Families and Friends for Drug Law Reform (ACT) Inc.

committed to preventing tragedy that arises from illicit drug use

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Next Meeting

Thursday October 25th

at St Ninian's Uniting Church

Cnr Mouat & Brigalow Sts, Lyneham

7.30pm

Guest Speaker at 8pm:

Rolf Ericsson from the Swedish Embassy will speak on the Swedish Drug Policy

Remembrance Ceremony Monday 29th October

Please see the enclosed brochure publicising this ceremony which will be held on Monday 29 October from 12:30 – 1:30pm.

Please let others know about the ceremony. Everyone is welcome to come.

Help Needed: Members are asked to bring along a plate of food which will be served following the ceremony. Also if you can bring some flowers to be placed at the ceremony please let Marion know (6254 2961).

If you want the name of a loved one read out at the ceremony, please contact Marion also.

Bring chairs or rugs for your comfort.

Make a note that the AGM will be held on Thursday 22 November

Editorial

By the time ACT members read this newsletter the election for the ACT Assembly will be over and the broad indication of the outcome will be known. But this will not be so for the federal election which still has three weeks of campaigning.

There has been quite a distinctive contrast between the two campaigns as far as the drug issue is concerned. In the ACT the issue of drugs came to the forefront.

Predictably law and order was a major issue for some candidates and parties. The most notable being the Liberal Party and independent Dave Rugendyke. There was also a bidding war on who could supply the most additional policemen for the ACT.

On the more positive side the Greens, the ALP and the Democrats came forward with good drugs policies.

In respect of the federal campaign a member in the audience of ABC's Australia Talks hit the nail on the head. He asked why, because drugs were the single biggest problem in Australia, was there such silence on this issue in the election campaign.

No real explanation was given by panel members representing the government or the opposition and the member of the audience was not satisfied. He repeated that there has been nothing in the campaign that raised this issue.

We too should be dissatisfied. At election time when our votes count we should help make this an issue. A simple letter to the newspaper editor from all our members, a phone call to candidates asking about their drug policy, speaking to the media may help to get the issue on the federal agenda. (See our Election Kit also.)

Letters to the editor

This first letter was submitted to all major morning newspapers following the Channel Nine's special on Kids, Drugs and Growing Up. Even though it was not published it is a good letter and worthy of publishing.

Dear Editor

Channel Nine's special Kids, Drugs and Growing Up told us the program aimed to inform and educate viewers on Australia's drug problem. More likely, it reinforced the many myths and hysteria that surround the issue.

While the program was effective in showing the devastating effects that drug misuse has on families, it gave the misleading impression that most young people who try illicit drugs such as cannabis or ecstacy will become heroin addicts.

The many comments from celebrities (often made out to be experts) are potentially more likely to incite interest in drug use, rather than discourage it. The few experts in the field interviewed were given little opportunity to highlight the facts about young people and drugs and the possible solutions.

The program failed to even mention the devastating physical and social effects of our most accepted and glamorised legal drug, alcohol.

Nearly 50% of all drug-related deaths amongst people aged under 35 are alcohol-related.

Young people are growing up in an Australia that is experiencing increased rates of homelessness, suicide, poverty and mental illness which is having a devastating impact on our young people. But Kids, Drugs and Growing Up would have us believe that the drug problem is simply because kids are unable to say "no".

The media plays a very important role in educating and informing the community about alcohol and other drugs. It has much to contribute to a better understanding of the issues and in finding a productive way forward. Increasing sections of the Australian media are demonstrating independent, balanced and accurate reporting on the issue. Unfortunately, this program did not.

Caroline Fitzwarryne, CEO
Alcohol and other Drugs Council of Australia

2nd Australasian Conference on Drugs Strategy, Perth WA 7 - 9 May 2002

Dr Alex Wodak has kindly passed on two abstracts that he has submitted for the above conference. If you are in Perth at the time it looks like an excellent conference to attend.

1. Health - drug law enforcement collaboration for harm reduction

Collaboration between health and drug law enforcement became an urgent need in the 1980s to prevent the spread of HIV infection among and from injecting drug users. Without the flexible attitudes demonstrated by police officers over the last 15 years, the remarkable achievements of harm reduction in Australia would not have been possible. Challenges grow with the increasing rate of drug overdose deaths, hepatitis C infection, increasing use of psychostimulant drugs and the inevitability of more injecting rooms and a heroin trial. Crime rates could be reduced by enhancing drug treatment (expanding capacity, broadening the range of options and improving quality); improving links between community and corrections drug treatment and; attempting to ensure that a minority of severely entrenched, treatment refractory drug users are attracted and retained in treatment.

