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

committed to preventing tragedy that arises from illicit drug use

PO Box 36, HIGGINS ACT 2615, Telephone (02) 6254 2961
Email mcconnell@ffdlr.org.au Web www.ffdlr.org.au

NEWSLETTER May, 2003 ISSN 1444-200

Next Meeting

Thursday, May 22
meeting 7:30pm
speaker 8:00pm

Topic:

Thinking about drug policy:

Some core concepts that might underpin the next stage of Australia's National Drug Strategy

Speaker:

David McDonald

A social scientist with research interests

at St Ninians Uniting Church,
Cnr Brigalow and Mouat Streets,
Lyneham

Please see enclosed invitation

Editorial

Vincent Dole's Birthday

Vincent P Dole turned 90 this month. Together with his wife Marie Nyswander he introduced methadone substitution therapy.

An extract of a small part of that history is included in this newsletter.

While you read that extract keep in mind the following points:

- methadone like most treatments is not without problems, many of which are because of the system surrounding the way the drug is dispensed;
- it does not suit everyone;
- current thinking is not to force abstinence by reducing dosage until the patient is ready.

Notwithstanding this, methadone is a very effective treatment for many people and because of it they might also wish Vincent Dole a happy birthday.

ACT Budget benefits

The recent ACT Budget for 2003 – 2004 contained some good news for drug treatment services. The most significant was the allocation of $9 million for refurbishment of a major alcohol and drug rehabilitation centre and other alcohol and drug services. The media release put it this way:

Accommodation at the Karralika Drug and Alcohol Service will be greatly improved with Capital Works funding of $5.085 million in the 2003/04 Budget, while another $4.7m will be spent on the much-needed refurbishment of several important health services and minor new works.

…..

Estimated expenditure for the Karralika refurbishment over two years is $2.735 million in 2003/04 and $2.350 million in 2004/05.

….

"At the Fadden site, funding will deliver new facilities for the clients of the long stay program, a new child-care centre and accommodation for the outreach program. "At Isabella Plains, there will be improvements for the intake and assessment team and a refurbishment of facilities for clients of the short stay program.

"The construction will provide additional accommodation capacity at Fadden, a total capacity of 60-70 places, 15-20 (25%) of these to meet a growing demand for places for children who accompany adults on the programs," Mr Corbell said.

It is pleasing that the ACT Government, is making this funding available to expand the facilities and to improve standards in accommodation for drug 'addicts' and for the staff who care for them. This improvement in accommodation will give a boost to the morale of staff and self image of the clients.

The Fadden facility could then offer better services to families – if families as a whole can be helped it is less likely that drug taking will continue into the next generation.

Further, if people are in treatment research shows that they are less likely to commit crime and society benefits from this.

Treatment is also better economically than putting drug addicted people in jail. The ACT does not have a jail and prisoners are either held in remand or transported

to NSW prisons. The cost per day of holding someone in remand is about $340 and in a NSW jail is $150. The cost per day in Karralika is about $70.

Thus, for every person in this treatment centre instead of remand or jail, the community saves between $80 and $270 per day or somewhere between $30,000 and $100,000 per person per year.

And furthermore the chances of a successful outcome are much more likely in a treatment centre than in a prison or remand centre. And the refurbishment of the Karralika facilities could possibly mean that more clients will want to stay.

Centenary medals awarded

Marion and I were recently awarded the Centenary Medal. The Canberra Times phoned on Easter Monday to say we had been awarded this medal and an article appeared in the Canberra Times the next day.

The medal was awarded for 'raising awareness of drug related issues through families and friends for drug law reform'. We would like to sincerely acknowledge in this newsletter that this award would not have been possible without the work and support of many members of the group – Families and Friends for Drug Law Reform. We received these medals with the hope that it will encourage other families to speak out when they see that laws and policies are wrong.

