D.A.C.A. (Drug Advisory Council of Australia) and Drugfree Australia (DfA) UNGASS 2016 Submission

Prevention & Demand Reduction Focus

7/1/2015
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Local/regional consultations:

a) DRUGS AND HEALTH: demand reduction and related measures, including prevention, treatment, as well as health related issues; and ensuring the availability of controlled substances for medical and scientific purposes, while preventing their diversion.

The Drug Advisory Council of Australia DACA and Drug Free Australia(DFA) take the position that demand reduction is a vital component of drug policy in the battle to reduce the harm to communities.

Treatment, rehabilitation and harm reduction are important components of an effective drug policy. However, these programs are most often applicable to those who have developed a severe dependence on drugs. It does not address the more important strategy of drug use prevention through supply and demand interventions.

Primary (supply reduction) and secondary prevention (demand reduction) strategies are more effective and undoubtedly more cost effective rather than treatment. In the context of primary prevention the fundamental principle applied by Public Health theory in dealing with epidemics, including drug epidemics, is that if the number of first-time contacts (users) are not reduced, then the strategy employed will not bring success. An emphasis on treatment tends to draw attention away from primary and secondary strategies and may send the message that drug use is not preventable and is therefore inevitable.

Discouraging people from initiating drug use, and stopping it as early as possible before long-term treatment is necessary goes hand-in-hand with visible enforcement of the law thus demonstrating a commitment to being a drug free society.

Critical to the success of the policy as implemented in Sweden is a cultural consensus that drug use is viewed as dangerous and we are best able to deal with it by reducing overall levels of drug use in society. This attitude accords with UN declarations and plans of action to date and seems to be the dominant one in Sweden because the people understand the sense of this approach.

On the other hand, in Australia, a soft attitude to drug use, which highlights outcomes for people whose use drugs and are resistant to change, has become entrenched despite public opinion. The evidence, which needs to be emphasised, is that reduced drug use in society is the most potent factor in reducing harm. Once a person begins drug use and becomes dependent on drugs the chances of reducing harm is vastly reduced.

To effectively achieve reduced drug use a shift from harm reduction policies, for example needle exchange and drug substitutes such as methadone, which are favoured policies in Australia, to a more drug-free attitude needs to occur. Policy needs to move away from the protection of those who have chosen to use drugs toward the protection of those who have not as yet started to use drugs or are in the early stages of drug use.

The Swedish model emphasises compulsory drug testing and early intervention including mandatory treatment. Not as an alternative to prison, which implies long-term problematic drug use, but as enforcement of laws relating to drug use (not just the crime that is related to it). It demonstrates society's commitment to protecting its youth from long-term damage including criminal convictions and physical, social and psychological harm. Sweden consciously moved back to a more restrictive anti-drug policy with the aim of a drug-free society and zero tolerance. The Swedish implementation of random drug testing has been found to be effective in identifying drug abusers and referring them to receive treatment at an earlier stage. Swedish Police do not require physical signs and presence of drugs to trigger drug testing. The offence of drug consumption in Sweden is, comparatively lenient with imprisonment is technically possible, but the maximum penalty in practice is a fine , and the criminal record can be completely erased after three or five years.

Australia has blindly adhered to a policy that puts harm reduction as the foremost strategic component and has not responded to the evidence that drug use and harm has increased compared to nations such as Sweden. Australia has one of the highest drug use rates in the world while Sweden has the lowest.

The evidence from Sweden is that early intervention even, if not wanted, can be effective once more accurate information as to the harm resulting from drug use has been received. However, early intervention implies detection before real harm has resulted. Compulsory and random drug testing at places such as rave dances, not only provides this opportunity to intervene, but acts as a

deterrent thus reducing demand and emphasises the concerns within society about the harm associated with drug use.

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b) **DRUGS AND CRIME:** Supply reduction and related measures; responses to drug-related crime; countering money-laundering and promoting judicial cooperation.

