

THE GERARD BRENNAN LECTURE 2000:  
INJECTING INSANITY? – WHITHER A SANE  
SOLUTION ...

*By The Hon Paul de Jersey AC\**

One otherwise sunny afternoon three years ago in the northern hills of Thailand, I witnessed the pathos of an aged woman smoking opium in the darkened inside of her rough hut. She was attended by her daughter and granddaughter. In January this year, in Zurich, I observed an emaciated intravenous drug user injecting himself with heroin in a government sponsored injection room, or in street jargon, 'fixerraume'. I also witnessed the lawful supply of heroin to addicts, extraordinarily enough heroin obtained by the Swiss Government itself from elsewhere and then sold to the users at 15 Swiss francs, about 15 Australian dollars, per supply. Each of those countries – Thailand and Switzerland – condemn heroin as an unlawful, dangerous drug. And so these experiences were naturally disturbing, especially you may appreciate for a judge committed to traditional notions of criminal justice. I should confirm that there was nothing voyeuristic about this. I was urged to enter the Thai hut so that I might experience the strength of enduring family support in the face of abject poverty and long term addiction. I was invited to enter the Swiss injection rooms so I might better appreciate the nature of the radical initiatives of those communities and thereby make a more useful contribution to our own debate about these issues. I will say at once that I saw the Swiss initiative as involving an enlightened and unprejudiced response to a remarkably difficult social problem for that country. Whether it would effectually translate to ours is a separate question.

These are intensely emotive issues. That does not excuse our rationally addressing them. Fortunately for most people, any trace of the romance possibly once injected by, as but two examples, Coleridge's Kubla Khan or Cole Porter's fashionable references to cocaine, has utterly vanished. Thinking responsible members of today's community regard every aspect of the drug trade – production, supply, use – as a vicious, utterly

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THE GERARD BRENNAN LECTURE 2000:  
INJECTING INSANITY? – WHITHER A SANE SOLUTION ...

distasteful blight upon humanity; and no doubt many users caught in the grip of addiction would also agree. But the sad fact is that unlawful drug use remains all too prevalent in our society. Australia has a comparatively high overdose death rate, said to be 32.8 persons per million of population annually compared with Britain's 31.1, Sweden's 28.4, France's 3.9, Finland's 3.7 and the Netherlands' 2.1 – 'The Canberra Times' 12 March 1999.

In Queensland in 1998, there were 38 opioid overdose deaths, translating to 24.2 persons per million of population aged 15 to 44 years. From January 1997 to September 1999, in Queensland, illicit drugs led to 206 deaths, 84% morphine related (source, Queensland Health). These matters, taken with the unrelenting parade of drug cases before the courts, the need for methadone and needle exchange programs, and regular police detection of trafficking and dealing and a substantial flow of drugs into the country, confirm the need for continuous vigilance – but also, possibly creative solutions. Are the current mechanisms working optimally?

The particular issue I wish to address this evening is the approach to persons addicted to the hard core ultimately deleterious drugs, heroin especially. Should they in this country be provided with new facilities, such as would be startlingly contradictory of very important current laws? What could be any justification for such a move? The issue is topical, with developments in New South Wales, Victoria and the Australian Capital Territory, and the high level of debate in Queensland. It is important that the thread of the debate not be obscured by slogans: it must be woven rationally, and in an enlightened way.

The Australian States and Territories already have well developed, sophisticated anti-drugs programs. They include active police enforcement of drug laws – with courts imposing appropriately deterrent sentences while recognising the importance of rehabilitating users where practicable, active anti-drugs education in schools and otherwise publicly, the availability of drug counselling and support services, specialised medical treatment and detoxification facilities, the availability of the synthetic substitute methadone and needle exchange programs, and so on. But now it is being suggested in this country that persons addicted to serious drugs should be given more radical, supposedly helpful provision: lawfully sanctioned injection rooms for example, and

the lawful prescription of heroin. One question immediately occurring is whether this would 'send the wrong message' to impressionable youth, as claimed by some, or whether that response obscures the real point by a slogan better avoided. I return to this.

