



WHY INJECTING ROOMS DON'T WORK

Australia's drug policy since 1985 has been called 'harm minimization.' It relies heavily on 'harm reduction' approaches to drug use where drug use is made 'safer' (they believe) while not necessarily trying to prevent drug users from using drugs. Harm reduction approaches include:

- needle and syringe programs (which attempt to stop drug users sharing used needles which carry very harmful blood-borne diseases)
- opiate maintenance programs (which attempt to stop heroin users from committing criminal acts to fund their heroin habit and also to stop them overdosing on heroin)
- heroin on prescription (to do the same as maintenance programs)
- injecting rooms (to prevent drug users from overdosing)

But when the world's most authoritative reviews of these interventions are considered, all fail to demonstrate effectiveness as can be seen by consulting these topics on our website.

Introduction

A Medically Supervised Injection Centre (MSIC), also known as Safe Injection Facility (SIF) or Supervised Consumption Site (SCS), seeks to provide a safer, hygienic site for high-risk drug users to inject, or in some cases in Europe, smoke drugs pre-obtained by clients. Because 1 in every 100 dependent heroin users will die each year from a heroin overdose anywhere in Australia, an injecting room seeks to provide a place where trained staff can supervise drug users' injections so that if there is an overdose they can immediately intervene to stop that overdose causing death.

The first of these facilities was opened in 1986 in Bern, Switzerland and since then this type of intervention has spread to 11 other countries worldwide, with 92 facilities at the beginning of 2009. The most recent facilities were opened in Melbourne, Australia in July 2018 and in various cities throughout Canada, with another in Ireland failing yet to open.

The Sydney Medically Supervised Injection Centre was the first facility to open outside Europe in 2003. It had three initial objectives, 1) decreasing overdose deaths 2) providing a gateway to drug treatment programs such as opiate maintenance programs or rehabilitation 3) reducing discarded needles and drug use in public places (improving 'public amenity' as they called it) and a fourth added before its commencement - reducing the spread of blood-borne diseases such as HIV and Hepatitis C.

The Sydney facility commenced operations on May 6, 2001 on a trial basis. During the length of the trial, and subsequent extensions to it, the facility committed to ongoing evaluations of all aspects of its operations. A first evaluation was completed in August 2003. From the outset any evaluation of changes

in 'public amenity', overdose deaths, hospital presentations for overdose and ambulance overdose callouts for overdose were vastly complicated by the advent of Australia's heroin drought, which commenced only 4 months before the MSIC opened in January 2001. Rather than looking for simple before and after changes within the Kings Cross area evidencing some positive effect by the injecting room, evaluators were forced by the heroin drought to compare changes in the Kings Cross area against other neighbouring areas or against the rest of NSW to determine whether the injecting room had made any difference at all.

Performance

From the first 2003 evaluation the following picture emerged:

- The Kings Cross injecting room continually and falsely publicised every overdose in the injecting room as a life that had been saved or 'potentially saved'. In reality only one in every 25 heroin overdoses is ever fatal, but the injecting room kept repeating the falsehood regardless, likely for the purpose of swaying public opinion in its favour.
- Despite often calling itself a "heroin injecting room" only 38% of injections were actually heroin, with other less deadly substances such as cocaine and the highly destructive but less deadly Ice being injected. Because cocaine and Ice cause considerably less deaths than heroin the injecting room was criticised for largely failing to fulfill its assigned purpose of saving lives from heroin overdose.
- Clients of the injecting room only averaged one out of every 35 of their injections in the facility, with all their other injections on the street, in a car, a park or at home. This indicates no real regard by drug users for their own personal safety or else they would seek to have had most of their injections in the room. While the injecting room is capable of hosting 330 injections per day, it usually averages only 200 injections per day, evidencing an under-use of the facility.
- The Sydney injecting room hosted massive rates of overdose which were 32 times higher than they should be expected to be. They were 32 times higher than the average rate of overdose clients experienced in previous years before registering to use the injecting room. From their records, clients previously averaged one non-fatal overdose for every 4,400 of their injections (or one non-fatal overdose every 4 years), whereas within the facility there was an overdose for one in every 139 injections. Rates of overdose this high have not been recorded anywhere else in the world, even in other injecting rooms.
- The high rates of overdose can have only two causes - injecting room staff are intervening too often when there is no real sign or real threat of an overdose but treating their clients for overdoses regardless, or alternately injecting room clients are experimenting with much higher doses of heroin or with deadly cocktails of heroin mixed with other drugs.
- Ex-clients of the injecting room in rehab have testified, as recorded in NSW Parliamentary records, that the massive numbers of overdose are in fact from clients experimenting with more drugs or drug cocktails in the safety of the room. This inevitably means that the injecting room is a State-funded accessory to the local drug trade making drug dealers richer. This is damning for the injecting room.
- The first government evaluation of the injecting room estimated that it had saved four lives per year in its first 18 months of operation. These false calculations were based on the massive number of overdoses in the facility, which were 32 times higher than they should have been. The researchers doing the first evaluation did not even bother to look at why these overdose numbers were so staggeringly high to begin with. When adjustments are made for these serious issues, the injecting room is only capable of saving one life every two years, which costs \$5.4 million to save each life. This is overly costly. The same money could purchase 900 Naltrexone implants which would prevent 900 heroin users from overdose for close to 12 months each. Because one in every one hundred

dependent heroin users die per year from overdose, Naltrexone would save 9 lives per year, nine times as many as the injecting room could possibly save.