Our son died from a heroin overdose just two weeks after we discovered he was using heroin. The intervention of the law at that time opened our eyes to the injustices of our prohibition drug laws which treated those getting into trouble with drugs as criminals but at the same time were generating huge profits for drug cartels. The least that can be done to rectify this injustice is to treat drug addiction as a health problem and for governments to provide as many treatment options as possible. The other important issue is for governments to acknowledge the root cause of the problem and take steps to take the huge profits out of illicit drugs.

Brian McConnell

President

Enter methadone maintenance

An extract from Chapter 14 of The Consumers Union Report on Licit and Illicit Drugs, by Edward M. Brecher and the Editors of Consumer Reports Magazine, 1972

Dr. Vincent P. Dole, specialist in metabolic diseases at the Rockefeller University, came to an interest in heroin addiction through his studies of obesity, which in some respects might be considered addiction to food. During the 1950s, when most experts were saying that obesity results from overeating and that people get fat because they eat too much and "lack the will power" to cut down, he launched at the Rockefeller Institute (now the Rockefeller University) a series of studies of metabolism in obese people. He soon discovered that many obese people metabolize food quite differently from other people. His technique was to hospitalize obese patients for substantial periods, place them on a scientifically formulated diet, and study their metabolic processes before, during, and after weight reduction. Dr. Dole's work, along with that of Dr. Jean Mayer at Harvard and of others at other centers, has profoundly altered scientific views on obesity. No longer is "weakness of will" an accepted cause.

The craving of his obese patients for food struck Dr. Dole quite early in his obesity research as remarkably reminiscent of a cigarette smoker's craving for cigarettes--or a narcotics addict's craving for narcotics. The tendency of obese patients to relapse after dieting also resembled the tendency of cigarette smokers and heroin addicts to relapse even after prolonged periods of abstinence. His obesity studies led Dr. Dole to conclude that, far from being due to weakness of will, relapses among some obese patients have a metabolic, biochemical origin.

In 1962, Dr. Dole began planning a similar metabolic study of heroin. His initial step, of course, was to review the existing scientific studies. He found a substantial medical literature, both in English and in other languages - but one very serious gap. Almost all of the American studies concerned opiates in the test tube, or in laboratory animals, or in nonaddicted volunteers, or imprisoned addicts. American physicians in general had divorced themselves from the problems of the addict in the street ever since the early waves of physician arrests under the Harrison Narcotic Act. Both the Stevenson study of British Columbia addicts and the O'Donnell report on Kentucky addicts were unpublished. The most significant published account of addiction under American street conditions that Dr. Dole could find was a book by Dr. Marie Nyswander, a Psychiatrist, entitled The Drug Addict as a Patient.

A graduate of Sarah Lawrence and of the Cornell University Medical School, Marie Nyswander had been commissioned a lieutenant (junior grade) in the navy late in World War II, assigned to the Public Health Service, and posted at the United States Public Health Service hospital for addicts in Lexington. Her experience with addicts there led her, unlike many psychiatrists, to accept addicts as patients when she entered private practice. In 1957, in a New York City storefront, she had launched a service project for addicts, with a team of New York psychiatrists and psychoanalysts offering their services to the city's addicts. Thus Dr. Nyswander had had experience with multiple approaches to the treatment of addiction-the Lexington approach, her own approach as a therapist with addicted patients, that of her storefront project, and the efforts of other psychotherapists and psychoanalysts.' She recognized that none of them accomplished very much. Like so many others during the 1950s and 1960s, she was thus eventually forced to the conclusion that maintaining addicts on legal opiates was the only

feasible solution. She was beginning to think about risking her reputation, and perhaps even her freedom, by launching private research - a narcotics-dispensing clinic of her own, using her personal funds - at just the time when Dr. Dole turned his attention from obesity to heroin addiction.

Dr. Dole read The Drug Addict as a Patient, and in October 1963 invited Dr. Nyswander to the Rockefeller Institute for a conference. Early in 1964, he invited her to join his new research project. (In 1965 they were married.) The two made a very nearly ideal team. Dr. Dole knew nothing about addicts, and Dr. Nyswander knew little about the complexities of biochemistry and human metabolism; each brought to the project precisely what the other lacked.

….