No Case for Legalising Cannabis

There will be groups making submissions to UNGASS promoting the decriminalisation of cannabis and indeed, other illicit drugs, on the basis that these drugs are essentially harmless and that most people suffer no long-term effects from recreational use. More so that cannabis use is harmless and the harm that does ensue is related to the illegality of cannabis use; unknown contaminants and constituents, the crime associated with using and obtaining it and being punished for doing so. The issue of whether cannabis is harmless or, indeed, has therapeutic properties and that it should therefore be freely available is one for medical and scientific evidence to establish. It is not an issue for politicians to decide based on political objectives or for pro-drug groups to undermine the medical evidence or the majority views opposing illicit drug use through relentless media campaigns. According to the 2013 National Drug Strategy Household Survey, a survey of more than 24,000 Australians, 90% of Australians did not approve the recreational use of cannabis.

The case to be put to UNGASS by DACA and DFA, is that cannabis has consistently failed to meet any legal standard that would allow authorities to decide it was not a harmful drug and should not be prohibited. It has failed to even establish that it safe to use as a medicine for a number of ailments let alone that it should be allowed for unfettered social use. If its use cannot be justified for medical purposes (where any side-effects may be outweighed by

the medical benefits) then the case to decriminalise or regulate its use, and to downgrade its classification as a prohibited drug, has no rational argument to sustain it.

A summary of the evidence is that cannabis has a high potential for abuse as it is addictive, it is harmful and there are no acceptable standards for it use, medical or otherwise, and that there is no accepted medical use for it. Moreover, unlike any other approved medication, smoking it means that dosage is uncontrolled and strength of dosage is unknown and is therefore unacceptable to medical authorities and the community. Crude cannabis contains hundreds of chemicals and is an impure substance. Smoking cannabis causes full and partial oxidation of thousands of chemicals, many of them highly toxic and carcinogenic including tars, polycyclic hydrocarbons and aromatic amines similar to those found in tobacco smoke. No regulatory authority in the world (e.g. FDA in USA or TGA in Australia) acknowledges any smoked preparation as a valid form of dosing of any medication. Moreover, the cannabis plant contains some 400 chemicals, that vary with habitat, which is impossible to standardise and often contaminated with microbes, fungi or pesticides.

The reason that cannabis use is unacceptable is that the harm associated with its use is well documented and irrefutable. Studies have shown that long-term use of cannabis affects memory, concentration, decision-making, coordination, psychological functioning, including heightened anxiety and depression and sleep deprivation, and respiratory health, fertility, brain structure and connectivity and that these effects have been shown to be worse in adolescents. There is some evidence of increased risk of psychosis. It is also well established that sudden cessation causes significant withdrawal symptoms.

Representatives of Drug Free Australia have argued before the ACT Government enquiry into medical cannabis that there are presently TGA approved alternatives to smoked or vaporised cannabis in the form of isolated THC, THC-cannabidiol (CBD) mixtures, CBD alone and other plant-derived and synthetic cannabinoids that have some evidence as useful medicines. These types of preparations have been legally used in Australia since the mid-1990s, when the THC capsule developed in the US called Marinol was imported into Australia under TGA Special Access for 100 patients. Marinol can be imported today under

the same arrangement. Alternatively, the whole-leaf extract of cannabis, called Sativex, was approved by the Australian TGA in 2012 for MS spasticity. Both medications are pharmaceutically standardised in terms of dosage, strength and purity, which crude cannabis products are not. Clinical trials have previously shown promise for both medications can be used for nausea, AIDS wasting, chronic pain and MS spasticity. A third pharmaceutical medicine which is high in CBD, Epidiolex, is currently being tested in the US and could be tested here under similar arrangements. CBD is the component within cannabis believed to be responsible for the relief of severe seizures in epilepsy-like syndromes for some sufferers, including children. There is consequently no need to legalise crude cannabis in Australia. Drug Free Australia has suggested that if it can be proven that other medicines are not better to treat specific ailments then these cannabis derivative substances should be listed under PBS rules to allow ready access for those who need them. At the same time it would make them much more affordable than crude uncontrolled cannabis.