- Only 11% of injecting room clients were referred to opiate maintenance programs, detoxification programs or drug rehabilitation programs. 3.5% of clients were referred to detoxification and 1% to rehabilitation, indicating that very low numbers showed any interest in trying to get off drugs via detox or rehab. With one study from Scotland showing that 57% of heroin users want to get off their drugs, these referral rates are inadequate.
- The injecting room did not improve 'public amenity', that is, it failed to rid the area of people injecting in public, nor did it stop people discarding used needles on the street. Of course the heroin drought which commenced shortly before the injecting room opened did reduce the numbers of needles being distributed due to a lack of heroin being available, but discarded needles on the street, where public injections still occurred, only reduced about the same amount as reduced needle handouts due to the heroin drought.
- Before the injecting room opened, Kings Cross had 12% of all NSW overdose deaths. After the room opened Kings Cross still had 12% of NSW overdose deaths. This means that while there were no deaths from overdoses (imagined or real) in the injecting room, there were just as many deaths on the streets outside the facility despite its presence. When it is considered that it can only be capable of saving one life (or averting one death) every two years it becomes abundantly clear why there were no observable changes in deaths in the Kings Cross area after it commenced.
- A 4th government-funded evaluation of the injecting room in 2007 falsely claimed that a study had found that the injecting room had reduced ambulance callouts for heroin overdose by 80%. But the reality was very different. Remember there was a heroin drought which started 4 months before the injecting room opened which reduced ambulance callouts for heroin overdoses across the whole of NSW by 61%, almost as much as in Kings Cross. But the reason Kings Cross had greater reductions in callouts than the rest of NSW was because police started using sniffer dogs to remove drug dealers from the area around the injecting room shortly after the MSIC opened. Drug users tend to overdose immediately after buying their drugs from a dealer but with now being forced to buy drugs in nearby Darlinghurst ambulance callouts increased there by roughly the same amount as Kings Cross decreased. It is certain that the injecting room had virtually no effect on ambulance callouts because ambulance reductions in callouts were greater at night when the injecting room was closed, than in the day time when it was open. If reductions were greater at night, it was not the injecting room that was causing the reductions but something else (like sniffer dogs being used more frequently at night than in the daytime).

NOTE: A 2011 study from Vancouver's Safe Injection Facility called Insite falsely found that the facility had reduced overdose deaths in Vancouver by 9% (in reality, on a two-year average before and after Insite's opening, deaths actually increased 23%) and that there had been a 35% reduction in overdose deaths in the area closest to Insite. What the study totally concealed was 'zero tolerance' policing changes shortly before Insite opened in 2003 which scared drug dealers into other parts of the city. As with Kings Cross, the policing led to drug users overdosing and dying in other areas into which drug dealers had fled, leaving the area around Insite with less deaths. But less deaths were not the result of the injecting room but zero-tolerance policing which has continued to this day around Insite.

All the above evidence is taken from Drug Free Australia's publications [here](#), [here](#) and [here](#).



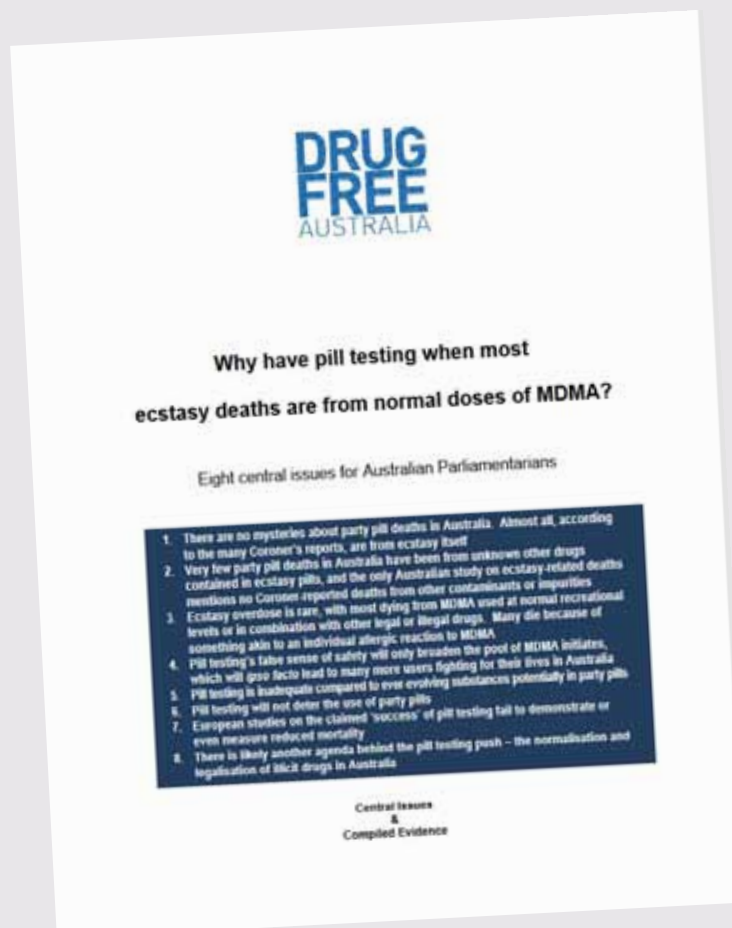
The Kings Cross
injecting room



WHY PILL TESTING DOESN'T WORK

Australia's drug policy since 1985 has been called 'harm minimization.' It relies heavily on 'harm reduction' approaches to drug use where drug use is made 'safer' (so they say) while not necessarily trying to get rid of drug use. Harm reduction approaches include needle and syringe programs, opiate maintenance programs, heroin on prescription and injecting rooms. But when the world's most authoritative reviews of these interventions are considered, all fail to demonstrate effectiveness. Pill testing is another harm reduction approach.

On the following 2 pages is a Drug Free Australia summary of pill testing arguments and why they are false or in one case, only partly true. Beside each explanation is a page number from Drug Free Australia's detailed pill testing document for Australian Parliamentarians where a much fuller explanation can be found. You will do well to look at this comprehensive evidence more closely because it is not good at all for pill testing.



