BIOETHICS OUTLOOK

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Supervised Injecting Rooms: A Symposium

Earlier this year the New South Wales Government conducted a 'drug summit' to consider the seriousness of the problem of illegal drug use in this state. At that summit, the trialing of a 'safe injecting room' was proposed alongside other initiatives. On 24th June the Darlinghurst Regional Board of the Sisters of Charity Health Services decided to offer to run such a service for a trial period of eighteen months under certain conditions. (These conditions were set out in a "Position Statement", part of which is reprinted on page six.) The Government accepted this offer.

The proposal to conduct even a trial of a 'supervised injecting room' is one about which intelligent people of good will differ. Most of the discussion has focussed not on the idea that there is something wrong in itself with providing such a service to people who are addicted to illegal drugs: rather it has focussed on whether or not it is wise to try *in this way* to minimize the harm that injecting drug users do, to themselves and to others.

This issue of *Bioethics Outlook* consists of a modest symposium on the proposed trial of a supervised injecting room. Our aim is to deepen our readers' understanding of the practical and ethical issues associated with the proposal: we hope to help readers to come to their own considered judgement about the wisdom of conducting such a trial.

We asked four people to contribute to this symposium. Dr Tina Clifton, as Chief Executive Officer of the Darlinghurst Region of the Sisters of Charity Health Service, has overall responsibility for planning and evaluating the trial. She explains what motivated the decision of the Darlinghurst Regional Board of the Sisters of Charity Health Service to offer to conduct this trial.

Dr Alex Wodak, the Director of the Alcohol and Drug Service of St Vincent's Hospital, Sydney, will have responsibility for the day to day conduct of the trial. He describes how injecting rooms are conducted in several places overseas and sets out their objectives.

Dr Anthony Fisher OP and Dr Gerald Gleeson, members of the Plunkett Centre, consider the ethics of the trial.

Dr Gleeson applies the traditional distinction between formal and material cooperation in wrongdoing to the provision of a safe injecting room for people who inject heroin, and concludes that since the room may reasonably be expected to do more good than harm it warrants a trial. Dr Fisher uses the same distinction as background to his explanation of the unease many people feel about the whole project.

Why we accepted this challenge

Tina Clifton

On 27 July 1999 the NSW Premier, the Honourable Bob Carr, announced that the Sisters of Charity Health Service would operate a Medically Supervised Injecting Service in the Kings Cross area. This followed a submission by the Darlinghurst Region of the Sisters of Charity Health Services (which operates St Vincent's Hospital) to the NSW Health Minister to take up the challenge of running the first legal "safer injecting room" in Australia.

In taking the decision the Regional Board, the National Board and the Congregational Leader and Council all knew that the topic was one on which there was significant variation in opinion in the community. We all knew that there would be some staff, some other service providers, members of the community and some members of the Catholic and other Churches who might disagree with our involvement. It has however been one of the most inspiring features of this project that throughout the entire process, from concept to implementation, the Congregational Leader and Council of the Sisters of Charity have supported this service. Some people are still asking why.

In coming to the decision, among other issues the following questions were asked: What would Jesus have done? What would Mary Aikenhead have done?

The rich history of the Sisters of Charity is full of stories of Mary Aikenhead and the Sisters who came to Australia in 1838, caring for the poorest of poor, the marginalised in society. Their first task in Australia was to minister to the women of the female factory (the Parramatta gaol). The situation of those women was similar to that faced by people who use illicit drugs today: they were a group of law breakers, outcast by society, struggling to regain their human dignity. And we know that it was the Sisters of Charity then as now who took up the challenge to try and give compassion to those on whom society is apt to give up.

After the 28 July announcement, the letters of support and encouragement were overwhelming.

Our first fax came from the father of a boy who had died recently when he was nineteen years of age. His son had suffered in his youth. He had just begun to get his life back together, with the help of the love of a friend, when tragedy struck and he died from an overdose. His father encouraged us because he believes we may be able to save lives.

Though there has been some criticism of our judgement and ethical framework, our commitment was often promoted by others in the media and we have received large numbers of supportive letters.

"It is entirely appropriate that the Sisters of Charity should volunteer for the difficult task of establishing and implementing the plan. They will marry their compassionate and non-judgmental approach with their clinical expertise developed through long years of services in the Darlinghurst area."

Professor John Dwyer, Prince of Wales Hospital

"The demonstrated commitment of the Sisters of Charity to helping people stay alive in order that they may seek support towards recovery is admirable. This is particularly so given the attitudes expressed by people who are critical of you."

TM, recovering from long term drug addiction

"... not every Catholic, or indeed Christian, will agree with their way of expressing such pastoral concern. Although there is no doubting the Sisters' courage, some will question their moral prescience or even accuse them of naivety."

James Murray, The Australian, 2/8/99

"We lost our 19 year old son in January this year ... Our son was sexually abused at 7 years of age and I believe that the majority of heroin users are, or have been abused in some way or other."

TQ, parent's letter

"... up to now all efforts to mitigate the problems associated with drug taking have been done within the square. And those have been unsuccessful ... To accept this challenge to work outside the square is surely to respond to a grace moment."

Social Justice Committee,

Conference of Leaders of Religious Institutes

"So .. my heart and best wishes go out to you and your team. Remember, if one person uses your service, that is already one life you have probably saved."

BL, prisoner in gaol

"So a bunch of nuns is being given the opportunity to be at the leading edge of drugs policy in Australia ... As in other parts of the world, nuns have become the de facto leadership in the church in one sense - by genuinely trying to define what it means to apply the lessons of Jesus Christ and the gospels in the late twentieth century. If that means working in unorthodox ways, so be it as long as it means the modern poor and the marginalised are reached."

Geraldine Doogue, Sydney Morning Herald

"If a woman finds a young addict about to inject with heroin... she can walk away. She can quote the laws - using heroin is not legal. Or, she can say 'I know this time he can't give up the drug but I will do as much as I can to help him.' "

KH, Catholic Weekly 12/9/99.

We provide a comprehensive range of rehabilitation services for people with drug addiction and our purpose in providing this new service is to save lives so people may come, eventually, to have the courage and support they need to kick their habit.