What follows does indeed relate specifically to those who have an apparently intractable addiction to high level dangerous drugs and that is accepted as amounting to chronic mental health disorder. What do we know of such people in Australia? A report of the New South Wales Bureau of Crime Statistics and Research, released at the beginning of the year, based on a survey of about 500 Sydney heroin users, put the average age for commencement of use at 18.7 years, with regular use commencing at 20.4 years. Forty-four percent of those surveyed said they had previously overdosed. Sixty-five percent said that they relied on illegal activity – such as selling drugs, shop-lifting and robbery – to support their habits ('Sydney Morning Herald' 6 January 2000). Generally these may be described as desperate members of our communities. There are, or were as at 31 December 1999, in Queensland, as many as 3,752 persons registered on the methadone program. By way of comparison, there are approximately 16,000 registered on the Swiss methadone program. The population of Switzerland is approximately 4.6 million – Queensland's is approximately 3.4 million. There are said to be approximately 30,000 heroine/cocaine addicts in that country. It is obviously impossible to know the precise extent of heroin dependency in Queensland. But the extent of the methadone problem is a fair indication. So is the extent of police charging: in 1998-99, there were 429 charges in relation to heroin and other opiates, half for possession and half for production, trafficking or supply. A Corrective Services Commission survey for that year found that 19% of male inmates, and 31% of females, used opiates. How to deal with these persisting substantial problems?

There is one frequent response to regular claims that current strategies are not working well enough. That is to legalise currently unlawful drugs. The theory is that removing the criminality, opening up the matter, would diminish any fascination for many prospective users, lower levels of associated crime, and render continuing use more hygienic, with less consequent drain on, among other matters, the public health system. I myself find these arguments deceptive and rather beguiling, ignoring

THE GERARD BRENNAN LECTURE 2000:  
INJECTING INSANITY? – WHITHER A SANE SOLUTION ...

the real point. It has to be a matter of 'drawing the line', and if that is a slogan, it is I suggest in this respect a helpful one.

Individual members of the community, and the community collectively, already suffer the adverse consequences of the misuse of addictive substances lawfully available. Why add to the panoply of possibly harmful substances already lawfully available? Although human beings 'of adult years and sound mind (have the) right to determine what shall be done with (their) own bodies' (cf Cardozo J, *Society of New York Hospital* (1914) 105 NE 92,93), that autonomy should not prevail where the community is adversely affected in the result. A suggested freedom, or right, to punish one's own body by consuming whatever deleterious drugs one likes, is surely negated, if by no other moral consideration, by the need not to burden the community with the cost of providing the necessary consequent health care and other public resources. I am simply not persuaded that the bar should be lowered. And so I proceed to the next question: can the community's response to the drug problem nevertheless be improved by resort to the sorts of initiatives I experienced in Switzerland, and currently proposed elsewhere in this country?

Let me describe now what I saw. The baptism of fire was a visit to an injection room, or as I say, 'fixerraume' in Zurich. It was located in a commercial, non-residential area. A security officer let me in. His presence was necessary to deter drug dealers from congregating outside the door. To this sort of facility, the user brings his or her own drugs, purchased elsewhere. About 100 users, or 'clients', visit this centre every day. They must be residents of Zurich. This particular centre, typical of another I visited in Berne, for example, contains a cafe, counselling room, and a discrete injecting room. The users help run the cafe, where they can purchase fresh food relatively inexpensively. The ambience of the injecting room is sterility. At two or three (in Zurich), up to ten (in Berne) tables, the users sit and prepare their drugs with sterile injecting paraphernalia provided by the centre. Once in that room, the user may stay for up to half an hour. A staff member, in this case in Zurich a social worker, is present: not to assist in the administration of the drug, but to keep order and to watch for any sign of overdose. Users must behave in an orderly way: breaking the rules may lead to temporary exclusion. Many of the users visit the centre to inject a number of times a day. A survey conducted in 1995 suggested, as the main reason for