ASSESSMENT OF EFFECTIVENESS OF PILL TESTING

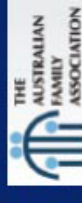
For each page reference in the grid below please go to www.drugfree.org.au/images/pdf-files/homepagepdf/PillTesting_paper-evidenceforStateandTerritoryParliaments.pdf for detail.

THE SCIENCE	PASS / FAIL	EVIDENCE
Almost all party pill deaths in Australia, which amount to literally hundreds since 1995, have been from normal recreational doses of MDMA (ecstasy)	✗	Pill testing WORLDWIDE greenlights normal recreational doses of MDMA p37 The only scientific Australian study of 82 MDMA related deaths from ecstasy (July 2000-June 2005) found the median blood serum level for MDMA toxicity to not be significantly different to deaths from accident or disease where MDMA was a significant contributing condition p25 Deaths from MDMA overdose are rare, so most deaths are from normal recreational doses of MDMA* p21
The majority of MDMA deaths are from polydrug use where MDMA is used alongside other legal or illegal drugs	✗	Pill testing cannot test for use of other drugs p30
A percentage of these MDMA deaths are from individual allergic-like reactions to MDMA itself	✗	Pill testing cannot test for individual allergic-like reactions p29
MDMA overdose is rare	✗	Pill testing onsite cannot test for dose p17 so advocates' spurious rationale that unknown purity or dose causes 'overdoses' would not be informed by onsite pill testing even if it was true
62% of Australian MDMA-related deaths are at home	✗	Pill testing is incapable of preventing home deaths p27
The triennial National Drug Strategy Household Survey indicates that 31% of Australians do not use drugs because of their illegality, and 18% do not use them for fear of death	✗	Pill testing gives a false sense of security by a. falsely removing users' natural fear of death and b. by making use appear publicly acceptable by neutering police detection of illegal drugs p34
THEIR CLAIMS	PASS / FAIL	EVIDENCE
Unknown impurities/fillers deadly	✗	The only Australian study of MDMA-related deaths indicated no deaths from fillers and impurities p14 Pill testing advocates have never detailed any deadly Australian impurities which caused deaths
Unknown other illicit drugs deadly	✓	DFA has only identified 11 deaths** since 1995 where other deadly drugs masqueraded as ecstasy pills p15 - 7 from PMA before 2007 and 4 from NBOME or NBOME/4-FA in 2016/17 - but hundreds from MDMA p15 Onsite pill testing can successfully detect one other drug cut with MDMA, but not more p17 Pill testing onsite fails to identify drugs where 3 or more are combined in the one pill p17 Onsite pill testing could not have identified the 3 x 2017 deaths due to 3 drugs being combined p15 The Canberra pill testing trial failed to identify 53% of the substances presented for testing p17

Continued over page...

THE SCIENCE

THEIR CLAIMS



THEIR CLAIMS

THEIR CLAIMS	PASS / FAIL	EVIDENCE
Unknown purity or dose deadly	✗	MDMA overdose is rare, as is admitted by the most senior harm reduction organisations worldwide p23 The science tells us there is not a clear dose-response relationship for MDMA, *** making fatalities more about individual reactions and synergies with other drugs p22 If purity was the issue, a group of the users from a highly pure 'bad' batch of, say, 200 MDMA pills would be expected to die. This is not happening. Recent rises in festival deaths most likely due to sharp increases in high-school age use since 2014 p26
Dr Alex Wodak - "pill testing will reduce, but not eliminate, the risks of drug taking"	✗	If normal recreational doses of MDMA cause most every Australian death, how will pill testing, which greenlights normal recreational doses of MDMA, possibly reduce deaths? p37
Dr Alex Wodak - The best way to avoid ecstasy deaths is to legalise ecstasy	✗	It's the MDMA that is causing deaths, and MDMA toxicity is not a factor of poor pill manufacture p42 The biggest Australian survey of 25,000 Australians in 2016 shows 97% do not approve of ecstasy use and 92% do not want ecstasy legalised
Bruker Alpha II can measure MDMA purity or dose	✗	This argument is implied by pill testing advocates' focus on unknown purity Onsite pill testing cannot measure dose p18
A small scraping or sample represents the whole	✗	Advocates are the first to say that quality control is non-existent for criminal manufacture, but pill testing hypocritically acts as if homogeneity of ingredients in a pill is assured p42
Use of pill testing in Europe has saved many lives	✗	European studies don't bother to assess or even count numbers of deaths, but only assess self-reported attitudes to party pill use p52
Pill testing is last chance to stop them taking a pill	✗	Pill testing is too late to tell people that MDMA is the major party pill killer. It is too late to tell them to bin their drugs and blow all that hard-earned cash. They need to be told by social media before they blow their money p40
Government-funded DART technology would allow pill testing to determine the dose of MDMA, thus saving lives from deadly high purity pills	✗	Seeing as people have died from taking as little as a quarter of a normal ecstasy pill, advising users to use a part of the pill then wait to gauge the effect does not stop people from suffering individual reactions to MDMA when the second part of the pill may move them over their tolerance threshold
Pill testing is the last opportunity to get a user to discard their ecstasy pill and useful safety information can be given that they will value	✗	The second Canberra trial made no mention of anyone discarding ecstasy pills Seeing as Harm Reduction Australia is seeking to legalise recreational cannabis which is harm production, not reduction, would we really trust them to try to deter ecstasy use? Safety information on a flashing sign at the festival would inform thousands rather than just 200

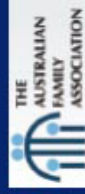
* The median for Australian MDMA toxicity deaths is 0.85mg/litre in a range of 0.03-93.0mg/litre, which means that 50% of deaths below 0.85mg/l were definitively normal recreational doses, and with overdoses rare, most of the balance outside suicides (eg 93.0mg/l) had to be nothing less than normal recreational doses. A typical range of deaths from MDMA recorded in a medical journal is between 0.1 and 2.4 mg/litre. The Australian toxicity median (0.85) is well within this range. Deaths from very low blood serum levels of MDMA indicate that telling a prospective user to ingest only a quarter of a pill still does not preclude a possible death.