In the tradition of the Sisters of Charity we will continue to help the poorest of poor even when others may judge them or our actions as misguided. We abhor the drug industry and drug taking. We see the wreckages from both legal and illegal drug abuse and are as frustrated as most of the community about our lack of ability to reduce drug and alcohol consumption. Going forward may not be easy but we applaud the diversity of views in our community and encourage all our staff and other friends to feel free to express to us and others the range of issues and the basis for them.

Why trial a supervised injecting room ?

Alex Wodak

What is an injecting room?

Injecting Rooms are places where self-administration of illegal substances is tolerated. In these settings, drug injecting is supervised by a healthcare professional and health and welfare services are also provided. In Switzerland, injecting rooms provide space for supervised injecting as well as ancillary services.

In the Netherlands the facilities also provide supervised areas for 'chasing' heroin. This is a technique which involves gently heating heroin base to release a vapour which is then inhaled. "Chasing" has a much lower risk of drug overdose. Another advantage is that there is no risk of transmission of blood-borne viral infections with this procedure. A wide range of ancillary services is available in most supervised injecting rooms. These ancillary services are probably even more important in producing health gains than the supervised injecting spaces.

Background to the decision.

From the late 1980s, unofficial injecting rooms were operated by the sex industry in Kings Cross. These continued until early 1999. The sex industry responded to the growing demand for places to inject drugs off the streets in Kings Cross, close to an expanding drug market which began to switch in the last few years of the twentieth century from a predominantly heroin to a mixed heroin-cocaine drug market. Cocaine injecting is associated with quite chaotic behaviour. The provision of supervised injecting places close to the drug market offers the possibility of reducing adverse consequences of the drug market. The sex industry responded to the growing demand for a place to inject drugs. At times there were up to a dozen facilities in the Kings Cross area where patrons could, for a small fee, hire a place to inject drugs under reasonably sanitary conditions.

Nevertheless, the NSW Police were placed in a terrible dilemma. Should they use discretion to enforce the law or "turn a blind eye" and thereby protect public health?

In 1997, the NSW Royal Commission into Police Corruption conducted by Justice James Wood recommended a trial of an injecting room. Subsequently, a Select Committee of the NSW Parliament considered the recommendation of Justice Wood to establish a trial for an injecting room but voted by a small majority (6:4) against the recommendation. In May 1999, an unauthorised injecting room was established at the Wayside Chapel in Kings Cross. Later that month, the NSW Drug Summit voted in favour of a trial (subject to conditions). Consequently, an 18-month trial was announced by the NSW Premier, Bob Carr, on July 27th. Mr Carr announced that the Sisters of Charity Health Service would conduct the trial, while independent evaluation would be conducted by a team of highly qualified researchers (Ms Helen Lapsley, Dr Don Weatherburn, Professor Mattick and Professor Kaldor). On the night of the announcement, the bodies of four drug users who had died from a drug overdose were taken to the Emergency Department.

Why the Sisters of Charity?

The Sisters of Charity Health Service has been working in the neighbourhood for 160 years. The long tradition of the Sisters of Charity is bound up with working with disadvantaged populations. St. Vincent's Hospital is a university teaching hospital with an excellent reputation; it is well-known for exceptional work during the HIV/AIDS epidemic beginning in the 1980s. The Sisters of Charity Health Service has long emphasised the importance of alcohol and drugs services at its many health operations.

History and evaluation of injecting rooms in Europe

Injecting rooms were first established in the United Kingdom in the 1960s. But these were poorly run, rarely researched, and ultimately abandoned. Dr. Robert Haemmug established

the first injecting room in recent times. This was in Bern, Switzerland, in 1986. There are now fourteen injecting rooms across (the German-speaking part of) Switzerland. Injecting rooms have also been established in the Netherlands and Germany. Switzerland, the Netherlands and Germany have all now adopted a harm reduction approach to illicit drugs. There have been no deaths in injecting rooms in Europe although one in five hundred visitors to these facilities is estimated to have an overdose. Overdoses occurring in injecting rooms are revived immediately, mainly with oxygen and physical stimulation. Occasionally, more severe interventions are required and sometimes an ambulance has to be called. Injecting rooms in Switzerland have abandoned the use of the short acting parenteral opioid antagonist, naloxone. Injecting rooms in Switzerland are well supported by their communities and make every effort to blend in unobtrusively. Injecting rooms have contributed to a declining number of deaths from drug overdose in parts of Europe.

Difference between "shooting galleries" and injecting rooms

"Shooting galleries" are only found in zero tolerance environments like the United States. These facilities are run by criminals who require patrons to pay a fee on entrance and pay an additional fee for the temporary hire of injecting equipment. The circumstances are most unhygienic. Hired injecting equipment has usually been used extensively without any attempt at decontamination. U.S. research shows a close correlation between attendance at "shooting galleries" and HIV infection in injecting drug users. The term "shooting gallery" is deliberately misused by zero tolerance voters rather than the more neutral term "injecting room".

What happens in an injecting room?

Injecting drug users entering the facility undergo an initial assessment. In some instances, injecting rooms register all people who enter the facility. Some injecting rooms have strict residential boundaries. Injecting rooms are often run side by side with a needle syringe programme. Injecting rooms vary considerably. In some, facilities are available for injecting drug users to have a shower, wash their hair and launder their clothes. Some have a subsidised cafeteria where injecting drug users are able to undergo supervised work which includes the handling of small quantities of change as well as the preparation of simple foodstuffs (coffee, toast, soup). The food is subsidised in some injecting rooms because so many of the people visiting are poorly nourished. The large cafeteria area allows health care workers to interact with injecting drug users and offer referral to a wide range of treatment, welfare, housing, and legal professionals. In some cases, nursing care is required to dress sores. Some injecting rooms provide clinics for the management of gynaecological conditions, sexually transmitted infections, and primary health care (including Hepatitis B vaccination).

One of the staff stands outside the locked injecting room only allowing people to enter when the same number of people have left. The rules of injecting rooms are usually clearly set out and displayed prominently throughout the facility. The rules are strictly adhered to. No dealing is permitted.

