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compiled and edited by Gordon Preece

The **Ethics** of Drug and Alcohol Care:



SOCIAL CHANGES AND **CHRISTIAN** RESPONSES



The Paper This paper summarises presentations given at a conference on the ethical issues involved in addiction as it affects society. Speakers were selected to encourage a dialogue that is often lacking in the drug debate, between a range of disciplinary and denominational perspectives on drug issues at large, methods of treatment, and supervised injecting rooms. The conference was sponsored by ISCAST (The Institute for the Study for Christianity in the Age of Science and Technology) Victoria and initiated and coordinated by one of their fellows, Dr Alan Gijbers.

The Speakers DR ALAN GIJSBERS, specialist physician for drug and alcohol treatment at the Turning Point Drug and Alcohol Centre, Epworth and St. Vincent's Hospitals, Fellow of ISCAST. PROFESSOR GREG WHELAN, Director of the Department of Drug & Alcohol Studies, St Vincent's Hospital, a Roman Catholic and member of the former Victorian Government's first Penington Commission. REV'D TIM COSTELLO, Pastor of Collins St. Baptist and President of the Baptist Union of Australia. REV'D DR NORMAN FORD, SDB, STL, Director, Caroline Chisholm Centre for Health Ethics, East Melbourne. MAJOR BRIAN WATTERS, Salvation Army, Chairman of the National Council on Alcohol and Drugs. DR GORDON PREECE, Director, Ridley College Centre of Applied Christian Ethics and Chair, Zadok Editorial Board.



The Ethics of Drug and Alcohol Care: Social Changes and Christian Responses

FAITH, SCIENCE AND DRUGS

Dr Alan Gijsbers, specialist physician for drug and alcohol treatment at the Turning Point Drug and Alcohol Centre, Epworth and St. Vincent's Hospitals, Fellow of ISCAST.

ISCAST (THE Institute for the Study for Christianity in the Age of Science and Technology), the sponsor of this seminar, is interested in the interface of science and faith. There is a lot of expression of faith in the drugs and alcohol debate, and this represents a very good area to explore the complex interaction between science and faith. Science by itself is all about 'is' whereas ethics is about 'ought'. The philosopher David Hume said that you can't get an 'ought' out of an 'is'. Science therefore needs an ethic that comes from outside science. There is also a whole metaphysic within which science is embedded. Recognising the metaphysic impacts on the way we pursue science. For instance, if you believe that human beings are nothing but a series of atoms and molecules, then that particular metaphysic affects the way in which you pursue your science. But if you believe that human beings have an intrinsic value, you will have a different approach.

Science can extend our understanding of the problems and evaluate the management strategies for drug and alcohol abusers. While it is bad ethics to base drug and alcohol strategies on bad science, we also need to proceed beyond science to issues of ethics and values. The first ethic is the way we conduct the debate. There is a lot of heat in the drug and alcohol debate. Thus we read statements questioning the intellectual integrity and character of people, like my former professor David Penington. This is unnecessary. On the other hand, Major Brian Watters has sometimes been demonized for his more conservative approach. You can disagree without demonizing someone. We need to create an atmosphere of Christian grace to go forward. Tim Costello once suggested that it is important to develop a 'politics of grace,' that is, the ability to disagree graciously.

Models of Drug Dependence

WHAT IS THE drug problem? Initially it was thought to be a moral problem for which legal sanctions were sufficient. This was replaced with the view that addiction is a disease needing treatment. Thus we get the slogan, 'not bad, but sick'. Psychologists challenged the supremacy of the disease model by saying that the drug problem is not a disease, it is a behavioural disorder, requiring behavioural modification. This view became more subtle as they talked about cognitive behavioural disorders – changed behaviour as a result of changed thinking. This is very similar to that Greek word *metanoia* which means to repent or change your mind, which is at the heart of the Christian Gospel.

Another view sees the drug problem simply as ignorance. This approach says that the drug problem should be addressed through education. The public health model takes a multi-disciplinary approach. The drug problem is multi-dimensional and the strategies we explore for dealing with it in this seminar will also need to be multi-dimensional.

It is often forgotten, however, that there is also the spiritual dimension to the drug problem. We need to ask why society has a drug problem now. Pain has been present always and we have so many better pharmacological ways of handling pain than before. Yet increasingly we seem to be unable to deal with suffering

We want some sort of pill solution to the pain problem.

meaningfully or spiritually or within a faith framework. We want some sort of pill solution to the pain problem. As I asked one of my patients 'what are the personal faith resources that are available to you to encourage change?' The major example of the spiritual approach is Alcoholics Anonymous, which talks not just of the encounter with the higher power leading to change, but also the fellowship of a caring, accepting, non-judgmental community, which can make a difference.

However there are problems in using any one model as the single explanation for drug abuse. We

cannot ignore the moral dimension. Society suffers when patients break the law while pursuing their particular dependence. It is too simplistic to say that there are no moral dimensions, and no need for legal sanctions. Further, while it might be liberating to regard it only as a disease, that implies that we have no responsibility for our behaviour. One of the signs of recovery can be to say 'I am responsible for my behaviour. I have the freedom to choose, and therefore I can stop'. After a breakthrough in his two year struggle with alcoholism, one of my patients told me what made a difference was 'when I realised I had a choice'. And exercising that choice made a difference. Thus we need the insights of each of these dimensions to develop a comprehensive picture of the complexities of drug and alcohol abuse.

Drug abuse in a broader context

a) Drug Deaths

To explore these perspectives further, and to put issues such as heroin deaths in a broader context, let's examine some scientific data. Dray Holman's 1987 research into deaths due to drug use is still reliable.

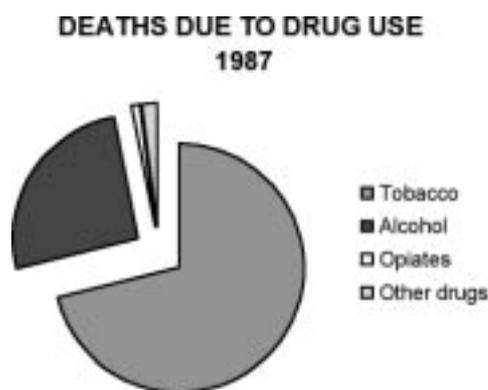


Figure 1: Tobacco contributes 71% of the total, alcohol 26%, other drugs 2% and opiates 1%.

The death rate of about 250 deaths each year in Victoria from heroin is nowhere near the thousands of deaths from legal drugs. This raises a profound question. Who are the real drug pushers in our community? Safeways and Coles are – that is where we buy alcohol and cigarettes. You may say that it is good that we are so hard on the illegal drugs and they are not a bigger problem in our society. But actually there may be an epidemic of legal drugs in our society.

Compare Figure 1 with figure 2. Figure 2 looks at the deaths in terms of number of years of life lost. Tobacco now contributes 51% of all deaths, and the contribution due to alcohol has gone up from 26% to

40%. This is because cigarette smokers might die at 55 or 60, so they have gone through a fair amount of their life span. But alcohol is the big killer of young people. Nearly 50% of 16-17 year olds get themselves regularly smashed on weekends. That is the silent epidemic in our society. In terms of the years of life lost, the impact of alcohol is greater than the impact of illicit drugs, even today. Despite this, reputable medical journals like the *Herald Sun* and the *Australian Women's Weekly* say that heroin is the biggest problem in our society now.

DEATHS IN TERMS OF YEARS OF LIFE LOST 1987

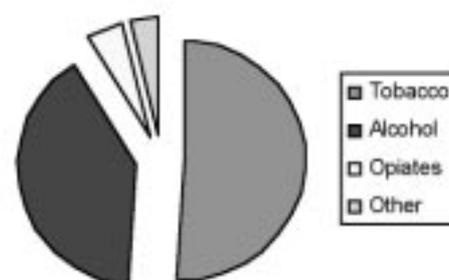


Figure 2: Tobacco now contributes 51%, alcohol 40% opiates 5% and other drugs 4%.

These figures should make us think about why there is such inconsistency regarding concern over illegal drugs and the acceptance of legal drugs. I'm not saying let's illegalise the legal drugs or legalise the illegal drugs – I am saying let's have a good look at that legal-illegal distinction.

b) Dependence, damaging drinking and intoxication

We tend (particularly those of us who are doctors) to think of drug use purely in terms of dependence, of the revolving door syndrome of the alcoholic or heroin dependent person who returns again and again. But there are many people in our society suffering from damaging drinking without being dependent. They drink more than the National Health & Medical Research Council's recommended 2 standard drinks a day for women, or 4 standard drinks a day for men. Controlled trials have shown that education can make a great difference here. There is also the area of intoxication, which may not be due to dependence, and may not be sufficient to cause damaging drinking but which particularly affects our young people. If our public health strategies concentrate on dependence we will miss out on those young people who are killing or

injuring themselves in car crashes. There are strategies in place with some effect, like the limiting of blood alcohol levels to zero blood alcohol for P plate drivers. But more is required. There are different dimensions to the drug problem which require different approaches.

c) Drugs, persons and environment

Further, the drug problem is not just the problem of the drug in itself. Dr William Osler once said that one of God's greatest gifts to humankind is opium. Every medical practitioner prescribes morphine after an operation or heart attack. Morphine by itself is not the problem, the problem is when morphine is used for dependence and not for the treatment of pain. When we understand that it is not just the agent but the way the host uses the agent and the environment in which it is used, we develop a more subtle approach to the drug and alcohol problem. We then don't just see it as the demon drink, but that drink may be a tool for pleasure or for pain.

d) A recurring condition

Another aspect of drug dependence is the failure to recognise the recurrent nature of the condition. Patients and relatives expect that once they have been through the withdrawal process, that will be the end of the issue. The dependence problem is not an acute one-off condition. Stopping is not the only problem; staying stopped is a bigger problem. Current government policies focus too much on stopping. Staying stopped is much more difficult and is not included as part of the stopping program. Currently there is not the seamless interaction between stopping and staying stopped that there should be

Stopping is not the only problem; staying stopped is a bigger problem.