** Drug Free Australia has not counted deaths, such as those between 2012 and 2014 where users knew what they were taking (NBOMe, nor have we considered Newcastle's mass hospitalization of users who had a prescription drug masquerading as ecstasy, who sought medical help when pills did not act as expected.

*** Although Drug Free Australia does recognise a more standard dose-dependent relationship for neuro-toxicity with MDMA.

Logical considerations

The Canberra STA-SAFE trial of April 2018 and 2019 has made much of N-ethylpentylone being identified by their onsite equipment. Assuming that this substance was in the form of a powder, pill or cap which is, in each case, usually sold from batches of several hundred, we would expect a number of deaths reported in Canberra or perhaps Sydney and Melbourne if the contained dose of the drug had been deadly. It thus appears that this substance was not at a dose level to cause death.





WHY NEEDLE & SYRINGE PROGRAMS DON'T WORK

Background – why Needle & Syringe Programs?

During the 1980's a new health crisis gripped the world. A disease called human immunodeficiency virus (HIV) was newly identified, a medical condition which fairly swiftly turned into the deadly AIDS for which there was no cure. As a sexually-transmitted disease, it was at first thought to be confined to the gay community worldwide, but it soon became clear that heterosexuals could also acquire it via sex with an infected person, by sharing someone else's infected needle, or by a blood transfusion drawn from an infected person.

Australia alerted the public to this new and deadly disease with the Grim Reaper ad on television while in 1986 a doctor in Sydney started Needle Exchange Programs, which soon were rather called Needle & Syringe Programs when it was found drug users couldn't be bothered returning used needles for exchange.

Many false claims have been made about NSPs. As can be seen here many people claim that Needle and Syringe Programs (NSPs) have been highly successful in stopping most drug users from getting HIV/AIDS from other drug users via the sharing of needles contaminated by HIV-infected blood.

The Claims are Simply Wrong

The most authoritative review of scientific studies on Needle & Syringe Programs' success or failure was conducted in 2006 by the prestigious United States Institute of Medicine (IOM), a part of their National Academies of Science. This review of all the scientific studies involved 24 scientists, researchers and reviewers and was a more extensive look at the scientific evidence than any other review ever done. Despite having given enthusiastic support for NSPs before good scientific studies were done they now concluded after looking at the new studies that:

HIV transmission

“evidence regarding the effect of needle and syringe exchange on HIV incidence is **limited and inconclusive**” (this means that there was no weight of evidence in the studies showing that NSPs were successful in stopping HIV, and that more study was needed)

Hepatitis C

“multiple studies show that (needle exchanges) **do not reduce transmission** of (Hepatitis C).”

The IOM did find that “multi-component” programs which had needle exchanges as one component were effective in reducing self-reported risk behaviours”, however this means that it would most likely be other elements such as counseling, HIV testing etc which were responsible for this success.

Of real interest is the fact that the IOM report also said that certain types of scientific studies which had *claimed* to show great success for NSPs, particularly in stopping Hepatitis C transmission, were wrong in their claims, having used the wrong scientific approach. The IOM said about these so-called 'ecological studies',

“ecological studies monitor populations rather than individuals, and therefore cannot establish causality” for NSPs”

(in other words you could not be sure exactly what was responsible for the success in large multi-component programs, even though NSP advocates had been falsely saying all along that the NSPs were responsible for the success.)

We can be sure they don't work

The reason we know they don't work is because the doctor who first started NSPs in Australia in 1986 was by 1997 recognising that NSPs did not make any difference to the rates of Hepatitis C transmissions within Australia. At that time he wrote an article called “Hepatitis C: Waiting for the Grim Reaper” in which he claimed great success for NSPs in reducing HIV while lamenting the fact that they did not work with preventing the transmission of Hepatitis C. In the article he said such things as:

“Despite the success of the harm reduction/public health approach in controlling the HIV epidemic and slowing the spread of hepatitis B among IDUs in Australia, it appears not to have reduced the incidence of hepatitis C.”

and

“Until Australia embarks on a major national awareness-raising exercise, such as a “Grim Reaper”-style public education campaign, the band will continue to play on for hepatitis C as it once did for HIV.”

What Dr Wodak is admitting here is that his programs have not been successful with Hep C. The reason they were not successful was because, despite being given fresh needles, as many as they want, drug users still continued to share dirty needles regardless. If it doesn't work for Hep C then it could not have worked for HIV either, seeing as both are diseases transmitted through sharing dirty needles. So there must be some other explanation for the reductions in HIV other than needle programs, most likely the Grim Reaper advertising campaign and other strategies launched at the same time.

Return on Investment 1 & 2

Despite all the evidence showing that NSPs do not work, two reports were released by the Australian Government where the researchers had failed to do their homework but made big claims about the 'success' of NSPs.

