Constant increases in drug-related deaths under Australian Harm Reduction policy

DRUG FREE AUSTRALIA

This document demonstrates that Australia's introduction of Harm Reduction interventions under its 'Harm Minimisation' drug policy consistently correlated with sharp increases in drug-related deaths from all illicit drug types. In the absence of viable confounders this suggests a causal relationship between Harm Reduction policies and increased harm and mortality.

The document then examines scientific studies and population statistics related to Harm Reduction's existing interventions, examining how each contributes to rising mortality tolls in every jurisdiction that has sought to implement them.

Each of these Harm Reduction interventions demonstrates a track-record of ineffectiveness while increasing drug use, harm and mortality.

This document seeks to be comprehensively evidenced and media or casual readers are encouraged to review the Executive Summary.


The Science consistently demonstrates constant increases in drug-related harm and deaths under Australia's Harm Reduction

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Executive Summary

Australia's Harm Reduction track-record

Australia moved to a Harm Reduction framework called Harm Minimisation in 1985, the world's leader with its novel Harm Reduction approach. ***Under its patronage illicit drug use went to the highest levels in the OECD developed world by 1998***, effectively double that of almost any OECD nation. Opiate overdose deaths peaked in 1999 at 7 per 100,000, with the media clamouring for change.

In 1998 the Tough on Drugs policy commenced, giving drug prevention, rehabilitation and drug interdiction precedence over harm reduction. Use of any illicit drug decreased 39%, with opiate deaths reducing by 67% (2.2 /100,000) through to 2007.

In 2007, Tough on Drugs was scrapped, with Harm Reduction again given the ascendency. Illicit drug use increased 34% by 2022, ***and opiate deaths increased back towards pre-Tough on Drugs levels at around 5.75/100,000, two-and-a-half times higher than 2007.***

The pattern of sharp increases in drug use and drug related deaths under a predominant Harm Reduction approach holds true for every illicit drug type, as well as alcohol use. The boom-bust-boom pattern holds for all.

Unacceptable levels of harm

In the absence of any viable confounders, Australia's experience with Harm Reduction suggests causality in regards to increased use and deaths, and demonstrates that Harm Reduction does produce unacceptable levels of harm.

Of course, the increases in drug-related mortality inevitably go hand-in-hand because drug use will always create more harm and mortality - if it didn't there would be no need for Harm Reduction programming. Even the very nomenclature of 'Harm Reduction' tacitly concedes this equation of unacceptable harm.

Because Harm Reduction interventions have consistently failed to decrease actual drug harms, Australia has been the beneficiary, under any ascendent Harm Reduction policy, of demonstrably increased drug-related mortality and other harms.

The seeds of HR failure lie in its derogation of drug prevention, where, as for shoplifting, it is happy for people to be educated it is harmful, while not tolerating a finger lifted against it. This is the internal dynamic of Harm Reduction's failure and increased use and harm.

All Harm Reduction interventions ineffective

This document demonstrates that each of the major Harm Reduction programs/interventions, from their own science or statistics, is ineffective and harm-producing. These interventions are thereby unable to actually reduce the harms they are tasked with suppressing. In a section by section examination of empirical evidence, this will be shown to be consistently true.

Opiate Substitution Therapy (OST)

The 2009 Cochrane Collaboration gold-standard review of 11 OST Random Control Trials found no statistically significant advantage for methadone maintenance as compared to no treatment for reductions in either criminality or mortality. These are the very things it is meant to reduce.

A 2017 Cochrane Collaboration examination of OST in reducing Hepatitis C (HCV) transmission could only make conclusions from 28 studies where almost all had either an adjudged 'serious' or 'critical' risk of bias. Any findings from that review must be moderated by the authors'

own determinations of bias for those studies. This measure extends drug-use careers, harm and mortality.

Needle & Syringe Programs (NSP)

The world's most prestigious 2007 review of NSPs by the US Institute of Medicine, which a decade before had expressed enthusiasm for the intervention even before adequate scientific studies had been completed, concluded that the science regarding HIV transmission reductions was 'limited and inconclusive' and that studies demonstrated no effectiveness with HCV.

It further found that 'ecological' studies cannot establish causality for NSPs, a determination which immediately disqualifies Australia's two most prominent studies claiming NSP effectiveness with both HIV and HCV transmission reductions.

The aforementioned 2017 Cochrane Collaboration review which also examines NSP impact on HCV found not one study not at serious or critical risk of bias. Furthermore, Australia's most prominent Harm Reduction advocates lament the failure of NSP to reduce HCV, at levels generally not superior to other countries.

NSPs likewise prolong drug-use careers, subjecting users to many added years of mortality risk from drug overdose or blood-borne virus illness.

Injecting Rooms

There is only one defensible review of injecting rooms worldwide that selects rigorous studies of quasi-experimental design. All other reviews, consequently scientifically invalid, are based on loose service evaluations of such facilities worldwide.

The RAND review found 5 studies that passed the test for rigour, while being unaware that the Vancouver study of reduced overdoses around its injection facility has been previously discredited, with abundant evidence demonstrating that policing changes were responsible for overdose reductions, not the facility.

A second Sydney study claiming that its injection facility had markedly reduced ambulance overdose callouts is likewise falsified by the study's own internal data, where reductions in callouts were significantly greater at night when the injecting room was closed. Again changed policing with sniffer dogs, most active at night, was very evidently the cause.

Data from the Melbourne injecting room shows that it failed to meet its legislated objectives, while hosting drug overdoses 102 times greater than on the street, evidencing experimentation by clients with bigger doses of heroin and cocktails of dangerous drugs. The facility also fails to save any lives at the population level.

Injecting rooms keep users addicted, prolonging drug using careers which extend the risk of harm and death.

Pill testing

Of the 392 MDMA related deaths between 2000 and 2018 in Australia, pill testing fails to address the real causes of such pill deaths in this country. Pill testing cannot identify those who will die from allergic-like reactions (14%), or those who will co-use ecstasy with other legal or illegal drugs (48% of deaths), or those who are accident-prone while intoxicated (29% of deaths).

There have only been 3 'bad batch' deaths over those years, implicating MDMA as the drug responsible for almost every Australian ecstasy death. Yet Pill Testing greenlights ecstasy in a pill, giving the thumbs-up to a killer drug. This will keeping adding to our mortality toll.

Drug Decriminalisation

The experience of Portugal, which started the worldwide rush to decriminalising the use of all illicit drugs in 2001, demonstrates why this Harm Reduction measure will significantly add more drug-related mortality and harm.

Portugal's adult drug use increased 59% by 2016, with use by high-school minors shooting up by 80% by 2011, but in 2019 back to 24% above 2001 levels. Overdose mortality though, is going exactly the same way as Australia's under a predominant Harm Reduction, showing that decriminalisation will add to death tolls.

Drug Legalisation

Colorado created loose medicinal cannabis laws in 2009, legalised recreational cannabis use in 2013, and by 2015/16 had seen a doubling of adult cannabis use, a 360% increase in cannabis-related hospitalisations, a 230% increase in cannabis-related road deaths and a 410% increase in cannabis-related suicides. All this while-the black market for cannabis mushroomed. This Harm Reduction measure increases death tolls.

We know exactly what works

We examine the drug prevention results of four countries:

Sweden	- reduced student illicit use **80%**
Iceland	- reduced student illicit use **60-90%**
Australia	- reduced illicit all-ages use **40%**
USA	- reduced student use **50-70%**

The 2022 survey of 21,000 Australians and their attitudes to illicit drug use shows they want less drug use, not more. Of the drugs that Harm Reductionists want to decriminalise, 99% of Australians do not give their approval to the use of heroin, 99% to use of speed and ice, cocaine (97%) and ecstasy (95%).

Again, Australians clearly want LESS drugs, not more.

All we lack is the political will . . .

The track-record of Australia - Harm Reduction world leader

Australia led the world in Harm Reduction

As per the text of the Guardian article copied below, Australia led the world in 1985 in initiating a Harm Reduction national drug policy for its citizens.