All of this illustrates that anybody who thinks that there is a simple drug cure for the drug problem, doesn't understand the drug problem. People who experiment with drugs, but are basically psychologically sound, don't generally have as much of a problem as those who have had a history of sexual abuse or physical abuse, or something similar. You are dealing with a whole lot of other issues, and therefore even using a drug as good as Naltrexone for instance, will not work if the person's underlying emotional pain and distress is not dealt with.

Ethical standards and the stance of grace

THE KEY ETHICAL issue in drug and alcohol therapy is that of setting and maintaining standards of behaviour, while at the same time accepting people who have stuffed up, and giving them another chance to change. How many chances? Seven? Seventy times seven? What is the role of law or standards? Standards need to be maintained, and the Christian church throughout the ages has done so, and yet at the same time Christian theology has a fairly realistic view of what law can achieve. The role of grace is central to the Christian Gospel, but the tension between law and grace is the fundamental ethical tension in drug and alcohol issues. By what power do people change? What do we do about those who don't change?

the tension between law and grace is the fundamental ethical tension in drug and alcohol issues

Let me focus on this question of setting standards versus caring for people. Christ set very high standards. It wasn't sufficient not to commit adultery; it was important not even to think of committing adultery. It wasn't sufficient not to murder; it was important not to even hate. Those were Christ's exacting standards. At the same time, as you read the Gospels you see Christ's compassion for those who have fallen short of those standards. In the story about the woman caught in adultery, Jesus was in the temple teaching when his enemies, the most Orthodox, rigid, religious people of the day, brought this woman to him to test him. For them she was simply an object of power politics. But they had the law on their side, they brought her to him saying she has been caught in the act of adultery. (How did they manage to catch her like that? And where was the bloke?) But there she was and Jesus was confronted with the dilemma: do I say 'Stone her' and risk the wrath of the Romans, or 'Don't stone her' and risk the ire of the local Jewish leaders and people? What did Jesus do? Rather than apply the law legalistically, he saw the issue in its entirety. Jesus said, 'Let he who is without sin cast the first stone.' Everybody walked away. In the end the woman was left alone with Christ. When Jesus asked, 'Is there anyone left to accuse you?' she said, 'No one'. Then he said, 'Neither do I condemn you, go and sin no more'. In that one pregnant statement he captures the fact that her adultery is wrong, but she is forgiven, transformed and she goes away with a new hope. This is the strong contrast that I find in the New Testament,

between sterile religion and living faith. Sterile religion adds to the burdens (Matthew 23:4), living faith says, 'Come to me all who are burdened and I will give you rest' (Matthew 11:28-30).

Rather than apply the law legalistically, Jesus saw the issue in its entirety.

Harm minimisation v. abstinence

LET'S CONSIDER the debate about harm minimisation versus abstinence. These are often opposed but I suggest that abstinence is the best form of harm minimisation. What can be done for those who are not prepared to abstain? Do we do nothing for them, or can we do something? The stages of change model, which is the fundamental framework used in the drug and alcohol field, is very helpful here (Figure 3).

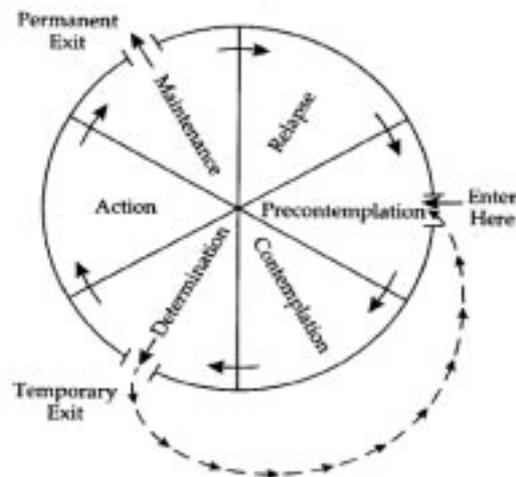


Figure 3: The stages of change model.

Start at Precontemplation. Harm minimisation philosophy states that we can do something for those in the precontemplation and contemplation stages while waiting for change to occur.

When people see a doctor about cigarette smoking, they are usually in a precontemplative state. For instance they have come for their symptom, the cough – they may not have thought about their drug use. The doctor makes the connection between cigarette smoking and the cough. The seed is sown and they begin to contemplate change. Maybe their money is running out, maybe the fact that their friend died from lung cancer or emphysema, or maybe something the doctor said struck a chord. Because they are starting to think, they become ambivalent and unsettled about

their drug use. They might decide not to do anything, or they might decide to change, and once they have changed they may maintain their decision or relapse.

In my experience it is possible to develop harm minimisation strategies for those in the precontemplation and contemplation stages which are helpful to maintain their safety while hopefully pushing people through those stages of change to a new dimension of life. This is the locus for harm minimisation strategies.

But how do we facilitate change? Shame, blame and guilt are often used to facilitate change. I had a patient this week who said that while at school she was put in a corner with a wastepaper basket over her head so that God would not see her sins. What a way of talking about a loving God! That is a great way of motivating people to change! As one comedian said 'What's religion, but guilt with different holidays'. Or as some say 'the Jews invented guilt and the Catholics perfected it!' But, being from a Christian Brethren background, I

Shame, blame and guilt are often used to facilitate change.

can tell you that we have got a pretty healthy dose of guilt as well! Most traditions have, because it is so easy to lapse into guilt as a motivator for change. But if Christians believe that Christ liberates us from guilt, what are we doing using guilt to motivate people?

On the other hand, it is well known in AA circles that simply enabling people to continue on in their drug use is counterproductive and disempowering. Harm minimisation strategies thus could be regarded as enabling continued drug use. How do we empower change in people? Once again we encounter on the one hand, unconditional acceptance, but on the other hand adequate boundaries between acceptable and unacceptable behaviour. In a therapeutic relationship these may need to be negotiated in a contractual form with some flexibility. It is an important part of the whole recovery process.

People need hope to be empowered. The patients I see struggling with dependence are expressing hopelessness but are wanting hope. They would really like a different lifestyle, but find themselves unable to change. The sense of an alternative, better lifestyle, and hopefully, because dependence is so often a disease of loneliness, a fellowship of accepting people will enable them to feel the force of human love and therefore learn of God's love. That is the fundamental ethical challenge for Christians involved in the drug and alcohol area.

THE SCIENTIFIC ETHICS OF DRUG AND ALCOHOL RESEARCH

Professor Greg Whelan, Director of the Department of Drug & Alcohol Studies, St Vincent's Hospital, Melbourne and member of the Premier's Drug Advisory Council (1996) chaired by Professor David Penington.

THE ETHICAL standards or guidelines that we might apply to treatment would:

- Be based on scientifically validated data demonstrating that it does work.
- Do no harm. Many treatments do good, but may be outweighed by their potential harm.
- Be accessible to all. It is of little value having a wonderful form of therapy that many cannot access.
- Be delivered in a way that treats people as individuals not numbers.

Let's explore these guidelines in a little more detail.

Is the treatment based on the best scientific data?

WE WOULD WANT evidence that the treatment we plan to use is based on the results of a well-designed research study called a randomised controlled trial. It is usual to compare any new treatment with the best available current therapy. In the absence of good current therapy, we would compare the new treatment with a group of patients given a placebo, where each individual will receive either the new drug or the placebo (allocated randomly). This helps in determining whether beneficial effects of a new therapy are over and above what might happen if you did nothing. It is also extremely helpful when you are wondering whether a particular drug has specific side effects. In most randomised controlled trials the incidence of side effects for people taking placebos is about 40%. Often they are trivial.

We should be aware of the limitations under which data is collected. Many years ago I was involved in a trial of a new drug for the treatment of heartburn. Unfortunately we had to exclude patients who smoked cigarettes or who drank alcohol heavily. This excluded 120 of our potential 200 patients. Thus the results obtained could not be generalised for the patients we would wish to treat. Likewise, a series of assumptions

are often made when applying scientific data to a new setting. Thus the results from studies performed in the northern hemisphere can't be applied automatically to a different culture or place unless we can assume that the setting is similar. A cynic might say that because each individual is unique, (not just spiritually but also physically), every new treatment is a new study.

It may be asked then, do we have enough data to know that every treatment we give is efficacious? Unfortunately, no. We often have to assess the risks when the evidence is insufficient. The danger here is that we may seek evidence that supports our ideas, beliefs, biases and ideologies. This may be overt or subconscious. In this setting authority figures often sway people in one direction or another.