visiting such centres, to inject in peace (86%), to obtain free injecting equipment (33%), and because medical attention was available (Dolan and Wodak: 'Final Report on Injecting Rooms in Switzerland', 26 July 1996, The Lindesmith Centre online Library). There have to date been no deaths in these Swiss fixerraumes, which have been running since 1986. They exist – in Berne, Geneva, Basel, Zurich and Schaffhausen – primarily to provide a hygienic injecting environment, with reduction in public health risks, especially HIV infection; and to reduce the public nuisance flowing otherwise from injecting in parks and toilets and other public places. They sometimes use the facility to check the purity of the drugs they have purchased. Also, there is the prospect of some useful social interaction among marginalised members of the community.

Interestingly in Berne, there is drug dealing immediately outside the centre on the pavement. It is confined, I was told, to those going on to use the injection centre: users selling to users. But this feature emphasises the difficulty, the sheer inappropriateness, of establishing these centres in residential areas. Also, selling, possession, use – these are all unlawful in Switzerland. The office of the Berne police director is situated adjacent to the injection room. This radical operation is currently tolerated by the police. They know that the many hundreds of injections which daily occur in the 'legal' room would otherwise occur in public, with associated nuisance, if not major crime. The police apparently prefer to suffer the problem carefully controlled in this way. If non-user dealers seek to muscle in on the dealing scene, the police are summoned. I later describe the Swiss approach as 'pragmatic': police 'co-operation' has been integral to its effectiveness. Could it *reasonably* be expected here, and in any case, could it properly be given? Queensland police have a statutory obligation, which is I imagine similar in other States, to prevent crime, detect offenders and bring them to justice, and uphold the law. (Police Service Administration Act 1990, s2.3 (c), (d), (e)). Presumably any such programs in Australia must in all their aspects depend on comprehensive legislative authorisation.

The other initiative is even more radical. A little further along the Seilergraben in Zurich is the Polyclinic 'Lifeline', for the lawful prescription and injection of heroin. This centre had 120 clients when I visited, then 20 short of its maximum 140 places allotment. There are now 1,000 places available in all Switzerland under this sort of program. To qualify for admission to such programs, a person must meet a number

THE GERARD BRENNAN LECTURE 2000:  
INJECTING INSANITY? – WHITHER A SANE SOLUTION ...

of criteria: be at least 20 years old, a daily user of heroin, dependent for at least two years, having failed at least two therapeutic efforts, with evident deficiencies in social integration, psychological well-being or health. Their average age there is at least 30 years. Their social condition on entry is generally characterised by bad housing, unemployment and poor financial management ('Social Characteristics of Participants in Swiss Multicentre Opiate Trials at time of entry – Preliminary results' 29 August 1997). As I suggested earlier, this program is really for desperate members of the community. Such programs began in Switzerland on a trial basis in 1994. They are now permanently established in various centres.

It is important, however, to note who usually use these programs: they are the truly desperate. The current average characteristics of those entering the Koda Institute's program in Berne, typical of the nation, are: age 33, 77% male, 13 years of heroin consumption, 10 previous attempts to stop, 50% having endured long term residential treatment, 48% having been hospitalised for psychiatric conditions, 43% having previously attempted suicide. Hence I say these are desperate people.

Participants in these programs pay 15 Swiss francs a day for their dose of heroin. They are allowed generally up to 300 milligrams three times a day, but often tend to cut back their dosage to optimise the so-called 'flash'. Provided with the drug, they must inject it on the premises, under supervision, using the sterile equipment provided. These users are subject to a disciplined regime: they must attend three times per day, seven days per week, at designated times. They must accept psycho-social care and counselling. Medical care is provided, and not just for drug related illness. Failure to accept this regulated regime can lead to exclusion from the program. That aspect of discipline may explain why all the places in Zurich, for example, are not filled. So may the view that injecting in such sanitary, controlled circumstances lessens any thrill of the experience. In Berne all places are filled, and more could be if available.

