support; dealing with past personal issues; remembering the past life; learning a new way of living; the rewards of a conventional lifestyle; work; use of other drugs; and spiritual influences.

This small investigation seems to have been the first of its kind in Australia. It shows that studies of ex-users can be valuable in informing existing policy regarding the provision of treatment services and proposed policy changes.

INTRODUCTION

This study forms part of Stage 2 of 'Feasibility Research into the Controlled Availability of Opioids'. Its primary aim was to gain some insight into what the effects might be on people who wanted to stop dependent heroin use if heroin was made available in a controlled manner. To do this, we documented the 'stories' of a diverse group of people who have been dependent on heroin in the past. We explored how the participants had come to give up heroin. They were also questioned on their views about the proposal to conduct a 'heroin trial', which would make heroin available to dependent users in a controlled manner. This is clearly an important part of the feasibility considerations. If a significant proportion of ex-users are opposed to a trial or if a significant proportion consider that the controlled availability of heroin would impair their ability to maintain abstinence or non-dependent use, these views need to be weighed as potential costs if a trial were to proceed.

During Stage 1 of the feasibility research in 1991, self-completion questionnaires were distributed through various service agencies, and friendship networks, with invitations to users and ex-users to complete and return them. Because of the tight time-line the responses of users and ex-users were not differentiated in the Stage 1 analysis. The results from the Stage 1 ex-user study are reproduced here in Appendix C.

In that study we were not able to obtain information about what it was that had enabled the ex-users to stop using heroin and how this might have been altered if a program of controlled heroin availability had been in place.

The aim of this study was to expand on the earlier work by interviewing a range of people who had given up heroin using a variety of methods. We were particularly interested in those who had given up without formal treatment, those who had used methadone, and those who had been in a therapeutic community. We encouraged people to tell us their stories and used qualitative techniques to analyse the data.

As well as eliciting views on the controlled availability of heroin, we focussed on the pathways out of heroin dependence, including factors that had influenced the decision to stop, the role of treatment in the transition out of dependence, and on factors important in maintaining abstinence.

We also asked the women who participated about drug use during pregnancy, to help us make decisions about the eligibility of pregnant women for a heroin trial (Appendix D).

This investigation therefore has relevance not only to the feasibility considerations, but also has broader ramifications for understanding pathways out of dependence and how both policy and service provision can have an impact on these.

This seems to be the first study of its kind in Australia.

Overseas studies have been used to develop various models for understanding how cessation of dependent heroin use may occur and what the motivators for change may be.

There seem to be a number of pathways out of heroin dependence. Abstinence is the aim of most treatment and rehabilitation programs, and they use a variety of strategies to achieve this. A review of the effectiveness of treatment programs is beyond the scope of this paper and has been covered to some extent by Heather and Tebbutt (1989).

For a long time, the view was held that heroin dependence is seldom overcome without treatment. However, there is growing evidence of "spontaneous remission" (Waldorf and Biernacki, 1979; Biernacki, 1986). These studies suggest that dependent users who do not go to treatment become non-dependent at approximately the same rates as those who do go to treatment, and that these numbers are larger than first thought.

Biernacki (1986), for example, interviewed 101 heroin users who had overcome heroin dependence on their own. He termed this 'natural recovery'. He described how a small proportion of users (5 percent) did not make a firm decision to stop using heroin. They drifted out of dependence either because of work commitments or because of lifestyle changes. A larger group (20 percent) hit rock bottom or experienced what he regarded as an existential crisis; that is, a profound emotional and psychological event that led them to question their lifestyle and identity as a heroin user. The largest group (75 percent) made a rational and explicit decision to stop using heroin either in response to an accumulation of negative experiences or because an event occurred (an overdose of a friend for example) that was particularly significant or disturbing on a personal level.

In an earlier study, Waldorf (1983) interviewed 201 ex-users, only half of whom had been in treatment programs. He identified six patterns of achieving non-dependence (although this was not sufficient to describe all the variations): maturing out; drift; change because the situation or environment changed; conversion to religious, social or communal causes; retirement, that is giving up the drug but maintaining the lifestyle; and becoming alcoholic or mentally ill.

One of the most recent papers on the topic of spontaneous remission is by Klingemann (1992). It presents findings from the first “autoremission” study in Switzerland on both alcohol and heroin dependence using a life history perspective and a grounded theory approach. He proposed that there are three stages of autoremission: motivation, action, and maintenance. The motivation stage can be negative and/or positive with negative forces including “hitting rock bottom” and deterrence. Positive forces include “maturing out” and advantageous life turning points. Klingemann believes that dependent users can be taught to deal more easily with withdrawal symptoms and be supported in their efforts to strengthen social ties. These social ties are necessary not only to establish a non-deviant identity, but to complement personal means of achieving non-dependence.

Others have also highlighted the importance of developing a new lifestyle. These include the avoidance of old friends and hangouts, combined with the simultaneous development of new friends and habits, as part of the process of stopping dependent heroin use (Jorquez, 1983; Waldorf, 1983; Wille, 1983).

Reviews of the literature suggest a considerable variety in the types of life events associated with cessation of dependent heroin use.

Simpson and colleagues (1986) conducted a twelve-year follow-up of 405 dependent opioid users who had been admitted to treatment. Of those who had stopped using (three-quarters), “65 percent said they became tired of the life, 32 percent stated a fear of the law ..., and 25 percent acknowledged the influence of family or friends” (p. 116). Demographic and background measures did not predict outcomes at year 12. The majority of respondents credited treatment programs as being very important in their stopping.

Similar key factors were reported by Waldorf (1983) and Maddux and Desmond (1981). While identified life events have included changes in the family, work, health, religion, or social pressure, other reported changes have related more to people’s perceptions of their situation than to specific events or external circumstances (Klingemann, 1992).

It is important to note here that abstinence does not necessarily signal the end of a using career. A number of authors, including Jorquez (1983) and Maddux and Desmond (1981), report that abstinence episodes of varying duration are common features of heroin using lifestyles. These may be either voluntary or involuntary.

Most documented research has concentrated on the prevalence and spread of dependence; on developing methods to control heroin use and its distribution; and on creating prevention and treatment programs. As we have indicated above, there is a small but growing literature on the various pathways out of heroin dependence. This is a complex process. An understanding of these pathways is necessary both to improve treatment programs and to ensure that social policy does not mitigate against cessation of use by those outside of programs. As well as its relevance to the considerations of whether or not a ‘heroin trial’ is feasible, this study documents some of these pathways in an Australian context.

METHODS

Eighteen participants were interviewed face-to-face by a researcher trained in qualitative data collection methods (SW). A semi-structured questionnaire with open-ended questions (Appendix A) was used to obtain a picture of the participant's lifestyle, experiences, and attitudes. Interviews lasted between two and three hours and participants were paid \$20. Responses to the questions were taped. The data were analysed using standard qualitative methods, including content analysis and the identification of common themes, views and characteristics.

A range of methods was used to recruit participants and these are presented in detail in Appendix B.

As with all research on "hidden populations", we have no way of knowing how representative the sample we interviewed is. The aim of our recruitment strategy was to elicit views from a diverse group of people, particularly in relation to the ways that people had stopped dependent use. We believe that we were successful in achieving this aim.

To be eligible for the study, participants had to have become non-dependent on heroin or abstinent at least two years ago and within the last five years. Dependence was defined as daily use of heroin for six months or more; non-dependence as no use or use less than four times in any one month for the last two years.

We wanted to interview people who had finally stopped dependent heroin use, rather than those who had simply stopped for a while; hence the criterion that they needed to have been abstinent or non-dependent for at least two years. We recognise, however, that there is a possibility that some of those in our group may not have given up for the final time. Because patterns of use and behaviours associated with illicit drug use change as society changes, we also wanted to interview people who had been dependent relatively recently; hence our criterion that participants should have been dependent in the last five years.

Five of the participants did not exactly fit our criteria. One respondent had only been a daily user for five months; one gave up six months ago; one 15 months ago; one 18 months ago; and the other respondent gave up six years ago.

The study was undertaken as part of the 'Feasibility Research into the Controlled Availability of Opioids', which has been gazetted as a prescribed study under the ACT Epidemiological Studies (Confidentiality) Act (1992). The confidentiality of respondents was further protected by using pseudonyms.

The following sections present and discuss the results. We begin with a description of the demographic characteristics of the participants and portraits of their using lives. To protect confidentiality, we present the portraits as three amalgamated stories rather than as individual sketches. Their attitudes to the heroin trial proposal follow, along with views on the effects of a trial on giving up heroin and the temptation to re-use. Then there is a description of pathways out of dependence: the decision to stop; participants' views on the role of treatment and other services; and a description of how participants have maintained abstinence.

DESCRIPTION OF THE PARTICIPANTS

For some of the analysis, participants were allocated to one of four groups to indicate by which method they had stopped using heroin dependently. These were: those who had successfully stopped using heroin with no or minimal formal treatment (No or minimal treatment group); those who had been in a detoxification centre (Detoxification program group); or on a methadone program (Methadone program group); and those who had successfully made the transition to non-dependence through long-term rehabilitation in a therapeutic community (Therapeutic community group). Not everyone could fit easily into these groups. For example, Andrew used methadone to stop using heroin, but doing this led to enormous problems in his life. Although he is included in the 'Methadone program group', the salient pathway out of dependence for him was coming off methadone and minor tranquillisers, which he did with no formal treatment. Freya was also on a methadone program for a number of years. However, she continued to use heroin and to participate in an illicit drug using life. She went into a detoxification program to stop using heroin and methadone (and other drugs) and is therefore included in the 'Detoxification program group'.

Demographic data are provided below on each group and include information on gender, age, length of time using, length of time stopped, highest level of education achieved, occupation, income, marital status, and number of children.

No or minimal treatment group

Two women and three men were interviewed in this group. With an age range from 20 to 32, they were the youngest group and had a length of time using heroin dependently ranging from five months to six years. The length of time that they had stopped ranged from 15 months to six years.

Two had never been in treatment. The others had tried various treatments in the past and received some minimal help (for example, from NA or a medical professional) as part of finally stopping.

While one left school before Year 10, three held the HSC, and one was enrolled in a Bachelor degree.

Only one respondent was currently employed, with the rest receiving government benefits.

One respondent was separated and four were never married. Two respondents had children living with them. Only one respondent in this group was from Canberra.

Detoxification program group

Two women and one man were interviewed in this group. They were aged from 27 to 35, with a length of time using from 10 to 17 years. While one had stopped six months ago, the others had all stopped two years ago.

One left school before Year 10, one held the HSC, and one a Bachelor degree.

All respondents were currently on government benefits: two on supporting parent's benefit and one on sickness benefit. One also worked part-time.

One respondent was now divorced, while the other two never married. Two respondents had children living with them.

Only one of the respondents was from Canberra. The others were from interstate.

Methadone program group

There were three men and one woman interviewed in this group. Their ages ranged from 33 to 37, with a using life from seven to 17 years. They had stopped between two and five years ago.

One respondent completed Year 11, two held TAFE certificates and one had partially completed a Bachelor degree.

One was self-employed, one was on worker's compensation and two were on government benefits.

One respondent was married with children living at home. Two were separated and one was divorced; they had children who were not currently living with them.

Three of the respondents were from Canberra, with only one from interstate.

Therapeutic community group

From this group we interviewed two women and four men, who ranged in age from 31 to 47. Their using life was quite extensive, ranging from 14 to 26 years before they finally stopped. They had all stopped between two and five years ago.

Two of the respondents left school before Year 10, three held a school (leaving) certificate, and one held a TAFE certificate and was currently enrolled in a Bachelor degree.

Two were working full-time in paid employment, one was on a pension, one had received an inheritance, one was unemployed, and one was on workers' compensation.

One respondent was currently married, with two separated, and three never married. Four respondents had children; of these, three had children currently living with them.

Only one of the people interviewed in this group was a long-term resident of Canberra.

Summary

In total seven women were interviewed and eleven men. Women and men were interviewed in each of the four groups.

Overall ages ranged from 20 to 47; the youngest were in the "No or minimal treatment" group and the oldest in the "Therapeutic community" group. The length of time that they had used heroin dependently was related to their age. For example, the 20 year old interviewed in the "No or minimal treatment" group had used for the least time, five months, while the oldest person interviewed had used for 26 years. The results suggest that younger users who have used for a shorter period may be the ones most likely to give up without treatment. However, this should be tested with a more representative sample and with follow-up to ensure that this group is not the most likely to begin using again.

There was considerable variation in the levels of education achieved within each group. This did not seem to reflect particularly on the employment status of respondents; most were unemployed or on supporting parent's benefit. Significantly, unless male respondents were married, the care of children fell solely to the women. Most of the respondents were either separated or divorced or had never married. This pattern held across all groups.

While several respondents were from Canberra, most of the respondents had moved here from interstate. Moving to another location appeared to be crucial in maintaining the decision to stay stopped. The reasons for this are discussed in the section on maintaining abstinence.

Portraits of their using lives

We decided to compose three amalgamated pen portraits to add colour to the descriptions of the participants, but to allow their anonymity and confidentiality to be protected. The first had relatively few complications associated with their heroin use; the second had a moderate number; and the third had a range of extreme problems.

Portrait 1 – Relatively few complications

There were four people in the first group– three men and one woman. Three started using with friends when they were in their teens; one was younger than 16. The fourth was in the mid-twenties. Two spent most of their using careers in Asia and one of these did not inject heroin but smoked or snorted it. Three characterised the time when they were using as sitting alone in their rooms. Three had quite short histories of using (less than three years).

One of those living in Asia supported their use as a courier; one stole to support their use and one shoplifted to eat. Compared to the other groups, the involvement in crime was minimal and the threat of jail was a significant deterrent.

Two had relatively few experiences of treatment and two had never been in treatment. Health problems included hepatitis C, weight loss and overdoses, but two had no significant health problems associated with their use.

Only one seems to have had major personal problems, including abusive relationships.

Portrait 2 – Moderate number of complications

Four men and two women were in this group. Three started using before they were 16, two at 17 or 18 and one was in the late-twenties. They were introduced to heroin by friends, siblings, a family acquaintance and partners. One had previously become dependent on morphine in hospital while being treated for the effects of a road crash. A family acquaintance recognised that this person was in withdrawal after release from hospital and introduced them to heroin.

All were involved in crime. The crimes were predominantly break and enter, fraud and selling drugs. One was also involved in more serious crimes, namely armed robbery. Three of the men had spent time in jail, all for relatively short periods. Both of the women also raised money through prostitution.

Three, two men and one woman, reported that physical violence was integral to their lives and only the woman was not violent towards others. One had had their teeth broken and been stabbed. The major health problems associated with drug use were hepatitis B and C and most reported no other problems. One reported no significant health problems apart from overdosing. One was homeless and living in a park for a period. Both of the women had been sexually abused.

All had only limited contact with treatment agencies.

Portrait 3 – Range of extreme problems

There were eight people in this group— four women and four men. Two had started using before they were 16, the rest in their late teens or early twenties. Most started using with friends, one with a partner and one with an older sibling.

All had extensive criminal histories; all had been convicted for various offences and five (three men and two women) had spent time in jail or on remand. Crimes included burglaries; safe cracking; assault; armed robberies; selling stolen cars; dealing heroin and other drugs; manufacturing drugs; fraud; and possession of firearms. Both women and men were involved in serious offences. A number of the women also supported their use through prostitution. Only one person seemed to have been heavily involved in crime before using heroin.

All but one had had serious health problems. They included hepatitis B and C; collapsed veins; severe ulcers; scurvy; major weight loss; cirrhosis of the liver; overdoses; dental problems; and sores that would not heal. Physical violence was integral to most of their lifestyles and many, both men and women, were violent towards others as well as being the recipients of violence. One had had both kneecaps broken.

Most had to deal with major emotional problems including, for three (one woman and two men), sexual abuse. One reported being sexually abusive. One reported that their children had been physically abused. Four had been in psychiatric institutions. One of the women was deemed to be “uncontrollable” when she was a child. One of the women reported attempting suicide and still suffered from the effects of stabbing herself.

Four had tried a range of treatment programs, three had used a limited number and one had never been in treatment apart from receiving minimal help after they stopped using the last time.

VIEWS ON A 'HEROIN TRIAL'

Of the 18 people interviewed, 17 were asked their views about a heroin trial. Eight (47 percent) were in favour of a trial, seven (41 percent) were not in favour, and two (12 percent) were undecided. Three out of four of those in the Methadone program group were in favour of a trial and two out of five the people in the Therapeutic community group were in favour, with the rest against. In the No or minimal treatment group, two were in favour, two against and one undecided and in the Detoxification program group one was in favour, one against and one undecided¹.

Understanding of the proposal for a heroin trial

Of those in favour of a trial, four out of eight talked about what they understood a trial to mean; for those not in favour, four out of seven responded, as did one of those who was undecided.

Those in favour of a trial

Amy's understanding of the trial was

'giving addicts a legal dose of heroin to cut down the HIV and illegal drug trade to see if a practicing heroin addict can hold down a job and have a lifestyle.'

She understood that the aims of the trial would be for heroin users

'to lead a normal lifestyle [and to] stay out of crime.'

Bob expressed uncertainty about the criteria that would be used in a trial, but said he would

'liken it to the British system that was working where people of long-time usage would be able to go down and be given their heroin a day and in that way freeing them from having to scam, steal, maim, kill, rape whatever goes on and taking it away from the organised criminal side of the drug world.'

Malcolm had read of the proposal for a heroin trial in the Sydney papers and understood that it would be run

'along the lines of the methadone program. There would be a certain amount of heroin each day to bring people off it or to give it to people who are going to be addicted for the rest of their lives.'

For Graham the trial would

'supply addicts with heroin, that's what it basically means, and only in Canberra.'

Those not in favour of a trial

Ross assumed that

'they want a controlled trial, like the methadone program.'

Andrew understood that a trial would be combined with the methadone program where

¹*Phone screenings of people ineligible to participate*

Besides the eighteen people interviewed, twelve other people telephoned to make enquiries. They were ineligible because they were either not dependent on heroin but were dependent on other drugs, usually amphetamines; or they had only given up for some weeks or months. At the conclusion of the screening questions, people ineligible for interview were asked about their views of a heroin trial. Eight (67 percent) were in favour of a trial going ahead, and four (33 percent) were against.

Of those in favour of the trial going ahead, five were women and three were men. Reasons given for being in favour of a heroin trial include that people who want to use will, regardless of the risks involved, and that a trial could reduce those risks. Risks were cited as contracting HIV; health problems due to impurities mixed with the drug; as well as death due to overdose. A trial was also seen as a way to reduce crime— particularly property crime. Current prohibition is seen as forcing dependent users into a deviant lifestyle. The main problem with using heroin was argued to be not the drug itself, but the cost, availability, and the illegality of the lifestyle. As well, some argued if methadone is available as a program, why not heroin.

Of those not in favour, two were women and two were men. Reasons against were the views that it would only increase the drug problem and people currently misuse the methadone program by selling their doses and being on higher doses than necessary, so would be just as likely to misuse a heroin trial. Concerns also arose over security, accessibility, and eligibility. Other concerns were that heroin would be given away, and that counselling be implemented to assess why some people need drugs at all. One of the women suggested that while there might be reduced crime, the trial was more for the community than the dependent user. She did not believe that the individual would benefit in any way.

'they're going to hand out the heroin at the methadone clinic, they want to see if it's going to work'.

Freya believed that

'if you are a heroin addict that you can go on this registry and go on heroin'.