Let's look at examples of treatments that didn't meet the gold standard. Last year the *Australian Women's Weekly* strongly promoted Naltrexone for ultra-rapid heroin withdrawal. But it wrote it up as a one-off cure. Intuitively the concept of rapidly transferring people from heroin to an antagonist drug such as Naltrexone makes sense, since people have trouble getting through withdrawal and therefore re-use heroin. It makes sense to telescope that time into a very short period, rapidly getting people onto a drug that would satisfy their cravings and make it less likely that they would re-use heroin. Naltrexone has gained broad support because of this appeal not because the appropriate trials show it to be superior therapy. However many clinicians worry about the potential dangers of the treatment and the high cost of ultra rapid withdrawal. No comparison has been made with other standard treatments.

Does the treatment do more good than harm?

VIRTUALLY EVERY treatment potentially can do harm — even doing nothing. Aspirin is wonderful for getting rid of aches or pains, yet it can cause catastrophic bleeding in some people. Treatment programs should demonstrate that they can be delivered safely with greater benefit than harm, otherwise we should be very cautious about using them.

Let me give some examples concerning the ratio of benefit to harm. Naltrexone is a non-addictive drug that is an opium antagonist. In other words, its effect is the exact opposite of heroin. Ideally it should be a good treatment for opiate dependence, because it should be able to attach onto the same receptors where heroin acts, be able to remove any cravings and therefore people should lose interest in using heroin. However, its role is uncertain. Evidence to support its use doesn't

reach the gold standard. Interestingly, it was a drug designed in the early 1970s. The Americans were worried at the heavy heroin use by their troops in Vietnam and as the war ended, felt that they were going to have hundreds of thousands of young addicts returning to the USA. As it turned out, when they arrived home, many young people were no longer interested in using heroin. They were more interested in going back to work. Nevertheless, the US rushed Naltrexone through without doing the appropriate studies, so we don't have information to tell us if this is the most appropriate treatment for assisting ex-heroin users to stay stopped. Its acceptance among people who are heroin addicted is low. The majority stop taking it within two weeks. This occurs because it doesn't alter a person's mood in a positive manner. It doesn't make you feel good, whereas heroin does.

Naltrexone unfortunately carries a high risk of heroin overdose in disorganised users who lose their tolerance to heroin through taking Naltrexone. These people are prone to take Naltrexone for days or weeks, use a little heroin, and find that nothing happens, so they use a little more. If they stop Naltrexone they are at risk of overdose if they reuse heroin.

Is the treatment accessible to all?

IMAGINE THERE is a drug that has a real benefit for heroin users. Barriers to access should be minimal. Methadone maintenance treatment is effective, but access is limited for some. Currently the very cheapest that any individual would be able to purchase Methadone at a pharmacy is \$35 per week. If at the same time they have a health care card and are receiving treatment for blood pressure they would pay <\$5 for a month's supply of these medications. The government has determined that Methadone treatment is not covered by the pharmaceutical benefits scheme. It is one of the quirks in the system that a treatment that works is at times unaffordable for some people. This is likely to occur if they are trying to pay off bills and owe thousands of dollars elsewhere. Distance from treatment facilities may be another access problem. There are some States with only one treatment centre, which is often situated in the middle of the city. If you live 100km away you cannot access that form of treatment.

When there are not enough specialist centres available, long waiting lists occur. I agree that we are not going to solve all our problems through opening more 'detox' centres. But if you break your leg you can usually get into an emergency room the same day, and yet if you withdraw from drugs it is often very difficult

to obtain prompt treatment.

These problems need to be addressed. Methadone maintenance is a scientifically proven effective therapy for heroin dependent individuals. Australia has inadequate numbers of Methadone dispensing pharmacists to supply the needs of the community. There are no really good incentives and some barriers to recruiting new prescribers as well as dispensers of Methadone.

Are people treated with compassion?

THIS IS WHERE we really fall down. How often in community discussions about treatments for heroin addiction have we heard the view that it would be better to let them die? That would solve the problem. Or banish them to Norfolk Island. Why not lock them up and throw away the key? Some prominent people say kids who use drugs should be thrown out of school. The inevitable consequence of excluding users from education is accelerated drug use, and difficulty in completing education and getting a job.

Regrettably, people who work in health care sometimes hold these community attitudes. Some say junkies choose to use heroin, nobody forced them to start shoving it up their arms. We could say exactly the same thing about cigarettes — did someone force people to smoke? On the other hand, I have heard the comparison made between heroin and alcohol users. Alcoholics are really deserving of treatment; they can't help it because they have inherited their disease. Sadly, in Emergency Rooms, I have heard people say 'that drug addict can wait because we are busy and have many more deserving people to see'.

In conclusion, I have emphasised that there are many important ethical issues to face when considering the delivery of care. Treatment needs to be ethically based and supported by research. It needs to do more good than harm. We need to have treatment accessible to everybody, and we need to be able to deliver it with dignity and compassion.

ETHOS, ETHICS AND DRUG ABUSE

Rev'd Tim Costello, Pastor of Collins St. Baptist and President of the Baptist Union of Australia

Our community's ethos and its messages

ONE OF THE major messages that communicates our community's ethos and choices is that we will do anything to minimise pain. Avoidance of pain, dulling pain is a cultural imperative. Young people on drugs are criticised, but have watched their parents, particularly fathers, drink far too much when stressed. They watch mum pop Carapace or happy pills. They have had a very clear message modelled about how to deal with pain and stress. Yet those same parents exclaim at how terrible the drug problem is without any self-awareness. I often say that the problem with our kids, contrary to parents saying they don't have our values, is that they do. We haven't noticed how dominant those values are because we don't see them; we are blind to them.

Avoidance of pain, dulling pain is a cultural imperative.

A second set of messages conveying our ethos is the shift of meaning to the individual self, 'As long as my house is all right, stuff the fact that the community is dysfunctional'. This is the NIMBY or Not in My Backyard syndrome. I have agonised over this concerning safe injecting facilities. Cultural messages are important and there is a lot of strength in the Prime Minister's view that safe or supervised injecting facilities may give the wrong message. I have been aware that by spending more than 600 million dollars a year on advertising messages like 'at Crown everybody is a winner', the gambling industry actually seduces individual decision and manipulates choice. It is not, as ex-premier Kennett used to say, that no one is forced to gamble, it is just a matter of choice and there are just a few problem people out there. No, 600 million advertising dollars sends an extraordinarily powerful message that 'if you want to be a winner, this is the place to be'.

The importance of messages and the educative effect of the law are illustrated by the legalisation of previously illegal behaviour. Along with many others living in St Kilda, I thought that maybe many of the

women being bashed and raped and hurt on the streets would be protected and visible to the law if brothels were legalised. Previously police often abused sex workers, because they knew that they could never lodge a complaint that anyone would believe. I thought legalising brothels would protect them, but I was wrong. All the evidence suggests that not only are there now more sex workers in St Kilda, but legalised brothels have introduced a whole new clientele of sex worker. They now include respectable university students paying fees and middle class housewives who have agreed with their husbands that this is how they will pay for private schools or the second car. Without the stigma of a criminal conviction and with regular health checks, a message has been sent out that, while not widespread, has shifted perceptions.

With gambling, the industry has argued that Australians love a bet. That is the Tattersalls logo. And we have to legalise TABs because there was the awful possibility that SP bookies could corrupt police. Remember that entire debate, a while ago? I maintain that a legalised, particularly privatised, gambling industry has done far more social damage than SP bookies ever did. Messages are very important. Having said that, I am not suggesting that we can impose our views, particularly on a society that seeks to allow as much freedom as possible, without prejudice to the common good.

Reluctant support for supervised injecting facilities

HAVING VOICED my concerns about wrong messages stemming from legalisation, why then have I become a reluctant supporter of supervised injecting facilities? It is directly because of our experience here at Collins St. If you walk out to the back lane, or even on the front steps, you will probably see people injecting. According to Melbourne City Council figures, 25% of the injecting in Melbourne happens in our back lane. The reason that we haven't had any deaths from heroin overdose in Baptist Lane, although there are overdoses every second day, is that the community living here calls the ambulances regularly.

What disturbs me about the supervised injecting facilities debate is that we have expended so much social and political capital debating something which is at most about 1% of the answer. At best all it can do is to keep people alive. Ninety-nine percent of the energy needs to go into prevention measures and other educational messages. But it seems to me that keeping people alive sends an important message also. In a culture

advocating euthanasia and a whole range of anti-life messages, to have a pro-life stance, to keep people alive is very important. Particularly in a culture at risk as manufacturing decreases and commodity prices are flat or declining. The service industries are the new growth industries where jobs are occurring in gambling, table top dancing and drugs. There is an economic imperative that drives the drug trade.

Values and faith – to judge or to heal?

A CHRISTIAN woman I know and respect told me she was totally opposed to supervised injecting facilities. I said ‘how do you face the fact that last year 357 people died, many of them young’. She said, ‘well, if they are on drugs, they are better dead’. Then she said ‘I think Jesus would prefer them dead than addicted to drugs’. Now I don’t think that is the view of many others who are against supervised injecting facilities, so I am not trying to generalise from her example, but she is not alone. At *The Age’s* Vision 2000 session, Tony Abbot was asked why he was opposed to supervised injecting facilities, given the number of deaths, and he repeated exactly the same view. He said that people who are on drugs are virtually dead anyway. I know what they mean, but I must admit these statements shocked me, and it pushed me to think about values and faith. I realised that I fundamentally disagreed with them.