Return on Investment (2002)

This report used an 'ecological' study design, (which we already have discovered to be false science) looking at journal studies of 103 cities with and without Needle & Syringe Programs (NSPs), comparing HIV and Hepatitis C (HCV) prevalence rates in the cities with NSPs against those without NSPs. It found that:

- Cities with NSPs averaged 18.6% decreases in HIV, cities without NSPs had 8.1% increases
- 25,000 cases of HIV and 21,000 of HCV were calculated as averted by NSPs in Australia over the previous ten year period
- For the \$141 million investment in NSPs from 1991-2000 there was a calculated saving of between \$2.4 and \$7.7 billion in treatment costs

Return on Investment 2 (2009)

The second report projected likely numbers of HIV and HCV infections in Australia if there were no NSPs by calculating from surveyed drug-user behavioural data and other Australian data on infection rates and mortality. It then costed the health treatment savings of the avoided virus transmissions. It found:

- 32,050 new cases of HIV and 96,667 new cases of HCV calculated as avoided due to NSPs between 2000 and 2009 - that's a lot of cases!
- For the \$243 million investment in NSP from 2000-2009 there was a net saving of \$1.03 billion, which will increase to \$28.71 billion over the next 70 years to the year 2079. That's a lot of money!

BUT BOTH REPORTS WERE TOTALLY WRONG.

If all the scientific studies have showed that drug users still share needles just as much as when there are plentiful clean ones they could obtain, and that NSPs were not working as intended for Hep C as a result, then NSPs most definitely could not have worked for HIV. All these fancy mathematics in both the Return on Investment reports are simply false.

Conclusion

Given all the evidence above we can be very sure that NSPs do not work as intended. For more evidence see Drug Free Australia's detailed document on Needle and Syringe Programs.





WHY METHADONE MAINTENANCE DOESN'T WORK

Introduction

People who are addicted to heroin, a powerful opiate, often find their lives spiraling out of control as they need more and more of a costly drug which can only be sourced from criminals. Because of the phenomenon called 'tolerance' to heroin, where a heroin user needs more and more of the substance to be able to get the same 'high' as when they started, it then becomes a costly addiction.

These high costs force them into criminal activity – stealing, prostitution, drug dealing – to fund their 'habit'. And if there is no money to buy heroin, a drug user will swiftly begin to suffer withdrawal. If you want to know what that is like, just watch this short Ted Talk. Even though the person in this Ted Talk was not a heroin user, but rather a person using doctor-prescribed opiates, he still went through what any heroin user suffers when withdrawal symptoms start kicking in. And those withdrawal symptoms start showing themselves within 6-12 hours of their last opiate dose.

Methadone programs were introduced to provide government-subsidised opiates to heroin users so that they no longer needed to commit criminal acts to fund their addiction. The effects of methadone are similar to heroin but each dose of methadone lasts much longer and it can be taken orally, which removes the damaging effects to veins suffered by injecting heroin users. At the same time it is meant to stop fatal overdoses from heroin which can be due to the unpredictability of heroin availability and cash to buy it. Having a sure source for obtaining the much cheaper methadone was meant to allow opiate users more stability in their work so that they could eventually wean themselves off opiates and become productive members of society.

Do these programs work?

For many years small poorly-done scientific studies had indicated that methadone programs were working, reducing overdoses and criminal activity. However, by 2003 it became evident that these many studies indicating methadone's success were not scientifically reliable studies, or meeting a standard that could be trusted scientifically, often done by researchers who had a bias towards creating a favourable outcome for their programs.

Thus in 2003, a review was completed under the Cochrane Collaboration which is the scientific gold-standard for reviews of scientific studies. Headed by Dr Richard Mattick, an Australian who had long been a strong supporter of opiate maintenance therapies, the review found that methadone was not the success it had been thought to be in reducing criminal activity. It is well documented that many heroin users who have commenced the much cheaper opiate maintenance therapy still seek out heroin to use alongside methadone regardless. This still requires criminal activity.

Then in 2009, Professor Mattick completed a second review in which his researchers found that methadone not only failed to reduce criminal activity, but also overdoses from heroin. The summary of the Cochrane Collaboration review states that “It does not show a statistically significant superior effect on criminal activity or mortality.”

Chemical handcuffs

A problem for methadone patients is that many express that methadone is harder to quit than heroin. A common expression they use is that methadone is like “chemical handcuffs” which leaves them with little hope of ever quitting opiates. Because opiates prematurely age those who use them, most opiate users die many years younger than the average person from overdose, or as many grow older they die from a normal dose of heroin or like opiate.

A scientific study from Scotland asked drug users in methadone programs what was their goal – was it getting free from drugs or was it to have continued maintenance on methadone. 57% said that they wanted to get off drugs. The problem for these drug users was that there were not enough rehabilitation centres to help them and so they felt stuck with the ‘chemical handcuffs’ that were so hard to remove.