[The first two patients] were started on small doses of morphine, a quarter of a grain (15 milligrams) four times a day. As in the obesity project, which began with patients being allowed to get as much as they wanted, these patients were allowed to increase their doses as they pleased; within three weeks they were requesting and getting eight shots totaling 600 milligrams (10 grains) a day. Morphine became their whole lives. "Much of the time they sat passively, in bathrobes, in front of a television set. They didn't respond to any of the other activities offered them. They just sat there, waiting for the next shot." In this sense they were good patients; "they cooperated beautifully and honestly" in the many metabolic tests to which Dr. Dole subjected them. But they demonstrated the major problem faced by all morphine-dispensing and heroin-dispensing programs the problem of dosage. In this respect, indeed, they closely resembled the obese patients in the earlier Dole study.

In Britain, in Kentucky, and in other places where legal opiates are dispensed, the dosage problem takes several forms. If a physician gives an addict less than he wants, the addict may obtain more from a second physician, or may buy additional drugs on the street. If the physician gives the addict as much as he asks for, the addict may share his large dose with others, or sell a part. The problem is solved in various ways. After staying for a time on a given dose - even an enormous dose - an addict becomes "tolerant" to that dose, and functions quite well on it; this no doubt would have happened to the two Dole-Nyswander patients if the work with them had continued. Some patients, moreover, are able and willing to stabilize themselves on quite moderate doses. Still others "bounce" up and down. In the case of their first two patients, however, Drs. Dole and Nvswander were not really trying to solve the American heroin problem; they were only seeking to determine the metabolic pathways that morphine follows inside the human body. When the metabolic tests on morphine were completed, their plan called for detoxifying and then discharging the two addicts. Indeed, Federal Bureau of Narcotics regulations required this.

The approved technique of detoxification in most hospitals today was developed in Lexington during the 1950s. The first step consists in transferring the patient from morphine or heroin to methadone, a synthetic narcotic developed by the Germans during World War II. The daily methadone dose is then progressively reduced over a period of ten days or so until a zero dose is reached. Most authorities agree that this methadone detoxification treatment is preferable to direct withdrawal from morphine or heroin because, even though it takes longer, it reduces the suffering. Drs. Dole and Nyswander placed their patients on methadone as a step toward withdrawal. Instead of reducing the methadone immediately, however, they decided to keep the patients on high doses of methadone for a considerable period while the same metabolic tests were rerun. Thus they would be able to compare morphine and methadone metabolism in the same patients.

While the patients were on methadone, however, surprising changes began to occur. "The older addict began to paint industriously and his paintings were good," Dr. Nyswander later told Nat Henty of the New Yorker. "The younger started urging us to let him get his high school-equivalency diploma. We sent them both off to school, outside the hospital grounds, and they continued to live at the hospital ." They also continued to take their methadone daily. So far as Dr. Dole and Dr. Nyswander could see, they had become normal, well-adjusted, effectively functioning human beings-to all intents and purposes cured of their craving for an illegal drug.

Swedish trials questioned

A letter from Dr Andrew Byrne

Dear Colleagues,

The Swedes have produced some of the most quoted data showing the life saving properties of methadone maintenance, [it is quoted] partly because this treatment is so severely restricted in Sweden. Thus trial candidates who are randomized NOT to receive prescription treatment, or who are discharged from treatment, rarely receive agonist maintenance therapy which might be available elsewhere in the normal course of medical practice.

From work performed in the 1980s, Grönbladh and colleagues showed a very high mortality in those rejected from methadone treatment - almost 8% per year. In an even more rigorous and controlled study using sublingual buprenorphine, Kakko et al. have found what the accompanying Lancet editorial calls: "massive 20% mortality at one year in the placebo group versus 0% in the buprenorphine group [which] is immensely concerning". Indeed, a trial using placebo in heroin addiction treatment would likely be considered unethical in most countries.

This trial provides strong support for buprenorphine maintenance since at a fixed dose of 16mg daily it had a 12 month retention rate of 75% and no deaths, com-

pared with placebo: 0% retention at 2 months and four out of twenty being dead by 12 months. All 'placebo' (actually '6 day reduction') cases had access to intensive levels of psychosocial supports, some of which were reported to have induced paradoxical cravings.