To heal or to judge are always in tension as we need to restrain evil with standards. But if we take the ministry of Jesus seriously, we should place the same emphasis on being alongside and healing as Jesus did. If the Christian church is actually heard to be siding with Abbott and that woman’s view, we have lost something of the radical scandalising faith of Jesus. In Jesus’ time, the lepers, the publicans and prostitutes in that society’s terms, were equivalent to the junkies of ours. It was because Jesus scandalised the religious society by being among the outcasts that he was charged with blasphemy and executed.

There is a faith dimension to the drug issue. When you hear people talking about drug use it is interesting to note the terms they use. People will say ‘are you chasing, do you want to score?’ That term ‘chasing’ resonates with people who are spiritually chasing and wanting to know the meaning of life. They will say ‘do you want a taste?’ We know the scripture, ‘taste and see that the Lord is good’. In a deconstructed culture people are hungering for true value. Some recovering drug addicts say ‘my parents will be pleased, but I don’t want to be like them. They have to check a diary to make dinner dates, to see their friends; nobody drops by and

sees them. When I was using there were people to hang out with me, to laugh, to cry, to score’. In other words, they were saying that there was presence, community and relationship in a culture that is suffocating these values. These are ultimately faith values.

Sometimes, being on drugs, not just anticipating the chasing which is a lot of the psychological excitement, curiously galvanizes the person to get up each day, and gives some meaning and structure and purpose to their day. A \$100, \$200 or \$300 a day habit, gives you meaning in a culture that says unless you can measure something it’s not real, without a benchmark it doesn’t exist. In such a culture going to score can give you purpose. You know by the end of the day, by the sub-cultural norms whether you are a success, whether you have scammed or burgled or whatever. Curious isn’t it? But it actually fits with the phenomenon of when people come off drugs, asking ‘What do I do? Where is the meaning that is going to get me going?’ Ultimately these are questions about values and faith.

it is not just the Naltrexone itself, but the caring and the follow-up that is really the genius of this program

Naltrexone and community

I THINK WE need to look at the Naltrexone programs. I heard Professor Whelan mention that this treatment did not reach the gold standard. But I thought that we went off the gold standard in 1972.

We need to realise that people have often done about 8 or 9 detoxes before they successfully stay off drugs, how costly these detoxes are, and how difficult it is to get carers to stay with them through that period. Rapid detox with Naltrexone in Dr George O’Neill’s system in WA allows a carer to be there to follow them up. I suspect that it is not just the Naltrexone itself, but the caring and the follow-up that is really the genius of this program. Rather than expending energy and tearing ourselves apart about supervising injecting facilities, we have got to find other ways to help people.

THE HUMAN PERSON, ETHICS, AND DRUG USE

*Rev'd Dr Norman Ford, SDB, STL, Director,
Caroline Chisholm Centre for Health Ethics, East
Melbourne.*

The human person

THE HUMAN person does not exist in the abstract without a name, family relationships, personality, nationality, culture, religious faith or system of beliefs and values. To touch one's culture or basic beliefs is to touch the person¹. Health carers and pastoral workers need to understand the nature of the human person if their encounters with people with drug problems are to have some chance of success².

Human person known through experience and reflection

WE MAY REFLECT on the human person in the light of experience, reason and the Christian faith. We experience ourselves in a variety of ways – through our emotions, pleasures, pains, growing up, love, social and political life, as well as cultural activities. Personal worth is often experienced and promoted in the secret intimacy of our minds and hearts.

We often experience ambiguity. We strive after happiness yet frequently are frustrated, we crave love and companionship, yet are rejected and abandoned or made neurotic through the din and tyranny of the invading crowd. We seek a personal transcendent God yet we are immersed in a materialistic world of self-indulgence, cynicism and violence. We struggle to be virtuous and fail. Suffering and death are inevitable for us all, yet reason alone fails to offer an adequate explanation without God and eternal life.

We identify with ourselves more deeply when we make sincere judgments about the truth in conscience. The importance of the truth gives rise to a sense of responsibility which requires us to be adequately informed about the state of our health, our medical condition and treatment options.

Likewise the exercise of free will reveals the inner core of our personal dignity as moral agents which should be used as mere means for others' ends. We are aware of our responsibility to become more personal beings through acts of free choice searching for

happiness and self-realisation. Yet as relational beings we cannot be complete or achieve fulfilment except by communicating with others through mutual understanding, love and recognition of other humans as equals in dignity, above animals, plants and things. We see ourselves primarily as persons before being men or women, husbands or wives, doctors or nurses, employers or employees, young or old.

Human persons known through reason

THE HUMAN person has to be considered as a whole in relation to all that pertains to human nature and integral human experience. It is by inductive reasoning, based on experience and guided by the light of sound philosophical principles that we can acquire a true understanding of the human person. The human person must not be conceived as something purely biological and unchanging. Though essentially personal and the same for all, human nature is somewhat dynamic as its significance gradually unfolds throughout history in various nations and cultures. Our moral concepts are based on human nature as the principle of our personal acts. We ever interpret anew what is good for persons on the basis of the available evidence and of our expanding knowledge of ourselves and our place in the world.

Suffering and death are inevitable for us all, yet reason alone fails to offer an adequate explanation without God and eternal life.

The inevitable presence of defects and aberrations in natural functions and processes does not mean they are natural. It is both a challenge and a risk to discern what is truly defective and pathological and what is naturally and morally good. What is artificial, a drug for example, might not be natural. This does not matter so long as something is not unnatural and contrary to the integral good of persons. It is not the task of right reason to invent, but to discover and formulate afresh a personalised account of the natural moral law.

The foundation for all human experience and capacities is to be found in our common human nature. The nature of the cat or dog does not enable them to have the rationally self-conscious activities of humans or to live personal lives. Human nature includes a body and soul, a material and a non-material principle,

which somehow together constitute us as living human individuals and enables us to perform rationally self-conscious personal acts.

A Christian perspective on the human person

THE CHRISTIAN faith complements the findings of reason on the meaning and destiny of human persons. Our faith teaches that in addition to our parents' love, we owe our being to the creative act of God who willed us into existence for our own eternal happiness. We are not to be absolute masters, but responsible stewards of our natural endowment and environment in our quest for wellbeing and happiness.

As a result of sin our minds are clouded, resulting in our inability to find out with certitude the meaning and purpose of human existence. Over the centuries humanity has struggled to acquire certainty about basic moral principles for guidance in our personal and social lives. Christ's commands and lived example, portrayed in the Gospels, provide a sure model of authentic human existence for living out the demands of love of God and neighbour.

Being a Christian neither imposes nor detracts anything from our humanity. Christ is no outsider. He is truly one of us and of our stock. The Christian faith holds that our fallen humanity was restored in the mystery of Christ. As the Vatican Council said: 'Whoever follows Christ the perfect Human Being, becomes himself or herself more a human being.' We can learn much about the meaning and destiny of ourselves from the life of Christ 'who fully reveals the human person to himself/herself'. Precisely because Jesus is truly a human being as well as truly God, a Christian may say with Terence 'I am a human being; I reckon nothing human is foreign to me'³.

Making right moral decisions

AMORAL ACT must be made with awareness, knowledge and freedom. It must be performed with a clear mind and without undue influence from addictions or emotions. Achieving a healthy use of one's sense of moral responsibility and personal freedom is a mark of a mature person⁴.

Our concept of moral goodness itself cannot be divorced from the nature of the human person. The moral good is conceived as that which is good for ourselves and/or others as persons. Freedom itself is

abused unless it is used to act in accord with the truth of the good.

Feelings, intuitions and guesswork are not reliable criteria to discover the true good in difficult cases. We cannot dodge the hard work of improving our self-understanding and of reasoning things out accordingly. We must assess the impact that an act (or its omission) has on the total wellbeing of others and ourselves. A careful analysis is needed of all that is involved in relation to the truth of our personalised human nature and its requirements. Whatever is opposed to the nature of the human person and of human acts cannot be truly good – consumption of dangerous drugs for example⁵.

Social relations

PEOPLE NEED a spiritual and intellectual life, freedom of choice, company, understanding, social contacts, and mutual presence combined harmoniously with the sensory need to belong to a group. Humans need to find meaning through a personal relationship with God, enjoying the company of others and assuming responsibility for their lives and wellbeing.

A proper education of the young would provide scope for such personal development. People who grow up socially inadequate will find themselves quite vulnerable in a drug environment. Helping parents to be involved in the lives of their children can help lessen the demand for drugs. Helping the young to develop and maintain healthy relationships will promote self-esteem and lessen the risk of alienation.

Autonomy

ACASE MAY be made in the name of individual autonomy for the moral permissibility of the personal use of some illegal drugs that may be harmless when taken in small amounts by adults (for example, marijuana). However, it may not be in the public interest to legalise the use and sale of such drugs as a matter of public policy lest these drugs become readily available to minors. It is well-known how easy it is for minors to obtain cigarettes and alcohol, even though their sale is banned to minors.

Persons and habits

PHYSIOLOGICAL HABITS principally affect the body, tobacco smoking, alcoholic drink and other drugs for example. Motor habits are

skills – a complex organisation of movements that through practice have become easy, smooth, well adapted, like typing or playing a guitar. There is pleasure in the learning stage but addiction does not result: the professional typist does not have an urge to type. Moral habits are virtues. Psychological habits are neither physiological, motor nor moral – for instance rising early, brushing one's teeth after meals, reading the paper after breakfast or watching the 7.00pm TV news, going to the football every Saturday. No skill is required but some repetition is needed. The need is inborn but the way of satisfying it is acquired; curiosity is inborn but satisfying it by reading the paper or watching the TV news is acquired.