Drug users who have left the injecting room are encouraged to stay in the cafeteria area for quite a while.

Health: the objective of injecting rooms

Injecting rooms are being established for trial in Australia at a time when deaths from drug overdose have increased fifty five fold from 1.3 per million in 1964 to 71.5 per million in 1997.

It will come as no surprise that one of the major reasons to conduct the trial of injecting rooms is to establish whether these facilities reduce overdose deaths. Reducing the morbidity of non-fatal overdoses is also very important.

Even critics of supervised injecting rooms recognise the potential for increased referral to health care and welfare services, especially drug treatment. The possibility of influencing the spread of blood-borne viruses is not great considering the availability of sterile injecting equipment. However, some successes have been claimed in Switzerland where staff managed to convince many drug users that

the 1ml tuberculin syringes was better than the 2ml syringes they were then using. Reducing the discarding of used injecting equipment in public places is another very important health goal. The discarding of used injecting equipment in public places seriously undermines the needle syringe programme which had been so critical in protecting Australians from an uncontrolled epidemic of HIV infection.

Supervised injecting rooms also reduce the extent of drug injecting in public places. The clarity of approaches reduces the opportunities of police corruption.

A substantial reduction in the number of calls for the ambulance service to attend the scene of an overdose is very important. We are also likely to see a reduction in hospital utilisation for non-fatal overdoses.

When Groucho Marx was elderly and somewhat decrepit, a journalist asked him what he thought of old age. Groucho replied: "It is better than the alternatives." No one can pretend that injecting rooms are an attractive sight. But what New South Wales is about to find out is whether or not it is better to have injecting rooms or better to stick to conventional arrangements. It is realistic to hope that drug overdoses in Australia may stabilise or possibly even decline with greater availability of injecting rooms. This would also require a considerable expansion of drug treatment centres. The Sisters of Charity project amounts to a very limited trial. It is only occurring on one site and only operating for seven hours a day over an 18-month period. It will be carefully evaluated in that time.

It is too early to say that the supervised injecting room will inevitably result in a major step forward. But what we can now say is that the strengths and weaknesses of conducting a trial of medically supervised injecting services will determine whether this is an option that should be more carefully considered for other places around Australia.

From the position statement of St Vincent's Campus:

A statement of the position of St Vincent's Campus on 'health services for people engaged in illicit drug use' was published in *St Vincent's Pulse* in July. The statement made it clear that whilst the Board does not condone drug trafficking or the use of illicit drugs, it believes that drug users must be given every possible chance to recover and be rehabilitated, that there is a need for a whole of government response to the drug problem which includes law enforcement, education, treatment and the minimisation of harm when people continue to use drugs. Setting out its decision in the context of conditions for legitimate 'harm minimization' strategies, the Board pointed out that its mission " ... is to respond to the immediate, often life-threatening, needs of people in our community and to minimise the spread of disease". The statement concluded with the following paragraphs:

While needle exchange programs are thought to have helped prevent the spread of disease, the urgency of the present situation may require more proximate strategies, including the establishment of safer injecting rooms. We support consideration of recommendation 3.15 on Medically Supervised Injecting Rooms in the Communique of the NSW Drug Summit. If and when these are legalised, our Drug and Alcohol service will participate appropriately. Individual staff who do not support the development of such services will not be expected to participate.

"Full and public community consultation will be necessary to ensure that safer injecting rooms are provided in suitable places and under conditions which both prevent any increase in illegal drug use and ensure expanded access to treatment programmes. Education is vitally important in the fight against illicit drug use. Well funded research based drug education for the community and schools developed by education and health professionals should be undertaken. As there are still long waiting lists for people seeking detoxification and other treatment programmes, greatly increased funding is needed in these areas. The trial and rigorous evaluation of a wide range of treatment options including the medical prescription of heroin should be undertaken in the context of drug rehabilitation. Criminal activity must be vigorously prosecuted. Penalties for unauthorised, large scale cultivation, production, transport, sale and possession of all illicit drugs should be maintained."

An ethical reflection on a medically supervised injecting room

Gerald Gleeson

The unfolding events in East Timor are rightly dominating the ethical reflections of Australians at the present time. These reflections provide a useful, though painful, introduction to an ethical evaluation of St Vincent's participation in a medically supervised injecting room.

In the case of East Timor, it is not clear with hindsight – though it was also argued by some experts beforehand – that the East Timor referendum on independence should have been held when it was. Some argue that only a clear vote for independence could have (eventually) moved the Indonesian government to accept UN intervention; others argue that the vote should have been delayed to allow for greater political stability in Indonesia, and for preparatory work towards independence. The killing and devastation that has followed the referendum should give all pause for thought about the wisdom of pushing for independence as early as many in Australia did.

At the very least, the East Timor tragedy highlights the crucial truth that good intentions and noble goals are not, on their own, sufficient to guarantee the rightness and practical wisdom of actions. There are many situations in life where it is easy to identify the *good goals* we would like to achieve, but much harder to identify the *appropriate means* to attaining those goals. Even when it is agreed that a goal is appropriate in the circumstances, the most contentious subject of ethical reflection is likely be that of the means to be used in pursuit of this goal.

Goals and means in drug strategies

In the case of the drug crisis in Australia today, most agree on the good goals to be sought, which include saving lives, rehabilitating those addicted to drugs, and eliminating the criminal activity, both systematic and random, which surrounds drug taking. Of course, a few people propose the more radical goal of simply legalising all drugs, but it is difficult to see how this could ever be appropriate. There is little analogy between the use of alcohol and the use of heroin and ecstasy. Apart from restricted medical uses, these drugs have no wise and life-enhancing use. In their case, use is inevitably an *abuse*, a form of self-harm which no sane society should endorse or facilitate.

Granted then that rehabilitation is an appropriate goal, our task is to identify the most suitable ways of trying to achieve this goal. As with all addictions, there is no simple or quick path to rehabilitation. Indeed, the wisdom with respect to addiction is that it is only when the addicted person "hits rock bottom" that he or she reaches the point at which a readiness for rehabilitation emerges. This is why aiding and abetting an addiction only postpones the chances of rehabilitation. On the value of "hitting rock bottom", religious wisdom both Christian and non-Christian concurs, highlighting the need for a surrender in faith, and for a prayer out of weakness, the "prayer of the tax collector", which is the first step towards healing and liberation.