The mortality rate is even more worrying considering that these candidates were chosen from over 400 applicants based on less severe dependency and less poly drug/alcohol use. Thus none of the chosen candidates was suitable for the stringent Swedish criteria for methadone prescription (4 years hospital-documented multiple daily heroin use). All but one were injectors.

All of the placebo patients showed positive urine tests for opiates before dropping out of treatment. Thus none was an early abstinence success - despite this being the consented aim of the trial. About 75% of urine tests of the buprenorphine patients were negative for illicit substances tested for. Thus despite continued if much less frequent drug use was still associated with good retention and reduced health problems measured in a variety of ways by these researchers.

Swedish drug policy is based on the belief that all drug addicts can and should stop using certain proscribed drugs immediately (abstinence orientated, or 'zero tolerance'). While this has been long abandoned in most other countries, Sweden continues despite their own research showing excess deaths, continued drug use and high rates of viral disease transmission when such policies are pursued. One fails to understand how in such a modern democracy such ill-founded policies are used.

Yet the world's two most persuasive studies are from their own country showing that if heroin addicts are left untreated (or "treated" in the compulsory manner used in Sweden) then the result is a high mortality of young Swedes from a totally preventable and treatable cause, mostly drug overdose.

For related editorial commentary: Law FD, Nutt DJ. Maintenance buprenorphine for opioid users. Editorial. Lancet (2003) 361:634-5

Dr Andrew Byrne, Medical Practitioner, Drug and Alcohol, 75 Redfern Street, Redfern,

Vancouver: Unsanctioned Safe Injection Site Opens in Midst of Police Crackdown on Downtown Eastside Hard Drug Scene

The Western Hemisphere's first safe injection site has opened in Vancouver, BC, but not under official auspices. While in recent months, officials at all levels have reached a general agreement to open a safe injection site for the drug-injecting population centered in the Downtown Eastside as part of the city's comprehensive, two-year-old Four Pillars plan (prevention, treatment, enforcement, harm reduction), delays in winning approval for a safe injection site at the federal level have stalled its opening. That was bad enough for community activists and users' groups who had worked for years to create such services, but when Vancouver police swooped down with a massive and continuing enforcement effort early last month, activists decided they could wait no longer for the government to act.

For more on this story connect to:

http://www.drcnet.org/wol/285.html#vancouverinjectionsite

Families Support Cannabis Law Reform

This media release was issued by our spokesperson in WA, Jan Steele.

A key family support group for families of drug affected children has condemned as a cheap political stunt the latest move by the WA Liberals to import a social worker from Lambeth in the UK to argue against the Government's proposed cannabis reforms.

Family & Friends for Drug Law Reform State spokesperson, Mrs Jan Steele, said comparing the Lambeth Cannabis Policing Experiment with the WA proposal is completely flawed and only highlights the weakness of the Liberal position on this issue.

"When an opposition party has to resort to importing an anti-drug law reform campaigner from another country on the other side of the world to back up their case – it is clear they haven't been able to win the argument at home.

"The Lambeth Experiment was just that – an experiment. It failed because it was not supported by legislation, was not backed by education and awareness campaigns about the dangers of cannabis and did not apply penalities of any description.

"The WA Government's proposal deals with all these factors, as well as tightening the laws relating to dealing and trafficking," said Mrs. Steele.

Mrs. Steele, whose own daughter has struggled with illicit drug use for many years, supports these reforms – as do many of families she deals with.

"The real issue is what is the best way to manage cannabis in the community. A criminal record (for personal use of cannabis) has been shown to not be any deterrent, yet it can possibly wreck lives in ways not related to the physical effects.

"The young will always experiment but do not realise a criminal record will affect entry into certain careers and will bar travel to certain countries for life. Parents of these young people have enough worries, they do not need the further worry of their child being branded a life-long criminal", said Mrs. Steele.

Media Contact: Jan Steele Ph: 0417 167 694