Current arrangements are expensive, ineffective, often counterproductive and also ensure that health and law enforcement are unable to achieve their own objectives. Harm reduction has occurred in phases: firstly concentrated on controlling HIV infection among injecting drug users; secondly focussed largely on reducing other harms arising from prohibition. The third phase of prohibition will be based on a recognition that, notwithstanding valiant attempts over recent decades, a sustained and substantial reduction of demand and supply of illicit drugs has not been achieved.

Consequently, communities will sooner or later be required to consider regulated forms of supply of some currently illicit drugs in order to reduce the harm to the community from current policies and from the drugs themselves.

2. The benefits of taxation and regulation of cannabis

The annual turnover of the Australian cannabis industry is estimated to be at least $A 5 billion, representing 1% of Australia's GDP. About 3 million Australians have used cannabis in the last 12 months and roughly 5 million Australians have ever used cannabis. By choice not chance, this significant component of the economy is reserved as a monopoly for criminals and corrupt police. Two state Royal Commissions within the last 15 years have concluded that police corruption is pervasive and linked to unsuccessful attempts to enforce drug laws.

Taxation and regulation of cannabis should be considered as an alternative to prohibition which was adopted by historical accident in Australia from the 1920s. Taxation and regulation would help to: separate the cannabis market from the market for more dangerous illicit drugs; provide an opportunity for point of sale health warnings; provide an opportunity to refer users experiencing problems to assistance; provide quality control; release scarce law enforcement resources for policing violent crime and generate income to adequately fund alcohol and drug prevention and treatment.

In contrast, maintaining current policy will increase the likelihood that: there is only one market for cannabis and other illicit drugs; cannabis law enforcement represents a significant government outlay; police corruption continues to be a significant issue; and that cannabis users apprehended by police continue to pay substantial social costs (eg employment, accommodation, resources).

The 1961 Single Convention (Article 2.5 b) requires countries to prohibit certain drugs (including cannabis) if prohibition is considered the most appropriate way of protecting public health and welfare.

Myths About Heroin Addiction

The ABC's Radio National Health Report on Monday 15 October 2001 talked about the myths of heroin addiction. It is important to separate fact from fiction when it comes to treatments that work for heroin addiction. A national trial in Australia evaluated three forms of treatment for heroin dependence. ***Associate Professor Richard Mattick*** *from the National Drug and Alcohol Research Centre in Sydney spoke on the program about this heroin study. The presenter of the program was Norman Swan.*

The full transcript of the program can be found on the ABC's website at htttp://www.abc.net.au/rn. The following is an extract from that program.

Norman Swan: ...when it comes to treatments that work for heroin addiction. Australian research has found, unsurprisingly, that they who shout loudest don't necessarily deliver the goods.

..the heroin study was a national trial evaluating three forms of treatment for heroin dependence: methadone maintenance, a drug called buprenorphine, LAAM, a long-acting opiate, and naltrexone, which has received enormous publicity in women's magazines and commercial television, putting the government under huge pressure to approve its use.

This has been a major battlefield, with the Prime Minister's office leading a charge against methadone, and some in Canberra taking up naltrexone's cause.

Associate Professor Richard Mattick is Head of Research at the National Drug and Alcohol Research Centre, and was one of the key people involved in the trials.

Richard Mattick: Methadone, because it was not well accepted by governments, was subjected to quite rig-

orous research in a number of trials and there's good placebo control studies and other studies in methadone. The same is true of buprenorphine and LAAM, it's less true of naltrexone.

Buprenorphine is an alternative to methadone. It has some unique properties. It is relatively easy to withdraw from, compared with methadone, although that should not be mistaken as guaranteeing lifetime abstinence. The other properties are that you can dose it every second, or third day, so you save both clinic and the patient's time and money. It's also safer in overdose; there are relatively few overdose deaths except in combination with benzodiazepines when it can be dangerous, but it is much safer than methadone.

Naltrexone is the medication which was introduced into Australia after an Israeli doctor visited Australia and told us that there was a cure-all for heroin dependence, and there was a lot of discussion and debate at that stage. Essentially what naltrexone does is that it blocks the opiate receptor sites in the brain and if there are opiates, be it heroin, morphine or methadone on those receptor sites, it will displace the opiate and if you inject heroin thereafter you will not feel anything.