Habits enable us to do many routine things that would otherwise exhaust us of nervous energy if we had to concentrate to do them, using a knife and fork at table, for instance or buttoning up our shirts. Hence they are a condition for the personal life and leave time and energy for things that deserve more thought, reflection and deliberation. Habits are good if they are like a 'groove' that enables us to attend to our duties, discharge our responsibilities and to live a morally responsible life at all times. Habits are harmful if they deprive us of the capacity to exercise freedom in a morally responsible way. It is possible to become slaves to our addiction. The use of harmful drugs of addiction risks serious harm to one's own and others' health. Once a habit becomes addictive one is caught in a 'rut', often ensnaring its dependent into irresponsible and criminal behaviour to find the money to buy drugs. A relatively small percentage of those who drink alcohol become addicted, but high percentages of people who use hard drugs become addicted.

Euphoric drugs

EUPHORIC DRUGS (for example, alcoholic drinks) that are harmless when consumed in moderation are morally permissible for social use and legitimate relaxation, provided one's awareness and judgment are not impaired to the point of not being able to act as a morally responsible agent. Since minors can easily abuse alcohol, public authorities may ban its sale to minors.

The first miracle performed by Jesus was to change water into wine at the marriage feast of Cana (John 1:3-10). St Paul urged Timothy to have a little wine for his digestion and his health (1 Timothy 5:23). But he warned that presbyters must not be heavy drinkers (1 Timothy 5:3) and that deacons must be moderate in the amount of wine they drink (1 Timothy 5:8).

The Bible does not condemn the moderate use of alcohol, but only its irresponsible use.

Habits are harmful if they deprive us of the capacity to exercise freedom in a morally responsible way.

Young people, who through curiosity and without awareness of the consequences, casually 'try' an addictive drug and become 'hooked' could hardly be said to be morally responsible for their initial addiction. Yet people who are aware of the nature of a harmful addictive drug and freely choose to use it, may be morally responsible for their addiction and its foreseen consequences, such as criminal behaviour to obtain money to satisfy the addiction. Up to two-thirds of drug users may have additional problems, like depression, anxiety or alcohol abuse. It will be more difficult to say all such people are fully responsible in a moral sense for their addiction to drugs. Specialist physicians could contribute valuable information on this question.

Again others may turn to drugs in an attempt to gain a perceived control of their lives, including relief from their personal burdens. The inability of some to act freely and to be fully responsible for their drug addiction may be due to human frailty of this kind or to other mental illnesses. It would be rash to judge individuals without a full understanding of their background.

This does not imply an addict is free of moral responsibility all the time. In a quite lucid period, one could become aware of a duty to seek help to get out of the 'rut'.

Compassion

COMPASSION IS needed for people addicted to drugs, for individuals in the community who have been assaulted and robbed by people addicted to drugs, as well as for the wider community which pays the social costs of the prevalence of drug addiction. True compassion must demonstrate a willingness to provide the means for the promotion of self-esteem, effective detoxification and long-term rehabilitation of people addicted to drugs, as well as addressing the causes. Short-term solutions that fall short of providing a commitment to rehabilitation are practically useless. A drug addict will not be able to overcome addiction all at once, but can only advance step by step. But this 'law of gradualness' does not

imply the 'gradualness of the law' as if there were different levels of objective morality for different individuals or situations⁶. The aim of therapy must include the complete rehabilitation of the person, including the ability to act as a morally responsible agent in the community.

Compassion does not deny the duty of justice to protect vulnerable members of the community who risk being bashed and robbed, or to punish and rehabilitate convicted perpetrators of drug related crimes. This requires political will to eradicate collusion with illegal drug related activities in the police force and the administration of the criminal justice system. The severity of any measures adopted should be in proportion with the seriousness of the damage likely to be caused to persons and the whole community, but without acting undemocratically.

Some aspects of the drug problem, then, should be treated as a health issue and others as a matter for the criminal law. Education, however, is needed for all aspects and situations.

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Education

IN SOME developing countries, the greatest problems are caused by natural disasters that are beyond the control of society. In many developed countries, including Australia, one of the greatest problems is drug abuse that is self-inflicted. We have ourselves to blame in one way or another. This is a sign that better education at all levels is needed, including education for assuming our responsibilities for basic moral and civic duties across the board.

The community should protect the young from drugs because of their immaturity, liability to exploitation and the greater harm drugs cause to their bodies and minds. Educationally effective drug programs must be designed for schools to help prevent young people becoming hooked on addictive drugs wittingly or unwittingly, out of curiosity, for example. Education to help children appreciate their own personal dignity and worth would be of great assistance. Much could be learnt from the successful campaigns of the T.A.C. and the Alcohol and Drug Foundation. Much harm resulting from drug abuse

could be avoided if its causes were to be accurately identified and addressed⁷. It is no use treating the symptoms if the underlying causes of drug abuse in the community are not remedied. This will require an improvement in the moral standards of the whole community if all concerned are to assume their responsibilities to fight the drug scourge.

Endnotes

¹ See N. Ford, 'The Human Person and Life's Journey', *Chisholm Health Ethics Bulletin* 2/3 (1997) 10-11

² For a more comprehensive presentation, see Norman Ford SDB "Dignity and Value of the Human Person" in *Live out the Truth in Love* (Melbourne: Catholic Education Office, 1991) 1-12.

³ Terence, *Heauton Timorumenos*, I, i 25.

⁴ See N Ford 'How to Find out What is Morally Right or Wrong', *Chisholm Health Ethics Bulletin* 5/1 (1999) 10-12.

⁵ For more details, see Norman Ford SDB "From Persons to Morality" in *Live out the Truth in Love* (Melbourne: Catholic Education Office, 1991) 13-35.

⁶ See Pope John Paul II, Apostolic Exhortation *Familiaris Consortio* on The Role of the Christian Family in the Modern World, 1981, n. 34.

⁷ The causes of drug abuse include the following: the initial taking of drugs out of curiosity; the demoralising impact of unemployment; social alienation; the loss of a sense of meaning in life due, in part, to a drop in religious belief and practice; the prevalent culture of individualism, living for the moment & the expectation of an easy fix for every problem; the breakdown in family stability; the effect of poor parenting skills on some youngsters, etc.

THE ETHICS OF DRUG AND ALCOHOL CARE: SOCIAL CHANGES AND CHRISTIAN RESPONSES

Major Brian Watters, Salvation Army, Chair of the Prime Minister's Advisory Committee on Drugs

IAM NEITHER an ethicist nor a scientist. But for more than twenty years I have worked in the field of addictions in a Christian setting and have hands-on experience of the reality and effects of addiction on individuals and their families.

Unconditional love

What is the distinctive and fundamental characteristic of the Christian ethic? I believe it to be unconditional love. I see this love and concern as the recurring central theme of the Bible and of the life and ministry of our Lord, indeed the very reason for his ministry. He is no God of detached serenity so beloved of the Greeks. Nor is it the Stoic concept of a God of *apatheia* – incapable of feeling. The pivotal text is John 3:16 which expresses God's divine and gracious initiative, nothing to do with our worthiness to be loved. Martin Luther said it so succinctly, 'Sinners are attractive because they are loved; not loved because they are attractive'. Because this love is a set of the will it can be expected and commanded of us.

But I say to you, love your enemies, and pray for those who persecute you, so that you may be children of your Father in heaven; for he makes his sun rise on the evil and the good, and sends rain on the righteous and on the unrighteous (Matthew 5: 44).

In my ministry I see the outworking of this command in the need to love the unloved and the unlovable. Let me illustrate: In my officer training days I was sent to work at Foster House, the Salvation Army's homeless men's shelter in Sydney. One day they brought in a poor, filthy creature who had been living in an abandoned car in the back lane of a slum. He and his mate had been drinking methylated spirits. They spilled some and his mate was accidentally burned to death. The officer in charge instructed me to strip this man; burn his clothes; shower him; shave him – head and body – then disinfect him as he was crawling with lice! Well, I rebelled! I didn't want to go near the man, much less touch him. It was then I had one of those luminous moments when Jesus seemed to intrude directly into my consciousness, with the words 'Why not? That's how you appeared to me, but I died for you!' I remembered the scripture that our righteousness is as dirty rags ... while we were yet sinners Christ died for us! I can honestly say that I have never thought of a person as a 'creature' since that day and my service has been underpinned by that ethic that tells me 'just as you did it to one of the least of these who are members of my family, you did it to me' (Matthew 25: 40).

The impact of this aspect of Christian ethics on drug policy should be recognition of the intrinsic worth of individuals. It should lead to a rejection of dehumanising stereotypes. I am offended by terms such as Junkies, Addicts, Potheads etc. While it may be asking

too much for society at large to see the Christ in these afflicted people, it is not too much to hope that we can engender an attitude and develop policies that recognise and value them as someone's brother, sister, child or parent. The policies should be designed to help restore these people to a position of dignity and a sense of value to self and to society. It is at this point that I have serious problems with proposals for 'trials' that involve human beings. From those who advocate heroin injecting room trials I have asked what happens to these people at the end of the trial? Do you say to them, 'That's it! No more! Back to where we found you!' I find that de-humanising and inconsistent with the medical maxim, 'Above all do no harm' – quite apart from Christian ethics.