As the article describes, its concept of Harm Reduction or 'Harm Minimisation' in 1985 was novel to UN participant countries. The Guardian records:

On 2 April 1985, the then prime minister, Bob Hawke, convened a meeting in Canberra with all six state premiers and the chief minister of the Northern Territory. The special premier's conference, usually


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Opinion
Drugs policy

This article is more than 9 years old

Australia's drug policy led the world 30 years ago. Now politics holds us back
Alex Wodak

Thu 2 Apr 2015 10.48 AEDT

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On the 30th anniversary of a drug summit that led to the adoption of harm minimisation in drug policy, it's disconcerting to note that this field is now more politicised than ever

'The Howard government was the first to provide commonwealth funding to the states and territories to support their needle syringe programs.' Photograph: David Cheskin/PA

referred to as the "drug summit", was said to be the first meeting of the prime minister and premiers since the second world war to discuss anything other than finance. Of the eight governments represented, five leaders (Hawke; Neville Wran, NSW; John Cain, Victoria; John Bannon, SA, Brian Burke, WA) represented Labor governments while three leaders (Joh Bjelke-Petersen, Queensland; Robin Gray, Tasmania; Ian Tuxworth, NT) represented National or Liberal party governments.

One of the items raised and approved at the drug summit, along with a raft of other decisions, was a proposal to adopt "harm minimisation" as Australia's official national drug policy. This decision was to have far reaching repercussions.

When Australia adopted harm minimisation in 1985, both the term and the concept were novel in other countries and in the UN system. But harm reduction, the preferred term outside Australia, has now become the mainstream global drug policy with all of the major UN organisations responsible for drug policy, as well as international organisations like the Red Cross. While there are still some exceptions to this trend, in countries such as Sweden, Russia and Saudi Arabia, and in a few minor UN organisations with responsibility for drug policy, these are diminishing. And while US officials are still required to avoid using the term "harm reduction", US opposition to harm reduction is also declining.

In summary, Australia's world-leading Harm Reduction policies have been in place for 40 years and have led to the world following suit, with Harm Reduction now central to the drug policy of most nations across the world.

Australia becomes drug-use world leader

Australia statistically tracks many aspects of its drug policy, making Australia a central case study for the success or failure of Harm Reduction policies.

From the first implementation in 1985 of the new Harm Reduction policy, use of the most predominant drugs according to the National Drug Strategy Household Surveys showed very substantial increases between 1988 and 1998, where 1998 was the survey in which drug use peaked at its highest levels. Metropolitan use increased as follows:

- **Amphetamine** increased 500%
- **Cannabis** increased 300%,
- **Cocaine** increased 400%
- **Ecstasy** increased 750%
- **Heroin** increased 300%

(using heroin deaths as a proxy for use in 1988 in the absence of a percentage).

Regional use saw increases that were not as substantial as for Australian cities, but nevertheless as high as 300% for some drugs.

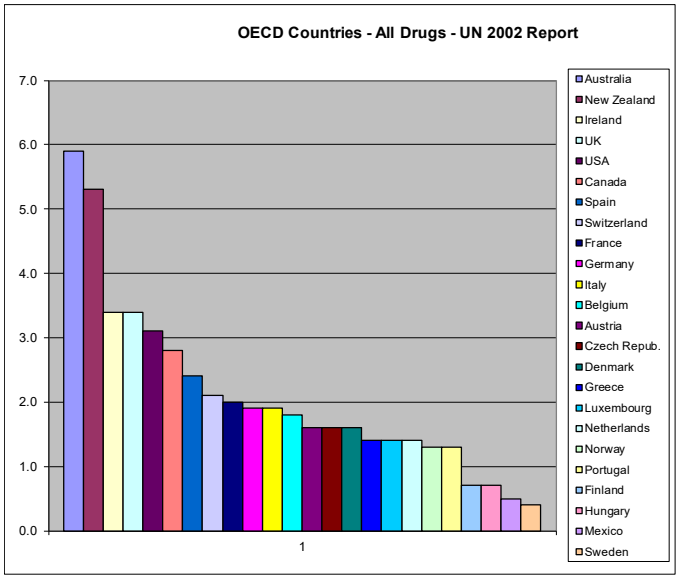
Table 2: *Standardised[a] rates of recent use of licit and illicit drugs in the past 12 months, by region, Australia, 1988–1998 (%)*

	Year of survey				
Substance	**1988**	**1991**	**1993**	**1995**	**1998**
Metropolitan					
Amphetamines	1.0	2.9	2.1	2.6	4.8
Barbiturates[b]	0.9	1.6	0.4	0.2	0.4
Cannabis	8.1	15.6	15.1	15.5	24.7
Cocaine	0.4	0.8	0.6	0.7	1.6
Ecstasy	0.4	1.3	1.4	1.4	3.0
Heroin	n/c	0.5	0.2	0.4	0.9
Inhalants	0.4	1.1	0.6	0.7	1.4
Injecting	0.5	0.6	0.6	0.7	1.1
LSD	0.9	2.2	1.7	2.1	4.4
Methadone[c]	n/c	n/c	n/c	n/c	0.3
Painkillers[b]	38.6	76.2	2.1	3.8	6.2
Steroids	n/c	n/c	0.1	0.1	0.2
Tranquillisers[b]	7.9	9.6	1.0	1.0	3.5
Regional					
Amphetamines	0.0	2.0	1.5	1.1	3.3
Barbiturates[b]	0.5	0.8	0.0	0.2	0.1
Cannabis	7.3	12.1	**10.5	**10.9	*18.7
Cocaine	0.0	0.6	0.0	0.4	1.2
Ecstasy	0.0	0.8	**0.3	0.2	2.2
Heroin	n/c	0.0	0.0	0.2	0.8
Inhalants	0.5	0.8	0.3	0.2	0.8
Injecting	0.0	0.0	0.5	0.4	0.7
LSD	0.0	0.8	0.8	**0.7	**0.3
Methadone[c]	n/c	n/c	n/c	n/c	0.0
Painkillers[b]	26.9	72.4	0.8	3.5	4.7
Steroids	n/c	n/c	0.0	0.2	0.0
Tranquillisers[b]	4.5	10.5	0.5	0.4	**2.2

Notes:
(a) 1991 persons 14+ years standard population
(b) 1988–1991 questions did not distinguish between medical and non-medical use
(c) diverted methadone
* p<0.01
** p<0.05
n/c = data not collected in that year

Australia's drug use against other OECD countries by 1998 made it the world leader amongst developed economies, as per the following graph (where Australia's 1998 data was the latest available for that United Nations' 2002 report) which shows an aggregated average of the five main illicit drug types. New Zealand followed in second place, having also adopted harm reduction programming with needle exchanges first opening in 1987.

Given the isolation of both countries, with no common borders shared with other nations,



the increased drug use in both early-initiating Harm Reduction nations is extraordinary.

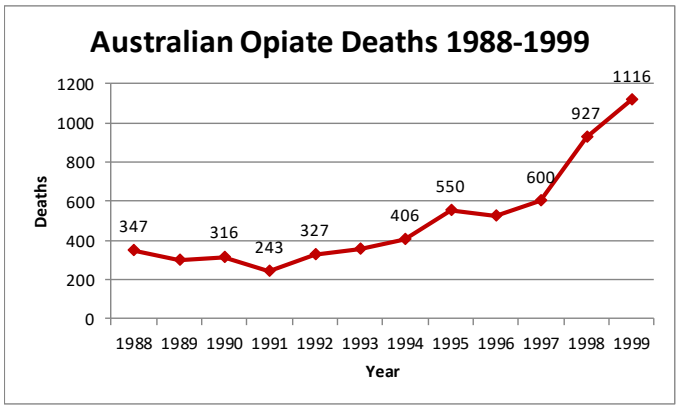
In contrast, the USA and UK, predominantly the homes to the 1960s counter-culture movement that spawned the resurgence of illicit drug use after 50+ years of negligible drug prohibitionary use, were significantly below the Oceania countries.

Note from the graph that almost every OECD country has less than half Australia's drug use. Sweden, which had virtually no Harm Reduction programming and a zero tolerance approach to illicit drug use, had the lowest use.

High drug use matched by high mortality

The enormous increases in drug use under the initial phase of Harm Reduction were matched by exponential increases in drug-related deaths, particularly with opiates. Heroin supply was plentiful and therefore cheap leading to a sharp uptake of the drug in the late 1990s.

These statistics became the centre of media attention by 1999, the year when opiate-related deaths peaked at 1,116 deaths for the year as per the graph below.



Tough on Drugs - 1998 to 2007

The very marked, accelerating Harm Reduction statistics for both use and deaths were entirely reversed by the time the 2001 Australian National Drug Strategy Household Survey was conducted.