If the pro-cannabis lobby, and that includes those who want to cash in on its commercialisation, thought that the easier case to win was for its approval as a medication, then they have failed. Instead, the evidence is overwhelming that for any other purpose cannabis is properly prohibited and should remain so.

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c) DRUGS AND HUMAN RIGHTS, YOUTH, WOMEN, CHILDREN AND COMMUNITIES, cross-cutting issues.

The United Nation Special Session on Illicit Drugs: The fight against illicit drugs must continue.

The Drug Advisory Council of Australia (DACA) and Drug Free Australia (DFA) wholly supports the UN declarations and action plans on illicit drugs and the reasoning that drugs are not harmful because they are controlled—they are controlled because they are harmful and that because certain unlawful transactions are hard to control doesn't mean that they should be made legal, and poses the question: should humanity accept paedophilia, human trafficking, or arms smuggling out of a naïve sense of market inevitability or intractability? DACA and DFA also support the contention that lifting the controls on drugs would weaken the fight against organized crime and fail protect the health of citizens.

The Drug Advisory Council of Australia and Drug Free Australia are concerned that the resolve to continue to counter the drug problem may well be undermined with groups such as the International Drug Policy Consortium submissions supporting decriminalising all drugs and a commitment to harm reduction policies. In response the Dalgarno Institute commissioned a report entitled 30 Years of Harm Minimisation - How Far Have We Come? The report forms a major part of the Dalgarno Institute's submission to UNGASS and examines the period from 1985 until the present critically evaluating the success or otherwise of the strategies to combat the harm associated with drug use in the Australian community including prevalence of drug use, drug related (overdose) death and transmission of infectious diseases.

The Australian strategy was ostensibly a three pronged approach to reduce supply, demand and harm to the community. The overall objective was to reduce the availability and accessibility of harmful drugs and to reduce the level of drug use. **However, over time this objective has increasingly been aimed at reducing harm to those who used drugs irrespective of levels of drug use and harm to the broader community.**

The shift in emphasis seems contrary to the UN declarations that have consistently emphasised supply and demand reduction as the principle means to combat drug abuse. The various UN statements do not promote harm reduction approaches such as needle exchange and injecting rooms as effective measures designed to protect member states and their citizens. The Dalgarno

Institute submission provides the evidence that **a focus on harm reduction has failed** to reduce drug use, with Australia continuing to be one the highest consumers of illicit drugs world-wide.

The belief by many who designed and implemented drug policy in Australia was that most people who use drugs, including those who injected them, experience little or no harm; that to use drugs recreationally and for pleasure was a legitimate lifestyle choice and that society was obliged to minimise the harm associated with drug use. However, this view seemed to be mainly associated with the use of illicit drugs, such as marijuana, heroin, ecstasy and stimulants such as cocaine and methamphetamines and the emphasis was on reducing harm not reducing drug use.

On the other hand, the attitude of those who designed and implemented drug policy toward other, mostly legal drugs, such as tobacco and alcohol, was different. The strategy was designed to make these other drugs less available and to reduce the number of users.
For example:

- Prescription drugs should be controlled by existing laws and medical authorities, and unauthorised and recreational use should be prohibited.
- Nicotine use should be discouraged, anyone smoking in public areas should be prosecuted, the price increased to deter use, that very confronting health warnings and public education campaigns against use be funded and deterrents and prohibitions enforced to prevent underage and other populations from using the drug.
- Alcohol should be banned for those under 18 and should be enforced, sales and advertising strictly controlled and that people drinking alcohol and driving, using machinery or in positions where public safety was compromised should be prosecuted and trading hours restricted. Compulsory or random testing for alcohol impairment was accepted in many workplaces.

The evidence is clear that levels of usage of nicotine and alcohol has declined and that the harm has been reduced in overall terms. Since 1993 the proportion of people over 14 who smoke daily has declined from 25% to 15.1% in 2010 (Australian Institute of Health and Welfare, 2010) and to 12.5% in 2014 (Australian Institute of Health and Welfare, 2014). More modest reductions in alcohol use and harm have been achieved, seemingly, as laws on alcohol supply have not been toughened due to the influence of the alcohol lobby.