Ethic of total concern

THE CHRISTIAN ethic is an ethic of 'total concern'. There isn't any mandate in Scripture for a Cartesian dualism or for a monastic disdain for the body. The founder of the Salvation Army was as concerned for the bodies as well as the souls of those he sought to save. He set up soup kitchens; shelters for the homeless; clothing and employment programs. William Booth told his followers 'No one gets a blessing, if they have cold feet, and nobody ever gets saved if they have toothache!'

One of the pleasing developments in the health sciences in recent years has been an expansion of patient care beyond the biomedical model, to what is often described as holistic medicine. During my years of ministry I have seen the shift in attitude in hospitals and prisons towards acceptance and recognition of the value of the chaplain in the process of healing and recovery. I am sorry to say that this is not so to the same extent in the area of addictions. I know too many health professionals who have the attitude that addiction is purely a medical problem and that spiritual counsellors are at best a nuisance and at worst a menace!

On the other side, I know the frustration of seeing a client's recovery subverted by religious advice that all that is needed is a zap from God and everything will be fixed. But our Lord clearly demonstrated his concern for the physical needs of his followers by both feeding and healing them. Christian influence on policy development should ensure professional medical care with ongoing research to identify best practice in the field of addiction treatment.

Christian ethic of community

COMMUNITY IS the final element of the Christian ethic that is most immediately involved in the formulation of social policy. John Wesley tells of the time in his youth when he was inclined to become a hermit. A wise older man said to him, 'God knows nothing of solitary religion'. The principle of love for my neighbour and responsibility for my brother is the obverse of the coin of Christian faith and practice, that is, to love God...and your neighbour as yourself.

Firstly, we have a responsibility for society at large and of which we are members. The principle of 'harm reduction' must be directed towards reducing harm for the community as well as for the affected individual. This is a source of conflict in our community. This week, at a community forum in Cairns I observed a debate between health professionals and local residents over the problem of discarded syringes. Rightly there was concern that injecting drug users should be helped to avoid blood-borne infections, while at the same time there was legitimate concern over the danger of discarded syringes in a local park and in school grounds.

In Romans 14 the apostle Paul discusses this tension between individual rights and responsibility to community. He does so in the context of diet, but the principle is applicable to the whole gamut of interpersonal and community relationships. He reminds us that none of us lives or dies to ourselves. This principle affects the claim that drug addiction is a 'victimless crime'. This is not the perception of the families – especially parents who watch the deterioration and even disintegration of their addicted loved ones. Nor is it the perception of the paramedics and hospital staff, or of the community who are called on to provide scarce health resources to meet the often-repeated needs of the severely addicted. John Donne was right, 'no man is an island entire unto himself'. We need each other. As William Barclay says 'A man cannot do without society and society cannot do without him'. It is a serious challenge to formulate social policy that meets the requirements of community and individual, as well as rights and responsibilities.

The other aspect of this Christian ethic of community is an even more contentious source of policy debate in society and among Christians. I refer to the ethic of responsibility for my brother – especially my weaker brother! There are two aspects that I would enlarge on:

Firstly, there is the requirement that out of love I will abstain from things and behaviours that might

prove a stumbling block to my weaker neighbour. Again in 1 Corinthians 8 Paul develops this theme of my being ready to deny myself for others '... if what I eat causes my brother to fall into sin, I will never eat meat again, so that I will not cause him to fall'. The Salvation Army is a total abstinence Church. We wouldn't contend that all Christians are forbidden to use alcohol – Scripture doesn't require that, but we do say that for the sake of those we work with, for whom it is a serious problem, we accept the discipline of abstinence.

I hear people saying that they can use illicit drugs recreationally with no serious problem and without becoming addicted. I am unconvinced. The recently published results of the Oswaldians survey in the ACT showed that no one is above addiction. If it is true that some of us can use illicit and addictive substances without detriment to ourselves, nevertheless a significant percentage of others will have their lives destroyed by those same drugs. God forgive me if my example was a factor in their fall. Romans again reminds us; 'We who are strong ought to bear with the failings of the weak and not to please ourselves. Each of us must please our neighbour for his good, to build him up' (Romans 15:1).

The second aspect of this ethic of love for our neighbour, is concern for their highest good. In Luke 4 we have Jesus' great manifesto which is both spiritual and social in its implications. 'He has sent me to proclaim freedom for the prisoners ... to release the oppressed.' Freedom was a major motif of Christ's words and works. There is no debating the fact that addiction is slavery. There is no freedom of choice, but an overwhelming compulsion to do things you hate and despise yourself for, and not to do those things you once loved, or that you know you should do, as a caring human being. Let me illustrate: Jim was a very clever industrial advocate. He had eight children whom he loved dearly. He is also an alcoholic. He told me of the Christmas Eve when he was struggling home after a heavy night of celebration with his friends, his arms laden with presents for his wife and kids. Half way home he realised that there would be no pubs open the next day, so he called into a bottle shop and bought a supply for the morrow – two cartons of beer. He then found that he couldn't carry everything and after a very brief hesitation he threw the presents across a fence into a paddock. Jim today is a judge, and by the grace of God, a sober judge. He tells that story of long ago with fresh remorse and horror at what his addiction did! Through God he found freedom.

Transforming power of Christ

JESUS WENT about healing and delivering people. He gave sight to the blind, restored the leper to cleanness, made the lame walk, forgave sinners and restored them to society. This was the inevitable outcome of his mission to restore fallen humanity to its rightful place as the crown of God's creation. Though defaced, the divine image in us has not been destroyed. In the context of this doctrine of humanity I cannot embrace as Christian an ethic that is not consistent with the transforming healing power of Christ, bringing freedom and deliverance.

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The implications for social policy development of this ethic are a commitment to the highest good. I know from long experience and from thousands of people I have worked with, that Christ still brings healing and freedom to the sick and enslaved. While I recognise the humane value and intent of some harm minimisation strategies, I am personally troubled and concerned that we as a society could write off people as being beyond hope; that we offer them less than the possible freedom that God intends for them. It is for that reason that I have dedicated my life in service to troubled and addicted people and their loved ones. I have a simple faith that God still works miracles in this area, and I have seen many of them. I could give numerous examples from personal experience of severely, long-term addicted people who, in the terms I hear in public debate, would be described as 'intransigent and beyond help'.

Around our Bridge Program in Eastern Australia we have displayed a slogan from William Booth 'A man may be down, but he's never out'. Fanny Crosby said it beautifully in the verses of her hymn 'Rescue the Perishing':

Down in the human heart,
crushed by the tempter
Feelings lay buried that grace can restore
Touched by a loving hand, wakened by kindness
Chords that were broken can vibrate once more.

The difficulty we face as Christians is to determine at what point our attempts to reduce the harm that an individual is doing to him or herself, become the

means which enables that self-destructive behaviour to continue, or even hinders the restoration of health and freedom. In some ways I see it related to the euthanasia debates. When do you determine that this case is hopeless and pull the plug? Christ is our great example of involvement with suffering humanity. As Philippians 2 so beautifully reminds us 'He took on himself the very nature of a servant, being made in human likeness.... He humbled himself and became obedient to death – even death on a cross'. He didn't stand from afar and shout directions, but actually came on to our 'factory floor' or as the Scripture literally means 'pitched his tent among us'. I salute my brothers and sisters from around the world whom I have seen 'dying to self, that others might live'. God forbid that we should do otherwise, or that we should hinder each other in the doing of it!

I conclude with the challenging poem entitled 'Shelter' that was written by a homeless woman after her country vicar promised to pray for her:

I was hungry
And you formed a humanities group to discuss
my hunger
I was imprisoned,
And you crept off quietly to your chapel and
prayed for my release
I was naked,
And in your mind you debated the morality of
my appearance.
I was sick,
And you knelt and thanked God for your health
I was homeless,
And you preached to me of the spiritual shelter
of the love of God
I was lonely,
And you left me alone to pray for me
You seem too holy, so close to God
But I am still very hungry – and lonely – and cold.

THE ETHICS OF SUPERVISED HEROIN INJECTING ROOMS

Dr Gordon Preece, Director, Ridley College Centre of Applied Christian Ethics and Chair, Zadok Editorial Board.

Drugs in a Risk Society

I'VE BEEN ASKED to address the ethical aspects of supervised (preferable to 'safe') injecting rooms. But first I want to set it in a broader context of danger and risk in society. Drugs are dangerous – especially Ecstasy – it makes white men think they can dance! More seriously, drugs are dangerous, but so are cars, sex, walking across the street, and playing sport. Life is full of risk and danger, that's part of its adventure. Often those who don't have appropriate forms of adventure or responsible forms of risk to absorb and challenge them are those most likely to get caught up in drug addiction. We live in what sociologists like Antony Giddens and Ulrich Beck call a Risk Society. Increasingly the public risk policies of society are being jettisoned and risk falls back on the individual. Increasingly we are seen as having responsibility for our own welfare, getting a job, providing for our health, wealth and retirement. User pays. There are positive sides to this, but for those less able to negotiate the risk society, there are also negatives. It's interesting that the same term 'user', that sees us as self-interested materialistic consumers, is a word used for someone on drugs. Maybe there's a connection there, for those who've dropped out of the consumer society, maybe there's not that much difference between their addictions and ours, theirs is just the tip of the iceberg, whereas ours is just less visible

In a consumer society we have to sell and risk ourselves to get on. But some, for various reasons, are less able to do this. They feel discouraged or worthless, are labelled as losers and find the risks or chances of illicit drug use (or gambling) not that bad compared with what they see as their poor chances of making it in the risk society. I believe that we have to address this broader social and ethical issue at the same time as addressing the more immediate one of risk management for heroin users. Firstly I will outline some general ethical guidelines based on a mixed ethical theory that does not reduce ethics to one dimension – rules. I will then describe the range of models used in evaluating drug problems, again trying

to avoid a reductionist view. I will then evaluate harm minimisation versus abolitionist approaches to drug problems.