Kylie had heard of programs overseas

'I've heard there's one in Britain, England and it's working. And I thought oh yeah because I've never heard anything like it before. And when they were going to try it in the ACT, they were going to have a couple of hundred people in the ACT and they were going to distribute the heroin to the drug addicts'.

Those undecided

Ellen had.

'heard about it a long long time ago. I read about it'.

She understood a trial to be

'free heroin'.

Arguments in favour of a trial

The arguments in favour of a trial can be divided into three groups: that there need to be new alternatives for users; that a trial would produce positive outcomes; and that a trial would work logistically. Unless otherwise stated, the comments are made by those in favour of a trial.

A trial would provide new alternatives

Amy supported a trial

'as a lot of drug addicts don't want to give up or believe they can't. ...[and] Rehab. only takes 50 people'.

Bob believed that

'There's no method that works for everybody. That's why I believe you must offer alternatives to people for their choice to see what they can do. Because the ones in effect aren't working. There has to be more. ... [and] because of the fact that heroin usage today provides the concept of a naughty person and I believe that society has become parasitic. The governments know what is going on. Politics and organised crime are the same bedfellow. Drugs are a controller. You've got jail, warders, police, social workers, that whole industry to keep drugs going in the world. It's employment'.

Bruce stated he could not understand

'why they just don't give it to them. If they're given it, most people will want to do something. Given the choice, if they feel OK, do something productive in one way or another. Or pursue something that they want to do ... Harm minimisation is the only way to go. These people are going to do it anyway. You can't buy motivation and give it to them. So why not regulate it. If people have got the will to come and ask I just don't understand why they just don't give it to them'.

Graham supported the proposal for a heroin trial, saying

'For some heroin users I think it would probably be a good thing. If they take the right attitude towards it sure. I don't think it's the fact that heroin is illegal does anyone any good. I think if someone really wants it they'll do anything to get it'.

Ellen, who was undecided about a trial, also thought it could serve a harm reduction function. She thought a trial might encourage her to start using again, but if she did

'if I do get myself in strife I know where to get free heroin'.

Malcolm thought that

'heroin is better than methadone ... If you're a junkie you're going to do it anyhow so you're going to rob, steal, whatever it takes to do it. And I think you can cut all that out. I don't think it's for everyone but it's been glorified so much that people are willing to take it and they're not in a position to deal with it and therefore that leads to crime ... Prohibition of anything has never stopped people from doing it ... you can make people understand that you choose to live that way and that's your lifestyle. You're not going out and harming other people by robbing them, beating up old ladies'.

Freya, who was against a trial, did consider that

'maybe it would be better than methadone'.

Nick, for whom methadone had provided 'stabilisation', which allowed him to re-examine his life, believed that a trial would assist others to stabilise while they worked on issues. He also believed that some people could function quite well on heroin if they did not have to deal with all the other stresses of a heroin using life. However, he did caution that only stabilised users of methadone or those who were long-term users of heroin should be offered the option of a place on a heroin trial.

Ross and Andrew, who were against a trial, also mentioned the stabilising effects of methadone, but this effect was not viewed as a positive aspect of a heroin trial going ahead.

A trial would produce positive outcomes

The most likely positive outcome was seen to be a reduction in crime and some also thought a trial would help prevent the spread of HIV/AIDS.

Erin thought that

'your crime rate will drop a lot ... It's worked in Holland² and it's working in England ... it will keep AIDS down. You're taking away their excuse to be a criminal, the aspect of trade through the dealers. Most of these people have never touched it. That was one of the major issues I wanted to get off because I was making somebody nice and rich and comfortable while my life was in the gutter.'

Freya, who was opposed to a trial, shared some of Erin's views

'The only benefit I can see is that it might put those people who are dealing for the money out. I hate those kinds of people but they'll pop up again on the black market.'

Graham believed that

'The more expensive it is, the more extremes they'll go to. I would think that a lot of crime is associated with heroin. If it was available free, or at cost, and people could use, it would cut down on a lot of crime. There's a lot of talk that if heroin was more widely available more people would use but in other cultures like Thailand where heroin has been available for how long and India, heroin and opiates have been used for hundreds of years and their problems are no worse than ours really.'

Ian reported

'You can maintain your levels of use and it does cut crime quite a lot.'

Dale, who was opposed to a trial, thought

'For the community it makes a fair bit of sense, you're not as likely to steal granny's purse if you can get free heroin.'

While Des was undecided on the proposal for a heroin trial, he believed that

'It might be good for cutting crime. It could cut down the illegal side of heroin.'

A trial would work logistically

Relatively few comments were made about logistics by those in favour of a trial; those against thought there were many logistic problems (see below).

Erin thought a trial would provide an educational and research opportunity

'you'll be able to look at why people use, how they function, it will give an aspect to this country of education.'

Malcolm had a similar view

'I think that would be a condition of it, look at the reasons why people are addicts. It's really easy to say I've got an addictive personality, or I come from a dysfunctional family, or I've got no self-confidence so therefore I'll go and have a hit.'

Graham did not think a trial would increase the numbers of users

'I think a significant proportion of the population wouldn't go near it.'

Ian's view was that

'they should hand it to you and let you go away and do it when you want.'

² In fact, heroin has never been legally available in Holland; Holland has a policy of "normalisation" for cannabis.

Arguments against a trial

These arguments can be grouped into three categories as well. The first is that a trial would work against dependent users being helped to be able to lead 'normal' lives. The second is that a trial would not have positive outcomes; and third, that a trial would not work logistically.

A trial would not allow dependent users to reintegrate into normal life

For Dale

'Just the thought of giving people heroin I disagree ... If I had've gone onto a heroin trial I don't think I would be in the position I'm in now. I'm not talking about working ... I'm talking about having friends, about having an interest in and the ability to be able to go to Uni and meet people, having a social network around me, not that much at all that involves people that use drugs, having children and being motivated and able to look after them in the way that I want to. I don't think I would've been able to do those things. Even my interest in music and being able to develop it, the things I own...'

He went on to say

'... I do not believe that people who are using heroin seriously would have any motivation of bettering themselves, bettering their life, changing the focus for things that they could achieve if they were still using heroin. It is just like wasting lives.'

Freya argued that

'I just feel that you're enabling addicts to keep them out there longer so they won't hit their rock bottom and it's easier than it might've been. I can't say that definitely. But you can't prop them up because they'll keep on using and using people around them until there's no-one else to use and then they'll fall flat on their face and either die, end up in jail, or go to recovery. It might change them on the outside, they might be able to get jobs ... but unless they start working on issues, on personal issues, it's not going to work. My attitude to my counsellor when I was on methadone is what the fuck do you know you've never been out there, you can't tell me anything, you read your book and you think you know it all. And this is the attitude of most addicts. When they brought in the methadone program in Canberra, people believed in it at the time but they won't support it anymore because it's a joke. Addicts can lie, and they'll honestly believe it at the time. ... It's hard to get realistic information from using addicts.'

For Kylie, arguments against a trial going ahead included considering

'the people who are in rehabs trying to get clean who can't do it by themselves, will they leave? or will they not? ... [for] the people that are clean now it's going to be a big decision whether they go back to it. One of the reasons people give up heroin is because they're sick of the running around trying to score it all. ... people should be trying to solve the problem ... And I don't think that's solving the problem.'

For Ross

'It's my philosophy that you can't overcome addiction by substituting another drug and then trying to control it. When I was on methadone it did stabilise my life but it didn't do anything else either, being on a control drug didn't help me get my life together. All it did was stop me having to do the junkie thing but it did nothing to teach me how to do anything else. It takes away the need to score because it supplies your drug for you but does nothing else for you. The scariest thing is that recovery's so fragile. I've had to work really hard to get three years up clean. And there's nothing that will do it for you, you've got to do it yourself.'

Roxanne was

'really opposed to it because I think the only people it's helping are the people that are getting their videos knocked off. Maybe they should just get bars on their windows instead and it'd be cheaper for the whole community. It's not helping the junkies, it's not helping the children or neighbours of the junkies, all it's helping are the people up the road. There's really only one answer and that's family therapy, let's fix our families, put that money into fixing families. I don't really think that drug workers really have a good understanding of what a junkie goes through.'

Andrew believed that

'it'd be a total disaster. They're offering to people the drug that the person is there for help for ... It'd only stabilise it to a point. They'd still be a junkie. They'd still be sick. It's offering them no way out. Once I got the methadone I didn't think about stopping, it didn't cross my mind ... [and] If people get offered it they're home and hosed, they don't want to stop ... I don't believe anyone knows what they're doing when they're controlling someone's drug habit. It'll be no different. People won't be worried about using because they can go to the clinic. It takes a long time. You think you're never going to get better.'

For Gary

'it's not going to help. It's not going to stop, the more heroin you've got the more you want'.

Ellen was undecided about the trial and expressed her views as follows when asked if a trial should go ahead

'Yes and no. The no part is that it's dangerous. If I knew of a place that I could get free heroin I'd probably start using again (and the yes part is if I do get myself in strife I know where to get free heroin)'.

A trial would not have positive outcomes

There was a view amongst a number of those opposed to a trial that it would not lead to a reduction in crime, particularly if people moved to the ACT from elsewhere in Australia. One person was concerned that a drop in price might encourage young people to start using.

Freya believes that

'I don't think [the trial] will do any good. Because there will be an influx of addicts from other states ... the crime rate's not going to stop or lessen'.

She also said

'Now you can go and do crime and reap the benefits, spend up big. Now I don't have to spend all this money on fucking dope I can spend it on shopping, having nice things around me. The major motivator in crime is to get money to get on. But there are other things, the heroin rush, the benefits of having money, I don't see a trial having much of a difference in that area of crime'.

Similarly, Gary said

'It's not going to stop thieving. You'd have every addict in Sydney coming to Canberra to live'.

Graham, who was supportive of the proposal for a heroin trial, shared these concerns

'people will come from other states to Canberra which may not be the thing for Canberra ... it's mainly the fact that it's only in Canberra which is a bit of a worry. ... If they only come here to get heroin whatever they get won't be enough for them and they'll still be carrying on, so they'll still be buying black market heroin'.

Ellen, who was undecided about a trial, said

'People from the black market will do something else, or prices will go down and then even teenagers will be using it. Because no-one wants to pay high prices if you can get it at your hospital clinic'.

A trial would not work logistically

There were a number of concerns about the logistics of a trial.

Dale said it

'would be nightmarish'.

If participants were provided with take-aways, users who were not on the trial could

'come around and take your heroin'.

If participants were to use it there (at a clinic for example), then they would need to travel

'at least 3 times a day'.

Regarding the security of a clinic

'armed robbers ... would want to come around. The security would be a nightmare. I know at the methadone hospital a couple of guys tried to armed rob that a couple of years ago, tried to steal the methadone from there'.

Kylie asked

'Will they be able to take their heroin away and sell it?'

Freya's concerns were that

'addicts will always try to get more than they need, how can you monitor all that ... doctors just have no idea, what it's like to use, how you become really greedy, you lose all your morals if you had any in the first place'.

Amy was supportive of the proposal for a heroin trial, but believed that there were some disadvantages. She was asked a series of questions about logistics, which were dropped in later interviews. In response to these questions she said

'[it] would take some of them hours to find a vein with a big queue of people saying hurry up. It would take me two to three hours to have a shot. It can take 10 or 20 minutes to find a vein for other addicts'.

She was also worried about security and the possibility of armed robberies. The safety of workers and heroin users on the premises at a time of robbery was also a concern. While she was in favour of take-aways

I would like to do it in the comfort of my own home and surroundings, not having someone to hassle you to hurry up',
she foresaw that

'someone would hit me over the head in the street'.

She also thought there could be a problem regulating doses

'You can never get enough, you always want more.'

Graham, who was also in favour of a trial, said it would need to be policed properly and raised a number of questions

'Would it be people putting their names down on a register and getting it daily? A lot of these programs are a good idea. Do they get enough to get the effect or do they get enough to stop them withdrawing? If they only get enough to stop withdrawing and they want to get stoned they'll go off to the black market and buy more'.

Ellen was undecided about the trial. Among the reasons against she said

'I can see so much trouble behind it. Like with methadone you get people who stand over other people for their methadone and people who intimidated other people for their methadone and it'd have the same thing'.

Ellen also held some concerns for security

'I'd hate to be the person who's dishing it out. I'd fear for my safety if I was them. It's a security risk. Like being robbed when the methadone first came out and people were taking the methadone. Even in jails they have a methadone clinic in there and people would break into it or stash it and stash it till they OD'd with it'.

Would respondents be tempted to start using again so that they would qualify for a place on a trial?

Fourteen respondents were asked whether they might be tempted to start using again in order to qualify for a place on a trial. Five (36 percent) thought they might be and nine (64 percent) that they would not. Of those who thought they might be tempted, two were in favour of a trial, one was against and two were undecided about a trial. Of those who thought they would not be tempted, four were in favour of a trial and five were against. Of those who thought they might be tempted, two had given up with no or minimal treatment, two with detoxification and one in a therapeutic community. Of those who thought they would not be tempted, three had given up with no or minimal treatment, one through detoxification, two through methadone programs and three through therapeutic communities.

Those who thought they might be tempted

Malcolm said it was

'A hard question. It's not going to happen in Sydney, it's going to happen here. I don't see Canberra as having a really bad heroin problem. I don't really know. But sure it's a temptation. I'd like to think I'll never get a habit again, as for using again I can never say'.

Malcolm had a long-term health condition that caused him a lot of pain and also made it difficult for him to get about.

For Amy

'Three years ago I would've made sure my name was on the top of the list. [It] would be tempting now though'.

Kylie believed that if trial were to go ahead she might be tempted to start using again

'Yeah, I've thought about it because I love heroin, I really do. The crime became my first habit, and drugs became my second.'

Both Des and Ellen might be tempted. As Ellen explains

'I could. It might come into consideration, I'm not quite sure'.

Those who would not be tempted

Erin did not believe that she would be tempted by a trial going ahead, as heroin was already available if she wanted it

'it's only a phone call away'.

However, previously she would have wanted to go on a heroin program if one had been available

'There'd be a lot of education with it. I can't see any difference between how you use a drug. There's no difference between heroin and methadone. It stabilises your life if you do want to get off or you can't function anymore'.

For Ian, heroin was also readily available

'I've actually got a hit sitting in one of my backpacks'.

He added, however, that

'I don't want to die that way'.

Andrew did not believe that he would be tempted, as the methadone program was already available

'Personally no. I'd never go back, I've gone too far now. I'd never go back. That's OK to sit here and say that. But if that's available, I could get back on the methadone easy. When you go to jail they ask you if you'd like to go on the methadone program. But just because the trial is going wouldn't make me go using again'.

Bob would not be tempted to start using again

'No way. I thought it was quite ironical that when I came up here I got myself clean and next minute they're proposing heroin. But no, I've come too far. I've got another lifestyle going for me. I'm not saying that in the future something might come against me that will absolutely cripple me and I might look at it as an option again but nobody knows. I can't predict that far. But today no way, no thanks'.

Graham believed he would not be tempted to start using again

'No. I don't really like what it does to me. If I started using then I'd want to use more and I'd have a habit and that could be the end of my life'.

While Gary would not be tempted, it still

'frightens me to think of that'.

Ross acknowledged that

'That thought's crossed my mind.'

However, he believed he would not be tempted to start using again

'no I wouldn't. I would like to think that I'd stay stopped'.

And for Freya and Roxanne, the idea is out of the question. As Roxanne said

'No. It's like wild horses. It's like saying cut your right foot off. I wouldn't go back to that non-existence'.

Effect on decision to stop

Respondents were asked

'If heroin had been available in this way when you were using, would you have stopped using heroin?'

and

'If yes, would you have stopped using in the way that you did?'

Twelve people responded to this question. Seven respondents believed that if heroin had been available in a trial when they were using they would not have stopped using heroin. Four respondents were unsure of whether they would have given up in the way that they did. Only one respondent definitely believed that he would have given up in the way that he did and he would not have participated in a trial.

Of those who thought they would not have stopped using, five were against a trial, one was in favour and one was undecided. Two had stopped with no or minimal treatment, three with detoxification, one with methadone and one in a therapeutic community. Of those who were unsure, three were in favour of a trial and one was undecided. Two had stopped with no or minimal treatment, one with methadone and one in a therapeutic community.

The person who felt that a heroin trial would have made no difference was against a trial and stopped in a therapeutic community.

Those who would not have stopped

Malcolm believed that he would not have stopped using heroin and that instead of going through a detoxification program

'I would've gone on a [heroin] program'.

He also recognised that he had had periods

'all my life where I've stopped even for some lengths of time but I've always gone back to it. I might stop for 10 years and then go back to it when I'm 42. You can't say. It's like being an alcoholic, once you're an alcoholic you're always an alcoholic, once you're an addict you're always an addict whether you're actually doing it physically or not, mentally you're still always an addict. And that thought is always in your mind you've always got that experience of what it's like to do it, the rush, the needle sticking in your arm, the release that comes after it.'

Kylie also would have participated in a trial

'It would've been respectable in society. It would've been my dream.'

Roxanne did not believe she would have given up in the way that she did as

'I would've seen someone giving me heroin as a good alternative. Stopping is hard, it's not the physical side, that's very minor. We're led to believe, from the movies you see, the physical side is very hard. It's not. No worse than having a bad case of the flu. It's the social side. It's much easier to keep using than it is to give up.'

Freya believed that

'I probably would've tried it. If you offer a using addict free heroin I would've gone for it. Of course I would've gone for it. I would be lying if I said no.'

Andrew, Ellen and Gary would have continued to use heroin. As Gary explained

'I wouldn't have stopped using if it had been going...if they had a trial I would've had a go at that before I had a go at a rehab.'

However, Gary felt that he would still have stopped in the way that he did

'It wouldn't have stopped me doing what I did. The circumstances were right. It just fell into place. A lot of hard work and frustration, 12 months of it but I'm clean today for it all.'

Those who were unsure

Erin was unsure whether she would have stopped using heroin. Bob also was unsure whether he would have given up using heroin, and doubted that he would have given up in the way that he did

'Not initially, I think it would've been lovely. I don't have to do rorts. What I think it would've done would've given me the space and the time to actually look to where my life is up to at the time and do I want to continue this on or don't I. It would've given me the freedom to make choices and I would've been able make that choice. Maybe I wouldn't have. I don't know. But I still would've seen it as the far better option than the ones that were open to me.'

For Graham, the conditions of a trial would have been a factor

'I suppose it would depend on how available it was. I probably wouldn't have for a while, for a couple of months at least until I was getting over the effects. I was pretty tempted as I said. If I had to go and put my name down at the doctors and be registered then I wouldn't have. But if I could've just gone down the street and bought it then I probably would've. I found that I was more tempted six months after than I was a month after. I think I convinced myself that I didn't really want to stop. And then I saw the effects it had on me. It changed my personality. I became a different person while I was using heroin and I didn't particularly like the person I was and that was pressure in my mind and after more time passes I tend to forget the bad points. I tend to remember the good points about it and the feeling that it had and I liked that feeling. And that's always in the back of my mind.'

While Des had not heard of a heroin trial before, he concluded that

'It's really hard to say [and that] I might've calmed down a lot.'

Those who would still have stopped in the same way

Ross believed that he would have given up in the way that he did and not participated in a trial as *'methadone was available, I could've gone back on that'*.

Alternatives to a trial

Respondents were asked if they could suggest a better alternative to a trial (better in terms of improving the well-being of heroin users). There were ten responses.

Those in favour of a trial

Graham's alternative was

'Sometimes I think it should be legalised.'