The submission presents the evidence to show that instead, **authorities have pursued policies that promoted greater permissibility and acceptance of illicit drug use and have curtailed supply and demand reduction strategies, and that such policies fail to reduce harm.**

The evidence from the period between 1998 and 2004, when a more stringent deterrent and supply reduction approach to illicit drug use was enforced, showed a clear decline in drug use and drug related harm when compared to the periods preceding and following this period when harm reduction strategies dominated. An examination of the emerging evidence of the direct impact of harm reduction policies, such as needle exchange opiate substitute treatment and injecting facilities, despite being heavily funded, shows that it has failed to reduce harm as BBV infection has increased.

Moreover, harm to the community has increased given the evidence of the detrimental effect that illicit drug use has on families including increased incidents of drug fuelled domestic violence and a potential upsurge in HIV and STD infections due to the rise in unsafe sex, stimulated by increasing use of stimulants, ICE in particular. To take a broader view of the evidential base the report also examined the impact of various policies implemented in other countries and compared them to Australia. To conclude, the report makes several keys recommendations based on the evidence. These include an increased emphasis on prevention including education about harm, early detection, including drug testing, mandatory treatment where individuals, families and communities are at risk of imminent harm, monitoring of methadone programs to ensure some exit strategy is included and trialling of naltrexone as a treatment option.

Specifically the report makes a number of key recommendations for drug policy based on the failed Australian experience and the success of the Swedish model.

- Firstly, that a there be a continued strong emphasis on deterrents to drug use through law enforcement to reduce drug availability, increase price and the reduce the perception of permissibility.
- In terms of prevention, it is recommended that member country governments actively discourage materials that promote the drug liberalisation/legalisation agendas and instead encourage the use of anti-drug use materials in schools that accurately reflect the real harm associated with drug use.

- The evidence indicates that programs such as needle exchange and methadone do not work. Neither program has succeeded in reducing the prevalence of HIV or HCV; indications are that they have most probably led to increased drug use for longer and to increased levels of harm. With the increased incidence of methamphetamine use it is known that neither of these programs will reduce usage nor harm from use of these stimulants. It is recommended that both programs be phased out and the funds redirected into treatment programs aiming to reduce overall drug use in the community.
- The evidence. mainly from Sweden, also shows that early intervention before harm becomes serious should be the primary strategy for prevention among younger people. Young people often have very low motivation to quit drugs, especially when the message is that they are harmless and controllable. Many only seek help when they are incapacitated and unable to lead a normal life. Sometimes coercion to take up treatment and counselling programmes is required. Medical evidence shows that drug-induced brain damage hampers the cognitive function of drug abusers, hence their ability to make decisions, such as self-protection, which might be natural response to potential harmful behaviour for an average person. Research has found that the longer the duration of drug abuse, the poorer the chance of complete recovery. The evidence is that the earlier the treatment can be given to the drug abuser, the better the result.
- To facilitate early intervention, it is recommended introducing compulsory drug testing. Police should not be required to identify physical signs and presence of drugs as the prerequisites for drug testing. As with random roadside drug testing it should be seen as a preventative strategy to discourage drug use.
- It is recommended that treatment facilities be better funded and that people who relapse can more easily re-enter recovery-based treatment programs. A further recommendation is that mandatory treatment of drug users who pose a danger to themselves, their families and society be implemented. Especially in respect of heroin and methamphetamine use as retention in treatment is very poor with high levels of criminal activity and harm to the community among these groups. Mandatory treatment is recommended when the individual and/or their families are being endangered by continued use of a drug that leads to morbidity and mortality, criminality, mental illness and loss of social functioning.

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d) NEW CHALLENGES threats and realities in preventing and addressing the world drug problem in compliance with the relevant international law, including the three drug control conventions; strengthening the principle of common and shared responsibility and international cooperation.