What's different about drug addiction?

There is, however, good reason to think this approach is not always appropriate in the case of drug addiction. For some of those who are addicted to drugs, the very activity itself is life-threatening, to self and others – whether due to the poor quality of the drug used, the amount used, other drugs already ingested, the unsanitary conditions of injection, the remoteness from medical assistance, etc. In the case of this particular addiction, there is a group of desperate people, in many ways the poorest of the poor in our society, for whom "interim measures"

are needed just to make it more likely that they will remain alive long enough to seek rehabilitation.

This is the basic reason for considering a 'medically supervised injecting room' (MSIR) in the context of a wider drugs strategy. The goals are first, to keep alive those people most at risk, by having medical assistance close to where they use drugs, and secondly, to connect these people with the opportunities for rehabilitation. (Typically, the prospective clients of a MSIR are not as yet linked to primary health providers.) While these *goals* are obviously good in themselves, it is not evident to all in our society that the *means* to be used – legalised provision of a supervised injecting room – is ethically justified.

About the *means* used, there are always two major ethical considerations:

First, are the means used ethically sound in themselves?

Second, do the means used actually do more good than harm, and do more good than other available means to the same end?

Not surprisingly, the ethical debate about injecting rooms turns on precisely these two issues.

First, there is the issue of principle: some argue that by providing the room, its staff and facilities, one is inevitably endorsing drug taking and making it easier (by making it safer). In other words, provision of an MSIR involves *complicity* in the very activity we are supposed to be opposing, an activity which is wrong in itself (because of the harm it does to the addicted person and others). In technical terms, those who argue in this way are claiming that a MSIR constitutes "formal" cooperation in the wrong of substance abuse, and its perpetuation.

Secondly, there is the issue of effectiveness: some argue that providing a MSIR will do more harm than good. They claim the availability of a MSIR will only delay the likelihood of rehabilitation, it will make it easier (because safer) for people to experiment with drugs, and it will send a message of toleration for drug taking. Those who argue in this way presumably accept that, even if an MSIR might save a few lives in the short term, the wider and longer term effects will include greater addiction and more deaths.

On the evidence of long term effectiveness, Dr Lucy Sullivan, for example, questions Australia's harm minimisation approach by comparing the results of strategies here with those in Sweden which now aims at a drug free society (by contrast to a previous policy of drug legalisation). She cites the *UN World Drug Report 1997* which puts the percentage of dependent heroin users in Australia at 8.2% and in Sweden at 1.5% as evidence that our approach is less effective than Sweden's.[1]

I wish to comment briefly on these two issue, in reverse order.

Will a MSIR be effective?

On the question whether an MSIR will do more harm than good, the evidence seems to be mixed. They appear to be successful in some European countries, where they operate in a variety of ways. Presumably, there are numerous factors at work in different countries which influence the way harm minimisation strategies work, and how successfully they work. Further, there are numerous political considerations bearing upon the kind of law enforcement strategies, educational policies, and approaches to rehabilitation which provide the context within which an MSIR must be evaluated.

The situation in Australia at present would seem to be that in the absence of more success with other strategies, and in the absence of the political will for radically different strategies, the use of a MSIR is at least worth trying, subject to a continuing review of its effectiveness (in saving lives and promoting rehabilitation). The issues here are more about evidence and evaluation than about fundamental principle, and because the issues are not clear cut, reasonable people may have to agree to differ on the likely success of an MSIR.

Is a MSIR wrong in principle?

On the question whether a MSIR involves "formal cooperation" in wrongdoing, it is less a matter of finding "hard evidence" and more a matter of ethical principles and their interpretation. For some people, of course, this question of principle is a non-issue: all they are concerned with are the various

consequences of actions. But for other people, and notably for those in the Catholic tradition, consequences (like good intentions) are never the sole consideration in ethical reflection.

Even when our intentions are good, and even when the foreseen consequences are good, there is also the question of the rightness or wrongness of our own actions *in themselves*. There are some things one should never do because they are inherently wrong, no matter what one's good intentions or the beneficial consequences one hopes for. To return to the analogy with East Timor, let us suppose that shortly before the referendum was held the UN supervisors discovered an elaborate plot to rig the election in favour of independence. Would it not have been *wrong in itself*, wrong in principle, for them to cooperate with such a manipulation of the vote, even if it would guarantee that self-determination was attained, and ensure a peaceful transition to independence?

Provision of a MSIR raises a similar question of principle: does it involve a cooperation in harmful drug taking that is wrong in itself?

Whenever a question of cooperation is raised, Catholic teaching advises us to distinguish between "formal" and "material" cooperation.[2]

The focus of **formal cooperation** is one's *intention*. Formal cooperation is ***explicit*** when one does something with the intention of assisting another's conduct. Formal cooperation is ***implicit*** when, in spite of denying that one intends to assist another's conduct, there is no other reasonable explanation for, or interpretation of, one's involvement. In short, whether explicitly or implicitly, someone who formally cooperates is "of one mind" with the other, in this case "of one mind" with a person using drugs.

If, without intending to assist the other's conduct, one does something which in fact assists the other in some way, one's cooperation is said to be *material*. In giving **material cooperation**, the assistance one gives is really "incidental" to the other person's conduct, and is not the true purpose of one's cooperation. Material cooperation is about what one actually does in relation to the conduct of the other. Material cooperation is *immediate* when it is so closely linked to the conduct of the other as to be "of a piece" with it. Material cooperation is *mediate* when a clear distinction can be made between what one does and what the other does.

The danger of "implicit" formal cooperation

No responsible critic would suggest that St Vincent's *intends* to cooperate formally with drug taking. However, those critics who oppose provision of the room as a matter of principle are claiming that St Vincent's will be guilty of "implicit" formal cooperation, on the ground that just providing such a room *necessarily* sends a signal of support to drug takers. Their claim is that a MSIR involves "implicit formal cooperation" because it involves "immediate material cooperation". In short, the claim is that running a MSIR involves such close (such "immediate") assistance with drug taking that one is thereby implicitly agreeing with such self-harming conduct. Irrespective of one's stated intentions, one is really "of one mind" with the person taking drugs.