Bob also said

'Legalisation would be lovely and I think it should be looked at realistically.'

He also related that

'I don't think you can get out of it any other way than by a trial basis. I think it has to be done correctly, with a lot of thought. And the only way is by trial and error. There's no magic wand. There's no method that works for everybody. That's why I believe you must offer alternatives to people for their choice to see what they can do.'

Malcolm did not offer an alternative, but made specific suggestions for a trial

'You have to have a trial. It depends on the aim of the program. If you do the program for 12 months but say 'we're not going to support you on heroin for the rest of your life'. It makes it too easy for people. It's like saying you've got this group of people in society, you may as well make it available in chemist shops, merchandise it the way they merchandise alcohol. So if you trial it on the basis of methadone say 'you've got 12 months to get your act together, we'll help you but we're not going to support you being a heroin addict', and involve heavy duty therapy along with it.'

Those against a trial

Dale believed that there should be

'more rehab places, more funding for rehabs, more different options within rehabilitation, options for short term programs to go out and for half way houses, more non-medical treatment, more places in detox that are more like Jarrah House in Sydney which is a six week program in detox where they have education in there as well, and offer options in continuing treatment or halfway house options. More drug free stuff, more educational stuff, more stuff that involves reading somewhere.'

Freya believed

'Proper information and education from a child five years old onwards is an alternative. I think we need more of detox because people don't want to go into a therapeutic community ... but they don't want to go back into their old environment of their old using friends and contacts, so more halfway houses where they can be safe. We need more NA based services introduced around because sooner or later once they've been introduced they might still go back out and use for a couple of years, maybe only once or twice more, but sooner or later they all come back. I think methadone should be restricted to pregnant people and cancer patients or terminally ill addicts to enable addicts to go on a bit longer.'

Ross stated he was

'biased to recovery the way I did it, naturally because it got me well. Five years of misery in attempts and then go and do it in a long term rehabilitation centre.'

He also believed that

'It's got to be education.'

Andrew's response when asked about an alternative was that

'people have got to be pushed just to knock it on the head. To detox it. While they're getting it, either that or methadone, they won't stop. They're never going to stop. Unless something really horrible happens in their life like it did with me. All the people I knew back then are still using.'

For Gary, an alternative was to

'Build another rehab around here and put them through the 12 step program'.

Roxanne's response for an alternative was

'methadone for all it's really bad faults actually bides people time, it takes away the needle'.

Those who were undecided

Ellen thought that an alternative could be

'Maybe make the methadone program a lot easier to get on to. It's a very hard program to get onto'.

PATHWAYS OUT OF HEROIN DEPENDENCE: THE DECISION TO STOP

All but two of the respondents, Ian and Roxanne from the No or minimal treatment group, had tried stopping before. For most this lasted a few days, weeks or months and for a number, periods of abstinence corresponded with time in jail. Four had had extended previous periods of abstinence. Graham and Malcolm stopped early in their using careers: Graham for a year and Malcolm for three years. Erin stopped for a year in a therapeutic community and for ten months immediately following. Nick was abstinent for more than a year while in a therapeutic community and for five years while working in a remote area. While the decision to stop reported here was likely to have been final for most participants, the results from their previous experiences suggest the possibility that some might start using again.

From the interviews, we identified various factors that precipitated the 'final' decision to stop. Some people gave quite brief and straight-forward accounts of how they came to the decision to give up. For others, the story was much more complex. We have reflected this in the account below. We discuss the stories in relation to previous research findings at the end of this section.

No or minimal treatment group

Although both Des and Ian linked stopping with a particular experience, it took both of them some time after the event to actually give up using.

For Des, the key event was when his girlfriend fatally overdosed. He describes it as follows

I was on smack, and I was really pinned and I met my girlfriend at the pub and she was trying to give up and I was just really rude and I couldn't cope with where I was, there were too many people and I just left and then two days later I found out that she'd OD'd that night. And it ripped me apart. And I just had a look and thought life was just too hard and then I tried to kill myself because I couldn't cope with living without her.

He stopped using for two days, but then started again. Four months later he went to a doctor, who prescribed doloxene and valium, which became substitutes for heroin. However, he was worried about taking the pills and eventually sought the help of a psychiatrist. His parents, who did not know about his drug use, but were worried about his depressed state, also helped push him to see a psychiatrist.

An overdose was also a turning point for Ian

I blacked out and remember waking up with all these books falling on my head because I'd been banging my head on the ground.'

For some respondents the decision to stop was not so dramatic. Falling in love was a way out for Kylie

I got out of jail and I met someone. And I hadn't met anyone like this person before and he really cared for me and he fell in love with me and I fell in love with him and he was a social user. Very different to what I was, I was the type of person who would have one and couldn't stop. He could have one and he could stop. So after being with him for a while he gave me the incentive to give up because he could do it and I couldn't. I wanted to be clean. I had so much happening in my life I really wanted to be clean. We got clean together and we stayed in a motel for about two weeks before we came up to the ACT. My mum had the kids so we could dry out. We used marijuana, serpax, rohypnol to stop the pain but I guess nothing stops the pain. You have to keep going through withdrawals and the cold sweats. After the fourth day I suppose it got easier, hot baths, but it was 7 days before I could get up and walk around on my own.'

Graham was someone who started using in Asia. The combination of running out of money, wanting to come back to Australia and not wanting to get caught trafficking in any of the Asian countries, which have harsh penalties, or in Australia was the incentive for him

Basically I ran out of money, I had no money left. I lived for the last month and a half, 2 months on pretty well nothing. I just wanted to get back to Australia and I had no money and there was no choice involved. ... my motivation to stop was to come back to Australia. I didn't want to go to jail. I certainly didn't want to carry heroin into Australia.'

He spent the last week before beginning his return journey cutting down his drug use and recovered from the worst of the physical symptoms in the few weeks over which the return trip took place.

Roxanne also spent a significant portion of her using life overseas. Returning to Australia was also key in her decision to stop. When she arrived back in Australia her peers were supporting their heroin use by prostitution and criminal activities and she did not want to get drawn into that life. Roxanne made a decision to stop using and went on a methadone program for two weeks. She found that it was quite a different drug from heroin and that while it helped with withdrawal symptoms, she could not function with it either. Because she continued to use amphetamines, she was 'kicked off' the methadone program. When she was about six months pregnant she stopped using amphetamines and became abstinent.

Detoxification program group

Freya stopped using heroin because she found

'my life had become unbearable. It was either stop using or try suicide. ... I had come to such a rock bottom.'

She went on to say

'I've actually got a life now, before it was an existence. In the beginning it was great, I had a great time, we went out, I didn't have to do things that I was ashamed of, getting out of it was fun, but it didn't take long for that to change. And in the end it was just an existence.'

Part of the reason for finding life unbearable was the degradation that was part of prostitution. Although she was on a methadone program, she continued to use and be involved in prostitution and crime.

As she describes it, she did not go into a detoxification program to stop using

'I went in because financially my life was becoming miserable. I never thought it was my fault or related to my drug use. I was sick, I didn't have any money to get on with and I didn't know what else to do, so I went into detox.'

Another reason Freya gives for going into a detoxification program was because she was pregnant at the time. She did not want another baby and tried to terminate the pregnancy by going into a detoxification program. However

'somehow it got out that I was pregnant and the detox I was going to go to wouldn't accept me. I had to pay more money because I was so far gone and I didn't really have it so it was just the end, just horrible, that last termination, it nearly killed me.'

In a space of three weeks she terminated her pregnancy, organised to stay with her family when she came to Canberra, and went into another detoxification program.

The turning point? She says

'I don't know what happened. I always thought I was one of those people who could not use. I guess when I was in detox I just saw that there was a possibility, I saw a little bit of hope for me, a bit of light at the end of the tunnel, and I then thought I could do it one day at a time. When I was in detox I found that out.'

Her daughter also supplied some motivation

'I didn't give up for her but she was a motivator. If you want to stop, your children will motivate you but it's got to be your choice.'

Ellen had been in jail for 12 months and had only been out for three months before being arrested on assault and robbery charges. She was given an alternative to returning to jail and this led to her decision to stop. She went into a detoxification centre for 12 weeks and then relocated to Canberra. Ellen was in a detoxification program for this long because she was not only withdrawing from heroin, but tryptanol, cocaine, amphetamines, alcohol, and *'literally whatever I could get my hands on'*. Her counsellor and probation and parole officer encouraged her not to start using again. She is currently under supervision with probation and parole. She sees a counsellor once a week and gives a urine specimen twice a week to show that she is not using.

Malcolm describes his experience as follows:

'I was going 3 or 4 days without using. I didn't have any money. I didn't want to steal from anyone. I knew that if I started stealing what was going to happen. I just got to the point where I didn't want to do it anymore. It had become too much of a hassle. It just controls your life so much.'

He went on to say that he thought

'My god, I'm 36, you just can't keep going on like this, you can't keep running away from life. No matter how many problems you have, you've got to face your responsibilities at some point. I never thought I'd get to be this old to begin with. And here I am and it feels really shit to know you have nothing, you can't offer anyone anything. I don't intend getting involved with anyone ever again because I have absolutely nothing to offer. ... Materially I have nothing. Most people my age are quite successful by now or in a family situation. It's very frustrating to realise this is where I've ended up. You reach a crisis point and say I can't face it anymore.'

Methadone program group

Erin reported

'I was sick of the lifestyle, dependency on a substance that wasn't legal, the social aspects of it like people would avoid you if they found out. The well-being of my children. To be honest, I was sick of it, completely, heartily sick of it. I was ready for a change.'

She went to see a specialist, who organised for her to receive methadone from a pharmacist near where she lived. She stopped using methadone when she moved from this program to one which was hospital based when she changed cities. She was very unhappy with this program (see section on Treatment) and decided to stop methadone

'I didn't feel comfortable with the situation. So I went home and I was sick for three weeks ... withdrawing from methadone and I haven't touched anything since.'

Nick associated his decision to stop using with having no work, nowhere to live (he had been living in a park), having the police catch up with him for criminal activities and knowing *'I could do better than that'*. He had felt for some months that he would either go to jail or die from an overdose. He also considered he was getting too old to be using heroin anymore. Having tried other treatments before, this last time he tried a methadone program, which as he said *'seemed to work for me'*. He believes the most significant change was his own decision not to use. He was tired of the life, had had enough, wanted to finally stop and to stay stopped.

Stopping for Bruce was triggered by falling in love

'I met my wife and fell in love, and for the first time had a genuine desire to get off'.

In addition, he wanted to change. He wanted to keep the *'pretty reasonable job'* that he had and realise the scope for advancement it offered. He also did not want to be at risk of going back to jail

'Methadone helped me. ... It's a stop gap measure, it's time out, gives you time to think, that's all. It stabilises you.'

He added

'Basically it was a matter of deciding ... within yourself. It took me a long time. If you want to you can!'

Getting off methadone was motivated by the same reasons. In addition, he was tired of going to the clinic every day and of having to mix with other users, which meant that there was always access to other drugs. He reduced his methadone dose over a period of about 12 months. When his dose was down to 20 mg he decided that the temptation of being around other users every day was too great. He did not want his child to see him withdrawing, so went away with two friends, who helped him through the final stage of getting off. He found the withdrawal much harder than withdrawing from heroin had ever been and likened the physical symptoms to 'torture'.

For Andrew, the situation was quite different. Being on methadone was successful in getting him to stop using heroin, but it led to a whole range of problems in itself. For Andrew, the salient event in finally stopping was coming off methadone; not heroin. He had gone onto methadone because

'I was that sick and I was too afraid to go through a withdrawal. I'd made myself so violently ill.'

He was on methadone for five years; for the last three he lived in a place where

'the doctor who was controlling the methadone, he used to admit to me he didn't know anything about it, and I was really sick. I was about 7 stone. I was nearly dead and he wanted me to stay on it for life. He was prepared just to leave me on it. Plus I was on valium, serepax...'

He found that

'The drugs worked opposite on me. I used to go to the doctor and say it's not calming me down. Every time you put the dose up it's making me like speeding. He'd say a few more pills here and we'll put it up a bit more. But it didn't work.'

Eventually, after three years he 'flipped out'

'...I knew there was something terribly wrong with me. I couldn't talk to me wife or anyone or go to anyone and say help. Something's really wrong in my mind. I knew. ... I smashed all the house up in the end, all the windows, attacked the police.'

The story received media coverage and, as a result, his wife's family found out about his using history

'They wiped me. I lost everything. ... She took the whole lot.'

The police took Andrew to a psychiatric institution where

'they found out I wasn't actually mad I was just withdrawing from methadone, the pills and all that. That was it, I made my mind up then finally. I tried over the years to get off it, and I thought that's that, you're either going to die or you're going to get better.'

He later added

'When they threw me in the nuthouse that give me a big shake up. I was locked in a cell in a straight jacket. I'll never forget it. If I could've killed myself that day I would've.'

When he was released he went to live with his mother. He

'stayed there for four months and never left the house. My sisters and brothers would come up and help me and eventually I started to put on weight and got better.'

Therapeutic Community group

For Ross, the process of deciding to stop was a gradual and cumulative one. As he describes it

'So I got sick and tired of that really and I was going nowhere in my life and after 15 to 20 years of that I just realised that I'd come to the end of the line as far as being a junkie or being an alkie goes and so I decided to try and give it away. But the process of giving it away took quite a few years. I first came into the recovery scene because of other people. Family and friends and courts and counsellors, bosses and all those people directed me towards recovery before I in fact wanted to get into recovery. So there was a few years, 3 or 4 or maybe 5 years where I played around with giving up drugs or giving up booze but I never had the desire, the sincere desire to do it. But that came gradually as a process. I'd go into a detox or a rehabilitation centre or I'd get myself in some situation where it would be possible to get away from the scene, get away from drugs and get away from booze and start living the way I thought I should because I never really knew how I should be living but after a while of that I'd revert to my previous behaviour. I'd go into a rehabilitation centre and I'd go really well for 6 weeks or 8 weeks or 14 weeks and I'd have 14 weeks of clean time up and then I'd go out on leave or a bit of time out and I'd sneak a drink or have a shot and I'd go back and sometimes keep it a secret, sometimes not. So I was playing around with recovery. I wanted my cake and I wanted to eat it too. I wanted to be well but I didn't want to stop using.'

He describes the process of finally giving up as follows

'There was a significant decline in the last 2 months, the arse really fell out of everything. If you look at recovery as 3 fold: physical/financial, mental/emotional, and spiritual, all previous times I'd hit rock bottom and gone right down, it's always been the financial/physical that suffered. Mentally and emotionally I've just been immature; and spiritually I've been non-existent. But after attempts at rehabilitation I became aware of this spiritual thing. In that last rock bottom, in those last 2, 3 months I was OK physically, financially, but mentally and emotionally and spiritually I was just bankrupt and that really took me lower than I've ever been before. So it wasn't that I had nowhere else to go which was a new thing for me. This time I didn't have to go, it was because I wanted to go, I wanted the out, and I think that was because it was a new low. It was an emotional, spiritual low. I knew I was beat. I knew I was never going to drink or drug successfully. It was a sad day. It was a personal realisation. I made a decision that I'd never made before. Give it a try, give it my best shot.'

He added

'When you get to the point where there's no money, no friends, nowhere to live, no clothes, no nothing, I'd reached that point, no job, no prospects, no hope. I got fed up. I'd reached that point many times in my life, 20, 30, 50 times I'd reached that point. But this time I decided to try and stop. And I knew from experience that the best way for me to stop was enter a rehabilitation program and try and do what they say.'

Gary also had a spiritual experience, which he described as an awakening and the turning point in his recovery. Gary was sent to treatment on a court order. During that time

'They found my father dead... He was an alcoholic. I went up to the chapel that night and he was there. I felt him there and saying "hang in there, give this a go and do it". You could say I had a spiritual awakening.'

For Gary, it was the first time he had been 'clean' since he was twelve years old. Although not intending to stop using heroin or other drugs initially, he believed his spiritual experience gave him the strength and determination to stop and to stay stopped.

Sometimes children had a role to play in the decision to finally stop. Janine, for example, regained custody of her daughter and found that she could not give her the kind of lifestyle she wanted to while she was still using

'Can you imagine wheeling a three year old up in a pram trying to get on for hours and hours on end at two o'clock in the morning. It was terrible, I couldn't do it. And yet I wanted her. She was a beautiful child and I felt so lucky to have her. I just knew if I didn't do something I was going to lose her. It wasn't fair for her. There were a few things that happened. A few people had OD'd in my house, she'd seen that. I was very protective of her, no-one could hit up in front of her. I had these rules, she wasn't allowed to see fits, I didn't want anyone talking about drugs or crime in front of her because she was starting to talk, and of course it didn't work that way. She was watching people hitting up, spilling blood on the carpet, she was watching people with knives and guns, and one of them was me, and it just wasn't a good look. It was a decision to let her go or whether I got clean. If it wasn't for her I wouldn't have bothered.'

Janine also said she had had enough of the lifestyle

'I think I was coming to a stage in using where you just get tired, I was getting tired.'

In addition, on an appearance in court the magistrate threatened her with a jail sentence if she appeared before him again, even on a trivial charge. Although she had been arrested before, she had never actually been faced with a sentence and the prospect of this worried her. A counsellor gave her the final push

'She put me in a taxi and she sent me up to detox and I lasted a couple of days there. And I remember her giving me the bus ticket to [a therapeutic community interstate], and for about a week she was saying to me you've got to go, you've got to do something otherwise you'll be lucky to see Christmas, you'll OD. She was quite concerned. ...And I thought if she's worried, she can see something I can't. So I probably wouldn't have gone if it hadn't been for her.'

For Amy, who had used heroin for 25 years, court charges and ill health finally caught up with her

'I was in a lot of legal bother, with drug charges and trafficking charges, for myself and my husband. I was put in jail and refused bail. I could only get bail if we went to a rehab or TC. So we went to a TC to get out on bail, I didn't really want to stop.'

She also said

'We were slowly killing ourselves and we had just had it. The drug scene wasn't like the 60s of love and flowers, it was a violent, heavy scene based around big money— too dangerous to live in.'

Although she did not plan to stop using when she entered the therapeutic community, her enforced stay led her to change her mind.

Bob had already spent 14 years in jail and the prospect of another jail sentence was part of the motivation for change. He was also concerned about the model he was presenting to his son and the effects of using on both his and his wife's health

'I think the effects of looking at another jail sentence after doing 14 years, I didn't like the prospect of that. I was dying physically, I was grey, my zest for life was going. I have a son that's 23 now that did an armed robbery that's living with me. I thought as a father what am I showing this boy when I'm carrying guns, money across the table, there's drugs going on. My wife was dying. The courts, I'd run through every possible option.'

He added

'I think for myself it was just that I'd had enough. I'd had enough of being hounded, I'd had enough of police kicking doors down, I'd had enough of the lifestyle.'

Dale also had used heroin for a long period of time and been in trouble with the police for the last six years of using. For him the decision to stop was related to a series of events

'The last time I had no intentions of stopping. I suppose everyone who uses comes to the point where they feel pretty down and out and they think I wish I could stop, and I was the same like that but usually that only lasted until I could get the money or the dope, so I always considered that I had a problem with money not drugs. ... I stopped physically because I was in the remand centre at [jail] and no way of doing things. I was in there for 3 weeks, so my mother and barrister got me out on condition that I went into rehabilitation. ... I said fine ... I had an interest in getting out of jail and being able to use again. ... I just went out and kept using so I breached the bail ... I think that lasted about 10 days and I got picked up again, taken before the same magistrate and put back in [jail] and that lasted 45 days and I got the same sort of bail again. It was the third time I'd been before the same magistrate. ... I was looking at 5 years and my best bet was to go to rehab to avoid jail. I jumped on a train and went to [a therapeutic community in another city]. ... I was there for 8 months. I got kicked out ... At that time I still had my bail extended. I'd been found guilty but not sentenced. I went back to [city] and used again. I felt like I'd done my share, I'd tried and in typical addict resentment, the world let me down and I'll just use and use and I did over a period of two months and I had a court case coming up. My parole officer said I'll revoke your bail now unless you go into another rehab.'