The ICE Epidemic and Health

DACA believes that the major challenge for nations is the abuse of ICE and the widespread harm to communities. DACA recommends to UNGASS that the main strategies to reduce social harm from ICE use involves supply and demand reduction, rather than about users rights or harm reduction. This is due to the associated high levels of mental illness, crime and violence, harm to families members and the community, the highly addictive nature of these drugs and the high-risk sexual behaviour. Of great concern is the potential spread of HIV and STDs between drug users and into the non-drug using community associated with methamphetamine use.

Facts and figures disseminated by the National Drug Strategy Survey (AIHW 2012) and the Australian Crime Commission (2014) inform us of the extent of the 'ICE' epidemic. Noticeably, Australia has one of the highest rates of use of methamphetamine in the world, particularly amongst developed countries, increasing 10% since 2011; drug seizures are at record levels and the weight of amphetamine-type drugs detections has increased 230% from 2010/11 to 2012/13.

ICE is quite different from other drugs of dependence in three very important ways. While the harm associated with nicotine, alcohol and cannabis often manifests many years after initiation of use despite the inherent dangers. Not so with ICE. The harm becomes severe and intolerable very early on. This is almost invariably the case as use quickly becomes compulsive due to the highly addictive nature of the drug. The result is that the time using ICE is going to be much shorter. Before too long consequences become so severe, both to the user and their immediate environment including family, that change is inevitable, either cycling in and out of use or cessation, either spontaneous or due to forced withdrawal in prison or hospitalisation.

This difference in patterns of use is likely to impact on the raw statistics in an unpredictable way and indicate much lower use of the drug than is the case. At any point in time numbers of users will seem much lower, despite the consequences being more noticeable, compared to total numbers who have used the drug because of the shorter average time using.

The second point of difference is that ICE stimulates compulsive sexual acting out. While other drugs stimulate sexual appetite none does more so than ICE: Not only enhanced desire and sexual performance but risky and deviant sexual behaviour.

The third difference is that conventional treatment is largely ineffective. Those who become dependent on the drug do not seek treatment until after an average of 3 years from initial use and until symptoms become very severe and they do not stay long in treatment.

Methamphetamine use has been found to be independently related to decreased condom use during vaginal and anal intercourse, prostitution, sex with injecting drug users and having a sexually transmitted disease. The inherent dangers of this drug to users and the community has been apparent for some time and yet policy does not reflect the urgency to implement effective strategies needed to avert a looming social crisis.

Not only are there no practical harm reduction measures available , including drug substitutes, but it seems that treatment is difficult as users are unlikely to seek or engage in treatment. However, particularly heavy or dependent users (some 73,000 in Australia) are more likely to come into contact with law enforcement and the courts and, as a result the court system has an important role in responding to ICE related problems and dependence. There exists an opportunity for the courts and health systems to take an integrated approach along the following lines: Mandatory detention is of vital importance in any treatment response as it takes some time to overcome the prolonged withdrawal (psychosis/depression) and it is virtually impossible to retain people in treatment during this phase. As crime is so closely linked to stimulant use some period of detention (3 months) is legitimate, justified and necessary for effective treatment. Specifically designed ICE prisons/detention centres need to be established, as happens in other jurisdictions (ie. Canada). Focus needs to be integrated with health/mental health services responding to withdrawals and other health related problems (cardio-vascular, dental, STDs, HIV etc.), D&A services focussing on education about the harm and psychological and social change required and an out-reach service (like parole) to monitor progress and prevent relapse by intervening in other social risk factors, especially among indigenous communities. In other words, instead of diversion into health or treatment services, which have failed, involuntary treatment including dedicated prisons need to be a part of those health and treatment services for treatment to be effective. Civil libertarians will be up in arms, but if we are to tackle this very serious and growing problem then an integrated and uncompromising approach as suggested is imperative.

Further there is the need for early intervention among young people based on compulsory drug testing and a vastly enhanced education and information program about the risks associated with ICE. Also a program of peer identification and support should be encouraged in schools, workplaces and in indigenous communities, including training of identified peer mentors as modelled on the Aust Navy program. Naltrexone was found to be effective in reducing amphetamine use in a recent double-blind, placebo-controlled

outpatient clinical trial. Naltrexone therefore appears to be a highly promising medication for amphetamine dependence.