This particular program began experimentally in 1994. It was designed to determine whether hard core addicts could stabilise and reduce their usage if assured a legal, safe and stable source of heroin. Could they hold down employment, even though injecting two or three times a day? Would they cease using illegal heroin and other drugs? Would their

criminal activity diminish? Would their health improve? And would it be possible to overcome the 'not in my back yard' objections frequently raised against methadone and other programs for addicts? (E. Nadelman: 'Switzerland's Heroin Experiment'. National Review, 10 July 1995, pp46-7). I come to the question of results. But may I say at once that those who run these programs in Switzerland suggest that heroin is taking on the image of a loser's drug. There is seen only to be a downside. There are few young users involved in the programs. It is regarded as an older person's drug: heroin in Switzerland is tainted with the whiff of middle age. And so the Swiss believe the heroin epidemic which began in the 80s may be over. What they see as left, is to manage the chronically addicted, now in their mid 30s.

It must clearly be understood that the common denominator of both these initiatives – the safe injection rooms and the prescription programs – is not the goal of abstinence, and that has provoked criticism. The objective is really the hygienic maintenance of addiction, nevertheless with the hope of improvement in social behaviour and health. The Government is of course alive to consequent reduction in the cost of associated public health services, and ancillary public facilities, such as policing. A fundamental objective is 'to educate addicts to use drugs in the least harmful way, while not primarily 'helping them to get off drugs' (E Aeschback: 'Flawed Swiss Drug Policy', The International Drug Strategy Institute, 18 June 1998).

Has the program succeeded? The heroin prescription program was conducted on an experimental basis from the beginning of 1994 to the end of 1996. The assessors claimed success and recommended continuance on an established basis (Program for a Medical Prescription of Narcotics, Final Report of the Research Representatives, Swiss Federal Office of Public Health, 1997). The assessors claimed considerable successes: long term improvement in the physical health of participants, regression of depressive psychiatric states, proper treatment of pre-existing HIV and hepatitis infections, substantial reduction in illicit heroin and cocaine use, rapid improvement in housing and fitness for employment, reduction of debt, dramatic reduction in income from illegal activity, and in crime. As to retention rates, 89% of entrants persisted for six months, 76% for 12 months, and 69% for 18 months.

THE GERARD BRENNAN LECTURE 2000:  
INJECTING INSANITY? – WHITHER A SANE SOLUTION ...

These claims of success have however been the subject to trenchant criticism, especially because of the difficulty of certainly attributing the gains to the programs. That difficulty was accentuated by the absence of an enduring 'control group', intended to use morphine and methadone only, by contrast with the participants using the prescribed heroin (cf Aeschbach, 'On the Final Report of the 'Programe for a Medical Prescription of Narcotics' in Switzerland'; 'The Swiss Heroin Trials: Testing Alternative Approaches', editorial, British Medical Journal, 28 February 1998). Because of the lack of a proper control group, the results are 'descriptive' rather than scientifically validated. Maintaining a control group can be inherently difficult in this context. Ideally, one would assess gains for the controlled heroin group against a cohort on methadone. The sad reality is that those on methadone regressed into heroin.

But after allowing for that deficiency in assessment, the latest report available, by 23 internationally recognised experts from ten countries auspiced by the World Health Organisation, generally favours the program. That report, dated 16 April 1999, concludes that 'the medical prescription of heroin in a strictly regulated environment that provides for injection at the dispensing centre is feasible and safe, responsible and can be implemented in a way that is acceptable for the community'; while recording also that 'according to the self reports of participants a clear improvement was noted in the state of health, the social situation and the reduction in the criminal behaviour and consumption of illegal heroin'.