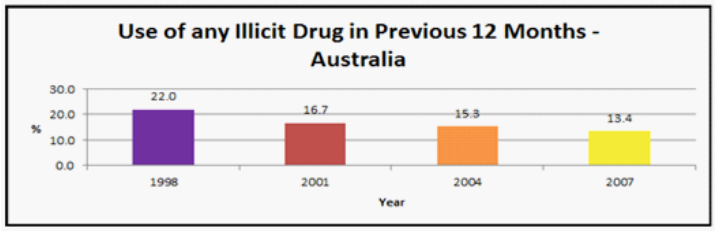
Those reversals were the result of the Howard Federal Government, elected in 1996, implementing a central focus on drug prevention while nevertheless preserving the existing Harm Reduction programming. The name of the new drug policy mix was Tough on Drugs.

An excellent description of Tough on Drugs from the 2008 UNODC report on Australian drug policy notes:

> *The strategy strengthened supply and demand reduction activities, improved and clarified community messaging, and increasingly built on research and evaluations to guide policy development. In parallel, the establishment of the Australian National Council on Drugs helped to incorporate the know-how of the community of experts working in the various fields of drug control at the federal level and in the various States. Significantly, it helped to substantially increase the overall drug budget for the implementation of the Federal Australian Government's strategy (AUD$1.3 billion over the 1998-2005 period). The total anti-narcotics budgets of the national and state governments was estimated at AUD$3.2 bn in the fiscal year 2002/03, equivalent to 0.41% of GDP (up from some 0.1% of GDP a decade earlier), one of the highest such proportions among the industrialized countries (almost three times as much as the West European average (0.15%) and close to the ratios reported from the USA (0.47%). Australia also experimented successfully with rather broad powers of the police and the establishment of drug courts.*

1998-2007 - Tough on Drugs decreases use

The new spending and public messaging on drug prevention and rehabilitation in Australia led to decreases in illicit drug use by 39%.



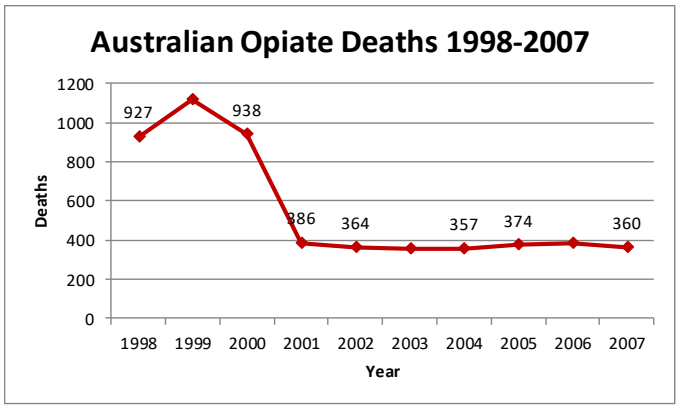
The NDSHS report for 2010 heading the next column provides a comprehensive table detailing these reductions in use. There can only be conjecture on significantly greater decreases without the dynamics of Harm Reduction running interference.

Table 2.1: Summary of recent[a] drug use, people aged 14 years or older, 1993 to 2010 (per cent)

Drug/behaviour	1993	1995	1998	2001	2004	2007	2010
Illicit drugs (excluding pharmaceuticals)							
Cannabis	12.7	13.1	17.9	12.9	11.3	9.1	10.3
Ecstasy[b]	1.2	0.9	2.4	2.9	3.4	3.5	3.0
Meth/amphetamines[c]	2.0	2.1	3.7	3.4	3.2	2.3	2.1
Cocaine	0.5	1.0	1.4	1.3	1.0	1.6	2.1
Hallucinogens	1.3	1.9	3.0	1.1	0.7	0.6	1.4
Inhalants	0.6	0.4	0.9	0.4	0.4	0.4	0.6
Heroin	0.2	0.4	0.8	0.2	0.2	0.2	0.2
Ketamine	n.a.	n.a.	n.a.	n.a.	0.3	0.2	0.2
GHB	n.a.	n.a.	n.a.	n.a.	0.1	0.1	0.1
Injectable drugs	0.5	0.5	0.8	0.6	0.4	0.5	0.4
Any illicit[e][g]	14.0	16.7	22.0	16.7	15.3	13.4	14.7

Tough on Drugs - 67% decrease in mortality

The graph below from official Australian mortality statistics shows the effect of Tough on Drugs on opiate overdoses, a 67% drop in deaths, significantly greater than the overall decrease in mortality for ***all*** illicit drug types as per NDARC Drug Trends on the following page.



Tough on Drugs had particularly targeted the Asian heroin trade, introducing a heroin drought to Australia from which the heroin trade has never really recovered.

What is highly signoificant about the Tough on Drugs era is the very apparent reversal of Australia's drug 'problem' as it was then positioned by the Australian media.

Tough on Drugs' reversals of HR increases

From 1985 to 1999 there had been a very evident acceleration in opiate-related deaths, where Harm Reduction policies had been associated with exponential increases in illicit drug use and exponentially increasing drug-related deaths and harm, the very thing it was tasked with reducing. This was failure on any accounting.

With the introduction of Tough on Drugs and its more intentioned strategy of drug prevention there was a dramatic and instant reversal in drug use, and after 1999, when the Tough on Strategies really began to bite, an immediate and dramatic reversal in drug-related deaths.

There will always be the objection that correlation is not causation, but in the absence of any viable

confounder producing these reversals, it should also be remembered that wherever there is causation there is also correlation. Causality is thereby suggested.

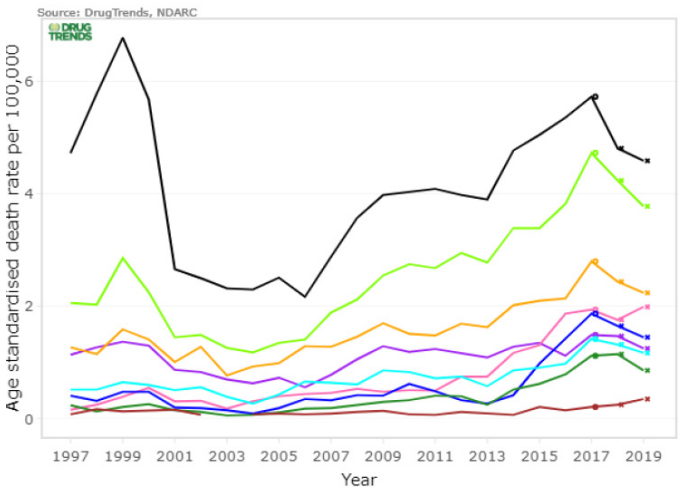
Prevention policies are an efficient and sufficient cause, which have been proven in countries like Sweden and Iceland, to produce exactly the same reversals experienced by Australia. The graph in the next column, where opiate-related deaths (black line) are adjusted per capita year by year, demonstrates just how significant was that sharp reversal of trajectory.

2008-2017 - the accelerating dynamic returns

With the newly elected Rudd Federal Government scrapping Tough on Drugs in 2008, the same dynamic of accelerated harm is very apparently back in play as per the graph in the next column. This replicates the sharp and accelerating increases in drug deaths that typified the pre-Tough on Drugs policy regime.

Harm Reduction - the tide that lifts all boats

Countering once again the objection that the reversals in opiate deaths may have been more to do with opiate markets than Tough on Drugs, the following graph topping the next column shows the same trend across every illicit drug - HR lifts all boats and prevention does the opposite with all drugs. Decreases start in



1999 and increases resume in 2008 when the well-funded prevention emphasis was removed to concentrate rather on binge alcohol consumption.