As there is no evidence that the harm minimisation policies have benefited users or the community and with the looming ICE crisis perhaps we can learn from the experience of Sweden in dealing with consumption of illicit drugs. Sweden went from being one of the first European countries to experience a large scale drug problem in the 1960's to now being a country with one of the lowest rates of drug use.

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e) ALTERNATIVE DEVELOPMENT, regional, inter-regional and international cooperation on development oriented balanced drug policies, addressing socio-economic issues

No Evidence to Support Harm Reduction Strategies

DACA takes the position and strongly urges UNGASS to adapt the proposition that funds spent on harm reduction (HR) policies would be more effectively spent by adequately funding policies that prevent risky behaviour and treat drug addiction. Not only would it be more effective in reducing the incidence of HIV and HCV infection there would be many other substantial benefits for the community. Since the early 1980s there has been a largely uncritical acceptance among health authorities that the introduction and funding of harm reduction (HR) measures among intravenous drug users (IDUs) is an important strategy to prevent the transmission of blood borne viruses. The main motivation for the urgent implementation of these policies was the threatened transmission of HIV and HCV among IDUs through unsafe injecting practices, mainly via sharing of needles and injecting equipment within this community and the wider community with whom they may interacted.

Needle exchange programs were introduced on the basis that they intuitively made some sense. When these programs were introduced there was no evidence to support them or to indicate that they may cause more harm than good. Central to HR thinking was that these strategies need not necessarily seek to reduce frequency or duration of injecting drugs but to minimise harm among those who continued to practice these risky behaviours.

The spread of these infectious diseases is mostly associated with marginalised groups adopting behaviour that is at odds with mainstream convention in situations where the means not to do so is compromised by ignorance and poverty. This often leads to unsafe sexual and drug using behaviour due to attitudinal factors, lack of exposure or access to preventive measures and often associated with addiction to a drug. In the case HIV and HCV this inability to change behaviour has been undermined by the HR message that the transmission of these diseases can be stopped without people having to cease injecting drugs and indulging in risky behaviour.

As with most chronic diseases lifestyle factors play a significant role and can be changed. For example, Hep A involves changes in hygiene practices to contain infection rates. A complicating factor is the extent that these prevention and treatment strategies infringe on personal liberties and rights, even more so as HIV and HCV prevention involves stigmatised and often illegal behaviour. As well as requiring individuals to make changes to protect their own health it also entails some responsibility toward those who can acquire the disease through others deliberate and risky behaviour. The traditional emphasis on each person taking responsibility for protecting his or her own health has a tendency to reinforce HIV-related stigma, potentially alienating those persons from prevention and treatment. Often though, they do not change their behaviour as the messages they receive reinforce the notion that it is a matter of individual rights and to require change is an abuse of those rights.

Surveys of IUDs and other at risk groups in Australia clearly demonstrate that HIV is primarily transmitted through unsafe sexual activity and that injecting drug use has minimal if any impact on infection rates, while HCV is almost exclusively transmitted by unsafe drug injecting and that sexual contact has had very little, if any, impact on transmission rates. Furthermore, the reviews of the studies in NSPs and HCV and HIV showed that there was insufficient evidence to demonstrate any

benefit of NSPs in the transmission of HCV and that the few studies on HIV showed that transmission was primarily due to risky sexual behaviour and no conclusions could be reached regarding the effectiveness of NSPs on HIV transmission. Despite this, advocates for HR continue to claim that the evidence is "substantial" and that needle syringe programmes are effective and cost-effective even when no evidence is cited.

Attention therefore needs to shift to other preventative strategies, including community education and to treatment. Despite the clear differences in the means of transmission HIV and HCV the factor that was common to both groups was persistent risky behaviour, hence resulting in cross infection that was found to be up to 80% among some groups. Accordingly, prevention should target those at risk of acquiring the viruses and should involve providing education, risk reduction counselling, HIV and HCV screening and substance abuse treatment. For HCV, counselling should be focused on drug treatment, while for HIV the focus of prevention should be on safe sex practices. In both cases those found to have viral infections need to be counselled to reduce the risk of HIV and HCV transmission to others. They should also be offered counselling and treatment for alcohol abuse and other STDs.