The Swiss are particularly, and justly, pleased to note substantial reduction in drug related deaths (excluding deaths from AIDS) – from 419 in 1992 down to 209 in 1998, and estimated to be as low as 159 in 1999 (Koda Institute). This reduction cannot however of course be related just to these two particular initiatives, which form but part of a comprehensive national drugs strategy, including elements, or 'pillars' as the Swiss style them, of prevention, therapy, harm reduction and law enforcement. It is significant to note that in Switzerland, the mortality rate for those on heroin prescription programs is 1%, compared with 8.9% for those said, otherwise, to be 'out of treatment'.

These Swiss models are now being promoted here. Would they work? The World Health Organisation group's report was concerned also to note that 'Switzerland's unique political and social situation limits the

applicability of the trial results to other countries'. While generally conservative in outlook, Swiss society is markedly socially cohesive. Because of the density of residential housing, serious social problems tend to become well known, and there is a push to solve them. It is an orderly society. Yet even allowing for all that, why were the sophisticated and conservative Swiss driven to these radical measures? To answer that, and to address the question whether such measures could effectively translate to Australia, it is helpful to identify the relevant anterior historical events.

The use of illicit drugs took on world wide prominence in the 60s, associated with the rise of the hippie movement. Drug usage in Swiss cities noticeably increased through the 70s. In the early 80s, youth riots in Zurich protested against conservative government initiatives. An alternative cultural scene developed. Students showed solidarity with marginal groups, including drug users. These developments were not peculiar to Switzerland. But by the mid 80s, the Zurich drug scene secured an international notoriety which was peculiar and deeply disturbing to the conservative Swiss especially. Fuelled by the international drug mafia, the open drug scene spread through Zurich, settling in 1986 at the Platzspitz 'Needle Park'. About 3000 drug abusers and dealers were said to frequent this place daily, up to 8,000 at peak times. The park, and its successor at Letten, an abandoned train station, were tolerated for almost a decade. They were the site of major criminal activity, including murders. Through television footage, the world came to learn vividly of this extraordinary example of what was condemned elsewhere as totally misguided tolerance.

To this point, drug treatment in Switzerland was geared ultimately to abstinence. It was therefore paradoxical to see official tolerance of needle park fiascos. With drug deaths frequently occurring in public streets, the rise of AIDS, and the reluctance of addicts to enter programs based on an abstinence they believed they could never achieve, the Swiss Federal Government in 1991 intensified its drugs commitment, and soon after co-operated in the radical initiatives on which I have dwelt.

Many commentators link the Swiss public acceptance of these initiatives to the glaring public visibility of the problem, from images of needle parks beamed across the world to the embarrassment of the Swiss, to dramatic increase in drug crime within a naturally ordered community,

THE GERARD BRENNAN LECTURE 2000:  
INJECTING INSANITY? – WHITHER A SANE SOLUTION ...

and sharply rising rates of drug related deaths – often within public view. These features led to substantial well informed public debate. The community, naturally inclined to help solve social problems, recognised the need for radical responses, and they were made. (See H Klingemann: Drug Treatment in Switzerland: Harm Reduction, Decentralisation and Community Response, *Addiction*, 91 (1996): pp723–736).