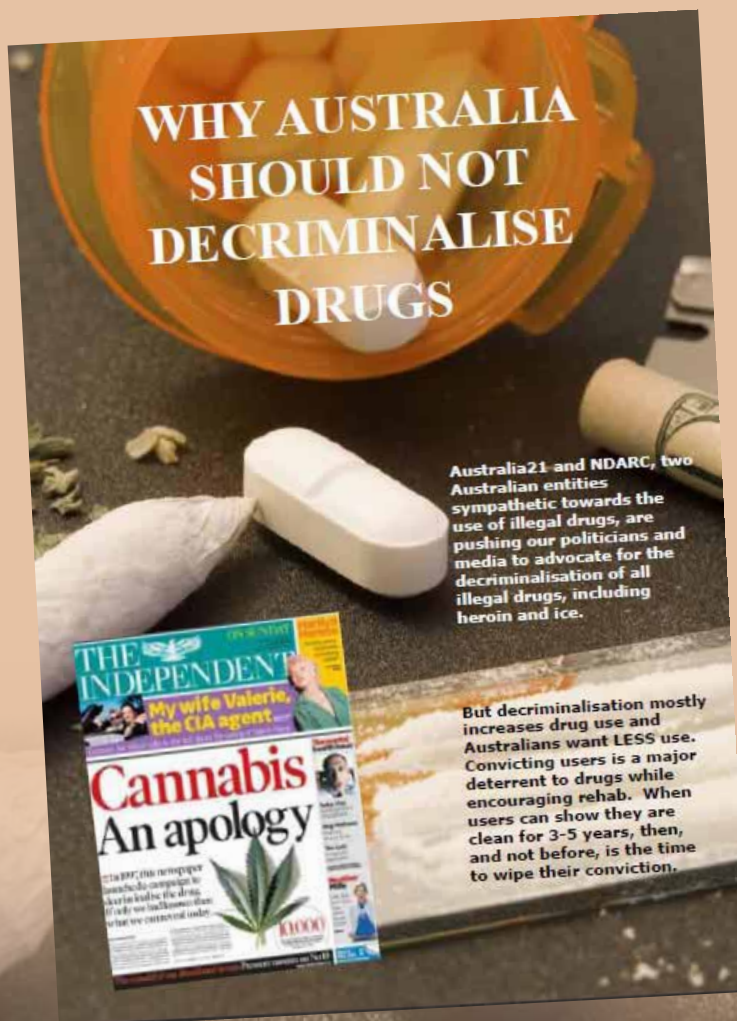
Conclusion

Methadone has failed to fulfill its imagined promise of reducing opiate overdose deaths and reducing criminality. The world’s gold standard review, the Cochrane Collaboration, led by a Professor who has been a strong supporter of maintenance therapies, made this finding after looking at unbiased scientific studies that were of a quality standard.



WHY DECRIMINALISATION HASN'T WORKED

See Drug Free Australia's detailed document on how decriminalisation increases drug use when Australians want less drugs, not more.





WHY PORTUGAL'S DRUG POLICY HASN'T WORKED

See Drug Free Australia's detailed document on how Portugal's decriminalisation of all illegal drugs increased its drug use by 59% and opiate deaths by 59% as well.

In this document you will find that:

- Portugal's drug policy needs to be compared to what has successfully worked in Australia - our Tough on Drugs policy from 1998 to 2007.
- Australia's Tough on Drugs reduced the use of all illicit drugs by 39% between 1998 and 2007. It reduced opiate overdose deaths by 67%. ([go to page 5](#))
- Portugal decriminalised all drugs in July 2001. By 2007, use of any illicit drug had risen by 9%. This was followed by decreases in drug use by 2012, in line with decreases in other European countries. By 2017 though, drug use was 59% HIGHER than in 2001. This represents a failure in Portugal's drug policy. ([go to pages 7 through 10](#))
- Use of any drug by high-school students aged 16 and over was 36% HIGHER in 2011 than it was in 2001, despite initial decreases up to 2006. ([go to page 10](#)) According to a separate ESPAD survey, use of cannabis by 16 year old high-school students was 59% HIGHER in 2015 than before decriminalisation. ([go to page 11](#))
- Claims that decriminalisation in Portugal was responsible for reduced opiate use fail to recognise that opiate use was already falling BEFORE July 2001, from 0.9% in 1998 to 0.7% in 2000. A successful opiate reduction strategy was already in place before decriminalisation. ([go to page 14](#))
- Claims that Portugal's drug use fell below European averages likewise fails to note that Portugal has always, other than for heroin use, been below European averages. In 2001, Portugal's drug use per capita was one-fifth that of Australia's. ([go to page 15](#))
- Those overdose deaths in Portugal which are directly comparable to Australian overdoses have INCREASED 59% since 2001. ([go to page 16](#))
- Reductions in HIV in Portugal are constantly attributed to the 'success' of decriminalisation. However, HIV notifications reduced from their 1999 high by 23% BEFORE decriminalisation even commenced, demonstrating that successful reduction policies were already in place before July 2001. ([go to page 19](#))
- Portugal, with no complaint from those who promote its drug policies, coerces rehabilitation. Australia would well do the same. ([go to page 19](#))
- Iceland has shown that its resilience-based education for school children can significantly lower drug use, as did our own Tough on Drugs. ([go to page 23](#))
- Portugal's decriminalisation has produced increased drug use and increased deaths. Tough on Drugs markedly reduced both. Extensive surveys of Australians show that they do not approve the use of illicit drugs, indicating that Australians want less drug use, not more. Portugal's drug policy has produced more drug use, not less. ([go to page 22](#))

WHY DRUG LEGALISATION MARKEDLY INCREASES DRUG USE

See Drug Free Australia's detailed document on how successful the prohibition of drugs has been, as well as how prevention approaches in Australia reduced our drug use successfully between 1998 and 2007. Read the page that exposes the false claim that the War on Drugs has failed in Australia for what it is – a very false claim.





WHY HEROIN ON PRESCRIPTION DOESN'T WORK

People who are addicted to heroin, a powerful opiate, often find their lives spiraling out of control as they need more and more of a costly drug which can only be sourced from criminals. Because of the phenomenon called 'tolerance' to heroin, a person needs more and more of the substance to be able to get the same 'high' as when they started. It then becomes a costly addiction.

These high costs force them into criminal activity – stealing, prostitution, drug dealing – to fund their 'habit'. And if there is no money to buy heroin, a drug user will swiftly begin to suffer withdrawal. If you want to know what that is like, just watch this short Ted Talk. Even though the person in this Ted Talk was not a heroin user, but rather a person using doctor-prescribed opiates, he still went through what any heroin user suffers when withdrawal symptoms start kicking in. And those withdrawal symptoms start showing themselves within 6-12 hours of their last opiate dose.

There are some who have argued that the best way to treat a heroin user's addiction is to have the government give them free or subsidised heroin. This is a similar approach to that taken by methadone maintenance programs except that methadone is synthetically made and much cheaper than the organic drug heroin. Also, each dose of methadone lasts longer than a dose of heroin, nor does it require injections (it is swallowed) as is most common with heroin, avoiding the constant damage to veins.