This same attitude to opiate substitution treatment, particularly methadone should be adopted by UNGASS. The introduction of methadone was an attempt to reduce the harm associated with heroin addiction. The major harm to be prevented was from HIV infection related to sharing needles to inject the drug. However, there has been no convincing evidence to demonstrate that methadone has had any impact on HIV rates. Some observational research has shown that methadone tends to reduce heroin use, improve health outcomes, reduce overdose deaths and reduce drug-related crime. However, the evidence is weak and reviews of the controlled trials comparing methadone to no treatment indicate that there is no difference in terms of criminality and mortality. No trials have shown any improvement in health outcomes and reduction in HIV transmissions.

Moreover, people dependent on methadone continue to overdose and die at alarming rates. In Scotland 60% of drug related deaths implicate methadone. Very few people manage to stop with only 3% ceasing use each year despite being 'in treatment'. Research shows that those who have no treatment and have never been on methadone achieve abstinence at much higher rates.

Methadone does not have any proven effect other than to retain people in treatment or reduce injecting drug use in the short term. And yet in Australia thousands are hopelessly addicted to this dangerous dug that costs in the region of $150m each year.

It is also more addictive than heroin and has negative long-term consequences in terms of health and social outcomes. Moreover, many people on methadone continue to use heroin and to develop addictions to other drugs. They also often find it very difficult to find or retain employment, they find it difficult to be emotionally available to their partners or children and their freedom is compromised; and despite the claims to the contrary retention in these programs is also poor with less than 50% staying in the programs at 6 months.

As a secondary benefit, methadone was meant to enable heroin addicts to stabilise their lives and then move from addiction to abstinence. These aims have clearly been abandoned, with people now having been on these drugs for 30 years or more and a black market in methadone thriving, meaning that these drugs are often more accessible than heroin. Most disturbing is the fact that health authorities have no idea how to get people off methadone once its usefulness has expired.

At present in Australia there are around 46,000 people on agonist maintenance programs (mainly methadone), which directly cost our community some $150m each year at an estimated cost of $4500 to maintain each person on methadone.

While methadone maintenance remains the most researched treatment for this problem, and despite the widespread use of methadone maintenance treatment for opioid dependence in many countries, it remains a controversial treatment whose effectiveness has been disputed for good reasons. It purported benefits have never been proven and research shows that these claims are not supported.

It was also thought that if methadone could reduce injecting behaviour among heroin addicts then it would by default reduce needle sharing and hence prevent HIV infection and improve health outcomes. For a number of reasons this has not been shown to be true. Firstly injecting drug use is at best reduced, not stopped. Moreover, as people tend to stay on methadone for many years it is likely that overall injecting behaviour is prolonged. Secondly it is recognised that it can only be effective if injecting drug users stop sharing needles. To prevent needle sharing sterile needles have been provided at a cost of some $40m each year. The research indicates that the many tend to continue to share due to factors such as impulsive behaviour associated with drug use and the social

norms among injecting groups, and that provision of clean needles reduces sharing by some 15%. However, all the research shows that needle sharing at most is responsible for 3-4% of HIV transmission. The vast majority of new cases results from unsafe sex, particularly among homosexual men, and is associated with high rates of sexually transmitted diseases.

These statistics (facts) mean that even if methadone was effective in reducing injecting rates and needle sharing, it would still have negligible or no effect on HIV infection rates. Clearly, the claims made and the aims espoused have not been realised despite the costs to the community. An urgent review, based on the evidence, of the role of methadone is required.

Policies that have been effective have been neglected while harm reduction policies driven by a political agenda and showing no demonstrable impact on HIV and HCV rates have been the main focus in the last 30 years or more.

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Ref: Mattick, R. P., Breen, C., Kimber, J. and Davoli, M. (2009). *Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence (Review). Cochrane Review, 3.* doi 10.1002/14651858.CD002209.