Dale moved interstate to do this.

At this therapeutic community a number of things happened

'I think at the point that I did not go to jail and the inevitable did not happen, that I slowly started to change my perception of how I thought about using drugs. I came into contact with all sorts of people who worked there, who had graduated and stayed straight some of whom I'd known when they were using and thought they were pretty hopeless cases. But that didn't sway me as much as what happened to me personally. The next month my brother died of a heroin overdose and I'd always considered him to be pretty much indestructible. He'd always take more than me and more than most other people and obviously that's what he did. And that brought home to me that you'd die. I'd known of other people but they weren't friends. When [brother] died that really influenced me and I considered my future ..., I didn't quite believe that I could maintain staying straight. But I allowed [the therapeutic community] and NA to have more power over me, and I was less resistant to it.'

Summary and discussion

The diversity of experiences reported in this study reflects the results of earlier studies. For most participants, a range of factors was involved in finally stopping. Many were consistent with factors identified in US studies and included “hitting rock bottom”; change because the situation or environment changed; maturing out; fear of the law; and the influence of family and friends.

Biernacki (1986) defines hitting rock bottom as ‘a highly dramatic, emotionally loaded life situation’ (p.43), which then results in a decision to stop. Two of our participants, Freya and Ross, used those words to describe their experience. Four others mentioned a crisis which for Biernacki would be part of a rational and explicit decision to change, rather than hitting rock bottom. For Des it was the death by overdose of a girlfriend; for Dale the death by overdose of his brother³. for Ian his own experience of overdose and Malcolm identified a situation in which he had no money as a triggering crisis. In addition, for Andrew ‘flipping out’ and becoming violent was a crisis that precipitated stopping methadone use.

Five participants could identify a change in situation or environment as important. For Kylie and Bruce falling in love was a key component of their decisions to change. For Janine it was regaining custody of her daughter and for Graham and Roxanne it was moving back to Australia.

A number of respondents said they were sick of the life or something very similar. They included Erin, Nick, Bruce, Ross, Janine, Amy and Bob. Malcolm’s realisation of being 36 and having nothing to show for his life is the clearest example of ‘maturing out’. This could also be inferred from some of the other stories.

As well as identifying maturing out and change in situation or environment as important factors, Waldorf (1983) also identified drift; conversion to religious, social or communal causes; retirement, that is giving up the drug but maintaining the lifestyle; and becoming alcoholic or mentally ill. None of those were found in this study. However, two respondents, Ross and Gary, did mention the importance of spiritual experiences.

Maddux and Desmond (1981) and Simpson and co-workers (1986) cited fear of the law and the influence of family and friends as important. Certainly Ellen, Gary, Amy, Bob and Dale went into treatment as an alternative to jail; and Malcolm, Janine, Graham and Roxanne reported that they wanted to avoid getting caught up with the police and/or going to jail.

Family and friends were also important. For Kylie and Bruce it was a new partner, and for Janine her daughter. Bob was worried about his wife’s health and the role model he was providing for his son. Des’ parents played an important role, even though they did not know that he was using. Professional helpers were also important for Ellen and Janine.

Concern for children among dependent women can be an important pathway to non-dependence (Rosenbaum, 1981). As indicated above, this was also mentioned in our study. While our study was not as extensive, overall the findings support the work of Rosenbaum, who suggests that concerns arise during pregnancy of giving birth to a dependent child (in our study this led to women terminating the pregnancy rather than stopping use; see Appendix D). Women express concern about the level of care they can provide their children during infancy, and many feel that they cannot be ‘good mothers’ while they use opioids. Women also consider their heroin using behaviour as a negative example for their growing children. The last two were certainly true for Janine. Concern for their children was also a factor in staying stopped, even if not a factor for change, for some of the other women.

The following section discusses the role of treatment programs and particularly, helpful and unhelpful aspects.

³It should be mentioned here that for other participants the death of someone close was reported as a stimulus to keep using, not to stop

PATHWAYS OUT OF DEPENDENCE: THE ROLE OF TREATMENT AND OTHER SERVICES

This section focuses on aspects of treatment that were helpful or unhelpful in stopping heroin dependence. We draw on the participants' experiences through the whole of their using careers— not just the final step in stopping dependence. It needs to be noted that we did not probe deeply in this discussion; hence the results need to be seen as pointers to important issues, rather than a definitive exploration. There are also two other caveats. In recent years, some treatment services have changed quite dramatically and this needs to be borne in mind when considering the results, particularly in that some aspects of services that were reported to be unhelpful have since been improved. Further, the treatment services reported on were not just located in the ACT; participants had often used agencies elsewhere, particularly in NSW and Victoria.

There is discussion of methadone programs and therapeutic communities and we also report on Narcotics Anonymous (NA) and Alcoholics Anonymous (AA), counselling and doctors, use of which cuts across the four groups.

In addition, we asked participants about their perceptions of the need for expansion of services and for establishment of new treatments and these results are also reported here. We also report briefly on barriers to accessing treatment.

Methadone programs

Helpful factors

Some found methadone useful as a transitional drug from heroin dependence to abstinence. The most beneficial effect of being on a methadone program was reported to be 'time out' of the heroin using lifestyle.

For Erin, being on the methadone program meant that she had time to educate herself and to reassess her life. She could make and keep appointments with doctors and counsellors. She found that she could start working, socialise with people who did not use heroin, and begin developing a new lifestyle. The program she was on gave her some flexibility in dosage, which she found to be a great asset

'If I didn't feel good or wasn't coping he'd put the level back up and I'd start again. There's no strict guidelines, whatever I felt comfortable with, fine.'

Nick was on a methadone program for three years. He found this extremely useful as it 'stabilised' him so that he could deal with emotional issues, other personal issues, and court issues. As he says, it allowed him to

'deal with the rubbish before I had to deal with the drug.'

For Bruce, the beneficial effects were similar

'methadone helped me. It's a stop gap measure. It's time out, gives you time to think, that's all. It stabilises you.'

Erin spoke highly of the advantages of obtaining methadone from a local pharmacy. These included confidentiality and accessibility, the latter being especially important as she did not own a car. As Erin remarked

'We weren't treated like a leper or misfits in society. You were treated like a human being and that is the most important. Because you usually find coming off drug use you don't feel that good about yourself.'

For Erin, going to a pharmacist also meant that she did not have to associate with other people who were dependent on heroin. She could choose hours to suit herself and the pharmacist provided friendly service on a one-to-one basis.

Unhelpful factors

For Erin, moving to a methadone program based at a hospital created difficulties in maintaining her decision not to use heroin. She found that lining up at the hospital with everybody else provided temptation that sometimes would become too much

'You only need that one day where your self-confidence is down, you're feeling vulnerable ... and you're going to break it.'

Her resolve not to use heroin was further eroded by the way she considered she was treated at the clinic

'The way I was treated was like a rascal. I didn't feel comfortable with the situation.'

The rules and regulations of the hospital clinic made Erin feel 'like a criminal'. These included people not being allowed to talk to each other; restricted opening hours; and lack of personal contact. These factors contributed to Erin deciding to withdraw on her own from methadone treatment. Bruce, who attended the same clinic, reported similar disadvantages.

Erin, Nick and Bruce, who were all in the Methadone program group, reported that the withdrawal process from methadone was more difficult than withdrawal from heroin. As related in the section on the decision to stop, Bruce went away for a month to get over the worst of the withdrawal symptoms. For Andrew the process was dramatic and traumatic and it took him four months to get over the effects of methadone and other medication. Erin reported that she was sick at home in bed for three weeks. For Nick, the initial withdrawal period was also three to four weeks. He reported that the long-term effects took 18 months to two years to wear off. Similar difficulties were also reported by people not in the 'Methadone program group' who had tried methadone treatment before their final decision to stop.

Although methadone helped Andrew stop using heroin, in the end he felt that being on methadone had done nothing good for him

'It was a total waste of 5 years. I couldn't see that I'd be right in a few weeks.'

Freya, who was also on methadone for a number of years, was similarly scathing about the program

'It made me feel like I was getting my life together when I wasn't and you think you're thinking straight but you're not really.'

She found that her lifestyle was unaffected by being on the methadone program

'I was still working as a prostitute when I was on methadone. I still did crime while I was on methadone. Nothing really changed.'

When her dose was reduced she would use heroin

'There would have to be one shot in there to get me through.'

In order not to be caught out, she would sometimes substitute her daughter's urine sample for hers.

Freya finally went into a detoxification program to get off

'I felt if I didn't get off then I would be on methadone for the rest of my life. And that was one thing I couldn't put up with. ... Because I'd had enough of six years of fronting up to the methadone clinic, not being able to go anywhere, going away for the weekend or anything like that, having to put up with how I got treated, being treated like a second-class citizen and thinking that I wasn't warranted it. Having to all year round. I'd had enough.'

Freya also complained of side effects of rotten teeth, putting on weight, constipation, and crooked bones. Health problems incurred from being on methadone for a long time, or from high doses, were common complaints among respondents. Some, like Dale, also reported that increasing tolerance levels were a disadvantage.

A number also commented that methadone was not helpful in dealing with their desire to inject or 'needle fixation'. Malcolm reported

'It might work for other people, but everyone I know on methadone still uses. It's needle fixation, the sheer perverse pleasure of sticking a needle in your arm. The ritual of mixing it in a spoon, everything about it. It's quite an attraction.'

Neither Ross nor Dale viewed methadone as a treatment. Both continued to use other drugs, with methadone being tolerated as a cheap way to be stoned

'free dope that wasn't as good as smack.'

and that

'when you've got a huge habit it's costing hundreds of dollars a day ... methadone is a real cheap way of getting stoned.'

Although both found that methadone eased them out of the heroin using lifestyle and particularly reduced the need to commit crime, neither were supportive of the program. Dale considered that methadone desocialised him, as he lacked the motivation to do anything

'Heroin is a very euphoric feeling but methadone is a very dozy, fairly contented, you feel like an old man.'

Dale also mentioned that

'I never knew anyone who got straight from methadone. I know those people do exist because I've met them since but in my experience when I was on it ... I never knew anyone who got straight and I never knew anyone who when they were on methadone wasn't using something else at some point.'

Ross reported

'as soon as the methadone ran out I was straight away starting to use other things. So it didn't solve my problem, just took it away for a while.'

He added

'I don't think methadone works. It's my philosophy that you can't overcome addiction by substituting another drug and then trying to control it. When I was on methadone it did stabilise my life but it didn't do anything else either, being on a control drug didn't help me get my life together. All it did was stop me having to do the junkie thing but it did nothing to

teach me how to do anything else. It takes away the need to score because it supplies your drug for you but does nothing else for you. The scariest thing is that recovery's so fragile. I've had to work really hard to get three years up clean. And there's nothing that will do it for you, you've got to do it yourself.'

Some respondents discussed why they had never been on a methadone program. Des knew of people who had raised tolerance levels from being on a program

'and now they've got to use three times as much'.

He also did not want to go on the methadone program because

'I've seen people walk out of that and be horrible people'.

Similarly, Kylie saw herself

'as an upper class junkie and going onto methadone [was] if you couldn't afford heroin'.

Gary as well had heard that methadone

'was no good. I always had the gear. I didn't need that.'

Therapeutic communities

Helpful factors

The most helpful aspect of a therapeutic community was the protected and supportive environment that it provided away from familiar drug using environments.

Bob had never thought that it was possible to actually give up heroin. However

'I think what coming to treatment in [new city] did was just give me time out away from my environment. ... Up here I didn't know anywhere, I didn't know anybody, I didn't know what the road was out the front of me and I had no inclination to find out. So it gave me time out to try and get away from it for a while and try and work through is this what I really want. ... [And] I've never looked back'.

The lack of distractions or temptations was also noted as helpful by others in this group.

The structured environment, with regular meal times and activities, which meant that residents were not left to their own devices, was reported as helpful by Janine and that the treatment provided a route out of dependence, some aspects were still reported to be problematic.

The length of time in a therapeutic community was sometimes considered detrimental to progressing to the outside world. For those respondents who had spent most of their lives in institutions, ranging from psychiatric institutions to jail, therapeutic communities extended their institutionalisation. Others also considered it unhelpful to be cut off from society for long periods of time. As Erin remarked

'It didn't give me a chance to socialise. ... For therapy it's excellent. ... But sometimes therapy doesn't 'What was I going to do with myself, what was going to replace that whole lifestyle, 24 hour a day job. And what was I going to replace that with?'

Therapeutic communities also enabled personal issues to be dealt with. These issues were identified as: low self-esteem; lack of self-confidence; lack of self discipline; not knowing what to do in given situations; self-doubt; and developing a sense of right and wrong. As Ross reported

'I think that one of the most important things it helped me with ... apart from the self-esteem and self-confidence and knowing what to do in given situations ... was self-discipline in that I grew up. As a child I had no self-esteem or sense of right and wrong. I think my using stopped me from maturing in that way maybe'.

Residents of therapeutic communities also valued the opportunity to learn basic living skills. For Janine, it was important that she learnt

'just basic stuff that maybe other people take for granted but for me I had no idea'.

She wanted to develop conversation skills. Interacting with other people was often cited as problematic. For Amy as well, part of treatment was

'interacting with the human race as a straight; that was difficult'.

Similarly, for Bob

'I had to find how to talk all over again, I had to learn to talk to people that don't have anything to do with narcotics. It's a whole change around to be able to talk to someone other than someone who is drug orientated, or crime orientated. It's very hard'.

Responding to their own feelings rather than reacting to someone else's emotions was also part of the learning process. The staff in therapeutic communities were often seen as instrumental in providing positive support necessary for dealing with the underlying issues of heroin use.

Between them, respondents had experience of mixed sex and single sex therapeutic communities. For Janine, who spent time in a women-only community, a big advantage was being able to take her daughter with her.

Male respondents who were in a mixed sex community reported that it proved helpful to be around women in a non-sexual environment. For men who had problems relating to women, going into rehabilitation and taking away that sexual element often meant a realisation that they did not know how to relate to women. Although this created another issue for them to deal with, it was nevertheless considered helpful for their future relationships with women. As Dale remarked

I don't think the services should be segregated because a lot of the issues that people have are relationship issues and it gives you a strong opportunity to work on those issues'.

He believes that rehabilitation programs work better when numbers are more evenly balanced. None of the women interviewed cited this aspect as being important.

A quotation from Ross sums up the positive aspects of therapeutic communities

'Anything that's happened to me has been helpful in one way or another. Where do you start? I got to know myself, understand myself. I've gained life experience to be able to deal with things.'

Unhelpful factors

As with methadone, some people reported the treatment to be totally unhelpful. Of those who fowork. To me it was a horrifying experience, I couldn't wait to leave. It wasn't for me. I was there for a year. I wanted to get off heroin. But it's trial and error until you find a way you feel comfortable with'.

The structured nature of the program also had disadvantages. Bob reported

'A lot of this stuff is forced and a lot of these people that go through these programs have been forced into things, forced into courts, forced into making decisions themselves and the choice doesn't become theirs then. It becomes the program's hierarchy making decisions for you and it's like giving it to Mum. They start you off as a child and you're supposed to work your way up. I went in there and I was 43 and I certainly wasn't a child. I may have had things in me that I didn't deal with as a child but I was treated as a child. Treated as if I didn't know what I was doing and you're just a drug addict'.

To Bob, this aspect of treatment was not conducive to his growth or to his self-esteem.

Ellen said

'I thought it was just as bad as being in jail. ... I don't like being told what to do and how to do it and I would rebel and that's why I consider it like a jail. ... I wouldn't let it work. I wouldn't go their way to try and see how it worked, I just wouldn't let it. I had my way'.

Dale considered his earlier experiences in a therapeutic community to be harsh and strict, with too many rules and regulations. He also reported that in this environment problems can become magnified and issues seen in terms of black and white

'it taught a yes and no answer for anything. Issues to be discussed and opinions canvassed among people didn't work'.

Some experiences of group work were not seen to be helpful. Dale gives an example

'the confrontation groups where you yelled at other people and were expected to get yelled at. ... It frightened a lot of people off and put me off being in groups'.

Some women staff members were considered unhelpful by some of the male respondents

'for males, who make up the majority of the program, you are often left floundering, and certainly the staff have a problem with men. They are more receptive to women than they are to men. A male can do less and still get discharged. A woman can do all sorts of things'.

These respondents considered that there was a bias in favour of women residents and that there were not enough male staff.

Bob elaborated

'A lot of these places are feminist based, they look towards the woman as victim and the man as perpetrator and the men's issues don't really get addressed as much as the women's issues do.'

He viewed matters such as sexual abuse, marriage breakdown, and issues of self-esteem to be just as important for men as for women.

Another difficulty was the jargon used. Erin stated that she
'sat on the fence for six weeks because I didn't understand what they were talking about'.

Amy also mentioned that when self-esteem is low it can be hard to get a sentence together. A therapeutic community tends to exacerbate this problem as they
'have a TC lingo and no-one has a clue what you're talking about'.

The way therapeutic communities viewed children could also become problematic. When Erin took her youngest son into treatment with her, she reported that
'he's never used drugs and he was treated like an ex-drug user and that hurt. The environment wasn't good for him and that was another reason I left. He was seven at the time.'

One woman had not considered going to a therapeutic community because she had never heard of one where you could go with children. She was also concerned about the intervention of welfare agencies if she approached a treatment centre.

Others found the initial approach off-putting. When Des was trying to get into treatment he
'made a couple of phone calls, and one place she said 'OK alcohol or heroin' and she was just really cold and I hung up'.

Another
'was really Christian based and I just had a fear that religion is just another addiction. It was really difficult to find a treatment thing that wasn't religious. So I had to find my own way'.

Narcotics Anonymous (NA) and Alcoholics Anonymous (AA)

Helpful factors

Respondents who had been in therapeutic communities were often channelled into NA or AA meetings as a continuing support. As Bob explains

'When you get out of the program you're programmed. That's what you are. You've got all these program things going through your head, NA, the 12 steps. You're not your own person and then you start to find your own person. You start to make choices and decisions for yourself. Will I have a drink? If I have a drink does that mean I'm busted? Am I going to become an alcoholic?'

Bob also describes how he learnt to relate to people and how he

'had to become vulnerable, knowing that everybody could see exactly what I was going through and it was really painful. And all these people go through the same thing. How do you get back into feeling mode, because you don't feel. Heroin suppresses everything'.

Others who had never been in treatment also approached NA groups seeking support in their resolve to stop using heroin. As Kylie explains, NA

'was helpful because everyone was the same, being a heroin addict'.

The NA group was an important source of support for Freya. She acknowledges that even now, after a period of two years, when she has a compulsion to use she can ring another *'recovering addict'* and talk about it. She recognises that
'I know I've had a choice today. While I was using I never had a choice, it was a known fact that I would pick up again. But today it's my choice and I've got too much to lose if I pick up. Or I'll ring up friends to come around and keep me company. There's a whole lot of things I can do or choose to do before I choose to pick up again. And so far that's what I've done'.