At this point some readers may be getting impatient with so much technical language. But although this terminology may seem complex, its purpose is simply to clarify the distinctions we need when reflecting on complex issues. We need to be clear about what others are doing, and about what we are doing; about the links between what they do and what we do, and about the unavoidable implications of our involvement with them. Of course readers will be particularly impatient if they can't see much wrong with drug use anyway! To feel the force of these distinctions, I invite readers to try the following thought-experiment: take an example of conduct by others that you find morally abhorrent, and then ask yourself just how closely you would want to be involved in that conduct, *even if by so doing you could perhaps minimise harm*. I suggest that in trying to determine the extent of your involvement, you will need to make just the kind of distinctions used above.

To return to the challenge being urged by critics of the MSIR: does it involve implicit formal cooperation? The short answer, I suggest, is: it might or it might not. It might, if a person's goal was legalisation of drug

taking and that person saw the MSIR as a first step towards this goal. But if a person's goals are simply those of saving life and increasing the chances of rehabilitation, it need not. As in some other situations, the same "external" activity can be open to different moral interpretations, depending on what a person is up to, on what his or her goals and chosen means really are.

Moreover, in reflecting on interpretations and "signals sent", we must not forget the crucial Catholic teaching that as an "outsider", one cannot always just "read off" a person's intentions by *observing* what he or she does. For example, one cannot tell from a photograph of a nurse turning off a life-support machine whether the nurse is intending to kill the patient or is intending to withdraw burdensome treatment (see *Veritatis Splendor*, n. 78).

Clearly, the challenge for those operating a MSIR within a Catholic context is for them to ensure that their intentions are not misunderstood; that the support they offer *people* addicted to drugs is not confused with, or undermined by, signals of support for *drug-taking* itself. In the case of a MSIR, "all that will be done" strictly speaking, is that a place will be provided in which the self-administration of drugs is legally permissible, a place where there are staff on hand should a person suffer an adverse reaction from the drug taking; a place where the addicted person can make contact with professional medical help, and be introduced to rehabilitation programmes. A supervised injecting room, unlike an alley or a squat, is a place where the effects of an overdose can be treated quickly and effectively. Nothing in the establishment of such a room *must imply* that those who operate it are in the business of endorsing drug taking as such. Those responsible for the room can simply be intending that help be available should a person's life be endangered, and that rehabilitation be encouraged.

I thus conclude that participation in a MSIR need not be wrong in itself, it need not involve formal cooperation. If this is correct, it follows that provision of a MSIR may be considered as one element, albeit as an "interim measure", within a wider drug strategy. The crucial question remaining is whether it would really do more good than harm. So far as I can see, there is sufficient evidence on this point to warrant trial of a MSIR in Sydney.

Correcting a fundamental mistake

In conclusion, I wish to highlight the fundamental mistake commonly made both by some supporters of a MSIR and by some Catholic critics of a MSIR, namely, the mistake of failing to distinguish between the conduct of the person taking drugs and the cooperative action of those providing a MSIR. Time and again, critics claim that because drug taking is wrong, all forms of cooperation with it are wrong (i.e. are formal cooperation). Conversely, some supporters think an MSIR is justified, simply because no one should interfere with another person's right to use drugs if he or she so chooses.

The whole point of the Catholic teaching on legitimate cooperation is to help us think our way out of this impasse. Just because harmful drug taking is wrong, it does not follow that we should never do anything to minimise its harmful effects or to save the lives of those addicted to it. On the contrary, it is precisely when drug taking is wrong, and when it has such terrible effects, that we should strive to minimise those effects *without at the same time endorsing or encouraging the drug taking*. The distinctions between formal and material cooperation, and between mediate and immediate cooperation, should help us determine how to do both things at once: how to minimise harm and to keep clear of complicity in conduct we believe to be wrong in principle. The moral theologians of old remarked that applying these distinctions was the most difficult task in all of moral theology. But that's no reason for not trying to grapple with the difficulties. Some issues in life really are difficult, and simplistic approaches have little to offer.

[1] Lucy Sullivan, "Drug policy: a tale of two countries", *News Weekly*, August 26, 1999.

[2] For further discussion of these terms, see my previous articles in *Bioethics Outlook*: "Involvement without Complicity" (*Bioethics Outlook*, Vol 6, No 4, December 1995); "US Bishops revise health care directives" (*Bioethics Outlook*, Vol 6, No 1, March, 1995).

Why some people are uneasy about injecting rooms

Anthony Fisher OP

Some months ago I had a long and broad-ranging discussion with a taxi-driver about, among other things, supervised injecting rooms. Though not a Christian himself, he expressed himself appalled that the Christian church—in this case the Wayside Chapel, not the Sisters of Charity Health Service—was getting involved in what he called 'shooting galleries'. It was sending the wrong message to children, he thought. It was telling them drug taking is OK. That was the last thing they needed to hear. If church and state were now colluding in providing facilities for drug abuse, who was left to tell the young this is wrong? It's hard enough being a parent today...

The announcement of the proposed establishment of an eighteen-month trial of a 'medically supervised injecting service' by St Vincent's Hospital Darlinghurst occasioned considerable public controversy. Representatives of the Sisters of Charity Health Service, Catholic Health Australia, and the Conference of Leaders of Religious Institutes, among others, made statements of spirited support—some of which are reported in this journal. Such a service would save lives, link addicts to rehabilitation opportunities, ensure fewer people inject drugs in public places, enable the Sisters to remain in the forefront of care with the people at the margins.

Not everyone was so enthusiastic. Rev John Edmondstone of the NSW Council of Churches had previously criticised such proposals as "a blind knee-jerk reaction" and "an irrational panacea which will do nothing to free people from heroin addiction" but "send the wrong message out to the community".[1] The Catholic Archbishop of Brisbane, John Bathersby, likewise described such measures as a "bandaid solution" which "does not really tackle the problem of why people are taking drugs". Adelaide bioethicist Fr John Fleming argued that such strategies only maintain and deepen the harm of addiction. "It is wrong to encourage behaviour which is demonstrably harmful to addicts, to do so at a time when they are in no position to give informed consent, to sponsor activities which are illegal thereby undermining the rule of law, and effectively to abandon addicts to their addiction," he said. "In any case, there is no evidence that shooting galleries help people get off drugs."