Providing an overall summary, see the comprehensive graph below adapted from

http://doi.org/10.26190/g2bk-t998

DRUG TRENDS

Drug-Induced Deaths

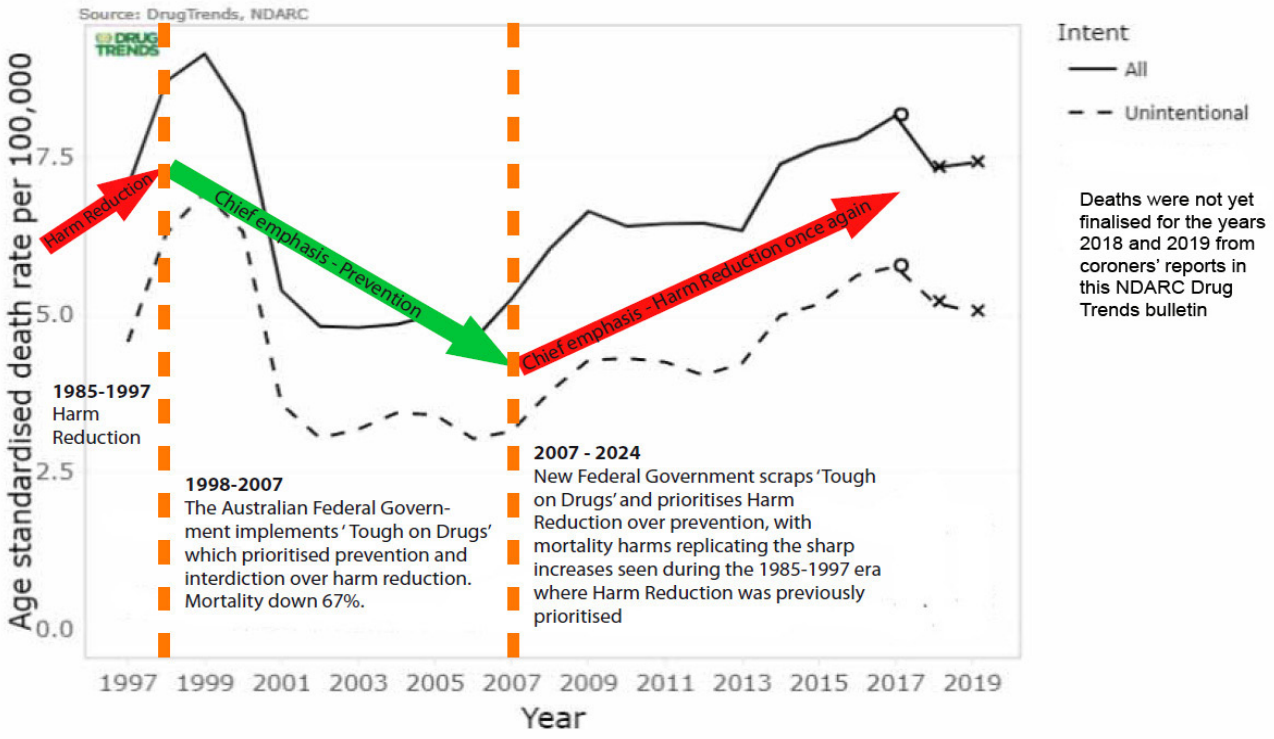


Figure 2. Age-standardised rate (per 100,000 people) of drug-induced deaths for the Australian population, by intent, 1997-2019.

the official NDARC report on drug-related deaths in Australia.

Why does Harm Reduction produce harm?

Australia's, as the initial world leader in implementing the new approach of Harm Reduction, has seen substantially increased drug harm whenever it has been given drug policy ascendency.

Because the Tough on Drugs era acted as an effective control, sandwiched between two time-periods where Harm Reduction was given priority over prevention, in the absence of suggested or viable confounders there is an incontrovertible relationship between Harm Reduction and increased harm and deaths.

The conclusion must be that Harm Reduction generates increased harm. There is therefore a dynamic at play within its founding philosophy and practice which seeds accelerated harm.

The rest of this document will analyse, via its variety of ideological programming, why Harm Reduction is producing the very opposite of what it purports to counter - greater harm and increased mortality counts.

Harm Reduction ideology

Prevention of drug use not its interest

The International Harm Reduction Association is the peak Harm Reduction body globally.

It best defines what Harm Reduction seeks to achieve and has historically asserted that its emphasis is on the prevention of drug harm "rather than the prevention of drug use itself." The screen shot below is of their website definition dating from 2016.

What is harm reduction?

A position statement from Harm Reduction International

Harm reduction refers to policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs.

The latest definition by the IHRA has conveniently dropped the "rather than prevent" juxtaposition, suggesting that the IHRA has suffered some level of discomfit regarding general community reaction to its outright disinterest in drug prevention.

WHAT IS HARM REDUCTION?

Harm reduction refers to policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws.

This reaction is based on a perception that the Harm Reduction movement is sympathetic to illicit drug use, something they have vehemently denied for decades until only recently. It is now abundantly evident that perception was always correct.

With Harm Reduction organisations worldwide now out of the drug policy closet, where hiding their pro-drug-use credentials had been their stock in trade, they now boldly back cannabis legalisation and drug decriminalisation as faux "harm reduction" measures.

The suspicion that they were always pro-drug-use had been due to their "war on drugs has failed" slogan which suggested that they were comfortable with nothing more than drug prevention education, equivalent to education programs that shoplifting is harmful, while not being willing to lift a finger against it.

So with the Harm Reduction movement's pro-drug philosophy, and their promotion of a drug user's 'right' to use drugs - a right that is recognised by nobody other than drug users and their Harm Reduction cheer squad - it would reasonably be expected that drug user numbers will increase under a Harm Reduction policy, matched by greater numbers of drug-related deaths sheerly as a reflection of increased drug user numbers.

Yet paradoxically, 'Harm Reduction', by its very nomenclature, agrees that illicit drugs present unacceptable harms to the user and those in the community that surround them. If not, there would be no aspiration for Harm Reduction to reduce harms.

It is precisely all of those inner contradictions and dynamics which drive the Australian dilemma with its harm reduction policy failures which have correlated with escalating drug-related deaths. Harm Reduction contains the seeds of its own failure - an internal dynamic not necessarily influenced by outside forces.

The remainder of this document will analyse that dynamic as it plays out in the various HR interventions.

Opiate Substitution Therapy

Adding to the mortality toll

This chapter describes reliable scientific reviews of random control trials which finding that Opiate Substitution Therapies (OSTs) fail to demonstrate effectiveness in reducing mortality or criminality, nor HIV or Hepatitis C (HCV) transmission. All of these are their primary purpose. They also demonstrate that significant percentages of patients still purchase and use heroin, thereby signalling why deaths continue to spiral upwards under Australian Harm Reduction policies.

Controlled trials don't support effectiveness

Cochrane Collaboration reviews are recognised as the gold standard for systematic reviews worldwide, only reviewing studies that can demonstrate scientific rigour.

In 2009, the the gold standard Cochrane Collaboration review of 11 Random Controlled Trials of methadone maintenance, some double-blinded with placebo, found that, when compared to no treatment at all:

"methadone was 'not statistically different in criminal activity or mortality."

In other words, methadone patients die at similar rates to heroin users, with similar criminal activity.

It is notable that the lead researcher for this review was Dr Richard Mattick, former head of the Australian National Drug and Alcohol Research Centre (NDARC) at NSW University, an ardent harm reductionist.

It is true that methadone was found more effective than other approaches in retaining patients in treatment and for suppressing heroin use, both of which are entirely to be expected when supplying users with a cheap supply of opiate in place of far more expensive heroin. Akin to giving heavily-discounted alcohol to alcoholics, there can be no mystery in retaining patients or suppressing other alcohol purchases.

Results suggest even more are using heroin

Nevertheless, other studies indicate that up to 45% of methadone maintenance patients are still purchasing and using illegal heroin, but with methadone's "chemical handcuffs" prolonging opiate use for up to 30-40 years, the chance of contracting HIV or Hep C accumulates, while not an issue for those who seek and achieve recovery.

With the 2009 Cochrane Collaboration review finding that methadone maintenance fails to improve overdose mortality and criminality outcomes it appears clear that use of heroin may be considerably under-reported in study groups.

From the Cochrane review by Mattick et al, the included studies show that a varying percentage of methadone patients still use heroin, with one study finding 73% still using the substance. High heroin use

Analysis 1.3. Comparison 1 Methadone maintenance treatment vs No methadone maintenance treatment, Outcome 3 Self reported heroin use.

Review: Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence

Comparison: 1 Methadone maintenance treatment vs No methadone maintenance treatment

Outcome: 3 Self reported heroin use

Study or subgroup	Methadone MT n/N	Control n/N	Risk Ratio M-H,Random,95% CI	Risk Ratio M-H,Random,95% CI
Dolan 2003	41/129	92/124		0.43 [0.33, 0.56]
Dole 1969	2/12	15/15		0.20 [0.06, 0.61]
Gruber 2008	30/41	15/24		1.17 [0.82, 1.68]
Gunne 1981	5/17	12/17		0.42 [0.19, 0.93]
Kinlock 2007	28/70	39/64		0.66 [0.46, 0.93]
Yancovitz 1991	21/75	83/94		0.32 [0.22, 0.46]

0.01 0.1 1 10 100

Favours methadone Favours control

percentages are corroborated by other studies.