While there might be a temptation for her to use in the future, her strategies have so far been successful. As she says

'I expect to stay clean for the rest of my life by doing it one day at a time, I can't say about the future, but I try to. Just for today I know that I'll never use again. Tomorrow it might be different. I never thought I had a choice in using drugs. I thought that that was my lot in life and that I'd never break free of it. In the beginning I thought 'hey why would you want to be one of those straights, why would you want to be', and I am now one of those straights and I don't mind.'

NA and AA were important sources of support for respondents. They also provided new social networks, particularly for those respondents who were from interstate.

Unhelpful factors

For some, the spiritual connotations involved in 12 step programs were difficult to accept. For Malcolm
'this higher being above yourself, I don't believe in that. All the power rests in you. A lot of people say 'well I can't take any drugs whether it's alcohol or whatever because I realise I have no control over it'. ... Because it is up to your control. You can't convince me that there is a power outside of you that can make me control it'

Others reported that going to meetings made them want to use again. Des reported

'I went to two NA meetings ... and I went with a friend and we just felt like getting on after it. So I found it destructive'

Kylie also said that knowing that NA participants had gone out and used together ('busted') 'scared' her

'Because we're all addicts, all in one room, we know the rorts and scams and where to get it and what to do, and sometimes they would bust, use again'

She finally stopped going to NA, as she wanted a new start in life

'I didn't want NA. I wanted to deny. I suppose I just wanted to be myself as a different person. A new person with a new house and the kids going off to school'

For her, staying in NA meant a continual confrontation by her past lifestyle.

Ross found AA unhelpful because he had misunderstood the purpose of the meetings

'Another misconception I had was that if I went to AA I'd stop drinking and I think that came from way back when you go to school and one day you can read and write. I figured if I went to AA I'd stop drinking but I wasn't doing anything about it myself. I was just letting them do it for me so it wasn't happening. I might stay in detox for two weeks, feel real good about myself and within a few hours I'd be drinking again and I'd start drugging. The two go hand in hand'

Gary did not find his experience of NA helpful, as

'there's too many big shots there'

Others considered that NA fostered co-dependence by giving power over to a program without self responsibility.

As Bob explains

'It's like an identification, you can go in there and say yes I had a bad time and yes I'm a drug addict, but I think there's a network of people out here too. I've changed my friends. ... As far as NA is concerned I think it can be detrimental to a person's growth because you can get stuck there.'

Counselling

Some participants reported that counsellors had been helpful by encouraging them to go into treatment and/or by providing on-going support once they had stopped using.

Janine, for example, found a drug and alcohol counsellor to be instrumental in her recovery. As is described in the section on the decision to stop, the concerns of her counsellor were a major influence in her seeking and obtaining treatment

'She was quite concerned. I had a lot of faith in her. ... She wasn't a drama queen, to me she was a really down to earth sort of lady and she was getting worried. And I thought if she's worried, she can see something I can't. So I probably wouldn't have gone [into treatment] if it hadn't been for her'

Ellen received weekly counselling. Her counsellor reminded her of her previous drug using lifestyle, and Ellen acknowledged that she might not survive if she reverted to her previous lifestyle. Her children were learning to trust her. Another significant event occurred when a friend died of a heroin overdose. Ellen found that once she was out of the detoxification program she required ongoing counselling to help maintain her decision not to use.

Doctors

Only one respondent in the study mentioned the assistance of medical professionals outside alcohol and other drug services in stopping the use of heroin. Des reports that initial contact with a general practitioner was a crucial step for him

'like I went to a doctor because I'd slashed my hand and I had to, to get stitches, and that was a really big thing for me, like I just have a fear of that kind of stuff.'

Rather than being referred to a treatment centre, Des was put on doloxene and tranquillisers. However, as he explains
'I was still getting on, only it was cheaper. ... It wasn't doing anything for me.'

Des thought that once he gave up heroin all his troubles would be over

'I thought I'm going to get off, I'm going to get really clean, really straight and be different. But I forgot about who I was before I got on. ... you get these ideals of what you're going to be like when you're off, but they don't come true. You still get energy and you've got to disperse it somehow whether creatively or whatever. So I wasn't given any channels, I was given something, for the effects it would have, not the cause.'

To get further help, Des started seeing a psychiatrist. His confidence increased through her support and encouragement and she also helped him deal with personal issues that he had to overcome in order to stay stopped

'it got to the point where I could tell her about stuff which I think helped me focus.'

Suggestions for expanded and new services

Participants held a range of views about the need for expansion of services and the need for new services.

Ross maintained

'there's probably enough now. If somebody wants to get well they'll find a niche. I don't think anyone can say they didn't get well because there wasn't a service that understood them. ... If it doesn't work one way you've got to try another way.'

For some, the variety of existing services was confusing. As Bob remarks

'you've got so many different agendas, ways that it's giving double messages to people who just want to get straight ... You might have to go to six people a week by the courts, bail conditions, police, and everyone has a different idea on how you should work and how they can get you clean.'

However, Bob added

'you must offer alternatives to people for their choice to see what they can do. Because the ones in effect aren't working. There has to be more.'

Needs identified by participants included (these are not in any particular order):

- more detoxification programs;
 - halfway houses for users who were not prepared to go into a therapeutic community for long-term rehabilitation, but who also did not want to go back into their old environment of using friends and contacts;
 - a better geographical spread of services, particularly within Canberra;
 - more immediately available counselling services;
 - more rehabilitation places, with increased funding for existing programs;
 - more options for short-term programs;
 - more non-medical treatment;
 - more collection points or distribution through pharmacies for those on methadone programs;
 - easier access to methadone programs;
 - retraining of life skills and examination of deeper issues for people on methadone programs. As Roxanne remarked
'every junkie thinks they're a really good junkie. So if you've been a really good junkie, you've survived, you're a real survivor, you're very smart, what else would you like to do with that energy. Because a lot of energy goes into being a junkie.'
- She believed, as did other respondents, that methadone programs should deal with the lifestyle issues associated with heroin dependence
- 'Heroin is just a small part of it.'*
- more NA based services. Freya argued that people who have been exposed to an NA program
'they might still go back out and use for a couple of years, maybe only once or twice more, but sooner or later they all come back.'
 - more places for couples. As Bob explained
'what they try and do is split them up because they think there's a dependency and co-dependency between them, and they've got issues of their own and they've got to sort their own out. I don't agree with that, I think if you're married and you've got children or whatever then you need to be there together because the family nucleus is where it works from. If you

can work out your family stuff and work out your own stuff, which should be available, then separating the people and taking one to Sydney and one to Victoria only adds to the pressure and grief and worry ... I think you should be able to work as a family unit'.

Suggestions were also made that there needed to be increased education. As Freya suggests
'proper information and education from a child five years old onwards'.

One respondent also suggested that the truth about drugs needed to be told, so that people could make up their own minds about whether or not to use. He suggested that it was not helpful to exaggerate the dangers of drugs, because when people dismissed the exaggerations they often also dismissed the useful information as well.

One suggested legalisation as the only *'sensible alternative'*
'just give it to them'.

Barriers to treatment

This issue was not addressed to any real extent in this study; however, some insights were obtained.

Kylie reported that she did not go into treatment because
'it never became a topic of discussion. I thought this is my lot in life.'

Some reported that there was lack of information
'There's no advice. It's just for you to seek, find, and go.'

Concerns about children and welfare intervention were another factor. As Kylie explains
'what would happen with welfare? If I thought about it, it never went any further because of the kids. I didn't believe that there was any help out there anyway'.

For Kylie, her heroin using lifestyle was
'a dark secret that I kept to myself'.

Some participants found it difficult to approach services. Des reports
'I still have a social phobia, as far as systems and organisations go. I still haven't got my driver's licence. I can't even buy underpants. I just avoid things like that'.

As described above, circumstances eventually forced him to see a doctor and for him this was instrumental in stopping dependence.

Summary

The methadone program provided many with stabilisation. For some, this was an opportunity to rebuild their lives and hence methadone provided them with a successful route out of dependence. For others, the stabilisation was not enough. Some viewed methadone as an additional free drug; some continued some association with the heroin using life and some saw that methadone provided no motivation to change. They needed something else to enable them to finally stop using and detoxification or therapeutic communities provided successful alternatives. Health problems perceived to be associated with methadone were commonly reported, as was a difficult withdrawal process. The way that the methadone program was run was also seen to be an important advantage or disadvantage. Methadone was not seen to be helpful in enabling some people to deal with their desire to inject themselves. For some, the perceived disadvantages of being on methadone stopped them from ever seeking assistance through this form of treatment.

The very aspects some perceived as the strengths of therapeutic communities were what others found unhelpful. The same person could also find aspects both beneficial and problematic. The protected environment could be perceived as a haven or as a barrier to integration in society. For some, the structure was an essential aid in rebuilding their lives; for others it was a continuation of institutionalisation or a threat to independence. Two areas reported as needing improvement were whether and how programs accommodate children and couples. (One therapeutic community in the ACT has made considerable progress in dealing with both of these issues.)

The proximity to others who had also been through similar experiences, which was provided by NA and AA, was also seen to be a two-edged sword. Contact with other ex-users could be a source of understanding and support or a reminder of a past lifestyle and a temptation to return to it.

What these results highlight is that different treatments and services work for different people at different times. Not only do a range of treatments need to be available, but there also need to be various supports for people who want to stop dependent use without formal treatment.

The following section looks at participants' experiences in maintaining abstinence.

PATHWAYS OUT OF DEPENDENCE: MAINTAINING ABSTINENCE

Respondents in this study used a variety of strategies to maintain their decision not to use. All but one of the participants had been abstinent from heroin since stopping dependent use this time. The one person who had used occasionally did so from time to time with a work colleague.

Key factors in maintaining abstinence were reported to be: relocation and avoiding old haunts; supportive close relationships; professional and peer support; dealing with past personal issues; remembering the past life; learning a new way of living; the rewards of a conventional lifestyle; work; use of other drugs; and spiritual influences.

Relocation and avoiding old haunts

While six respondents in this study were from Canberra, the remaining 12 had moved here from interstate. Moving away from the using scene and not knowing anybody in Canberra seemed to help in maintaining the resolve not to use. For example, Freya reported

I left them all behind. I moved from Sydney to Canberra to stop using. ... I didn't feel confident that I could stay in Sydney where I did most of my using because it was so easy to go out and work to get money. I just didn't feel confident that I could stay stopped basically'.

For Kylie as well

'you've really got to make that clean break. You really do. You've just got to get away. Those using thoughts they become so strong at times'.

When Kylie wanted to use, she would convince herself that she did not know anybody or anywhere to buy heroin in Canberra. This was a major factor in assisting her in maintaining her decision not to use.

However, moving could also have important drawbacks. For Kylie, moving away from a supportive family who could also be called on to provide child care when needed was difficult.

For those who were from Canberra, avoiding the usual haunts and avoiding heroin using friends were necessary in maintaining an abstinent lifestyle.

Moving away from, and breaking relationships with, heroin using partners was a significant factor for some of the women respondents. This factor was not cited by any of the men.

Supportive close relationships

Forming a new relationship could be important. In Kylie's case

I remember him saying to me that he wouldn't marry a junkie and that's always in the back of my mind. I always think of that. ... Over the years I've had men in my life that have abused me and emotionally abused the kids. But he's not like that. I think he grew up in a situation where there was no violence. I'm so lucky'.

If she began using heroin again, it would not only threaten her new found relationship, but place in jeopardy her new found lifestyle. Although her partner was currently in jail and too far away to visit, he phoned three times a week and that was an important source of support. She was somewhat worried though about what would happen when he was released.

For both Bruce and Des a new relationship was also important. Des reported

I've met someone now and I don't want to hurt her. I'm starting to be quite happy with who I am and I couldn't see any way of turning back'.

As we have alluded to in an earlier section, relationships that some people had with family members, children, and friends played an important part in stopping dependent use and in maintaining their decision not to use.

For Des, the parental support he received enabled him to become an easier person to be around

I'm feeling easier to be with. I could see definite changes in the way I related to people and the way I related to my job as well. All this positive feedback from work and socially'.

Des had previously hidden in his room, due, he maintains, to the effect of the drug.

Kylie's parents were important

'my mum and dad have supported me all the way through'.

Often, for women and men, children were an important influence and source of support. As Erin explained

'My children influenced me a lot. Even though they knew what I was, I still had the support of them, I still had the caring. They helped even more than they realised.'

Erin's children, while not a factor in stopping using, were an important factor for her in staying stopped.

When Dale's children were born his life changed

'The thing I value the most is my relationship with my wife. and my children. My dad was an alcoholic. I think staying straight I could do it solely for my children. ... They are a strong influence on me.'

Children then were often seen as a new start in life, and provided respondents with further reason to stay stopped.

Professional and peer support

Relationships with treatment agency staff were sometimes influential in supporting respondents in their decision not to use heroin. For Erin, it was the trust displayed by her doctor and the pharmacist who dispensed her methadone that were important

'those two supports made it so much easier'

even though she acknowledges that giving up heroin

'is the hardest thing I think I've ever done'.

Counselling was also used by some participants to assist in maintaining a resolve not to use. Nick, for example, had counselling every few months while he was on the methadone program. He found that this was enough to enable him to work through personal and legal issues, as well as to adjust to a new life without a dependency on heroin.

The importance of counselling for other respondents has been discussed in previous sections. The help provided to some by NA and AA has also been discussed earlier. Others also found such self-help groups to be important. The initial phase appeared to be the most crucial, with the level of participation dropping off with time.

For Erin, whose family had

'turned their backs. They just didn't want to know me'

her substitute family became the therapy groups. As she acknowledged

'that's my family, and the friends I've made. My immediate family were more interested in themselves and the shame I'd brought on the family, their own images. That was hard'.

The main source of support for Dale was his peers and friends who had used drugs previously, become straight and stayed straight. He also stayed in contact with the staff at the therapeutic community. While NA was important initially

'it's a social club for addicts'

he had discontinued meetings, as he found support elsewhere with work colleagues and friends.

Dealing with past personal issues

The importance of dealing with personal issues to stay stopped was also mentioned by a number of participants. These included the scars left by early family relationships, including sexual, physical and emotional abuse. Other personal issues arose from incidents during the 'using life', such as experiences of violence or remorse over ways money had been raised. Other issues were not necessarily related to using, for example relationship problems in early adulthood.

For Freya, cravings for heroin became a problem because she was

'going through a really hard time and all these feelings are bombarding me which I never had to deal with before because I always just had a shot. Personal issues came up after I stopped.'

She maintained that her support networks were crucial to her resolve

'If I didn't have that support ... I'd be out there using again. ... I started using heroin because I couldn't handle reality anymore, the real problems in my life or my feelings for them. So I started using heroin to block everything out and in the end after ten years you're so worn out you've forgotten personal issues and you just use to feel normal, to feel OK'.

Des found it helpful to talk with a psychiatrist

'I dealt with heaps and heaps of things going right back to the past. ...I finally started to deal with it because I'd gone through getting off and that was such a fight that I just had to fight all these other things which at one stage were an excuse for me to get on, inside anyway.'

For Erin

'After I had a chance to stop I could deal with this. When I was using, you're numb and you don't focus on anything realistic or feel like other people do in society. You're different.'

For Bob

'Sometimes I struggle with the bottle, I battle with it because I'm going through turmoil about shame, guilt, anger, blame, resentment and I have to daily maintain where is that coming from. Let the movie go across your head, grieve for it, let it go, replace it with a new tape.'

Gary had to deal with personal issues on a daily basis once he had stopped using

'Yeah every day. When I was using it would come once a month. But when I stopped it was there all the time. I'd use the 12 steps. A lot of things got dragged up. There was a hell of a lot of hurts there. The counsellors chucked that much positive that the negative went.'

Remembering the past life

Sometimes, the memory of past lifestyles or particular incidents was enough incentive to stay stopped. For Erin it was both

'The lifestyle and just remembering and the realising of why I started. It's been a long process of self-education but now I know why I do things and why I couldn't cope. ...There's only one way to keep off and that's to live day by day and keep away from it.'

For some, memories of time spent in jail were significant. As Bob explains

'I don't want to go into that system because it's abusive. And most of these people, including myself, have been in abusive situations their whole life and it's just a perpetuation of abuse. I'm not saying it's easy, but I certainly do not want to go back inside four walls again, never in my life. The effects of that are just horrific.'

Being off heroin meant that Bob could now take some pride in himself and his new lifestyle

'I want to do what I can for my family. I want to hold my head up high. And I can nowadays.'

Learning a new way of living

Malcolm needed to find new purpose in life

'Everyone's got to find out what's going to make them happy. ...If something happens in my life what do I do, turn around and use heroin again. ...Heroin gives your life a purpose. The purpose is to get up every day and get on and that gives your life a purpose. So you have to learn how to redirect all that energy.'

For Ross attitudinal change was important

'I think it was just a slow attitude change, a personal growth, a confidence growth, more commitment, more life experience, being straight and watching other junkies fall over and seeing myself, knowing that if I did that the same would happen for me as it does for them. And then just knowing I don't have to do that.'

Ross also mentioned

'One of the biggest lessons I learnt was that I had to get honest, do I or not want to give up. And that's helped me get honest with other people. It's still hard for me to pay a \$300 phone bill. I'd rather keep the money, but I go and do it and that helps with peace of mind. I don't have to duck, and weave, and hide, and run. And when I feel good I don't need drugs.'

The rewards of a conventional lifestyle

The adoption of a conventional lifestyle, acquiring the associated material rewards and fitting in was important for some.

For Ross, it was a realisation that

'I fit in more now. I've got a licence and a car, and the car's registered, and a boat and the boat's registered, and I've got a boat licence, and the boat trailer's registered, and the address on all those registration papers is exactly the same and the name's the same. So socially I'm more acceptable. I fit in and it's more comfortable to fit in than it is to be an outlaw. So the better I get, the better it becomes. And that's a factor to stop using. I like being normal.'

Ross sees his life becoming filled with things that are normal, that are socially acceptable, that he does not get into trouble with the law over, and that other people are happy to see him do. This has taken the place of drugs. Ross also says he would rather have the peace of mind at the end of the day

'knowing that I've done the right thing by myself for the day than the pleasure of getting stoned.'

Work

For respondents who had been in therapeutic communities, work with newer residents was often part of the process of staying stopped. For Janine, working with newer residents meant learning

'how to look after, and care about other people.'

Similarly for Amy, her work with new residents made her wonder why she ever started taking drugs

'Most of them are prostituted out, sexually abused, and incest survivors. There is a story for every single one of them and they're not even 20 [years old] yet. ...Their problems and issues make me wonder why I ever took drugs.'

Work was often cited as one of the strategies employed to maintain abstinence, particularly with the increase in time and energy often found once respondents stopped using. For Des

'one of the hardest things when I had stopped was not working, having something to do. Something that makes you feel good. If you don't have something like that, it's really hard. That's what I've found. Without work I'd think about it all the time.'

Work then became an important substitution for a heroin using lifestyle.

Using other drugs

Some participants substituted other drugs for heroin. Andrew's story has been recounted in the section on the decision to stop.

Marijuana was currently used by a number of respondents. They found it helpful in overcoming chronic sleeplessness and excess energy, especially during the period immediately after they stopped using heroin.

Two respondents used alcohol as a substitute for heroin. For one this led to separation from his partner; the other is currently seeking help with problems associated with alcohol use.

Another two respondents used bach flowers and other naturopathic remedies to manage their cravings for heroin.