Why all the fuss about a proposal which is only intended to be a trial and which is obviously so well-motivated? Enthusiasts for injecting rooms sometimes accuse their opponents of 'intolerance' and 'moralising'. But there is no hint of this in the series of Church statements consistently opposing the legalization of drugs of addiction and supporting a three-fold approach of preventing drug abuse, suppressing the drug industry, and rehabilitating drug users. What such statements make absolutely clear, however, is that no Catholic institution may encourage or co-operate 'formally' in drug abuse; and while 'material' co-operation in drug-taking might sometimes be tolerated, it is only in certain carefully circumscribed circumstances. It is here that the real moral debate begins.

Are injecting rooms 'intrinsically' wrong?

Some opponents of supervised injecting rooms have asserted that such projects are 'intrinsically evil' because they promote drug-abuse or deliberately facilitate it with a view to achieving some other good end (saving some lives at the expense of others, cleaning up the streets...). These claims should be taken very seriously since, if they are true, they would establish that any such project was wrongheaded, indeed immoral.

The Catholic moral tradition insists that the morality of human acts depends primarily on their 'proximate end' or 'directly intended

object'.[2] It is not enough that the person is well-meaning or that the good consequences of an act 'outweigh' its bad consequences or that the act is expected to produce 'a better state of affairs for all concerned'—whatever these claims might mean. Nothing can justify deliberately acting contrary to the commandments of the divine and natural law; it is never lawful, even for the gravest reasons, to do evil that good may come of it.[3]

Drug abuse should never be reduced merely to a 'health' issue or a 'social' problem requiring public health 'containment' measures. It is a psychological, moral and spiritual problem—as well as a medical and social one. The Church teaches that "the use of drugs inflicts very grave damage on human health and life. Their use, except on strictly therapeutic grounds, is a grave offense."[4] Illicit drug-taking impedes the ability of the human person to think, will and act responsibly. It destroys bodies, minds, lives. It kills, sometimes slowly, sometimes quickly. It destroys families and harms communities. This stark reality must be foremost in any genuinely Catholic drug abuse strategy.[5]

Yet if drug abuse is always wrong, it does not necessarily follow that supervised injecting rooms are themselves intrinsically evil: this requires further argument. Some people say "drugs are immoral and that's the end of the matter: you can't be involved with drugs". In his masterful treatment of formal and material co-operation,[6] Germain Grisez points out that "some unreflective and/or unsophisticated people imagine problems regarding co-operation can (and perhaps should) be avoided by altogether avoiding co-operation. That, however, is virtually impossible and sometimes inconsistent with doing one's duty." Syringe manufacturers, for instance, produce their products and pharmacists dispense syringes intending that they be used for appropriate purposes but foreseeing that some will be misused: but we do not conclude that all those who manufacture or dispense syringes are morally complicit in drug abuse or drug pushing.

Is the establishment and running of an injecting room formal co-operation in the evil of drug abuse? Do the owners, management and health professionals of the Sisters of Charity Health Service share in the bad will of the drug abusers? Is drug abuse the 'proximate end' of their project? Here we have to look closely at the objects of the scheme. If those involved can honestly say that it is *not* their goal that anyone take drugs, that their scheme is aimed at discouraging drug abuse and not at encouraging even a single additional case of injecting, that if those who entered the injecting room chose not to inject themselves with drugs the scheme would not be thwarted but would rather be a success, then they may well not be engaging in formal co-operation in evil. This is why Bishop Pat Power and others who have given cautious support to such strategies have emphasized that the end of such programmes must always be abstinence from drugs and the rehabilitation of users.

We must be careful here that we are not deceiving ourselves. Grisez points out that even "without any overt involvement in wrongdoing, many people in positions of authority—including administrators of non-profit organizations, managers of businesses, and public officials—sometimes formally co-operate with wrongdoing they personally deplore and perhaps even make serious efforts to prevent or end". Someone who deplored drug abuse and who engaged in various projects to prevent or cure it, but who nonetheless provided some people with the wherewithal or a 'safe' environment for drug abuse *intending that such wrongful activity continue* would be doing evil. This would be so even if this action were motivated by the hope of some other good effect, such as building a relationship of trust with drug-abusers, eventual rehabilitation of some, and so on. Once again, a good end cannot justify evil means. Nonetheless it seems clear that those who engage in programmes such as injecting rooms *can* in principle do so without formally co-operating in the evil of drug abuse.

This is not the end of the matter. Since establishing and running an injecting room foreseeably facilitates drug abuse and has various predictable good and bad effects, we must still consider whether it is reasonable to go ahead with such a plan.

Are injecting rooms a declaration of despair?

'Harm minimization' has become the catch-phrase for all sorts of programmes, including the nudge-nudge-wink-wink strategy of some parents, schools and pastors who tell their charges – perhaps cynically, perhaps well-meaningly – that "if you can't be good, be careful". Beginning with "if you can't" falsely implies that the particular behaviour – sexual promiscuity, underage drinking, speeding, drug abuse ... is somehow unavoidable.[7] Of course addicts are in a different category to those who simply choose to take drugs; their personal responsibility may be very limited due to the physical and psychological effects of their addiction. Yet even with addicts we must be wary of the all-too-common view that they are 'beyond help' and doomed to a life of drug abuse. Reverence for the human person and hope even amongst great difficulties counsel against such despair. Many addicts do in fact find a cure for their addiction but this is only likely to happen if we as a community continue to hold out the hope and provide the support that make this possible. If, on the other hand, we class addicts amongst the 'incurables', best dealt with by damage limitation measures, then we may only confirm the despondency that drives or maintains many in their tragic situation.