Because it is not possible - as with Naltrexone maintenance with its 'Naltrexone challenge' to test abstinence from heroin - to obtain any objective measure for methadone maintenance - the poor results from rigorous studies only further deepens the dilemma of failure for opiate maintenance.

2017 inferior Cochrane Collaboration review

In 2017 a worldwide team of Harm Reduction researchers completed a Cochrane Collaboration review of Opiate Substitution Therapy (OST) and Needle & Syringe Program effectiveness, this time focusing on HCV transmission.

While adhering to the strictures of Cochrane Collaboration review procedure, which demands that studies be judged for their level of bias and that same adjudged bias clearly delineated and declared, the 2017 team made conclusions regarding Opiate Substitution Therapy that derived from loose scientific studies with a very high risk of bias through poor study design.

Comparisons with the 2009 HIV review

Studies that were included in the 2017 HCV review were a number with snowball recruitment processes (Nolan 2014, Craine 2009, Bruneau 2015 [unpublished], Judd 2015 [unpublished]), where those already enrolled in the trial recruited their peers. This kind of recruitment bears no comparison to previous studies that were double-blinded and in some cases placebo controlled.

Normally studies that have a high risk of bias are excluded from adjudged results in Cochrane Collaboration reviews, however the researchers in this particular review were content to say in the text of their review that of the 28 studies chosen to contribute to their findings that,

"We judged only two studies to be at moderate overall risk of bias**, while **17 were at serious risk** and **7 were at critical risk**; for two unpublished datasets there was insufficient information to assess bias. **As none of the intervention effects were generated from RCT evidence, we typically categorised quality as low."

Clearly, as compared to the 2009 Cochrane Collaboration HIV transmission review using ***only*** Random Controlled Trials, the 2017 HCV review used ***not one*** RCT.

RCT trials are eminently just as possible for studies on OSTs reducing HCV as they are for HIV (11 RCT studies by 2009). When such RCTs have been completed, then will be the time for a valid Cochrane Collaboration review.

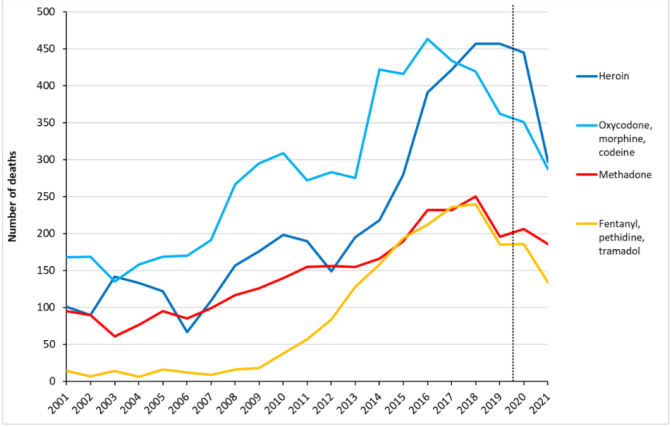
With only two studies out of 13 included in their 2017 OST review having a moderate risk of bias, where many reviewers would have simply refused to perform the review on the basis of only two acceptable studies lacking sufficient power, the 2017 Cochrane Collaboration review can't be considered of any real scientific merit.

The best conclusion that can be made about the 2017 review of 13 OST studies on HCV transmission is that the results carry a heavy risk of bias and therefore cannot be scientifically relied on.

Final word - OST part of the mortality problem

For any benefits that Harm Reductionists have imagined for substitution therapies, the graph below, which is limited by use only of raw numbers of opioid deaths rather than the more reliable per capita counts, demonstrates that OST is part of Australia's increasing mortality problem. The orange line represents opioid deaths in which methadone was involved, where 2018 represents the peak at 250 deaths. This is nothing but failure at every level.

Figure 29. Number of unintentional drug-induced deaths by opioid type, 2001-2021



Note: Data to the right of the dotted line (2020 and 2021 data) are preliminary, and likely to rise.

Needle & Syringe Programs

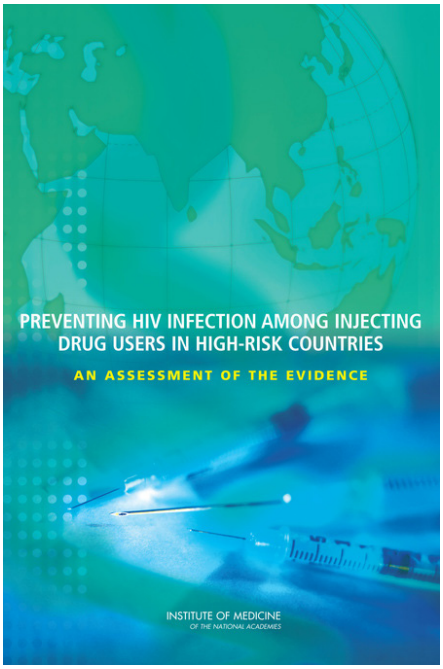
NSP - no demonstrated positive effect

The most prestigious review of Needle & Syringe Programs (NSPs) in 2007 found the evidence for their effectiveness in reducing HIV transmission "limited and inconclusive" and ineffective in reducing Hepatitis C (HCV).

Two later reviews used either flawed studies or studies with serious or critical risk of bias. Two heavily-hyped Australian studies used designs incapable of establishing causality. Furthermore, all studies that have claimed effectiveness of some kind are countered by population level indicators of ineffectiveness.

The most extensive and prestigious review

In 2007 the prestigious US Institute of Medicine (IOM), with its extensive panel of 24 scientists, medical practitioners, and reviewers did a comprehensive review of the literature on needle exchanges.



In their late 1995 review of needle exchanges, the IOM had noted the poor design and lack of rigour in most of the studies on the effectiveness of NSPs to that time, but nevertheless advocated for their implementation in the United States, signalling that they were sympathetic to the intervention even before the evidence was in. This bias toward harm reduction makes their later 2006 conclusions against the effectiveness of NSP important.

Almost all rigorous studies on Needle and Syringe Programs have been done between 1995 and 2005, which allowed the IOM to better review NSP effectiveness in reducing HIV and HCV (Hepatitis C) in their 2005 Geneva Conference.

While the IOM report found that *multi-component programs* which contained needle exchanges were effective in reducing self-reported risk behaviours, the IOM review, when considering the effectiveness of NSPs *alone* found (page 149) that:

- ***"evidence regarding the effect of needle and syringe exchange on HIV incidence is limited and inconclusive"***
- ***"ecological studies monitor populations rather than individuals, and therefore cannot establish causality" for NSPs***
- ***"multiple studies show that (needle exchanges) do not reduce transmission of (Hepatitis C)."***

It is abundantly clear that if NSPs are ineffective with HCV, where there is a large pool of infected users transmitting Hep C via shared needles and equipment, then the failure of NSPs to stop the high rates of shared needles and equipment must logically be as ineffective against HIV as it is against HCV.

False claims for NSP and HIV prevention

The fact that Australia has low rates of HIV transmission can be easily explained by the initial small

pool of infected users, by the success of Australia's Grim Reaper television advertising campaign, and to high rates of freely available HIV testing.

In fact, Dr Alex Wodak, the doctor responsible for introducing NSPs within Australia lamented the ineffectiveness of NSPs with HCV in this country, where rates are little different to other countries of the world with no NSPs. His 1997 MJA article titled "Hepatitis C: Waiting for the Grim Reaper" made the following telling points:

"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."

"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."

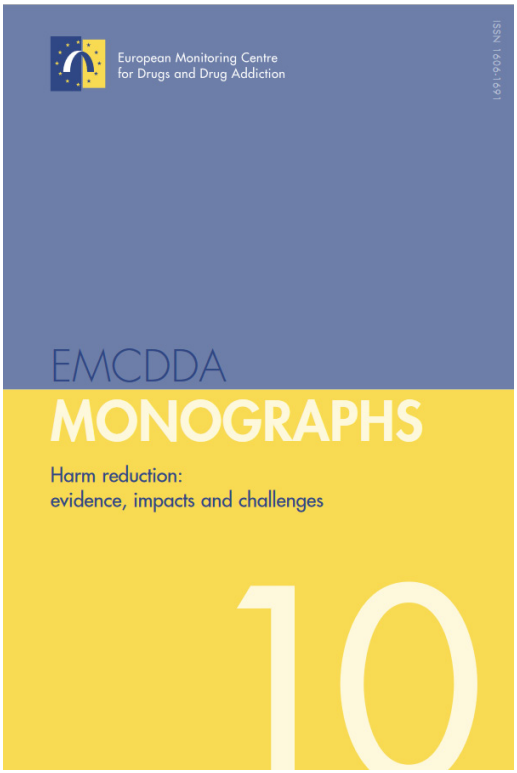
EMCDDA review does not supersede IOM

An objection by the harm reduction lobby to the authoritative IOM review is that it has been superseded by a later review. But the latter review has very apparent errors.