Spiritual influences

Organised religion was rarely an important factor. However, for Ross a church based group allowed him to develop a code of ethics that he felt had been lacking in his previous lifestyle

'Part of recovery is an examination of spiritual values and I link that with what's right and what's wrong, and what's moral and immoral, positive and negative'.

Spirituality outside organised religion was important for other participants in this study. As Freya explains

'I have God in my life, that's what I call it for want of a better word, but I prefer to be spiritual than religious'.

Summary and Discussion

All the factors cited here have also been found to be important in other, usually American, studies. It should also be noted that most of these factors had been tried before by at least some of the respondents and had not led to long-lasting abstinence, although they may have been successful for a time.

It also needs to be pointed out that, while some of the participants felt quite secure in their new lives, others were not complacent about their ability to stay stopped.

Nevertheless, both this and previous studies give some pointers to how a decision to be abstinent from heroin can be maintained. Waldorf and Biernacki (1979) found that one of the earliest indicators of a drug user's serious intent to permanently abstain was a geographic and social distancing from the heroin scene. They found that as this distancing progressed, respondents tended to create a more conventional life, and that social supports— either from family or friends, and from institutions such as reform groups and churches— were helpful to long-term abstinence.

Jorquez (1983) suggested that evaluating behaviour is an important factor that helps account for long-term abstinence. Similarly, Waldorf (1983) argued that the heroin user may be visualised as 'pushed' by the misery of a drug using lifestyle or rock-bottom experience and simultaneously 'pulled' by the desirable aspects of conventional life into stopping drug use. Stall and Biernacki (1986) noted that the internal discussions of the negative consequences of using and the support of significant others were factors frequently mentioned as being important in the process of maintaining the abstinence.

The importance of social changes and the development of a new lifestyle has been demonstrated by Wille (1983). In addition, in reviewing the literature Maddux and Desmond (1981) identified the importance of the desire to be a good parent; the support of family and friends; and the accumulation of social and material assets.

Klingemann (1992) noted that ex-users often become helpers, either as informal experts or counsellors. He also suggested that most ex-users develop conscious strategies to maintain abstinence. These include the development of everyday behavioural concepts; ideas about effects of drugs; adequate substitutes for drugs; and techniques of distancing. The costs, financial and otherwise, of resuming the habit against the experienced benefits of reduced consumption were also important, as were medication to relieve the withdrawal symptoms, group participation, and attempts to create a drug-free environment by relocating.

In a study on women, Rosenbaum (1981) maintains that for women to achieve abstinence, three conditions need to be met: commitment to "cleaning up"; physical removal from heroin using environments; and the availability of an alternative, viable, and desirable lifestyle. One condition without the others is insufficient. So while relocation is important, the decision to stay stopped has to be combined with an alternative to a heroin using lifestyle.

In another study of women, Blackwell (1983) reports that women find it necessary to leave a relationship once they have made a decision to stop. This finding was supported in our study, where some women left a heroin using partner in order to stop. However, men in our study did not cite this as a factor at all.

CONCLUSIONS

Feasibility study

Not all the study participants had heard about the proposal for a 'heroin trial' and they had a range of views about what such a trial would entail. There was also a range of views about the desirability of a trial proceeding among 17 of the 18 participants. Forty-seven percent were in favour of a trial, 41 percent against and 12 percent undecided. In each of the four groups into which participants were allocated (according to whether they had given up with no or minimal treatment, detoxification, methadone or therapeutic communities), there were people who were in favour and people who were against a trial. In this study, there was a higher proportion of ex-users opposed to a trial than had been found in a survey conducted during Stage 1. In that study, 62 percent were in favour, 22 percent against and 16 percent undecided.

The study provides information about the potential advantages and disadvantages of a trial. This can be drawn not only from participants' views of a trial, but can also be inferred from their accounts of their experiences as users— especially from their encounters with treatment services. The importance of the availability of a range of treatment options has been highlighted and certainly a trial would provide a new option. Many felt that a trial would be a way of allowing people to 'stabilise' their lives, particularly in reducing criminal behaviour. A trial might also combat the spread of HIV/AIDS. There might also be a reduction in health problems; pure heroin was seen to cause less health problems than both street heroin and methadone. Heroin was also seen to be much easier to withdraw from than methadone.

On the other hand, accounts of the unhelpful effects of methadone suggest possible problems with controlled availability of heroin. A few people enrolled in a methadone program to get a free additional drug; not for treatment. No doubt this would also be a reason for some people to enrol in a heroin trial. Some of those opposed to a heroin trial gave the possibility of such 'abuse' as a reason. Some also reported that being on methadone did not bring with it any motivation to examine their lives or to stop using. One reported that methadone gave her the misleading impression that her life was under control when it was not. These could also hold true for a heroin trial.

A number of participants were opposed to a trial because they thought it would work against dependent users being helped to lead 'normal' lives. Among other potential problems participants foresaw were that users might be attracted to the ACT from elsewhere, so that overall crime would not be reduced. There might also be problems with security and there were concerns about the logistics of a trial. The way in which a trial would be carried out would be an important determinant of benefits and problems and the details of this have not yet been finalised.

All but one of twelve respondents would have participated in a trial if it had been available when they were using. Seven out of the 12 thought they would not then have stopped using heroin and four were not sure.

About one in three felt they might be tempted to start using again. In the survey conducted in Stage 1, two percent said they would start using again and 19 percent were unsure. Although it was not discussed, it is likely that this would be affected by the eligibility criteria for a trial. For example, if people had to have been using fairly continuously for a number of years to be eligible, this may deter many ex-users who might otherwise be tempted from starting again. Nevertheless, one likely cost of a trial is that some people might start using again. In aggregate terms this might not be a significant problem, since 'relapse' rates are high in any case; however, for some individuals it may be a significant cost.

The potential problems can be used to argue against a trial going ahead. They also effectively point to the limitations of a trial, which need to be considered if a trial does go ahead. A heroin trial certainly would not be without problems; as indicated by the stories of some people who simply used methadone as an additional drug, there would be people who would 'revert' a trial and others for whom it would not be a helpful alternative. There are likely to be people whose lives would be 'stabilised', but who would not find the motivation to become drug free. There are people who may start using again, although for others the availability of heroin rather than methadone may make stopping easier. It is worth noting that not everyone agrees that stopping dependent heroin use is important. Some would argue that users can function very well with a controlled supply of pure and affordable drug. However, this is unlikely to be the case for everyone. In suggesting how success for methadone programs should be evaluated, Newman (1993) has also suggested that 'recovery from opioid dependence' should not be the aim of treatment; instead, treatment success should be measured by "cessation of [illicit – our words] heroin use, sharply reduced morbidity and mortality, and restoration of the ability to lead a productive and self-fulfilling life".

The potential advantages and disadvantages of a trial outlined above need to be taken into account in light of all the feasibility considerations before a final decision can be made. This cannot be done until the other components of the feasibility study have been completed.

Comments on existing treatments

This study illustrates that different treatments work for different people at different times; and hence that there is a need for a diversity of treatment services. In addition, there are no magic formulae for giving up. What seems to have worked for one person may not have worked for them in the past; nor will it necessarily work for someone else.

It is clear that people need to know what is available in the way of treatment services and that they need to be accessible. The study does point to some specific improvements that could be made to existing services or which should be more fully investigated.

One participant gave insight into the advantages of pharmacy-based methadone programs. These are currently being introduced in the ACT. There was also some evidence that methadone program clients might benefit from wider application of counselling to examine reasons for using and to improve their life skills. Alternatively, therapeutic communities might be encouraged to take people on methadone into their programs to facilitate these aspects of treatment. Hence, diversity of treatment options might be increased by combining aspects of existing programs.

Therapeutic communities might be improved by being more accessible to clients with children and to couples and families. They might also consider introducing shorter and less structured programs for some clients. Again, one of the therapeutic communities in the ACT is introducing such changes.

Medical professionals outside of alcohol and other drug services are noticeably absent in treatment for heroin dependence in this study. General practitioners seem to be used mainly to obtain prescription drugs. These are often used to cope with withdrawal symptoms, which can be brought on when people are trying to stop using voluntarily or when they are forced to do so through illness, lack of money, or similar reasons. Enhancing the role of general practitioners, especially for people who do not want to go to formal treatment services, may be an area worth exploring.

A number of people who have been dependent on heroin have past personal issues which need to be dealt with. Some— for example, problems stemming from early family experiences— may have contributed to the person becoming heroin dependent. Others may have arisen as part of the heroin using lifestyle. Many existing treatment services are realising the importance of helping clients to deal with such issues. It may also be important to enable people to continue to obtain assistance when they have finished treatment programs.

Social policy needs to address such issues more effectively; not only to improve the chances of re-integrating people into society, but also to prevent many people from being drawn into an illicit drug using lifestyle in the first place.

It is also important to recognise that at least some people stop using heroin dependently without formal treatment. Social policies should not cut across people's ability to do this.

Further work

This small investigation seems to have been the first of its kind in Australia. It shows that studies of ex-users can be valuable in informing existing policy regarding the provision of treatment services and proposed policy changes. Systematic 'exit surveys' of people leaving treatment programs and documentation of follow-up contacts with them would be a valuable beginning to further work. Agencies would need to be appropriately funded and supported by research expertise to allow this to happen. In addition, much could be learnt from studies similar to this one which were conducted on a larger scale; a large scale prospective study would be particularly valuable.

REFERENCES

- Biernacki, Patrick (1986), *Pathways from Heroin Addiction: Recovery without Treatment*, Philadelphia, Temple University Press.
- Blackwell, Judith Stephenson (1983), 'Drifting, Controlling and Overcoming: Opiate Users who Avoid Becoming Chronically Dependent', *Journal of Drug Issues* 13(2), pp.219–233.
- Heather, Nick and Jennifer Tebbutt, editors (1989), *The effectiveness of treatment for drug and alcohol problems. An overview*. National Campaign Against Drug Abuse, Monograph Series, No.11. Canberra: Australian Government Publishing Service.
- Jorquez, James S. (1983), 'The Retirement Phase of Heroin Using Careers', *Journal of Drug Issues* 13(3), pp.343–365.
- Klingemann, Harald K. (1992), 'Coping and Maintenance Strategies of Spontaneous Remitters from Problem Use of Alcohol and Heroin in Switzerland', *The International Journal of the Addictions* 27(12), pp.1359–1388.
- Maddux, James F. and David P. Desmond (1981), *Careers of Opioid Users*, New York, Praeger.
- Newman, Robert G. (1993) 'Methadone Maintenance and Recovery', *American Journal of Drug and Alcohol Abuse* 19(1), pp.135–137.
- Rosenbaum, Marsha (1981), *Women on Heroin*, New Brunswick, New Jersey, Rutgers University Press.
- Simpson, Dwayne D., George W. Joe, Wayne E.K. Lehman, and S.B. Sells (1986), 'Addiction Careers: Etiology, Treatment, and 12–Year Follow–Up Outcomes', *Journal of Drug Issues* 16(1), pp.107–121.
- Stall, Robb, and Patrick Biernacki (1986), 'Spontaneous Remission from the Problematic Use of Substances: An Inductive Model Derived from a Comparative Analysis of the Alcohol, Opiate, Tobacco, and Food/Obesity Literatures', *The International Journal of the Addictions* 21(1), pp.1–23.
- Waldorf, Dan (1983) 'Natural Recovery from Opiate Addiction: Some Social–Psychological Processes of Untreated Recovery', *Journal of Drug Issues* 13(2), pp.237–280.
- Waldorf, Dan and Patrick Biernacki (1979), 'Natural Recovery from Heroin Addiction: A Review of the Incidence Literature', *Journal of Drug Issues*, Spring, pp.281–289.
- Wille, Rolf (1983), 'Processes of Recovery from Heroin Dependence: Relationship to Treatment, Social Changes and Drug Use', *Journal of Drug Issues* 13(3), pp.333–342.

APPENDIX A: INTERVIEW SCHEDULE

CONSENT FORM

I.....[pseudonym] understand that this study is for the purpose of research into the lifestyles of past dependent users of heroin. It is conducted by the National Centre for Epidemiology and Population Health (NCEPH) at the Australian National University. This research is a part of a larger study to determine if a trial to provide heroin and other opioids to dependent users should go ahead.

I understand I will be asked questions about my background, previous and current drug use, cessation of dependent heroin use, experience of drug treatment, and my views on a 'heroin trial', particularly its possible effects on the cessation of dependent use.

I understand there is specific legislation passed in the ACT which means any information I give cannot be used against me in any legal context (eg in court or by the police) and the researchers are obliged to comply with strict secrecy provisions.

I understand that all possible precautions have been taken to protect my identity and the security of the information I provide.

I understand the results of this study will be made available in a public document but it will be done in a way that no information identifying me will be published.

I understand I can ask any questions during the interview at any time and as long as these do not involve a breach of another's confidentiality, the questions will be answered.

I understand that I have the right to decline to answer any question during the interview and that I can terminate the interview at any time.

I understand that this interview will take about two hours.

I understand and agree to having this interview recorded by audio tape.

I understand that I will be provided with the opportunity of participation in the interpretation of the findings of the research.

I understand that I can take any complaints I have about the conduct of this study to the ACT Board of Health's Ethics Committee, PO Box 875 Canberra ACT 2601.

.....
Signed (Pseudonym or interviewer)

.....
Date

INTERVIEW FORM FOR THE STUDY ON PATHWAYS OUT OF HEROIN DEPENDENCY

The main focus of this study is on the different pathways out of heroin dependency – how you stopped (or cut down on) using heroin, for example why you stopped, the sorts of things you did to stop, whether anybody in particular helped you to stop, and so on; and I'll be asking a series of questions that relate to this issue. I'd also like to find out a bit about your background, your lifestyle when you were dependent on heroin, and what you think about the proposal for a heroin trial.

But first of all I would like to ask you about how you stopped being dependent on heroin.

1. Why did you decide to stop using heroin?
 2. Had you tried stopping before? Explain.
 3. What made this last time different?
 - Did anything happen in particular? (eg pressure from others, threat of jail, overdose)
 - 3a. Specifically, what did you do to stop?
 - What was helpful about this?
 - What was unhelpful?
 4. Have you tried treatment in the past?
 - If not, why not?
 - If yes, what sort of treatment did you try? (eg formal detox, counselling, methadone, therapeutic)
 - How many times did you try this treatment?
 - For what period of time? (eg days, weeks, months)
 5. Was the treatment to stop using heroin or other reason?
 - What was helpful about the treatment? (ask for each)
 - What was unhelpful?
 6. What problems did you encounter when giving up?
 - How did you handle your cravings?
 7. Did you have a heroin using partner when you decided to stop?
 - If yes, how did she or he influence you?
 8. Did you have family and/or children and did they influence you to stop?
 9. Was there any one person, or any people, in particular who influenced you to stop? (eg family, child, treatment staff)
 10. Did giving up using heroin affect any of your relationships with other people? (eg drug using friends). Explain.
 11. Is something taking the place of heroin in your life now? (eg use of other drugs, gambling, alcohol, religion, children)
 12. Is there anything else that helps you maintain your decision not to use heroin?
 13. Do you have to deal with any personal issues to maintain your decision not to use heroin? Explain.
- I would like to get some idea now of what it was like for you when you were using heroin.*
14. How old were you when you first started using heroin?
 - What was your first experience like?
 - Why did you start using? (eg peer pressure, boredom, curiosity, escape)
 15. Why did you keep using? (eg relaxation, reducing anxiety, peer influence)
 16. Did you use other drugs as well? Describe
 17. Was heroin your drug of choice?
 - If yes, was there a reduction or an increase in the year before you stopped?
 18. When did you first realise that you might be dependent on heroin?
 - What made you realise this?

19. In the year before you stopped, were you using heroin continuously or did you have periods of abstinence or non-dependence?
- If periodic, how many times since you started using were you abstinent or non-dependent?
 - Why did you have periods of abstinence or non-dependence?
 - What did you do to become abstinent or non-dependent?

and some idea of your lifestyle

20. In the year before you stopped, what was your heroin lifestyle like? (eg hustling, scoring, raising money)
21. Did anything about the heroin lifestyle influence you to stop? (eg cost, availability, losing a dealer, drugs in prison). Explain.
22. How did you support your heroin use? (eg employment, criminal activity, prostitution, dealing)
23. Did you commit a crime because of your heroin use? (If multiple, ask the following for each)
- If yes, what crime were you involved in?
 - How old were you?
 - Did you get any warnings?
 - Did you get any convictions?
 - Did this influence your decision to stop?
 - If yes, which factors? (eg activity itself, losing a dealer, prison)
 - If no, were you ever worried about the possibility of being in trouble with the law? (eg fear of arrests, conviction, imprisonment, drug use in prison)
24. Did you have any health problems because you were using heroin?
- If yes, when did they first occur?
 - Why were they problems for you?
 - Did they influence your decision to stop or cut down on using heroin?
 - In general how would you describe your health now?

For women participants ask the following; for male participants go to Q 33.

25. Have you ever been pregnant while using heroin?
- If yes, how many times?
26. Were you using drugs when you were pregnant?
- If yes, which drugs were you using?
 - Were there any changes in your drug use? (eg types of drugs, method of administration, binged)
 - If yes, why was this?
27. How many weeks pregnant were you when you found out you were pregnant?
28. Was this pregnancy planned? (ask for each pregnancy)
29. What did you do when you found out? (eg termination, treatment)
30. Were you in treatment at the time?
- If yes, what sort of treatment?
31. Do you think you got adequate antenatal care? Explain.
- Do you think you got adequate postnatal care? Explain.
32. Is there anything else you would like to say about pregnancy and drug use?

I would like to ask you some other questions about your background and your drug use. Remember you don't have to answer these questions if you don't want to.

33. Have you ever been a victim of physical violence (and/or assaulted another person) because of your heroin use? (also ask for emotional and sexual abuse).

- If yes, did this influence your decision to stop using heroin?
- 34.. In the year before you stopped using heroin, did you experience prejudice as a result of your heroin use?
 - Could you tell me more about this or give examples?
 - Did this prejudice influence your decision to stop?
- 35. Did other people's expectations of you influence you to stop? Explain.
 - Did your own expectations or feelings about yourself influence you to stop? Explain.
- 36. Were there any particular factors associated with your using heroin as a woman/as a man that influenced you to stop?
- 37. Just before we go onto the next section, is there anything else that you would like to tell me about how you stopped?

I would like to ask you now about your views on the feasibility of a trial of controlled heroin availability.

- 38. Have you heard about the proposal for a heroin trial?
 - if yes, what do you understand it to mean?
- 39. Do you think such a trial should go ahead? Explain.
- 40. If heroin had been available in this way when you were using, would you have stopped using heroin?
 - If yes, would you have stopped using in the way that you did? Explain.
- 41. If a heroin trial were to go ahead, would you be tempted to start using again so that you would qualify?
- 42. Can you suggest a better alternative to the trial (better in terms of improving the well-being of heroin users)?
- 43. Would you like to see any existing treatment services expanded or improved?
- 44. Would you like to see any new or different treatment services established?
- 45. Is there anything else you want to tell me about, or is there anything else you think I ought to know?

Finally, socio-demographic sheet to complete.