Among the many important things Catholic agencies offer our society is witness to the dignity of the human person as a free and responsible agent; we declare not merely by fine-sounding words but also (and perhaps more persuasively) by our deeds that every human person can avoid evil, do good, flourish as a human being and ultimately be a saint. This is no distant ideal but something we are confident is true of everyone with God's help. But our own experience of tragic individual cases, and of near-paralysis in the face of the enormity of the drug problem in contemporary Australia, can threaten our confidence in these truths. We can start to think less of human potential, less of the human being. And in lowering our expectations of people to what seems to be more 'realistic', and communicating this in our words, our tone, our programmes, we can end up, however unconsciously, creating or confirming that lesser reality. It is hard to see how injecting rooms can avoid communicating the message to drug abusers and potential drug abusers, especially young people: "To be honest, we don't have much faith in you, and we do not really expect you to give up drugs. It would be nice if you did, and we'd help you if you were willing. But since you probably won't, we'll at least help you avoid killing yourself."

Some will deny that injecting rooms amount to 'giving up' on addicts and assert that, on the contrary, they are a positive move at a time when precious little is being done for them. The commitment of the Sisters of Charity and their Health Service to expressing the compassion of Christ through healthcare clearly motivates their volunteering to run this trial; and the goal of saving life and promoting health (by means which are not themselves intrinsically wrong) justifies risking some bad side-effects. Other factors which might militate in favour of such material co-operation might include: whether one can presume that all those who will use the injecting rooms would otherwise be taking the same drugs but in more dangerous circumstances and that no additional drug abuse will be occasioned by the establishment of the service; whether or not there are other healthcare providers who could easily assist in this way; whether other healthcare providers would be as likely to achieve the lifesaving and rehabilitation goals of the project or less so; whether non-cooperation in this venture might risk the position and ultimately much other good work of the Health Service; and so on. But there are other side-effects which many would count persuasive arguments against such a programme.

Are injecting rooms bad for users and potential users?

There are three immediate 'side-effects' of establishing an injecting room. The first is that it *contributes materially* to people abusing drugs and therefore themselves; that in turn causes additional short and longer-term harms to the user and perhaps others. Secondly, it may encourage the notion that drug abuse is somehow *safe or safer* if indulged

in at these venues, thereby encouraging people to experiment with drugs, or to use more drugs than they currently do, or to put off seeking treatment. Thirdly, an injecting room run by 'the nuns' with government approval may be thought by some to represent the *approval* of drug use by those moral authorities. Once again this could serve to confirm existing drug users in their present habit, encourage increased use and discourage abstinence, and invite others into the scene. And while drug addicts may themselves have very limited responsibility for what they are doing, those who choose to facilitate their activity by providing injecting rooms are rather freer and therefore arguably more responsible.

Then there is the concern that by further concentrating users in an already high-concentration drug location we might be facilitating the *sale* of these illegal drugs by creating a new market-place and giving pushers, dealers and older addicts the opportunity to influence 'Sesame Street kids' (the street term for younger users). As Major Brian Watters asked the NSW Inquiry into Injecting Rooms: "Can it seriously be denied that the provision of legal facilities for the use of drugs and safe from police interference will not generate a supply to meet the demands for the substances? These places will become a 'Mecca' for dealers and pushers. They will not only be supplying the existing demands, they will be stimulating and expanding their markets."

There is considerable dispute over whether injecting rooms work. Experience overseas varies and is interpreted very differently by different commentators. Some argue that since some people are going to take drugs no matter what we do, it is better that they do so in a medically supervised environment where conditions are sterile, needles (and therefore diseases) are not shared, and nurses are on hand to assist overdose victims. Lives will be saved; some will join rehabilitation programmes; other approaches are not working. Others argue that injecting rooms have failed where they have been tried: users will not travel inconvenient distances to get to them; they often want to take their fix as soon as possible after buying it; injecting rooms do nothing to get them off drugs. In order to attract clients the clinic will avoid any strong message about the evil of drug abuse or the values of rehabilitation; it may also convey implicitly despair about the possibility of users ever getting off drugs.

Melbourne bioethicist Nick Tonti-Filippini notes that "the great danger is that establishing injecting rooms can be a political substitute for adequately funding rehabilitation services. Politicians can claim to have done something when in fact they will have achieved nothing. The scandal throughout Australia is the long and restricted waiting lists for those who have reached a point when they are prepared to take the step to rehabilitate." Other critics of injecting room proposals have likewise suggested that such programmes serve to mask inactivity and niggardliness by governments. They go further to claim that the recent moves are motivated less by a concern for addicts and more by a desire to "clean up the streets for the Olympics" or to ensure that shop-keepers and pedestrians are not troubled by the sight of drug users. On such a view injecting rooms represent not the Good Samaritan intervening to help the addict drugged and left for dead in the gutter so much as the Priest and Levite crossing the street and looking away.

Are injecting rooms bad for the providers?

In addition to the bad effects upon the 'clients' the providers and operators of injecting rooms may also be adversely affected themselves. They may, for instance, become desensitised to the evils of drug abuse, find it less and less repugnant, come to view it as a merely medical matter, and eventually find themselves supporters not only of injecting rooms and needle exchanges but then of prescription heroin, then of the legalisation of drugs (first 'softer' ones, then 'harder' ones), then of 'tolerance' of drug taking as a 'life-style choice'. Of course, some supporters of injecting rooms are already on the record as supporting such moves,[8] but others, who at present oppose them, may gradually find themselves drawn into such a way of thinking by their habitual co-operation in at least one form of facilitating drug abuse. The strong interest which all concerned will have in

finding any trial to be a 'success' may mean that the goal posts are moved and it will become harder and harder for those who initiated the injecting rooms to extricate themselves from the project. Contracts, pride, reputation, even jobs may be on the line. Eventually the original rehabilitation goals may be lost sight of altogether.

Even were the Sisters of Charity Health Service to resist the 'normalisation' agenda, the provision of injecting rooms may make it harder for the Church in general, and the Sisters of Charity Health Service in particular, to campaign and educate against drug abuse. Grisez suggests that those with "a special responsibility to set a good example for those who might be scandalised by an action constituting material co-operation" have a stronger reason to forgo it than do others: it might be worse for a Church agency than a state agency to engage in activities such as sponsoring injecting rooms.