[The heroin] study is unique because it's actually an Australian study, and we looked at 1500 patients in Australia trialled with the different treatments.

No, they didn't come out the same, but if you remained in treatment you did quite well. Naltrexone was heralded as providing 100% cure rate initially, then the advocates of it dropped it to a 60% cure rate.

Norman Swan: Cure meaning what?

Richard Mattick: Well they were unclear about what cure meant. Naltrexone is highly effective for a very small group of people. It is not particularly effective for the broad heroin dependent population. Of the 300 patients who entered naltrexone treatment, only eight remained in treatment six months later. The vast majority drop out within the first two to four weeks and they go back to heroin use, or to other treatments.

The group that does benefit are those who are highly motivated, who have very good structures in place to help them to be abstinent. Usually they're employed and they've got good reasons to stay clear of opiates. The typical best is a pethidine-dependent doctor, it is not a heroin user on the street.

Norman Swan: But it's not a magic answer?

Richard Mattick: No, and I think that's one of the problems that's occurred in Australia, and actually round the world. And if you look back historically, therapeutic communities were introduced in the '70s as a way of curing the heroin problem. Methadone too, was heralded as being a way in which the heroin problem would be fixed. And more recently, naltrexone has been heralded in that way. Heroin prescribing is said to be a way of fixing the problem. The reality is that we've got a chronic disorder which requires management across time, to keep people alive and relatively well, so that they can get clear of it in five or ten or more years if it takes them that long.

Norman Swan: So the outcome you're looking for is abstinence while on the medication, whether it be buprenorphine, whether it be naltrexone, whether it be methadone, and then at some point, you hope in the future, the person will be amenable to coming off all medication?

Richard Mattick: Indeed. I think it's actually quite important to realise the chronicity of this problem. Not many people do. We think that it is a short-term problem. There have been 20 and 24 year follow ups in the USA which found that about a third of people are prematurely dead. They start in these trials, these studies, about 25 years of age, and 20 years later when they're 45, maybe 49, on average, they're dead, a third of them. A third of them become clear of opiates, and the rest, that's about 40% cycle in and out of a number of treatments, and in and out of jail and in and out of heroin use. So about two-thirds of people either die, or don't overcome this problem, across a 20 year period. It is a very serious problem once you become dependent on heroin.

Norman Swan: So take us through buprenorphine and methadone, what do they show?

Richard Mattick: Methadone in fact was shown to be the most cost-effective intervention for the management of heroin dependence available in Australia. It is relatively cheap to provide, and it provides good outcomes. To put that into a context, in terms of reduction of heroin use, prior to entering treatment of these individuals who were heroin users regularly, were injecting heroin three times a day, 25 out of 28 days. Yet the six months of treatment they were injecting heroin relatively rarely, in fact only two days a week. So you still get a little bit of heroin use. But a massive reduction in heroin injection and a massive reduction in spending and also in crime, we found that the rates of crime particularly property crime, but also drug dealing, dropped significantly and dramatically, and that's also consistent with the international literature.

Norman Swan: So let's take the 300 type people who enter a trial; how many [remained in the program] six months in, compared to say, naltrexone?

Richard Mattick: For naltrexone it was about 4%, for the other pharmacotherapies on average it was 44%. So ten times the number. If people leave treatment, they need to be linked into another treatment, or have the ability to come back into treatment easily.

Australia's got a good track record of keeping people alive and relatively well. Methadone, plus needle and syringe programs have provided an environment where we have relatively low rates of death from opiates compared with other countries, but also relatively low rates of HIV.

... we studied 400 patients who either were assigned to methadone or buprenorphine, and that was the biggest trial conducted internationally, and found that buprenorphine was equivalent to methadone suppressing heroin use, suppressing criminal activity, improving health and psychological well being. It retained people slightly less than methadone, about 10% less patients, and that's partly because buprenorphine has this unique property, it doesn't have the full opiate effect of methadone. It actually makes the

users feel more normal, they say, they get less of a buzz and they feel more normal on buprenorphine. And we think that's because they're less sedated on the drug.

Norman Swan: Now let's go to cost. If you actually translate these effects per heroin user treated and/or heroin user treated successfully, namely still in treatment, what? six months later, that was your criterion. How did they compare costwise?