(A time line was used during the interview where appropriate)

No	Question and filter	Coding																								
A1	Sex [Interviewer observed]	Male 1 Female 2 Transsexual 3																								
A2	How old are you?	<input type="text"/> <input type="text"/>																								
A3	What is your highest level of education?	Did not attend high school 01 Left high school before leaving certificate (equivalent year 10) 02 Leaving/school certificate (year 10) 03 High school certificate (year 12) 04 TAFE certificate (eg. trade) 05 TAFE/CAE Diploma 06 Bachelor degree 07 Postgraduate qualification 08 Other 09 Non-response 99																								
A4	What is your current occupation? [Including student, parent or homeduties]	<input type="text"/> <input type="text"/>																								
A5	During the last 6 months what were your sources of income? [Allow multiple responses]	<table border="1"> <thead> <tr> <th></th> <th>Yes</th> <th>NA</th> <th>NR</th> </tr> </thead> <tbody> <tr> <td>Paid employment</td> <td>1</td> <td>0</td> <td>9</td> </tr> <tr> <td>Self employment</td> <td>1</td> <td>0</td> <td>9</td> </tr> <tr> <td>Government benefits</td> <td>1</td> <td>0</td> <td>9</td> </tr> <tr> <td>Illegal sources</td> <td>1</td> <td>0</td> <td>9</td> </tr> <tr> <td>Other (specify)</td> <td>1</td> <td>0</td> <td>9</td> </tr> </tbody> </table>		Yes	NA	NR	Paid employment	1	0	9	Self employment	1	0	9	Government benefits	1	0	9	Illegal sources	1	0	9	Other (specify)	1	0	9
	Yes	NA	NR																							
Paid employment	1	0	9																							
Self employment	1	0	9																							
Government benefits	1	0	9																							
Illegal sources	1	0	9																							
Other (specify)	1	0	9																							
A6	Which was your <u>main</u> source of income in the last 6 months? [One source only]	Paid employment 1 Self employment 2 Government benefits 3 Illegal sources 4 Other (specify) 5																								
A7	Did you have a full time or part time job last week?	Yes, worked for payment or profit 1 Yes, but absent on holidays, on sick leave, on strike, or temporarily stood down 2 Yes, unpaid work in family business 3 Yes, other unpaid work 4 No, did not have a job 5 Non response 9																								
A8	In what country were you born?	Australia (go to A10) 01 England 02 Scotland 03 Italy 04 Greece 05 New Zealand 06 The Netherlands 07 Other (specify)..... 08 Non-response 99																								
A9	When did you first arrive in Australia?	<input type="text"/> <input type="text"/> 19																								
A10	How many children live with you and are financially dependent on you? [If 00 go to A12]	<input type="text"/> <input type="text"/>																								

APPENDIX B: RECRUITMENT STRATEGIES

Participants were recruited in a variety of ways. There seems to be little Australian information about the success of different recruitment strategies; therefore we report on them in detail here.

One strategy was to have agencies identify ex-users who met the eligibility criteria from among their former clients. They could either approach them informally or send letters to them on our behalf. In the second case, we could match the demographic characteristics of those who contacted us with the characteristics of all of the former clients written to by the agency and this could give us some idea of how representative our sample was.

Other strategies were to place advertisements in local newspapers and to distribute flyers through various contact points and through study participants.

We aimed at three different groups of participants: those identified through agencies; those who had never been in treatment; and, towards the end of the study when we only had a small number who had given up in the ACT, those who had successfully stopped in the ACT.

Recruitment by treatment agencies

A form letter (see below) was provided to alcohol and other drug agencies in Canberra.

The Drug Referral and Information Centre (DRIC), a non-government agency, handed out at least 20 letters; from those we interviewed one respondent. The Women's Addiction Recovery Service (WARS), based at Toora Wimmins Refuge, also distributed letters informally. They had 10 letters and also approached women verbally; this did not result in any interviews. Mancare, a therapeutic community run by the Salvation Army, was not sent letters, but approached a few people verbally. Two interviews resulted from this.

Karralika, a therapeutic community, sent out 13 letters and also approached some additional people verbally. We interviewed 5 people from Karralika. While we cannot be sure whether or not they were recruited through the letters, they will have been included in the demographic characteristics obtained from Karralika. Therefore we can compare the sample we interviewed with all the eligible ex-users from Karralika and make some suggestions about the representativeness of our sample.

The eligible ex-users approached by Karralika were 7 men and 10 women; we interviewed 2 men and 2 women. Hence the sex ratio is comparable. Of the seven men, one was in the 26–30 year age group; four in the 31–35 year age group; one in the 36–40 year age group; and one in the 46 to 50 year age group. The two we interviewed were 34 and 47. Of the 11 women, one was a nineteen year old; one was in the 20–25 year age group; one in the 26–30 year age group; three in the 31–35 year age group; and four women in the 36–40 year age group. The two women we interviewed were 31 and 40. The people we interviewed were thus at the older end of the total sample. Five of the six people we interviewed were on court orders and Karralika estimates that about 75 percent of their clients are referred by the courts.

Newspaper advertising

Newspaper advertising also resulted in several interviews. Three of the advertisements were aimed at people who had never been in treatment and one was aimed generally at people who had stopped in the last 5 years. Advertisements were placed in *The Canberra Times*, the locally produced commercial daily newspaper. One in the Saturday Public Notices section resulted in one interview. One in "The Fridge Door" community notices section (aimed at people who had stopped in the last 5 years) led to interviews with three men. This advertisement was placed on a Monday; this edition of *The Canberra Times* also contains the TV Guide for the following week and is therefore widely bought. *The Canberra Chronicle* (a free weekly community newspaper) also placed advertisements twice, a month apart. Each resulted in one interview with a woman. An advertisement in *The ANU Reporter*, the newspaper of one of the universities, resulted in no interviews. Copies are appended.

Flyers

Several flyers were distributed in various locations. Examples of the flyers are provided.

The Building Trades Group of Unions distributed one hundred flyers to three major building sites located around Canberra. These flyers were aimed at people who had given up in the ACT. There were no resultant interviews. Ten flyers were posted by DRIC to attract those who had received no formal treatment. These flyers resulted in two interviews from men who were having a cup of coffee nearby. (DRIC is located in the central shopping district.)

Ten flyers were also provided to one of the participants who was to distribute them amongst her friends and support groups. Several other participants were also provided with flyers for this purpose. Five interviews were arranged from these contacts.

Ineligible enquiries

We had twelve other enquiries, seven women and five men, who were ineligible for interview. Four enquiries were responding to the advertisement in the Fridge Door. Thus this advertisement attracted the most enquiries. Two ineligible enquiries came from the advertisement in the Public Notices section and three from the advertisement in the ANU Reporter.

A flyer at DRIC attracted one ineligible enquiry.

One ineligible enquiry came through a referral from a concurrent study of current methadone users and one from a referral by a study participant.

Form letter sent to agencies on NCEPH letterhead

Researchers at the National Centre for Epidemiology and Population Health at the Australian National University are conducting a survey of some former clients of health services in the ACT.

The aim of this survey is to gather information which will be used to improve existing services and to assess the need for new services.

Agency staff are sending this letter to you on our behalf. However they will not be involved in the survey, nor will they have access to information from individual participants. Your name has not been released to us. Participation in the study will be completely anonymous.

If you are interested in participating in the survey or would like more information about it, please phone Sue on 249 5623.

You do not have to give your name.

This is an opportunity to have your say about some of the health services in the ACT.

Yours sincerely,

Dr Gabriele Bammer
Fellow
National Centre for Epidemiology and Population Health
16 March 1993

Copies of advertisements

GIVING UP HEROIN

Have you successfully stopped using heroin without formal treatment? The National Centre for Epidemiology and Population Health at the Australian National University is currently interested in interviewing anyone who has been dependent on heroin and has stopped using within the last five years.

If you are such a person, we feel that you could provide valuable information which may help us design future heroin treatment programs. Confidentiality of all those applying or participating in the study is provided through specific legislation and will be strictly maintained. If you would like to talk about your experience in giving up heroin please contact Sue on 249 5623.

Canberra Times: Public Notices
3/4/1993

Giving up heroin

The National Centre for Epidemiology and Population health, ANU, wants to interview anyone who has been dependent on heroin and has stopped using within the past five years. Confidentially maintained by legislation, recompense of \$20 to participants. Inquiries: 249 5623

The Canberra Times, "Fridge Door".
Monday, 24 May 1993, p.16

GIVING UP HEROIN

Have you successfully stopped using heroin without formal treatment?

The National Centre for Epidemiology and Population Health at the Australian National University is currently interested in interviewing anyone who has been dependent on heroin and has stopped using within the last five years.

If you are such a person, we feel that you could provide valuable information which may help us design future heroin treatment programs.

Confidentiality of all those applying or participating in the study is provided through specific legislation and will be strictly maintained.

Recompense of \$20 will be provided to all interview participants.

If you would like to talk about your experience in giving up heroin please contact Sue on 249 5623.

- (1) The Chronicle, Week ending April 26 1993, p.8.
- (2) ANU Reporter, 21/4/1993, p.12.

GIVING UP HEROIN

Have you successfully stopped using heroin without formal treatment?

The National Centre for Epidemiology and Population Health at the Australian National University is currently interested in interviewing anyone who has been dependent on heroin and has stopped using within the last five years.

If you are such a person, we feel that you could provide valuable information which may help us design future heroin treatment programs.

Confidentiality of all those applying or participating in the study is provided through specific legislation and will be strictly maintained.

Recompense of \$20 will be provided to all interview participants.

If you would like to talk about your experience in giving up heroin please contact Sue on 249 5623.

GIVING UP HEROIN

Have you successfully stopped using heroin in the ACT?

The National Centre for Epidemiology and Population Health at the Australian National University is currently interested in interviewing anyone who has been dependent on heroin and has stopped using within the last five years.

If you are such a person, we feel that you could provide valuable information which may help us design future heroin treatment programs.

Confidentiality of all those applying or participating in the study is provided through specific legislation and will be strictly maintained.

Recompense of \$20 will be provided to all interview participants.

If you would like to talk about your experience in giving up heroin please contact Sue on 249 5623.

APPENDIX C: RESULTS FROM A SURVEY OF EX-USERS CONDUCTED DURING STAGE 1 (MAY TO JULY 1991)

Those who worked on this survey were Gabriele Bammer, David Crawford, Phyll Dance, Remo Ostini, Stefanie Pearce and Adele Stevens.

For this data for ex-users, Gabriele Bammer and Remo Ostini did the quantitative analysis, Phyll Dance did the qualitative analysis and Gabriele Bammer wrote this appendix.

During Stage 1 of the feasibility research in 1991, self-completion questionnaires were distributed through various service agencies and friendship networks, with invitations to users and ex-users to complete and return them. Because of the tight time-line, the responses of users and ex-users were not differentiated in the Stage 1 analysis. Subsequently we have analysed the results for the sub-groups separately and the results for the ex-users are presented here.

1. Background information

The group that participated in this survey was fairly evenly divided between men and women and almost half were under 30. Just over half had some post-school qualification and just over 40 percent were in full- or part-time employment. Just over half had children aged under 25. Less than 20 percent practiced a religion (Table 1).

Nearly three-quarters had moved house in the last year, with more than half moving twice or more (Table 1). Just over 40 percent had lived away from Canberra for some time in the last year (Table 2).

They were spread across a range of living situations (Table 1). Less than one-quarter lived with people who were dependent users of heroin or other opioids and less than 20 percent lived with non-dependent users (Table 3a). Only 1 of 44 respondents said they had no friends. Twenty-three percent had between one and five friends; 39 percent had between 6 and 20 friends; and 36 percent had more than 20 friends. About three-quarters had friends who used illicit drugs, but most also had friends who used no illicit drugs (Table 3b).

TABLE 1. Socio-demographic profile of ex-user sample

	%
Sex (n=44)	
Male	52
Female	48
Age (years) (n=44)	
18 – 29	48
30 – 39	43
40 – 49	9
Qualifications (n=43)	
None since school	47
Certificate or diploma	21
Trade or apprenticeship	12
Bachelor or higher degree	19
Current employment status (n=44)	
Full time	27
Part time	14
Student	7
Home duties	9
Unemployed	43
Other	0
Living situation (n=44)	
With partner and/or children	25
Alone	7
In a group house	27
With parents	16
Other	25
Number of times changed house in the past 12 months (n=43)	
None	37
Once	19
2–4 times	40
5 times or more	5

Have children under 25 (n = 44)

52

Practice a religion (n = 44)

18

TABLE 2: Have you lived away from Canberra for any length of time in the past 12 months? (n=44)

	%
Yes	41
No	59

TABLE 3: Relationships with other drug users

a. People that live with

	None	One	A few	About half	All or most	Don't know	Not applicable
How many of the people you live with are dependent heroin/opiate ¹ users? (n=43)	72	14	0	2	7	0	4
How many of the people you live with are non-dependent or recreational heroin/opiate users? (n=42)	74	12	2	0	2	0	10

b. Friendships with other drug users

	None	Some	Most	Don't know	No friends
About how many of your friends (apart from any you live with) are dependent heroin/opiate users? (n=45)	27	62	9	0	2
About how many of your friends (apart from any you live with) are non-dependent or recreational heroin/opiate users? (n=45)	31	58	7	2	2
About how many of your friends use cannabis only? (n=45)	16	47	33	2	2
About how many of your friends use illegal drugs apart from heroin/opiates and cannabis? (n=44)	11	64	18	5	2
About how many of your friends use no illegal drugs at all? (n=45)	20	64	11	2	2

2. Drug use

Not all of the people in this group had been dependent on heroin; some had used other opioids in preference. Thirty percent of the ex-users were daily methadone users and all of these were in methadone treatment programs². Fifty-six percent of the ex-user group were not using any illegal drugs; 38 percent were still using some illegal drugs; and for 7 percent the responses about continuing use of illegal drugs were conflicting. Of the illegal drugs used, only cannabis use was relatively common. Smoking tobacco was common in this group. Alcohol use was also relatively high (Table 4).

¹ The word 'opiates' was used in the questionnaire and is therefore used here when reporting on questions respondents were asked. In the rest of the text the more accurate 'opioids' is used.

² People currently on the methadone program were not eligible for inclusion in the study reported in the main body of this working paper.

TABLE 4. Drugs used in the last month (n=45)

	Once a day or more	More than once a week but less than once a day	Once a week	Less than once a week	Not used
Cannabis	30	9	2	2	56
Alcohol	19	12	9	12	49
Tobacco	80	2	-	2	16

3. Treatment

In this group, 73 percent were currently undertaking treatment, with just under half having tried more than one form of treatment. Twenty percent had never undertaken treatment, but most had tried two or three, with some up to eight, treatment regimens in the past. Counselling was the single most common form of treatment currently being undertaken and, as with all other forms of treatment being undertaken at the time of the survey, it was seen as helpful (Table 5). More than 40 percent of respondents had tried each of the main treatment regimens in the past, and, of these, more than 60 percent had found them to be helpful (Table 5).

TABLE 5. Treatment history (percentages)

Treatment	Current (n=38)	Helpful	Ever (n=41)	Helpful
Methadone Maintenance	26	100	41	67
Methadone Withdrawal	9	100	40	64
Detoxification	0	-	41	69
Therapeutic Community	33	100	49	82
Counselling	28	100	47	87
12 Step Program	44	100	54	84

4. Health problems associated with illegal drug use

Eighty percent of ex-users had experienced health or other problems that they attributed to their use of illegal drugs. (Only 35 people answered this question.)

Four had hepatitis B; four hepatitis C; one had hepatitis A and four had unspecified hepatitis. Four ex-users also reported having overdosed (presumably on heroin).

Other health problems included hypertension (n=3); unspecified liver problems (n=2); leg ulcers caused by intravenous drug use (n=1); unspecified ulcers (n=1); septicaemia (n=2); malnutrition (n=2); respiratory problems (n=7); and "stress and depression" (n= 3).

5. Financing illegal drug use and criminal behaviour associated with illegal drug use

It can be seen from Table 6 that legitimate sources of income, that is full- or part-time employment or government benefits, had played an important role in financing illegal drug use in the past. However, these legitimate sources of income had been supplemented by illegal activities or prostitution for 74 percent of ex-users. (This does not include illegal activities conducted for other reasons: for example, shoplifting for food.) 'Other' ways of financing drug use had included fencing; selling possessions; using savings; gambling; and 'ripping people off'. A few users also relied on generous friends or family to give or lend them money.

In response to a question asking about health or other problems associated with illegal drug use, three ex-users mentioned financial problems. Employment difficulties, including job loss, were mentioned by two ex-users.

TABLE 6. Usual ways of financing illegal drug use in the past (n=39)*

	%
Full-time employment	41
Part-time employment	23
Government benefits**	62
Supplying illegal drugs	54
Shoplifting	21
Other stealing (including break & enter)	41
Robbery (eg mugging)	15
Fraud	33
Prostitution	21
Other	13

* does not include ex-users who are still using illegal drugs, other than cannabis

** unemployment benefits, pension

More than 40 percent had been involved in supplying illegal drugs in the last year, but less than one-quarter had been involved in other illegal activities (Table 7). We did not ask how long it was that people had stopped use of heroin or other opioids, so some may well have still been using in the last 12 months.

TABLE 7: Ways of financing illegal drugs in the last 12 months

	Never	Less than 10 times	10-100 times	More than 100 times
Shoplifting (n=39)	77	13	5	5
Other stealing (including breaking and entering) (n=40)	75	8	13	5
Robbery (eg mugging) (n=38)	92	5	0	3
Fraud (n=38)	76	24	0	0
Supplying illegal drugs (n=39)	59	21	13	8
Prostitution (n=38)	90	5	0	5

A small percentage 'currently' supplied illicit drugs; mostly marijuana (Table 8a). Of these half supplied to friends at cost price and more than one-quarter made a profit through this activity (Table 8b).

TABLE 8: Illicit drugs supplied**a. Type of drug (n=41)**

	%
I don't supply drugs	88
Just marijuana	10
Just heroin/opiates	0
A range of drugs including cannabis and heroin/opiates	2

b. Profit margin (n=40)

	%
Only supply to friends and do so at cost price	8
Only supply enough to cover your own drug use	3
Get a profit through dealing over and above what you need for your own drug use	5
I don't supply drugs	85

More than half had driven under the influence of alcohol or cannabis in the last year and somewhat less than half had driven under the influence of other illegal drugs during that time (Table 9).

TABLE 9: Driving under the influence of drugs in the last 12 months

	Never	Less than 10 times	10–100 times	More than 100 times	I don't drive
Alcohol (n=42)	43	29	19	7	2
Cannabis (n=42)	43	10	21	24	2
Heroin/opiates (n=40)	55	15	18	10	3
Other illegal drugs (n=39)	64	8	18	8	3

TABLE 10: Been a victim of violence because of these drugs in the last 12 months?

	Never	Less than 10 times	10–100 times	More than 100 times	Don't know
Alcohol (n=42)	60	26	14	0	0
Cannabis (n=40)	85	13	3	0	0
Heroin/opiates (n=42)	67	29	5	0	0
Other illegal drugs (n=40)	85	13	3	0	0

TABLE 11: Assaulted another person because of these drugs in the last 12 months?

	Never	Less than 10 times	10–100 times	More than 100 times
Alcohol (n=42)	83	10	7	0
Cannabis (n=40)	95	5	0	0
Heroin/opiates (n=41)	88	7	5	0
Other illegal drugs (n=39)	92	5	3	0

More than 40 percent of respondents reported being assaulted by others because of alcohol and illicit drugs, and had the highest proportion of victims because of alcohol and the heroin/opiates (Table 11). It is common for people to report being victims of violence because of other illicit drugs (15 percent; Table 10).

6. Views on drug use

Apart from marijuana, well over half of the respondents thought that use of illicit drugs, tobacco and excessive drinking of alcohol were serious problems for the community (Table 12).