Ethics

IN GENERAL I use a mixed ethical approach derived from the Bible and the best philosophical ethics traditions. It is summed up in an illustration from CS Lewis about a ship: Imagine you are on a ship on a voyage. The voyage will be a success only if:

1. The ship follows navigational rules and maps and doesn't collide with other ships or icebergs;
2. The internal mechanisms, engines, steering etc are in good order;

The voyage will not be a success if:

3. It doesn't reach its destination.

For Christians these three aspects correspond to God's commands, Christlike character and Kingdom consequences.

In ethics we need to look at 3As – 3Cs – 3Rs – 3 Ps or ethical approaches:

1. Act – Command – Rule – Prescription – Deontological or Duty Ethics
2. Agent – Character – Role – Person – Virtue Ethics
3. Aftermath – Consequences – Results – Purpose – Teleological or Goal Ethics

In relation to serious dependence inducing drugs in general I'd argue on all three counts that:

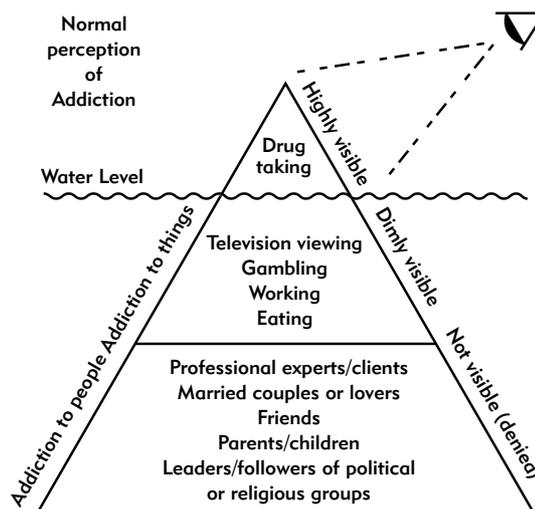
- we shouldn't engage in acts of serious, reckless danger to our own or others health;
- we shouldn't compromise our ability to be free, responsible, rational, relational agents in relative control of creation. We should be able to weigh up consequences and not compromise our characters by becoming enslaved to things that may be good but that can become gods. Some drugs, like heroin, in our social context, often enslave.
- all other things being equal, we should choose the less harmful or more pleasurable consequences, not just for the short, but also for the long-term; not just for ourselves, but also for society.

Models for dealing with drug problems

WE NEED multi-pronged, tailored approaches to drug problems (note the plural – it is not just heroin), not a reductionistic one size fits all approach. We need to see the heroin problem holistically, because humans have physical, moral and spiritual dimensions to their lives. It is not only a health or medical issue but a moral and spiritual one as well. To oversimplify, in pre-modern times drug addiction was seen as a moral or spiritual problem only. It was due to a weakness of will – still expressed in the ‘Just say no’ or abstinence approach today. This was challenged by the scientific or sickness model as the medical profession took over from clergy as the leading profession. In postmodernity this has since been challenged by a more sociological model that says we’re all addicted to our drugs of choice, it’s all relative. We define some as illegal as a means of social control, blaming the victims by criminalising them and making the consequences of relatively harmless activities much worse. According to this model, we should maximise people’s liberty to choose and minimise the harm caused.

There’s truth in each of these positions, but they each have problems. The postmodern sociological view, while highlighting inconsistencies in the way we treat legal and illegal drugs, is too relativist in saying that all drugs are basically the same. It doesn’t take seriously the first and second aspects of ethics – command and character. It tends to absolutise individual freedom, ignoring the importance of informed choices and the effects of our actions on relationships when rules are broken.

On the second ethical aspect of agency or character, the more postmodern approach is rightly strong on compassion, autonomy and tolerance, but often forgets that compassion needs a moral compass and that there are other virtues such as self-control. With addictive drugs our allegedly autonomous choices are abrogated, our desires become demands, and the harm to our own or others health or property can be enormous. With some drugs like heroin there is a greater likelihood of abuse and loss of self-control, not only due to their illegality, though that is a factor rightly pointed out by postmodernists, but also due to broader social factors like alienation and anomie. Other drugs such as alcohol, while badly abused, do allow a distinction between reasonable, responsible, relational use and abuse. I’m not saying all heroin users are addicts, but



The addiction iceberg in order to gain a broader, more unified perception of the addiction experience, it is necessary to lower the 'water level' and view the whole iceberg instead of focussing only on its highly visible tip.

after talking to a pharmacologist about the way heroin tends to blot out all other pleasures, unlike alcohol in moderation, there is a difference.

the more postmodern approach is rightly strong on compassion, autonomy and tolerance, but often forgets that compassion needs a moral compass

The modern medical model of the Penington report and the AMA also stresses the consequences through mounting loss of hundreds of lives, up 55 times from 1964 to 1997 and the failure of traditional methods to alleviate this loss of life. In regard to the third ethical aspect of consequences, the postmodern view tends to be overconfident about future results. On the basis of overseas studies of North European experiments, it argues that supervised injection rooms reduce the death toll, crime etc. This approach tends to be overconfident about the effects of these experiments and ignores conflicting evidence. The harm minimisation approach also seems to hold the high moral ground of compassion – the second level of morality, but plays down the wrongness of the act of drug taking, according to the first level of morality. While Dr Penington also proposes the decriminalisation of cannabis use, I would argue that the medical evidence is strongly against this.

Opponents therefore see the harm minimisation

approach as part of a wider agenda of normalisation of drugs. These opponents often support an abstinence or prohibitionist approach. They often stress the first ethical aspect of absolute or objective rules, but sometimes sound as if these rules are arbitrary, particularly in their application to non-Christians in a pluralist society. They sometimes forget to stress that the commands exist to encourage the flourishing of our personal and relational created nature and character (as Norman Ford noted), whether we're Christian or not, and to lead us toward the kingdom of right relationships. Often they have no fallback position for dealing with people who break the rules. They may appear to be lacking in compassion, when they have no answer about how to stop heroin overdose deaths in the short-term.

Harm minimisation or abolition/prevention?

LIKE THE WIDER community, many in the churches are divided on the issue of how to deal with drugs. Those against harm minimisation often come from more conservative, particularly, but not only Sydney churches, like the NSW Council of Churches, Brian Watters of the NSW Salvation Army and Prime Minister's Advisor¹. But a number of church groups – the Sisters of Charity at St. Vincent's Hospital in Kings Cross (an exception to the above generalisation), Wesley Central Mission and the Salvation Army and Anglican Social Responsibilities Committee in Melbourne support the heroin injecting centres.

Among those for and against the supervised injecting rooms the issue is not that it is something wrong in itself, but whether it is the best or wisest course of action. Tina Clifton CEO of St. Vincent's Darlinghurst asked 'what would Jesus do' (WWJD) and what would their founder Mary Aikenhead have done? She argued that Jesus reached out with compassion to the poor and outcast, just as the Sisters of Charity in Australia did to the female prisoners of the early colony². But this tells us more about the way Jesus acted, not what he did. Compassion needs a moral compass. Jesus said to the woman caught in adultery about to be stoned (in a non-drug way), 'Let he who is without sin cast the first stone'. Postmodernists point out that to some extent we're all addicts or potentially addicts with our own drugs of choice. 'I do not condemn you', Jesus said, but he also said 'go and sin no more', that is, repent, change. That divine balance is very hard for humans to get right.

That divine balance is very hard for humans to get right.

It is important not to resort to destructive rhetoric in this debate. Dr Penington accused those against his proposals of having blood on their hands. Often opponents of injecting rooms are accused of lacking compassion. Both sides claim to be compassionate, but the question is what will really help, both short and long-term? Opponents often misrepresent injecting rooms as 'shooting galleries' like something in a New York movie scene, but the Wesley Central Mission injecting room doesn't look like that.

The same caution applies to reductionist rhetoric. For instance, both sides can draw on the story of the Good Samaritan. Those in favour of injecting rooms stress the need to get involved and care for the wounded. Those against argue for the need to prevent the Jew from being bashed by providing better lighting and police presence on the Jericho Road – that is, cut the supply of drugs better provide education to prevent drug abuse. It is not necessarily an either/or choice – it could be a case of both harm minimisation and prevention.

HARM MINIMISERS CLAIM THAT:

- Overseas evidence indicates that MSIRs (medically supervised injecting rooms) reduce or eliminate overdose deaths (ODs) on their premises.
- They reduce discarding of used needles and injecting in public places
- They reduce ambulance and hospital calls for ODs.
- They provide the opportunity for other services including food, health and rehabilitation
- They reduce crime
- Rather than waiting till people hit rock bottom and ask for rehabilitation (the Alcoholics or Narcotics Anonymous model) interim measures are needed to keep people alive

The St. Vincent's Kings Cross proposal also stressed the importance of education, community consultation about the sites of MSIRs and the importance of heavy penalties for large-scale dealers, and increased funding to eliminate long waits for detoxification and other rehabilitation programs

While some admit the evidence from Europe is mixed, their apparent success in some places, for example Switzerland and Frankfurt, the absence of

alternative strategies and the political will to try them, indicate that MSIRs are worth a try if continually reviewed

Some like Alex Wodak quote Groucho Marx, who when elderly and decrepit, was asked by a journalist what old age was like, said 'it is better than the alternatives'³. They see it as the lesser evil.