The proposed benefits of heroin on prescription are that users would no longer have to resort to criminal acts to fund their addiction and that they would continue with the program, as is not always the case with methadone, because they were being given their drug of choice. Claims were made that there are certain heroin users who are 'refractory' to any treatment option, who simply refuse to even try a methadone program or get off their drugs, and it was these users that heroin on prescription would help. It was also claimed that users could be assured of pure heroin rather than the heroin sold to them by criminals which may have harmful substances 'cut' with the heroin (however in our Australian experience there have been next to no deaths [see page 24 of this study] from other substances cut with heroin). Yet another false claim was that heroin on prescription would stop overdose deaths because it was claimed that many of these deaths happen because users, when buying from criminals, are having to inject in haste without being sure how pure the heroin is and how much of a dose they are really getting (in reality that is very little evidence that this ever happens [see page 23 of the this study]).

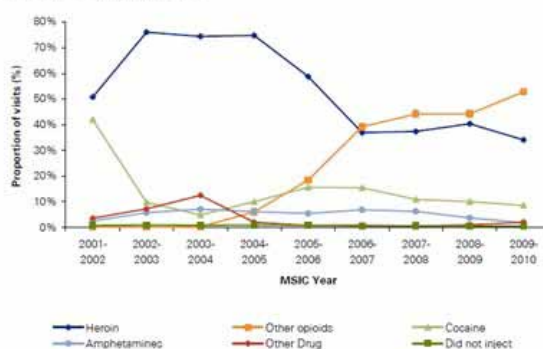
In 2009, a UK heroin trial was set up in which £15,000 per year was spent on supplying heroin and counselling/employment support to each heroin 'patient'. The results of that trial were that the researchers claimed they had successfully reduced their patients' crime, which had previously cost the community £15,600 per year in stolen goods or other like crimes, down to an average of just £2,600 of crime per year. Obviously, despite being given free heroin and all kinds of counselling and employment-seeking support, these heroin users were still committing crimes to find MORE heroin or other drugs which they could use with their heroin to enhance its effects. Nevertheless, the researchers made much of the

£13,000 lesser burden of crime for the £15,000 spent on each user, ignoring the fact that the taxpayer was still having to fund £2,000 per year for each user once the 'savings' were deducted.

In an article by a local London based journalist, criticism of the heroin trial was recorded. Gyngell wrote, "Steve Spiegel, a former 'hard core' addict now long term director of the Providence Project - the hugely successful abstinence based, low cost rehabilitation centre for those the system has failed, emailed me: "Next they'll be prescribing alcohol to alcoholics and crack to crack addicts! Who are these so-called experts? I'm not sure where they get their facts from regarding heroin users being the hardest to treat. This is certainly not our experience."

However, the best proof that heroin on prescription wastes public money is statistics from Australia where, since 2006 and an ongoing heroin drought, most heroin users have switched from using illegal heroin to the illegal use of prescription opiates. From the graph below taken from p 108 of an evaluation of the Sydney Medically Supervised Injecting Centre in 2010 you can see how 'Other opioids', which are prescription opiates represented by the yellow line, took over from heroin (the blue line) as the most-used kind of opiate by 2006-7.

Figure 8-1: Type of drug injected¹¹⁵



These opiates, such as Oxycontin or Endone, are prescribed medicines bought from any Australian pharmacy for people suffering chronic pain. So previous heroin users just simply make up some kind of illness that a doctor cannot really ever verify, and then ask a doctor for a prescription opiate to alleviate their 'pain'. After that these users 'doctor shop' by going to many doctors with the same unverifiable complaint, getting multiple prescriptions of government-subsidised opiates. Others who have not been able to get a prescription buy opiates off those who can.

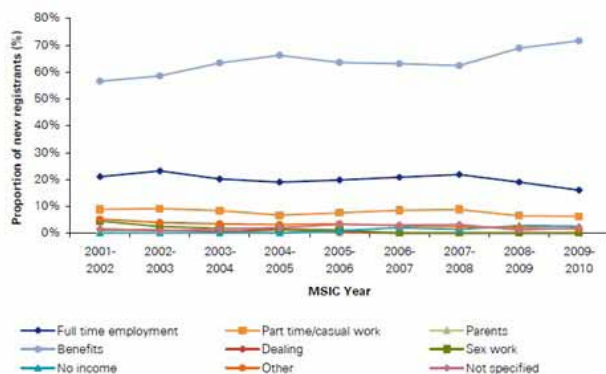
So rather than using impure, contaminated heroin (which as we have seen has caused few if any deaths in Australia) heroin users can live on prescription opiates while still committing crimes to buy heroin from criminals which they still believe is worth doing. This means that they are living on prescribed opiates as much as any 'heroin on prescription' trial, with all the supposed health benefits that a prescription trial offers except the counselling and employment support. However, as can be seen from the Table below of opiate deaths in Victoria, prescription (pharmaceutical) opiates are involved in roughly 80% of all opiate deaths in Victoria, showing that prescription opiates have not stopped people from dying from deadly opiates i.e. opiates are just as deadly whether they are on prescription or bought from criminals.