Are injecting rooms unjust to the rest of the community?

Many of the side-effects of injecting rooms suggested above will have wide-ranging implications not only for those most immediately involved with the clinic but for the broader community: some individuals may be helped but others harmed; social mores may be permanently affected; certain neighbourhoods may be further degraded; anti-drug strategies may be undermined. Public support from church and state for injecting rooms may make the job of parents, teachers, law enforcement officers and others who seek to discourage drug use more difficult. And since no standard by which an injecting service would be judged a success has so far been published, some have expressed the fear that the supposed 'success' of the trial is a foregone conclusion. Thereafter the demand will inevitably be for far more injecting rooms: after all, the one proposed for Darlinghurst cannot hope to provide for more than a tiny proportion of all the heroin users in Sydney, let alone New South Wales. Thereafter the campaign will undoubtedly be for prescription heroin. In its desperation to 'do something' our community may find it has joined a roller-coaster that is hard to alight.

Sydney barrister Ross Goodridge has asked many questions about injecting rooms such as: Would the police be discouraged from policing any drug selling activities in the vicinity of the injecting rooms? If so, then a certain area of Sydney will become "a lawless zone condemned to drug selling and collateral crime". What would be the legal consequences of giving an actual or implied consent to drug selling occurring in certain zones or districts? Would the sale of drugs be tolerated in or near the premises? Would the consent of all the neighbours have to be obtained before a room were established? What duty of care would the injecting room owe to users while they were in and as they left the room? What responsibilities, if any, would an injecting room have towards young or first time users? Would users who suffer injury or loss be able to claim damages against the clinic or the government? How would the safety of staff be guaranteed? Would the number of times a person could use an injecting room be limited? Would the privacy of the users be guaranteed? How would the programme be reconciled with Australia's international treaty obligation to do nothing that would facilitate drug abuse? And so on.[9]

Conclusions

All sides of the recent drugs debate agree that heroin use is 'out of control' in Australia today, that there is an alarming number of heroin deaths, that Hepatitis C has the potential to be of epidemic proportions amongst the drug-injecting population, and that past and present policies have had little effect in substantially countering these problems. All agree that we need to do something but that there are no quick fixes to be found to these problems. Sadly this is where the agreement ends.

Rhetoric supporting that trial, such as "nothing else works", "we *know* a medically supervised injecting service will work", "children are dying and we have to do something" and "we are compelled to do this", does not encourage reasoned debate of these issues; nor does talk implying that all those who oppose injecting rooms are "burying their heads in the sand", "moralising", doctrinaire "prohibitionists".

The rhetoric used by the other side is often equally unhelpful, as when the injecting room trial is tagged a "sell-out" and "acquiescing to the drug barons" or when it is implied that all those who support injecting rooms are "soft on drugs", willingly engage in "intrinsically evil acts", and are not truly committed to abstinence from illicit drug-taking. Both discourses are merely tactics to divide and exclude.

Many of the arguments for the proposed 'medically supervised injecting service' have been canvassed in the other articles in this number of *Bioethics Outlook*. I have presented some counter-arguments. No simple balancing of pros and cons is possible here. What is clear, however, is that there are strong prudential considerations on both sides, that there is cause for caution, and that no one should feel 'compelled' by justice or charity to engage in such activity.

Of course Catholic hospitals cannot avoid engaging in practices that will be misunderstood by some, misused by others or have other undesired side-effects. They would be paralysed to act if these were always deciding factors. But they remain important considerations, especially if there are other ways to address the particular problem which would not have these same disadvantages. In her submission to the NSW Inquiry, Dr Bernadette Tobin questioned whether the putative benefits for drug users and society of injecting rooms justify their various likely disvalues and whether, given limited resources, there were not more pressing social needs than those to which this form of harm minimisation is addressed. Australia has barely begun to provide adequate preventative drug education programmes and targeted family support, and has unconscionable waiting lists for access to detoxification, rehabilitation and assistance for former addicts to rebuild their lives. Addressing this radical underprovision would seem to be a more positive response to 'the drug problem' than the containment measures of the harm minimalisationists.

1 New South Wales Council of Churches, *Heroin Shooting Galleries Absurd*, Press statement, 1998

2 John Paul II, *Veritatis Splendor:* Encyclical on Certain Fundamental Questions of the Church's Moral Teaching, Sydney: St Paul's, 1993, §§74-83.

3 *cf. Rom* 3:8.

4 *Catechism of the Catholic Church*, Australian edition, Sydney: St Paul's, 1994, §2291.

5 *cf.* John Paul II, "Address to the participants at the International Conference on Drugs and Alcohol, 23 November 1991," *Insegnamenti*, XIV/2 (1991) 1249; Pontifical Council for the Pastoral Care of Health Professionals, *Charter for Health Care Workers*, Vatican City, 1995, §§93-96.

6 "Formal and material co-operation in others' wrongdoing," Appendix 2 of *The Way of the Lord Jesus*, vol. 3: *Difficult Moral Questions*, Quincy IL: Franciscan Press, 1997, 871-898.

7 Grisez, "Should a parent say: 'If you can't be good, be careful'?" *Difficult Moral Questions*, pp. 98-102 suggests that this is not only incompatible with sound philosophy but also with defined Catholic teaching.

8 e.g. Alex Wodak and Ron Owens (*Drug Prohibition: A Call for Change*, Sydney: University of New South Wales Press, 1996) who favour the legalisation and 'controlled availability' of even hard drugs. These writers compare 'the principle of harm minimisation' with respect to heroin with social attitudes to drinking and smoking. "Whether or not you wish to drink alcohol is a matter of personal choice. Society attempts to influence your consumption by controls on price and availability, and laws covering your behaviour when intoxicated. The aim is to reduce the damage you might do to yourself and others while minimising the limitations to your enjoyment of drinking. Government taxes help to cover the costs of alcohol to the community." The same approach, they think, should be taken to the 'choice' to use drugs such as heroin and cocaine.

9 Ross Goodridge, *Practical and Legal Problems in Respect of the Implementation of Legalised Heroin Shooting Galleries and Prescription Heroin Distribution: An Issues and Discussion Paper*, Sydney, 1999.

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