Those particular radical initiatives are carefully monitored, continually assessed. The Swiss apparently accept them as appropriate and worthwhile innovations. Yet the Swiss approach to drug control is certainly not open slather tolerance. There will clearly be no reversion to the disasters of the 80s. The current approach is one of very careful control. Significantly, in the 90s, the Swiss people by referendum rejected two alternative popular proposals or initiatives. One of them, ‘Youth Without Drugs’, called for a strict, abstinence oriented policy. Seventy-one percent of voters rejected that in September 1997, after some four years public debate. The other extreme proposal, ‘For a Reasonable Drug Policy’, was premised on the decriminalisation of drug production, purchase, possession and use for personal purposes. Seventy-three percent of voters rejected that alternative proposal in November 1998, again after about four years airing. The current State prescription program is authorised by law of the Swiss Parliament passed on October 1998, to run at this stage until December 2004. (See generally, ‘The Swiss Drug Policy – a Fourfold Approach with Special Consideration of the Medical Prescription of Narcotics’, Swiss Federal Office of Public Health, March 1999.) Although the most recent referendum, in 1999, showed only 54% popular support for the heroin prescription program, that is said to suggest much more substantial support, because only 36% of people voted: the public was generally at least acquiescent in the current approaches. Surveys conducted for example by the Department of Social and Preventive Medicine at the University of Lausanne confirm substantial public support.

The most appropriate tag for Switzerland’s drug policy is pragmatic. Unsurprisingly, it remains controversial. Significantly, it draws no sympathetic support from US officialdom, although the more radical initiatives are being replicated in some other European countries. Those to whom I spoke in Switzerland expressed their intelligently reasoned support for the initiatives. They included the on-the-ground operators

of the centres, drug addiction researchers, high level university and state (Cantonal) and national experts. They importantly emphasised that these particular initiatives are essentially directed towards a limited target group otherwise devoid of necessary help. They asserted the message being sent is certainly not that serious drugs are acceptable, but that the community is compassionately helping those in entrenched, desperate plight. According to the literature, critics on the other hand say the strategies 'minimise the consequences of bad behaviour. They ignore deeper philosophical implications. They assume no remedy exists for destructive behaviour, so reducing harm is preferable to radical, and particularly spiritual change. The question of ethics, right or wrong, is not seriously looked at.' ('Can't Kick the Quick Fix', World on the Web international archive from 18 October 1997, Vol 12, No. 22, author M Belz).

No one could reliably forecast whether such measures would necessarily prove effective in Australia. Their apparent effectiveness in Switzerland rests not just on careful management of the centres, but depends also on community acceptance, and that is I believe explained in part by the Swiss people's experience over the last 10 to 15 years of dramatically escalating drug problems to the point where they were apparently uncontrollable, a failure which was internationally highly visible. In that context, the Swiss preparedness to embrace these prima facie startling initiatives may more readily be understood. Events may not have prepared Australians in quite that way. That is not to say, however, that Australians may not ultimately be driven to support such initiatives, by a similarly high level of compassion for their fellow beings in desperate straits as moved the Swiss. And our drug problem is immense and visible.

Whatever the outcome in this country, I would, on the basis of what I have recently seen and read, and other experiences over a 15 year judicial career, urge the following six imperatives.

*First*, abstinence should remain a goal of all drug therapy. That is still the position in Switzerland. Although abstinence is no more than a remote possibility with very deeply entrenched addicts, it is sometimes achieved, and the primary focus with serious addicts on hygienic maintenance of the addiction in a disciplined regime, as in Switzerland,

THE GERARD BRENNAN LECTURE 2000:  
INJECTING INSANITY? – WHITHER A SANE SOLUTION ...

should not be allowed to exclude the goal of abstinence which, if secured, serves everyone best.

*Second*, the community must do its best to help those intractably addicted. A civilised society cannot relegate any of its members to a gutter from which they cannot lift themselves unassisted. If a new strategy, however apparently radical, could help such people into a healthier lifestyle, reduce disease and crime, and facilitate employment – while incidentally easing the cost of public health, policing and the like, then it obviously should seriously be considered. That has been the Swiss experience.

*Third*, we should however be reluctant to embrace radical measures like these, radical especially for their glaring incompatibility with traditional notions of law and order, unless they command substantial community support. That appears to have been very important in aiding the Swiss experiments. Whether it would be forthcoming here, allowing for the arguable cultural differences I have suggested, is moot. But this is, I believe, very much an initiative which should be driven by the people, not by politicians or bureaucrats.