Table 2: Annual frequency and proportion of overdose deaths by contributing drug types, Victoria 2009-2016

Drug types	2009	2010	2011	2012	2013	2014	2015	2016
Overall frequency	379	342	362	367	380	387	453	477
Pharmaceutical	295	266	275	306	313	316	358	372
Illegal	147	149	153	133	166	164	227	257
Alcohol	94	85	88	80	94	94	106	118
Overall proportion	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmaceutical	77.8	77.8	76.0	83.4	82.4	81.7	79.0	78.0
Illegal	38.8	43.6	42.3	36.2	43.7	42.4	50.1	53.9
Alcohol	24.8	24.9	24.3	21.8	24.7	24.3	23.4	24.7

Added to all of these deaths is that the switch by most heroin users to prescription opiates has not given them the stability that was promised by prescription-heroin advocates to go and get off government unemployment benefits by finding a job. As can be seen from the same evaluation of the Sydney injecting room we have already cited (see p 64 instead) the number of opiate users in this centre, as per the grey line in the graph below, increased as the use of prescription opiates increased. In 2002, when all of the opiate users coming to the Sydney injecting room were using heroin, less than 60% were on government unemployment benefits, but by 2009 when prescription opiates were more popular than heroin, 72% were on benefits. Prescription opiates certainly do not lead to more stability and more jobs for users.

Figure 5-7: Main source of income of new registrants



It is clear from all of the statistics we have looked at that prescription opiates do not save lives, nor do they give opiate users the stability to obtain and hold good employment. This is a fail for prescription opiates.





HOW EFFECTIVE IS MEDICAL CANNABIS?

There have been many claims made about cannabis as a medicine, but it is the scientific studies that have been done with large groups of patients that give accurate information on its effectiveness.

Because cannabis is addictive and has its own withdrawal symptoms such as pain, muscle spasm, agitation, fits, convulsions and rheumatics, cannabis users often confuse its effect on its own withdrawal symptoms, thinking that it is an effective medicine for them. A heroin addict deprived of opiates for a day will likewise start suffering withdrawal symptoms within 6-12 hours of their last heroin use, experiencing fever, aching muscles, vomiting and diarrhoea. As soon as they get their next 'hit' all those things magically disappear, which can give the appearance, as with cannabis, that heroin alleviates fevers or aching muscles.

This is where tens of thousands of scientific studies have been done over the last 5 decades, and the most authoritative review of those tens of thousands of studies has been done in 2017 by the National Institutes of Health (NIH), formerly called the US Institute of Medicine (IOM). This enormous 460+ page review which is summarised by Drug Free Australia here was done by 31 of the United States' most eminent cannabis researchers, including those with very liberal views on recreational cannabis use. This means that its findings are not conservative, but reflective of a consensus of conservative and progressive reviewers.

There are a number of conditions which medical cannabis treats, but mostly not very well seeing as there are usually many other medications on the market for these conditions which patients prefer over medical cannabis.

Nausea and vomiting - with cancer chemotherapy can generally be controlled adequately with current methods. The drugs most commonly used and often effective are prochlorperazine and metaclopramide. Chief amongst the newer agents is the 5HT3 antagonists such as ondansetron, tropisetron and dolasetron, some of which can also be given as a sub-lingual wafer or by subcutaneous, intramuscular, or intravenous injection if needed so that vomiting itself does not stop their usefulness. Similarly prochlorperazine can be given by suppository. These medications can all be given by many routes of administration. Other medications can also be used including steroids where required.

Chronic pain - an extensive review completed in 2018 of 104 scientific studies comprising 10,000 chronic non-cancer pain patients found that "It seems unlikely that cannabinoids are highly effective medicines for chronic non-cancer pain." Because medical cannabis is no stronger than codeine in managing pain, they recommended that it be used only as an 'adjunct' medicine, used to support other more effective medications such as opiates.

AIDS wasting – as noted by Australia21 representative, Alex Wodak, in a paper sent to Parliamentarians in July 2014, this indication is disappearing due to the efficacy of the newer treatments for AIDS.

Multiple Sclerosis - there are other treatments for MS stiffness. In particular recent advances in immunology have meant that the treatment of MS itself has dramatically improved in recent times with several newer options including teriflunomide, dimethyl fumarate, fingolomod and dalfampridine. Benzodiazepines, Lioresal, several anticonvulsants and local Botox can all find application when spasm is a problem.

Childhood epilepsies - this is an area where medical cannabis has been found to be effective and for which no other medicines measure up. Using an isolated constituent of cannabis (a cannabinoid) called Cannabidiol or CBD, researchers have found that for children suffering from Dravet's syndrome, Lennox Gastaut's Syndrome or Tuberous Sclerosis Complex (TSC) seizures from these conditions were reduced for 45% of those studied, with some children having all seizures stopped, while others' condition was curiously made worse by Cannabidiol.

Tourette's syndrome - this is a condition where a person has a nervous 'tic' and medical cannabis was found to have a small effect in reducing these tics.

Other than some conflicting evidence of cannabis' effect on post-traumatic stress disorder, these were the only conditions which showed good scientific support for effectiveness. There have been many other medical conditions for which medical cannabis has been claimed to be effective, but when proper scientific trials are done with patients it is found not to be effective at all, or even to make the condition, such as glaucoma, worse.

Given that medical cannabis has recently been found NOT to be particularly effective for chronic pain, the question must now be asked as to why so many people who are medical cannabis patients have it prescribed for chronic pain. The answer is fairly straightforward.

90-94% of medical cannabis patients in various US states access medical cannabis for chronic pain, and when it is now so well proven that medical cannabis does little for chronic pain the profiles for regular chronic pain patients need to be compared to the profiles of US medical cannabis patients. They are sharply different. A majority of regular chronic pain patients are women mostly in their 80s while men are in their 60s. Medical cannabis chronic pain patients are 75% men with an average 32 years of age, who mostly commenced cannabis use as teenagers. This suggests that medical cannabis for most is just a cheap form of recreational use accessed by ruse. Doctors, of course, cannot objectively verify chronic pain (there are no testing instruments to measure it), relying on a patient's own descriptions which they cannot verify with tests. So for pain management, medical cannabis is a scam being used by cannabis users to get cheaper access to cannabis for recreational use and at the same time to use it 'legally'.

Australians want less drug use, not more, so the government is trying to ensure that medical cannabis patients get it for the right reasons.