Richard Mattick: We looked at trying to achieve more heroin free days overall. The results were quite clear that methadone is the most cost effective intervention for achieving abstinence in Australia. The relative cost of methadone is about a quarter of the cost of naltrexone to achieve a good outcome, that is, abstinence. Buprenorphine is quite an expensive drug to purchase, the government has put it on the PBS, and that's a good thing. Even though it's equally effective because it's more expensive it's not as cost effective.

LAAM [long acting methadone] is not available in Australia so we don't know what the cost would be, [but] it was actually quite effective, and we're going to pursue it further because it seems to have advantages over methadone.

Norman Swan: And going back to your trial and just finally, what's your advice for policymakers, based on the trials, because that was the intention in the first place?

Richard Mattick: Well the advice that we have is that a range of treatments need to be available. They should be available at every jurisdiction, and they should be accessible to individuals. If you look at any other area of health care, whether it be hypertension or diabetes or schizophrenia or depression, there are a range of pharmacotherapies, a range of treatments, they're not just drug treatments, there are also behavioural treatments, which help people, and that's what should go on with drug dependence, rather than this horse race where one treatment has to beat the other one, and win.

Also in the same program was an interview with Professor Mary Jeanne Kreek, one of the three pioneers at Rockefeller University in New York who is now considered a giant in the study of opiate addiction.

She considers methadone to be a treatment for a chronic disease where it replaces a biochemical deficiency in the same way that insulin does in a person with diabetes.

Here is an extract of that particular part of the interview:

Norman Swan: .....So in many ways they are treating their stress biology with narcotics, especially the severe stress of drug withdrawal. So it makes the temptation to relapse greater. This hyper-responsivity even exists in former heroin users who are drug free. And it looks similar in cocaine users. So it helps to explain why periods of high stress put former drug users at risk of returning to their drugs.

Which brings us back to methadone and whether it's a chemical bandaid or a therapy.

Mary Jeanne Kreek: A better analogy is probably insulin treatment for type 1 or type 2 diabetes. A bandaid, no, but if you're speaking more correctly as a treatment for the receptor, indeed, just like insulin you're replacing that which should be there normally. We may in fact be doing the same with beta-endorphin. We are finding that there seems to be evidence for a relative endorphin deficiency, and persons who are now off heroin, off methadone and in this drug-free state.

Norman Swan: And of course we come now to the key question where prejudice about methadone treatment arises: can you ever get somebody off it?

Mary Jeanne Kreek: We have to ask why we'd want to get people off a drug if a medication is being helpful. I don't use the word 'drug', I use medication if you've noticed. In pharmacotherapy I think we should try to change our English language. But having said that, you don't get people off insulin, you want to maintain their insulin as long as they need it, because they have a relative deficiency. If we had beta-endorphin in a form which would pass the blood/brain barrier, in adequate amounts, we'd be delighted to use beta-endorphin. But on the other hand, methadone is as like beta-endorphin as one can get, and it's xeno biotic, we were very lucky. It has no toxicity, no long-term side effects, we know that methadone is acting precisely where we want it to be targeted, at the neuro receptor, so we don't see the need of getting people off treatment any more than you'd try to get people off treatment from insulin or any other medication even if it were synthetic like a medication targeted to manage hypertension or renal problems.

Norman Swan: One of the things that kills people, particularly on heroin, is not super pure heroin, it's not even getting the dose wrong, it's the fact they're on other drugs. They're on alcohol, they're on valium, they're on other things, mixtures, and then that sends them over the edge. Have you got any of the biology explaining why they're taking all this other stuff?

Mary Jeanne Kreek: Yes, we know that when people are in a treatment, about 70% have cocaine addiction. And if you go on to take their history, the majority started their drug abuse history with cocaine. Cocaine causes this hyper-activation of many systems. What do opiates do? Well, opiates, if self-administered, decrease the activation of stress responsivity, and what we find is that the long-term cocaine abuser will turn first to prescription medications like benzodiazepines then will turn to alcohol in excess, but ultimately frequently find that heroin attenuates what they don't like about their feelings after chronic cocaine use, they go on to become heroin addicted. That's the bad news.

Norman Swan: So they go through this pharmacological struggle in a sense, to self medicate their stress.

Mary Jeanne Kreek: Correct. The good news come from the fact that we found that the 70% that come in with co-dependency in effective methadone programs, that use adequate doses, combine it with good behavioural treatment, see a reduction down to less than 30% using any cocaine. So it's tough when you have poly drug abuse, but it's not impossible.