There is also the financial consideration. Such programs are expensive to run. The Swiss program costs 21,800 Swiss francs per person per annum – about the same figure converted to Australian dollars. To establish a context, however, the Swiss spend 17,300 francs per annum per registered methadone user. The Swiss estimate a year in gaol costs about 130,000 francs, and residential drug treatment about 120,000 francs per annum. An untreated, unregistered heroin addict is said to cost the Swiss public health system about 150,000 francs per annum. It is difficult to establish a net result reliably, but the Swiss regard their programs as cost effective. (My source for some of those figures was Dr J Gervasoni, Institute of Social and Preventive Medicine, University of Lausanne, one of the official appraisers of the Swiss program.) The Koda Institute in Berne suggests the scheme is cost effective, particularly because of the reduction in legal costs associated with drug related crime. The Swiss are apparently satisfied that their programs are overall cost effective. Looking at the matter very broadly, saving the drain on the public purse through avoiding even one HIV infection through unsafe injection, must be substantial.

Of course many important areas of public concern are currently underfunded in Australia. Legal aid and compensation for victims of crime are but two of particular significance to me. Where would these proposals fall within the public's perception of the right priorities?

*Fourth*, any implementation of such proposals must not be allowed to blur in any degree what must, I believe, remain as the primary public thrust: opposition to dangerous drugs. As in Switzerland, such initiatives must, if implemented, be presented unmistakably as a justified community response to a particular, acute problem – the intractably addicted if they are prepared to accept the discipline of a strictly regulated regime; and not as signalling any softening of a rightly, necessarily stern approach to this undoubted social scourge. No efforts should be spared to achieve a drug free society, however difficult to secure (cf 'Flawed Swiss Drugs Policy', supra, p5).

*Fifth*, such initiatives, if implemented, should not be allowed to develop insidiously into a foothold or platform for the legalisation or decriminalisation of currently seriously dangerous drugs. I have earlier in this address explained my reason for adopting that position, itself a controversial issue on which opinions differ. I am myself convinced that the bar should not be lowered; we should not as a society redraw the line to legitimate currently unlawful dangerous drugs. Any message signalled by such initiatives, were they to be implemented here, must be the compassionate treatment of desperately unwell members of the community; not that the community is developing a more tolerant attitude towards the ultimately deleterious drugs like heroin and cocaine, or any of the current battery of illicit substances.

*Sixth*, any implementation of such programs should not be rushed. It would have to follow careful, comprehensive, rational, informed, expert consideration, and measured public debate. Close consideration would need to be given to current law and necessary changes. It is difficult to conceive that such a set up could, in Australia, depend on police 'tolerance', as in Switzerland. Would that not plainly involve neglect of the police oath and statutory obligation – in fact departure from the rule of law? International strategies would fall to be considered. If the initiatives were set in place, their operation would have to be monitored, and the subject of transparent and comprehensive public reporting and periodic review, as in Switzerland.

THE GERARD BRENNAN LECTURE 2000:  
INJECTING INSANITY? – WHITHER A SANE SOLUTION ...

A particular difference between the Australian and Swiss situations would need to be addressed. The Swiss centres work because they are accessible readily by addicts who live in closely settled urban residential environments excellently served by public transport. Those on the prescription programs can therefore without great inconvenience attend three times per day, while, desirably, sometimes even holding down employment. The much greater residential dispersal of the Australian population raises a significant difficulty, although perhaps rooms could be established in districts where, in terms of residence, addicts tend to congregate. This is, however, but one of many matters of detail which would need very close consideration. I mention it now as an immediately obvious point of distinction.

I have been privileged to offer this evening views distilled from some most startling recent experiences. The issue is one of dramatic complexity. Whither a sane solution? All I can confidently say now, is that we are not yet in a position to answer that question. I hope however I have been able to signpost usefully some very important considerations.