The 2010 'review of reviews' by Norah Palmateer et al. in Addiction (105) pages 844-859 studying the effectiveness of needle exchanges found that "there is insufficient evidence to conclude that any of the interventions are effective in preventing HCV (Hepatitis C) transmission." This is a somewhat more optimistic outcome than that of the US IOM. Palmateer also concludes that there is "tentative evidence to support the effectiveness of NSP in preventing HIV transmission." Again, this is a more optimistic outcome.

However the 2010 Palmateer study, which was also reproduced in the European Monitoring Centre's Monograph on Harm Reduction, makes **a critical error** in its 'review of reviews', failing to adequately look into the primary studies guiding those reviews, as well as uncritically accepting the conclusions of the three former reviews. The three reviews included the 2004 Wodak/Cooney review completed for the World Health Organisation (WHO) and the 2007 Tilson et al. review representing the work of the prestigious US Institute of Medicine we have already outlined with its extensive panel of 24 scientists, medical practitioners and reviewers. The third study was the 2001 Gibson et al. review for which the Palmateer reviewers concluded that "their (Gibson's) conclusions were apparently inconsistent with the HIV studies reviewed" (p 851).

The more optimistic HIV conclusion of the 2010 Palmateer study, as compared to the formidable US



Institute of Medicine 2007 'inconclusive' finding lies visibly in a specific lack of scrutiny by the Palmateer reviewers of the 2004 Wodak/Cooney review. On pages 845-6, the Palmateer 'review of reviews' reports its methodology whereby, "(f)rom each review, we extracted reviewers' assessment of the evidence and the number, design and findings of relevant primary studies. Information on primary studies was extracted from the reviews; in the case where reviews reported discrepant study findings, the primary studies were consulted." Notably though, the Palmateer 'review of reviews' failed to check whether the 2004 Wodak/Cooney review's classification of 5 primary studies as 'positive' accorded with the internal conclusions of those five studies, or whether each had entirely defensible methodologies. This is something that the 2007 US Institute of Medicine review in fact did.

In their December 2005 Geneva Conference convened to study the effectiveness of needle exchange on HIV transmission, the US IOM had Australia's Dr Alex Wodak present the findings of his 2004 WHO study, followed by Sweden's Dr Kerstin Käll (a Drug Free Australia Fellow) who clearly demonstrated that three of the five 'positive' studies for needle exchange effectiveness cited by the 2004 WHO review were either invalid or were in fact inconclusive.

The 'positive' 1993 Heimer et al study did not measure HIV prevalence among IDUs but only in returned needles, which, she stated, cannot be directly translated into a population and therefore should not have been included in the WHO review. The 'positive' 2000 study by Monterosso and co-workers was misclassified as positive for NEP, whereas in fact

the result was clearly statistically non-significant and should have been labeled inconclusive. The purportedly 'positive' 1991 Ljungberg et al study had found HIV seroprevalence in Sweden's Lund, a city with needle exchange, to be maintained at -1% in contrast to 60% in Stockholm, but ignored the authors' own comment that incidence in Stockholm had been reduced to 1% by the time of the study without the implementation of needle exchanges, therefore she maintained that this study should have been moved to the inconclusive table.

The Palmateer 'review of reviews', while uncritically accepting the 'positive' classifications wrongly attributed by the 2004 WHO review, did look at the strength or otherwise of the described design of the studies cited therein, noting, to their credit, that "(f)our of the five positive findings were generated by studies with weaker designs."

Two invalid Australian studies on NSP

Two well-known Australian studies which calculated the cost-benefit for needle and syringe programs are thereby based on a falsehood, where they assumed that there was scientific support for the effectiveness of needle and syringe programs when there was none.

The first 2002 study, Return on Investment which was the kind of ecological study panned by the Institute of Medicine review but widely publicised in the media, calculated that to that date there had been 25,000 less cases of HIV and 21,000 less cases of Hepatitis C (HCV) as a result of Australian government investment in needle and syringe programs. The second 2009 report Return on Investment 2 calculated a staggering 32,050 cases of HIV and 96,667 cases of HCV avoided between 2000 and 2009 which created a net saving, they stated, at lowest estimate of $1.03 billion from an investment of $243 million.

How do two government-funded Return on Investment reports conjure up so many $billions of savings if the authoritative reviews of the evidence find no demonstrable HIV and Hep C prevention benefit from Needle & Syringe Programs?

The 2002 ROI report erroneously assumed that NSPs were responsible for ALL preventative interventions implemented when an epidemic is recognised. The 2009 ROI report relies foundationally on self-reported behaviours of injecting drug users, far less reliable than scientific studies which measure blood-borne virus incidence in specific populations.

When it is considered that the Hep C prevalence amongst Australian intravenous drug users (65%) is no different to the expected rates worldwide (50-70%), there is no immediately evident advantage for NSPs.

Mention has already been made of the 1997 Medical Journal of Australia article lamenting the failure of NSPs to control HCV. A 1997 article by Nick Crofts et al. titled "The force of numbers: why hepatitis C is spreading among Australian injecting drug users while HIV is not" clearly states that NSPs were not preventing Hep C.

In neither of these reports was there any presentation of defensible data or statistically derived evidence on needle and syringe programs from rigorous studies (ecological studies cannot infer outcomes), supporting any alleged success of such programs in averting HCV transmission, and where the evidence on the alleged success on HIV has in fact been scientifically inconclusive.

The one conclusion that can be well defended is that NSPs are ineffective in controlling HCV, and by their failure to control needle sharing, the very practice it was designed to remove, it cannot have ever been effective in decreasing HIV transmissions.

2017 inferior Cochrane Collaboration review

The 2017 Cochrane Collaboration review of NSP impact on HCV transmission is marred by a total reliance on studies with a high risk of bias.

Of course it must be acknowledged that needle programs could never become subject to the gold standard of Randon Control Trials, as does occur with Opiate Substitution programming. So study design is all the more critical in attempting to reduce bias.

As already discussed in the previous chapter on Opiate Substitution Treatment the 2017 Cochrane Collaboration review clearly states that,

> ***We judged only two studies to be at moderate overall risk of bias**, while **17 were at serious risk** and **7 were at critical risk**; for two unpublished datasets there was insufficient information to assess bias. **As none of the intervention effects were generated from RCT evidence, we typically categorised quality as low.***

It is notable each of the 5 NSP studies included in this review were at serious or critical risk of bias. Not one study had a moderate risk of bias. Therefore there can

be no scientific confidence in any conclusions drawn by this review.

The same Cochrane review of 4 additional studies examining OSTs working in tandem with NSPs to prevent HCV transmission concluded the following:

Combined NSP and OST

Primary meta-analysis of three studies involving 3241 anti-HCV negative participants and adjusting for confounders suggested a strong intervention effect for combined high coverage of NSP and OST, reducing the risk of HCV acquisition by 74% (95% CI 11% to 93%) compared to no OST and low/no coverage with NSP. The evidence is considered low quality because it was derived from observational studies with serious risk of bias, and the few studies identified precluded sensitivity analyses. Evidence for the combination of low coverage of NSP and OST was weaker. There were fewer studies with information on both OST and NSP coverage, and the studies represented a subset of people on OST (i.e. participants who continue to inject drugs while on OST), with those on low coverage NSP receiving an insufficient number of sterile syringes per average frequency of injecting.

Clearly, the use of studies with high risk of bias precludes any scientific confirmation of either NSP or OST/NSP-combined effectiveness for these Harm Reduction interventions in reducing transmission of HCV.

Summary of HIV and HCV studies

The science does not support the effectiveness of NSP programs in reducing either HIV or HCV transmission. Even when combined with Opiate Substitution Therapy, the science does not support effectiveness.