OPPONENTS of MSIRs disagree, not with the goals of saving lives and rehabilitation, but with the means:

- **Are the means moral in themselves?**

Is providing a room and safe supervision making it easier and implying approval of drug taking through complicity or formal co-operation in the wrong of drug abuse? Is it sending the wrong message of support for drug taking?

Some see MSIRs as a cop-out. John Edmonstone from NSW Council of Churches says MSIRs 'are an irrational panacea which will do nothing to free people from heroin addiction'. Father John Fleming says 'it is wrong to encourage behaviour which is demonstrably harmful to addicts, to do so at a time when they are unable to give informed consent, to sponsor illegal activities, thereby undermining the rule of law, and effectively to abandon addicts to their addiction'.

consequences don't cancel out commands and character as part of the ethical equation.

Father Anthony Fisher of Melbourne Roman Catholic Archdiocese notes that it is never right to do evil so good might come out of it, as the ends don't justify the means. In my earlier terms, consequences don't cancel out commands and character as part of the ethical equation. However, illicit drug taking has catastrophic consequences by destroying bodies, minds, lives, families, and societies. But if the intended goal is not to encourage drug taking but to save lives and lead to rehabilitation of the drug taker, then it is not wrong in itself (compare turning off a life-support machine). It may be merely material or incidental co-operation that is indirectly related to the addict's wrong purpose. Compare syringe manufacturers who don't intend them to be used for illegal drugs though they foresee some may be so misused⁴.

You can permit things without willing or wanting them or without that being your purpose. Otherwise God would have to be held responsible for the world's

evil. We could argue from Matthew 19 that for God to permit divorce in certain circumstances because of human hardness of heart and to minimise the damage, particularly to destitute women, was a harm minimisation strategy. Now that should not lead to wholesale legalisation of drugs in the way that Pharisees sought complete legalisation of divorce by asking Jesus if divorce is permitted for any reason. Then Jesus pointed them back to God's original purpose of one man, one wife for life.

Rehabilitation, which is a key goal of MSIRs, doesn't depend on drugs being injected. But it does depend on keeping people alive so they can be rehabilitated.

The harm minimisation approach can be compared to parents who tell their adolescent 'if you can't be good, be careful'. We need to stress loud and clear and often that sex before marriage is biblically wrong and unwise. But if it is clear the teenager is going to do it, we may need to buy them condoms or put them on the pill. There can thus be more than one message – a challenging moral ideal – and a fallback position for minimising harmful consequences.

- **Do the means demean people by counselling despair?** Or do they affirm their dignity and provide hope rather than suggest that this is all we can do for them?

By beginning with 'if you can't' it implies that bad behaviour is unavoidable or that addicts are not responsible at all, being beyond help or incurable, even though they may have reduced responsibility. But no one is beyond God's help, no addiction is impossible for God, even the rich young ruler and our society's addiction to riches (Matthew 19:26). In 1 Corinthians 6 Paul mentions 'drunkards' not inheriting the Kingdom, but then says to the Corinthians, 'and such were some of you'. Tragic cases and compassion fatigue can shake our confidence that change is possible. As Fisher notes, 'it communicates that we don't have much faith in you or God to give up drugs. It'd be nice if you did, but you probably won't, so at least we'll help you not kill yourself'.

This is a real danger for the providers as well as the users, who can slide down a slippery slope toward advocating normalisation of drug use. First MSIRs then supply of heroin, then legalisation first of soft, then hard drugs. Some of Pennington's proposals confirm this worry.

- **Do the means achieve more good than harm?**

This third ethical aspect of consequences leads us to ask – will it just delay the possibility of rehabilitation,

leaving people and governments content with maintenance? By sending a message of toleration and relative safety of drug taking, will it lead to greater addiction and more deaths in the long term?

Some heroin users say that MSIRs don't work for 'junkies'. Addicts won't travel inconvenient distances and will shoot up immediately when they get their heroin. Other people say that the clinics will modify their anti-drug message to attract clients. They claim that MSIRs will be used as an easy way out or as a quick fix politically instead of adequately funding rehabilitation for those on the long and restricted waiting lists. They say there will be pressure to find any trial a success as people's jobs depend on it.

Some cynically see MSIRs as a way of cleaning up the streets for the Olympics, tourists and business. The head of the Collingwood Traders Association, who runs a pub near the notorious Smith Street, pointed out that she has to have compassion not only on heroin addicts on the streets, but also on her employees who might be out of a job and on the streets too. Brian Watters, the chair of the Prime Minister's advisory group, argues that MSIRs will become a Mecca for drug users and generate a supply to match demand.

In general, Watters, The Centre for Independent Studies' Dr Lucy Sullivan, and Dr Joe Santamaria argue that Australia's harm minimisation approach since the 1980s has failed compared to Sweden's abandonment of harm minimisation or a free drugs policy, for a drug free policy⁵. Those in favour cite the Germanic harm minimisation MSIR model of Frankfurt and Zurich as leading to a reduction in the number of deaths.

Conclusion

IN COMING TO my own very tentative conclusion I find a helpful parallel with traditional Just War criteria for justifying the use of non-ideal means in dealing with sinful realities:

1. Is it the absolute last resort – have all other alternatives been tried? Have enough money and effort been put into education and rehabilitation? But will this stop people dying in the short-term so they can be rehabilitated?
2. There should be no innocent casualties – families, victims of crime, local communities and shopkeepers. In Melbourne City some are against MSIRs, others (approximately 74%) are apparently for.
3. There should be a reasonable prospect of good outweighing evil. It seems to many that the US war on drugs approach has produced greater evils such as a huge percentage of its black population in jail.

On the basis of these criteria and the biblical principle in Matthew 19:1-12, I am not against harm minimisation approaches and MSIRs if married to a strong education/prohibition and rehabilitation campaign, as seems proposed by the Victorian Government. Prohibition, as Ross Gittins, economics editor of *The Age* argues, has not failed, it has just not totally succeeded. But it has made the price higher and minimised consumption. We need both upstream and downstream approaches. We also need to deal with the poverty that drives certain nations into heroin production; more active policing before it gets to the street dealers (who are also often users it needs to be remembered by those who advocate harsh sentences). We need multiple models – medical, sociological, economic and spiritual approaches. We need both messages to be loud and clear – hope of change first and harm minimisation for those not yet ready for change.

¹ As David Marr argues in his *The High Price of Heaven*, Allen & Unwin, St. Leonards, 1999, ch. 1.

² Tina Clifton 'Why we Accepted this Challenge', *Bioethics Outlook: Plunkett Centre for Ethics in Health Care*, vol 10, no. 3, Sept. 1999, p. 2.

³ Alex Wodak, 'Why Trial a Supervised Injecting Room?' *Bioethics* vol 10, no. 3, Sept. 1999, p. 6.

⁴ Anthony Fisher, 'Why Some People are Uneasy About Injecting Rooms', *Bioethics Outlook*, vol 10, no. 3, Sept. 1999, pp. 11-16.

⁵ See Lucy Sullivan, 'Drug Policy: a tale of two countries', *News Weekly*, 26.8.99 and Dr J. Santamaria, 'A Drug Free Society not a Free Drug One', *News Weekly*, 10.2.96, pp. 14-15.

SUGGESTED READING

Gerald G. May, *Addiction and Grace: Love and Spirituality in the Healing of Addictions*, Harper, San Francisco, 1991.

Max Neutze, 'The ACT Heroin Trial' *Zadok Paper*, November 1997.

Alan Gijbers and Greg Whelan, 'Freewill and Determinism as reflected in the Treatment of Alcohol Abuse' *Zadok Paper* S75 July 1995

New Scientist, June 10, 2000.

5. In the drug issue is there a place for a 'hardness of heart ethic' (Matthew 19) where from the beginning it was not God's intention to allow divorce but because of human sin divorce was allowed in limited circumstances? Does this approach allow strategies like needle exchanges, supervised injecting rooms and methadone programs and where do the limits lie?
6. How can we develop sensible policies in a pluralistic society which will best respond to these current problems?

DISCUSSION QUESTIONS

1. Why is there a spate of drug and alcohol use? What are the sociological forces that have led to excessive alcohol and drug consumption? What has the Christian gospel of love, forgiveness and a new life of obedience to God rather than obedience to selfish desires, to offer to a society satiated with indulgence and amusement?
- 2a) What is a theology of enjoyment and reality and hence the place (if any) of mind-altering substances? In particular why single out some substances when mind-altering substances associated with changing the depressive or schizophrenic state are allowed?
- b) There is an ethical objection to people entering drug induced trance-like states – is that revulsion justified or is it simply a reflection of the marriage of Christian theology and rationalism?
3. What is the nature of addiction – is it a moral failing, a disease, a behavioural disorder, the result of poor choices or a combination of these? What do we do with those under compulsion to continue their behaviour even when it means burglaries, prostitution and death?
4. In relation to those using drugs, how do we uphold moral standards while at the same time caring for people – the tension between law and grace. How do we do both? Is the concept of grace acceptable or foreign to dealing with the dependent? How do we deal with those (eg alcoholics) who fail again and again?