TABLE 12: Responses to a series of statements about “activities that some people say are serious problems affecting the general community.” (n=45)

	Percentage Agreeing With the Statement				
	Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
...is a serious problem for the community					
Tobacco use	44	40	11	2	2
Use of amphetamines or speed	42	44	9	4	0
Marijuana/hash use	20	22	18	22	18
Heroin use	64	22	7	7	0
Use of hallucinogens or trips like LSD or magic mushrooms	47	18	22	11	2
Cocaine/crack use	47	22	22	9	0
Excessive drinking of alcohol	82	16	2	0	0

Just under 70 percent saw the use of heroin as a pleasant experience and the same percentage saw heroin use as a type of illness. Just over 60 percent saw heroin use as a way of dealing with life's problems. Less than half saw heroin use as basically wrong (40 percent) or as no different from getting drunk (44 percent; Table 13).

Table 13: Responses to the question “How much do you agree or disagree with each of the following descriptions for of heroin taking?”

	Percentage Agreeing With the Statement				
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Taking heroin is...					
a way of dealing with life's problems (n=44)	34	27	14	9	16
basically wrong (n=43)	12	28	26	26	9
really no different from getting drunk (n=43)	16	28	14	23	19
a type of illness (n=45)	47	22	7	18	7
a pleasant experience (n=44)	30	39	18	2	11

7. Views on a heroin trial

More than 80 percent had heard of the proposal for a 'heroin trial' and 62 percent thought it should go ahead (Tables 14 and 15). Two percent thought they would start using again to get on a trial and 19 percent did not know (Table 16).

Table 14: Heard of the proposal for a heroin trial (n = 45)

	%
Yes	82
No	16
Don't know	2

TABLE 15: Response to the following question (n = 45)

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

Other people think setting up a trial is just too risky because it might make the problems even worse. They would argue that it should not go ahead.

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

	%
Should go ahead	62
Should not go ahead	22
Don't know	16

TABLE 16: Would you start using again to get on the trial? (n = 42)

	%
Yes	2
No	79
Don't know	19

Eighty percent agreed or strongly agreed that a trial would reduce the spread of HIV/AIDS and that people would always use so that it was important to help them to use safely. Nearly three-quarters thought it would reduce crime and/or mixing with criminal elements and just over 60 percent thought a trial would improve health and reduce corruption. Smaller percentages thought that the potentially harmful effects of a trial were likely to eventuate. Just under half thought that it would take away incentives for people to cut back use or give up. About one-third saw a potential inconsistency between government policy on legal and illegal drugs. Around 20 percent thought a trial would increase the number of users, set a bad example for children or be bad for road safety (Table 17).

TABLE 17: Views on potential benefits and problems associated with a trial (n=45)

Providing users with heroin/opiates in a controlled trial:	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Will simply increase the number of people taking heroin/opiates	2	20	11	49	18
Will improve their overall health	29	33	11	13	13
Since governments are worried about the consumption of drugs like alcohol and tobacco, it seems illogical to provide heroin/opiates to users (n=44)	14	21	2	43	21
Will reduce the speed of HIV/AIDS in the community	42	38	0	11	9
There will always be some people who take heroin/opiates so it is important to provide them with it in the safest way	53	27	7	9	4
Sets a bad example for young people	11	13	18	36	22
Means there will be no incentives for them to give up or cut back in their use	24	24	7	31	13
Means they will not have to mix with criminal elements or steal to pay for their drugs	53	20	7	11	9
Will be bad for road safety because more drug affected people will be driving	2	16	22	44	16
Will reduce the amount of corruption in our community (n=44)	39	25	7	16	14

The ex-user respondents were also asked their views on a range of more specific details concerning a trial. Sixty-four percent were worried that a trial would attract users to the ACT from elsewhere in Australia (Table 18). Nearly 90 percent thought that if a trial allowed take-aways, people on a trial would be hassled for their drugs (Table 19); but just over a quarter thought that this would be the case if trial drugs had to be taken at the distribution site (Table 20). Partners and friends were thought to be the people most likely to hassle those on a trial for their drugs, although half thought that dealers and other people would also be involved (Table 21). The hassling was thought most likely to be verbal, but more than 60 percent thought it could be physical and about one-third thought it might be life-threatening (Table 22). Eighty percent thought it would either reduce or make no difference to hassling by police (Table 23).

TABLE 18: If a trial was conducted how worried would you be that heroin/opiates users would be attracted to the ACT from elsewhere in Australia? (n = 44)

	%
Very Worried	23
Somewhat Worried	41
Not worried	34
Don't know	2

TABLE 19: How likely do you think it is that people on the trial would be hassled for their heroin/opiates by people not on the trial, if the heroin/opiates could be taken home? (n = 44)

	%
Very likely	66
Likely	23
Unlikely	5
Very unlikely	5
Don't know	2

TABLE 20: How likely do you think it is that people on the trial would be hassled for their heroin/opiates by people not on the trial, if the heroin/opiates have to be taken at the distribution point? (n = 44)

	%
Very likely	14
Likely	14
Unlikely	43
Very unlikely	25
Don't know	5

TABLE 21: If you think people on the trial might be hassled for their heroin/opiates, who do you think would be likely to hassle them?

	Partner/ spouse (n=43)	Friends (n=44)	Suppliers/ dealers (n=41)	Others (n=34)
Yes	79	84	49	53
No	9	7	32	15
Don't know	7	7	15	27
Don't think users would be hassled	5	2	5	6

TABLE 22: If you think people on the trial might be hassled for their heroin/opiates, do you think that this will be:

	Verbal (n = 42)	Physical (n=42)	Life-threatening (n=41)
Yes	88	64	32
No	2	12	29
Don't know	2	17	29
Don't think users would be hassled	7	7	10

TABLE 23: Do you think being on the trial would increase or decrease the possibility of users being hassled by the police? (n = 44)

	%
Increase	11
No difference	41
Decrease	39
Don't know	9

The majority thought the price of street heroin/opiates would fall or stay the same and none thought it would rise (Table 24). There was a wider range of views about change in availability, but more than half thought it would stay the same (Table 25). There was also a range of views about effects of a trial on the price and availability of other illegal drugs; again more than half thought that each would stay the same (Tables 26 and 27).

TABLE 24: What would happen to the price of street heroin/opiates? (n = 44)

	%
Fall	43
Stay the same	48
Rise	0
Don't know	9

TABLE 25: What would happen to the availability of street heroin/opiates? (n = 43)

	%
Fall	19
Stay the same	56
Rise	12
Don't know	14

TABLE 26: What would happen to the price of other illegal drugs? (n = 43)

	%
Fall	19
Stay the same	58
Rise	7
Don't know	16

TABLE 27: What would happen to the availability of other illegal drugs? (n = 43)

	%
Fall	12
Stay the same	65
Rise	12
Don't know	12

More than 70 percent thought trial eligibility should be restricted to dependent users (Table 28) and there was a diversity of views about whether or not numbers should be limited (Table 29). Just under half thought that users aged less than 18 should be allowed on a trial (Table 30).

TABLE 28: If a trial to provide users with heroin or other opiates was conducted, do you think that it should only include people who are dependent on these drugs or should people who occasionally use heroin/opiates also be included? (n = 41)

	%
Dependent users only	71
Both	27
Don't know	2

TABLE 29: If users were to be provided with heroin as a trial in the ACT, do you think all dependent users or only a limited number should be included? (n = 41)

	those who said addicts	those who said both
All dependent users	37	15
Only a limited number	24	12
Don't know	10	2

TABLE 30: If a trial was conducted, do you think that it should include heroin/opiates users aged under 18 years? (n = 43)

	%
Yes	47
No	35
Don't know	19

Respondents were evenly divided in their views about whether or not trial participants should pay for the trial drugs (Table 31) and more than 80 percent thought they should be taken at the distribution point (Table 32). Just under 40 percent thought cannabis should be provided as well as heroin/opiates (Table 33) and just over 20 percent thought other illicit drugs should also be provided (Table 34).

TABLE 31: If a trial was conducted, do you think users should have to pay for the heroin/opiates? (n = 44)

	%
Yes	43
No	41
Don't know	16

TABLE 32: If a trial was conducted, should users be allowed to take their drugs home or should they be required to use them at the distribution point? (n = 42)

	%
Take home	17
Take at distribution point	81
Don't know	2

TABLE 33: Since most heroin/opiates users also take a range of other illegal drugs, should the proposed trial provide only heroin/opiates or should cannabis also be provided? (n = 43)

	%
Heroin/opiates only	49
Cannabis also	37
Don't know	14

TABLE 34: Should the proposed trial provide only heroin/opiates or should other illegal drugs like amphetamines, cocaine and hallucinogens also be provided to those who generally use them? (n = 42)

	%
Heroin/opiates only	64
Other drugs also	21
Don't know	14

Around three-quarters thought the trial should be used to encourage participants to cut down or become non-dependent and just under 60 percent thought it should be used to encourage participants to stop using (Table 35). There was less agreement that a trial should have these aims for non-dependent users (Table 36).

TABLE 35: Do you think a 'heroin/opiates trial' should be used as a way of encouraging dependent heroin/opiate users?

	Yes	No	Don't know
to cut down (n=41)	76	20	5
to become non-dependent (n=42)	71	21	7
to stop using (n=43)	67	26	7

TABLE 36: Do you think a trial should be used as a way of encouraging non-dependent heroin/opiate users?

	Yes	No	Don't know
to cut down (n=40)	55	35	10
to stop using (n=43)	51	30	19

Comparison between the two studies

Compared to the ex-users interviewed for the qualitative study for the main body of this report, slightly more respondents to the self-completion survey in Stage 1 were women. Similar age ranges were covered in both studies and there was a similar range in levels of education, but more of the people in the Stage 1 survey had post-school qualifications. Slightly more of the people in the Stage 1 survey were employed.

Of the 18 people interviewed for the main body of this report, 17 were asked their views about a heroin trial. Eight (47 percent) were in favour of a trial; seven (41 percent) were not in favour; and two (12 percent) were undecided. A larger percentage of ex-users were in favour of a trial in the Stage 1 survey, with 62 percent in favour, 22 percent against and 16 percent undecided.

In the qualitative study, respondents were not prompted about potential benefits and problems, whereas in the Stage 1 survey they were. In both studies benefits were seen to include that people would use anyway and that a trial could help them use with less problems; and that a trial would reduce crime and that it would combat the spread of HIV/AIDS. In both studies arguments against were that a trial would work against dependent users being helped to be able to lead 'normal' lives or it would provide no incentive to give up. In both studies, respondents were also worried about users from elsewhere in Australia moving to Canberra. There was a minority view in both that young people might be encouraged to use. In the qualitative study a number of logistic problems were also raised.

Out of 14 respondents to the qualitative study, 36 percent thought they might be tempted to start using again; 64 percent thought not. In the Stage 1 survey, 2 percent thought they would start using again and 19 percent did not know.

APPENDIX D: HEROIN USE AND PREGNANCY

One of the areas for consideration for the feasibility of a 'heroin trial' that has provoked considerable debate is whether or not pregnant women should be eligible for a place on a trial. On the one hand, it is argued that the shorter half life of heroin (shorter than methadone) exposes the foetus to increased health risks and that pregnant heroin users should therefore only be given methadone. Some would go so far as to argue that no women should be given a place on a trial in case they become pregnant. On the other hand, it is argued that pregnant users may well continue to use street heroin and that a controlled supply through a trial would be much safer and may make them more likely to report for antenatal and postnatal care.

Given that there is little sound evidence comparing the effects on the foetus of clinically supplied heroin with clinically supplied methadone, the debate is difficult to resolve. However, documenting what women using heroin do when they become pregnant may shed some light. There is little Australian evidence on this topic, hence information was gathered in this study and in studies of current heroin users.

Of the seven women in this study, all had been pregnant at some stage in their lives. Varying levels of information were collected about their pregnancies.

Two of the women began using heroin only after they had children and did not become pregnant again. One believes that if she had become pregnant when she was using heroin

'I think I would've still used, nothing would've stopped me back then. And the kids were babies and I was using and that wasn't enough incentive to give up.'

Of the others, one had been pregnant five times with four ending in terminations; one at 18 weeks. Drugs used during the pregnancies included cocaine, heroin, alcohol, benzodiazepines, and marijuana. None of her pregnancies were planned and she was never in treatment when she was pregnant.

She reports that she had her child

'Because I thought if I had another abortion I'd never be able to have children.'

In addition, she was three months pregnant when she realised.

She cut down on her drug use (heroin, cannabis and alcohol), had a homebirth with some antenatal care, but received no postnatal care. As she explains.

'I'm resentful about that still. I didn't seek it out. I have a lot of trouble with humility. I know best.'

Another reason for not receiving postnatal care was that she could not afford to pay the midwife.

Another woman had five or six pregnancies which all ended in terminations. She was using heroin each time she became pregnant, except for her first pregnancy at 16 years of age. She was also using speed, hashish and marijuana. None of the pregnancies was planned and she would terminate the pregnancy because of her drug use. She would usually know of a pregnancy within four to six weeks, and was never in treatment when pregnant.

A third woman was pregnant five or six times with two pregnancies carried to full-term; the others were terminated. None of her pregnancies were planned.

She relates

'While I was pregnant with my first child, with the daughter I still have, I got off on methadone and I was still using but I brought myself down and I was only having one shot a day at night and have my 'done [methadone] in the morning and slowly cut that out so that I wasn't hanging out anymore. I didn't use. I had one or two shots at Christmas and on my birthday. And when I had her, she wasn't hanging out at all. I told them what I wanted to do and told the doctors what I was doing and they said we don't think you should go any lower because you're too close to full-term and the baby's not going to hang out anyway so I stayed on a low dose. And I stayed on that low dose while I was breastfeeding and I wasn't using. And then I picked up my dope and my dose was getting higher again and I started using again.'

She received antenatal care as an outpatient at a major city hospital, but received minimal postnatal care.

'I very rarely took my daughter to the clinic. I think I got her immunised once or twice.'

The next time she went to full-term

'I got pregnant three months after I had the first. When I found out I went full on into it because I knew that I was going to give it up for adoption. I was four months when I found out. I chose to ignore the fact that I wasn't getting my periods. I just didn't know I was pregnant until I got big and it was too late for a termination and I couldn't go through

with it anyway because I'd just had a child so I went full on to cope with the pregnancy knowing that I was going to give it away.'

She went on to say

I saw my second baby hanging out and that was really bad but when you're using you can't stop it. Methadone is really good to bring you down but you don't have much choice when you're out there using. I think methadone is better than using heroin because it's more controlled and I had a definite wish not to use. I didn't want to see my baby hanging out. I think that addicts that use, it might not make a difference but they should see the a baby hanging out and maybe that will stop them. You don't give a fuck when you're using, even your own baby.

A fourth woman had a child before she began using heroin and then had another after she started. She changed her drug use and instead of heroin began using cocaine, which she believes has led to long-term health problems for her child

I was using coke and now she has side effects. She is very vulnerable to pneumonia and she's tiny. I feel that the chest part is part of my drug use. Most kids get a cold but she gets pneumonia.'

She relates that she changed her drug use

'because my boyfriend wouldn't give [heroin] to me. Because he thought of it as being extremely dangerous. As long as I wasn't hanging out it was OK. It took a while for my body to accept the coke and not the heroin but it was better than saying well I'm not having nothing and I think that's the way my boyfriend saw it too. And it was cheaper to support one person on coke and one person on heroin than to support two people on heroin.'

She chose not to go on a methadone program as

I tried the methadone twice while I was in jail but it never gave me the stoned thing that drugs did. It stopped the craving.'

While her first child was not planned

'the second one we decided to keep the first one company.'

She had a caesarean because of health problems

'I had septicemia, blood poisoning, and that was scary.'

We gathered less information about the fifth woman. She became pregnant when she stopped using heroin. She was briefly on a methadone program and continued to use amphetamines

I kept using amphetamines and got kicked off methadone. And that was it, I just stopped in February and in March I was pregnant with him.'

Summary

Of the five women who became pregnant after they began using drugs, detailed information is available for three.

Of the others, one stopped using heroin shortly before she became pregnant, but may still have been using amphetamines; and one stopped using heroin and started using cocaine at the behest of her partner. (This points to a need for better education for illicit drug users about the effects of various drugs on the unborn baby.)

The other three were each pregnant more than five times, with most pregnancies ending in terminations. None of the pregnancies were planned and this suggests that contraceptive practices among heroin using women might be worth further study and might be an area warranting education and other intervention strategies. It seems that the women were worried about the potential effects of their drug use on their unborn babies and chose terminations as a way of dealing with this. One woman had no live births and for the other two women pregnancies were carried to term when the women realised too late to have a termination and, in one case, when the woman feared that another termination would prevent her from ever having children.

Of the three pregnancies carried to term, one woman cut down her drug use, although details were not recorded. The other used methadone to cut down her heroin use dramatically and she then also reduced her methadone dose. When she unexpectedly became pregnant again though she used illicit drugs 'full on' because she had decided to give the baby up for adoption.

There are too few cases here to draw any conclusions about whether or not women and particularly pregnant women should be eligible for a place on a heroin trial. These results are likely to be of value used in conjunction with results from studies of current users.

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.

PUBLICATIONS

Reports

- * National Centre for Epidemiology and Population Health (1991), *Feasibility Research into the Controlled Availability of Opioids. Volumes 1 and 2*. NCEPH, The Australian National University, Canberra.
- * Bammer, G. and Gerrard, G. (eds) (1992), *Heroin Treatment – New Alternatives*, Proceedings of a one-day seminar, Becker House, Canberra, November 1991.

Working papers

- * Larson, A (1992), *Estimating the numbers of heroin users in the ACT*, Feasibility Research into the Controlled Availability of Opioids Stage 2, Working Paper Number 1.
- * Bammer, G. (ed) (1993), *Australian drug markets research: What are we doing? Where are we going? What are the gaps? Proceedings of a one-day workshop held at the Scarth Room, University House, The Australian National University, Monday 22 February 1993*, Feasibility Research into the Controlled Availability of Opioids Stage 2, Working Paper Number 2.
- * Sibthorpe, B., Sengoz, A. and G. Bammer in collaboration with The Youth Affairs Network of the ACT (1993), *Drug use and HIV risk among homeless and potentially homeless youth in the Australian Capital Territory*, Feasibility Research into the Controlled Availability of Opioids Stage 2, Working Paper Number 3.
- * Bammer, G. and S. Weekes (1993), *Becoming an ex-user: Would the controlled availability of heroin make a difference?* Feasibility Research into the Controlled Availability of Opioids Stage 2, Working Paper Number 4.

Published papers

- # Hartland, N; McDonald, D; Dance, P. and Bammer, G. (1992), 'Australian reports into drug use and the possibility of heroin maintenance', *Drug and Alcohol Review*, 11, pp.175–182.
- # Bammer, G. (1993), 'Should the controlled provision of heroin be a treatment option? Australian feasibility considerations', *Addiction*, 88, pp.467–475.
- # McDonald, D; Stevens, A; Dance, P. and Bammer, G. (1993), 'Illicit drug use in the Australian Capital Territory: Implications for the feasibility of a heroin trial', *Australian and New Zealand Journal of Criminology*, 26, pp.127–145.

Newsletters

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

These publications are available free from:
Dr Gabriele Bammer
Feasibility Study Co-ordinator
National Centre for Epidemiology &
Population Health
The Australian National University
ACT 0200
Phone: (06) 2490716
Fax: (06) 2490740

* These publications are for sale through:
Bibliotech
The Australian National University
ACT 0200