Why NSPs do not work

Needle & Syringe Programs create the illusion that illicit injectibles such as opiates or cocaine can be used safely. But the temptation for users to inject in groups often outweighs any safety messaging or provision.

Rather than putting funds into programming such as extra rehab beds that will help more users quit their addiction, this Harm Reduction intervention prolongs drug use careers, only lengthening the time in which a fatal overdose might occur. This adds to mortality tolls.

Australia, with among the higher HCV rates in the world despite best practice needle programs, will also witness continually increasing deaths from blood-borne diseases due to Harm Reduction's internal dynamic of continually increasing drug use - as has been established in the first chapter of this document.

Injecting Rooms

Increasing both morbidity and mortality

The two injecting rooms in Australia host extraordinary numbers of overdoses - 63 times greater than street overdose rates for Sydney's, and 102 times greater than street overdose rates in Melbourne's.

The written statements of ex-patrons claiming that they and other patrons used the injecting rooms to push use of opiates and other drug cocktails to their limits demonstrates the increased morbidity this will inevitably produce. And despite hasty interventions by injecting room staff with the exorbitant numbers of overdose, these interventions cannot remove all overdose health impacts, increasing morbidity and ultimately mortality issues, given that illicit drug use often causes death due to long careers of health attrition.

The Australian injecting rooms, otherwise called Supervised Injection Facilities (SIFs), only statistically reduce Australian overdose deaths by one death per annum each (see Appendix D), but add severe weight to the other side of the ledger via experimentation in the safety of these facilities, with the associated morbidity/mortality associated with the extended drug-using careers they encourage.

Only two rigorous reviews to date

Scientific reviews of formal evaluations of injecting rooms (Kerr et al., 2007; McNeil and Small, 2014; Potier et al., 2014; Garcia, 2015; Kennedy, Karamouzian, and Kerr, 2017; May et al., 2018 (retracted); Kilmer et al., 2018), have reported positive outcomes across a range of evaluated criteria, ***but most use non-peer-reviewed evaluations which notorously have drawn conclusions which demonstrably fail to accord with the data.*** This has led to a perception of being based on pseudo-science.

Just **two** reviews, May et al in 2018 and Kilmer et al. in 2018 (RAND Corporation) included studies only with a quasi-experimental design using control groups/areas. This has scientific validity. May et al. was subsequently retracted because of "methodological weaknesses linked to the pooling of diverse outcomes into a single composite measure" (International Journal of Drug Policy, 2018) but not for its selection criteria of high-quality studies on injecting room effectiveness.

Only RAND review remaining

The RAND Corporation similarly identified nine studies with quasi-experimental design, noting that four of the earlier studies had been superseded by others within the remaining five which studied the same outcomes with longer time series in the same locations. This effectively reduced the available number of reviewed studies to just five which are limited to overdose-related outcomes, discarded injecting equipment and crime. These studies examined SIFs in only three cities – Sydney, Vancouver and Barcelona.

Of these five studies, Marshall et al. found a 35% reduction in opiate overdose fatalities in the immediate area surrounding Vancouver's Insite, while Salmon et al. 2010 found a greater reduction in ambulance callouts for overdose in the Kings Cross postcode housing the Sydney MSIC than for the rest of New South Wales.

Donnelly and Mahoney found a null effect of the Sydney MSIC on crime in the Kings Cross neighbourhood, while Myer and Belisle found a significant reduction in property and violent crime in the area surrounding Vancouver's Insite immediately after its opening. Espelt et al. 2017 had conflicting results regarding discarded injecting equipment.

These results led to the Rand Corporation review delivering a largely positive report concerning the

possibility of implementing SIFs in the United States where no such facilities officially exist.

But RAND relies on two key discredited studies

The main two studies demonstrating the supposed effectiveness of a SIF in reducing overdose mortality (Marshall et al. Lancet 2011) and ambulance overdose callout reductions (Salmon et al. Addiction 2010) both demonstrate either incompetence on the part of the researchers or possibly fraudulent intent, and yet likewise form the centre of the other major literature reviews to that date (see for example the 2014 review by Potier, C., et al.).

Deaths INCREASED in Vancouver with Insite

The 2011 Marshall et al. Lancet study so central to these positive SIF reviews spuriously claimed that Insite likely reduced overdoses in Vancouver by 9% despite official BC Coroners' stats displayed at the bottom of this column clearly showing only increases in overdose mortality for Vancouver after Insite's 2003 opening as per screenshot of their records below. Drug Free Australia corrected Lancet on these statistics in a full page letter printed by Lancet in its January 2012 issue (See Appendix B).

The same study also claimed overdose reductions by 35% in the area immediately surrounding Vancouver's Insite. Drug Free Australia's Australian/Canadian/US team of epidemiologists and addiction specialists demonstrated in 2012 that the Lancet study *had concealed the tripling of police numbers around Insite in 2003*, falsely claiming that this was temporary when in fact it was permanent, as attested by the DTES Area Commander of that time, John McKay (See Appendix C).

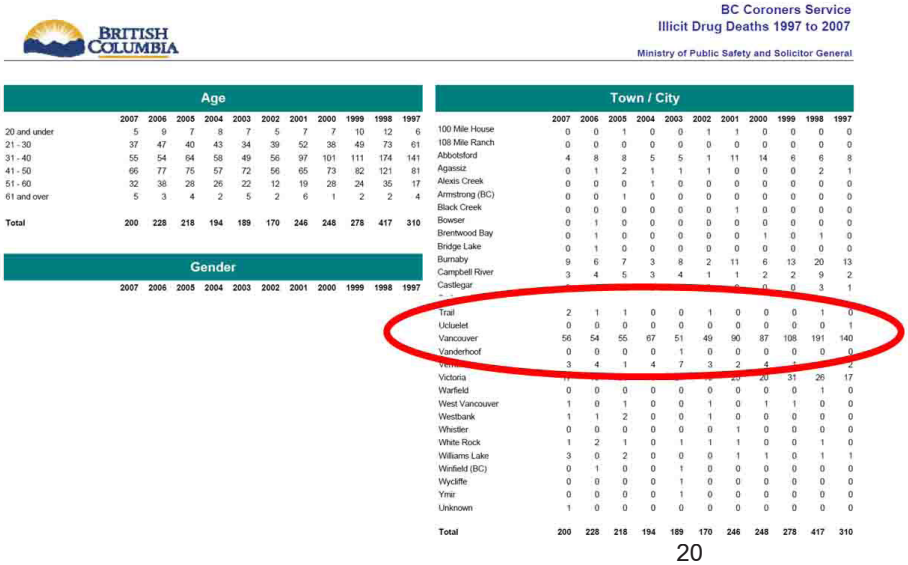
Such policing served to disperse drug dealers away from the area around Insite, ***reducing crime and loitering***, (as evidenced by the findings of the Myer/ Belisle study), as well as reducing overdoses which most often occur immediately after a purchase from a dealer.

Policing alone was shown to be demonstrably capable of reducing overdoses around Insite by 35%, *the result of tripled policing which changed to a zero tolerance approach away from a prior philosophy of 'containment' 6 months before Insite opened.*

Sydney study's own data discredits it

The 2010 Salmon et al. Addiction study, which claimed a 19% greater reduction in overdose ambulance callouts for Kings Cross (80%) than for the rest of NSW (61%) when Australia's heroin drought ensued, failed to note that there were proportionately GREATER reductions in ambulance callouts during nighttime hours, where Kings Cross, at 71% reductions was a full 29% better than the rest of NSW (42% reductions) WHEN THE INJECTING ROOM WAS CLOSED. This can be clearly seen in the ringed cells on the Table immediately above.

	During Op hours	Average per month	Outside Op hours	Average per month	Total all hours	Average per month
AMBULANCE CALLOUTS BEFORE MSIC OVER 36 MONTHS						
Postcode 2011 - Kings Cross	626	17.4	922	25.6	1548	43.0
Postcode 2010 - Darlinghurst	338	9.4	311	8.6	649	18.0
Rest of NSW	6779	188.3	2901	80.6	9680	268.9
AMBULANCE CALLOUTS AFTER MSIC OVER 60 MONTHS						
Postcode 2011 - Kings Cross	210	3.5	440	7.3	650	10.8
Postcode 2010 - Darlinghurst	311	5.2	383	6.4	694	11.6
Rest of NSW	4382	73.0	2806	46.8	7188	119.8
PERCENTAGE REDUCTION IN AMBULANCE CALLOUTS	During Op hours		Outside Op hours		Total all hours	
Postcode 2011 - Kings Cross	80%		71%		75%	
Postcode 2010 - Darlinghurst	45%		26%		36%	
Rest of NSW	61%		42%		55%	



BRITISH COLUMBIA

BC Coroners Service
Illicit Drug Deaths 1997 to 2007
Ministry of Public Safety and Solicitor General

Age

	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997
20 and under	5	9	7	8	7	5	7	7	10	12	6
21 - 30	37	47	40	43	34	39	52	38	49	73	61
31 - 40	55	54	64	58	49	56	97	101	111	174	141
41 - 50	66	77	75	57	72	56	65	73	82	121	81
51 - 60	32	38	28	26	22	12	19	28	24	35	17
61 and over	5	3	4	2	5	2	6	1	2	2	4
Total	200	228	218	194	189	170	246	248	278	417	310

Gender

	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997

Town / City

	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997
100 Mile House	0	0	1	0	0	1	1	0	0	0	0
108 Mile Ranch	0	0	0	0	0	0	0	0	0	0	0
Abbotsford	4	8	8	5	5	1	11	14	6	6	8
Agassiz	0	1	2	1	1	1	0	0	0	2	1
Alexis Creek	0	0	0	1	0	0	0	0	0	0	0
Armstrong (BC)	0	0	1	0	0	0	0	0	0	0	0
Black Creek	0	0	0	0	0	0	1	0	0	0	0
Bowser	0	1	0	0	0	0	0	0	0	0	0
Brentwood Bay	0	1	0	0	0	0	0	1	0	1	0
Bridge Lake	0	1	0	0	0	0	0	0	0	0	0
Burnaby	9	6	7	3	8	2	11	6	13	20	13
Campbell River	3	4	5	3	4	1	1	2	2	9	2
Castlegar								0	0	3	1
Trail	2	1	1	0	0	1	0	0	0	1	0
Ucluelet	0	0	0	0	0	0	0	0	0	0	1
Vancouver	56	54	55	67	51	49	90	87	108	191	140
Vanderhoof	0	0	0	0	1	0	0	0	0	0	0
Victoria								20	31	26	17
Warfield	0	0	0	0	0	0	0	0	0	1	0
West Vancouver	1	0	1	0	0	1	0	1	1	0	0
Westbank	1	1	2	0	0	1	0	0	0	0	0
Whistler	0	0	0	0	0	0	1	0	0	0	0
White Rock	1	2	1	0	1	1	1	0	0	1	0
Williams Lake	3	0	2	0	0	0	1	1	0	1	1
Winfield (BC)	0	1	0	0	1	0	0	0	0	0	0
Wycliffe	0	0	0	0	1	0	0	0	0	0	0
Ymir	0	0	0	0	1	0	0	0	0	0	0
Unknown	1	0	0	0	0	0	0	0	0	0	0
Total	200	228	218	194	189	170	246	248	278	417	310

It is crucial to recognise that ambulance callouts for overdose were reduced across every city in Australia because of the well-documented heroin drought which started 6 months before the Sydney facility opened in May 2001. Thus any positive effect of the injecting room, it was reasoned, might be demonstrated by superior reductions in callouts compared to the rest of Australia, or in this study's comparison, the rest of NSW.

To summarise the major error by the 2010 Salmon et al. study, their claim was that the Sydney injecting

room had indeed reduced ambulance callouts moreso than the rest of NSW. To lay this out more graphically:

REDUCTIONS IN AMBULANCE OVERDOSE CALLOUTS DUE TO HEROIN DROUGHT

Daytime - when injecting room was open

Kings Cross	-80%
Rest of NSW	-61%

Kings Cross 19% superior to the rest of NSW by day

Nighttime - when injecting room was closed

Kings Cross	-71%
Rest of NSW	-42%

Kings Cross 29% superior to the rest of NSW at night

This clearly indicates reductions were not due to the injecting room, and suggests it was rather due to sniffer dog policing introduced one month after the MSIC opened, where sniffer dog use was even more extensive at night. Any null effect of the MSIC on crime in the area can be slated to changed policing, just as was the case for Vancouver's Insite.

Thus the studies on SIF impacts on crime in the immediate area around an SIF are voided due to the effect of increased police operations. ***In fact, increased police operations explain every positive result for SIFS in the RAND review.***

The upshot is that there is no science which supports the effectivness of injecting rooms.

Latest MSIR evaluation well-illustrates the failure

The 2020 review of Melbourne's North Richmond demonstrates the complete failure of its Medically Supervised Injecting Room (MSIR) to meet objectives legislated by the Victorian Government. Below are the review's own data and verbatim conclusions demonstrating failure on five of the six objectives, despite rosier media reports indicating otherwise. The facility has also been associated with increases in drug-related crime, an outcome not anticipated by the six legislated objectives.

The Melbourne review records the following regarding its six objectives (please note the verbatim comments by the MSIR reviewers within the quotation marks):

1. **Reduce discarded needles on streets** - "Local people record no difference in seeing discarded injecting equipment" (p 76 of the review)

2. **Improve public amenity** - "significantly fewer residents and business respondents reported feeling safe walking alone during the day and after dark due to concerns about violence and crime . . . " (p 85)

3. **Reduce the spread of blood-borne viruses** - "There is not a significant difference between MSIR service users and other people who inject drugs in reporting that they had injected with someone's used needle/syringe in the previous month." (p 100)

4. **Referrals to treatment and other services** - "in the first year of operation (the MSIR) has not demonstrated higher levels of service take-up for MSIR users as compared with other people who use drugs." (p 48).

5. **Reduce heroin deaths** - Figure 17 on p 45 of the review shows that there were 12 heroin deaths within 1 km of the MSIR the year before it opened, and 13 the year after. Figure 19 on p 47 shows that for the top 5 Local Government Areas for heroin deaths in Melbourne there was a cumulative 65 deaths before the MSIR opened and 67 in its first year.

Clearly there was no observable reduction in heroin deaths in Melbourne or North Richmond in its first year of operation. Furthermore, had the 112,831 heroin injections in the MSIR over 18 months happened on the streets of North Richmond, there would, according to Australian statistics, have been only one death to be expected, (Australia averages one overdose death for every 109,500 opiate injections) indicating that the MSIR spent $6 million to save only one life, an extremely expensive failure.

6. **Reduce ambulance and hospital attendances** - On the streets of Melbourne, 112,831 opiate injections would have produced 26 overdoses, (25 non-fatal and 1 fatal) according to an important Australian study (see p 59). Of these 19 would likely have been attended by an ambulance.

Comparing 18 months before and after, the MSIR would therefore have reduced ambulance callouts by just 5%. Yet the Melbourne review egregiously claims reductions of 36%, which were clearly due to heightened police operations arresting drug dealers in the vicinity of the MSIR, sending drug dealers elsewhere to ply their trade. Because users most often overdose near where they bought their drugs (p 83), ambulance callouts were clearly the result of policing, which nullifies (see footnote on p 67) the review's spurious claims regarding callouts. Additionally, analysis of heroin OD presentations at nearby St Vincent's Hospital "found that the number of heroin overdose cases did not change significantly after the facility opened." (p 74)

Adding to the failure against objectives listed above, police complained of increasing crime around the MSIR, and residents of a honey-pot effect where drug dealers were drawn to the streets outside the MSIR.

See Appendix D for similarities between the Sydney and Melbourne facilities in their evaluation results.

Clearly, the science does not favour injecting rooms.

Pill testing

Why pill testing increases Australian deaths

Pill testing increases Australian drug deaths by failing to address almost every scientifically established cause of MDMA-related deaths in Australia, which averaged 22 per year before pill testing commenced in 2018.

MDMA is the substance that causes almost every pill death in this country, yet pill testing ***greenlights*** the substance, implicitly signalling that a normal dose is largely benign. The ANU evaluation of the 2019 pill testing trial demonstrated that some users intended to take more of a substance that pill testing procedures found to be unadulterated or relatively pure.

Ecstasy causal in almost every pill death

In January 2020 data on 392 ecstasy-related deaths between July 2000 and November 2018 was published in the International Journal of Drug Policy. This study extended the data beyond the MDMA-related deaths from July 2000 and December 2005 examined in the only other Australian study of ecstasy deaths.

There were three main causes of deaths. 14% of deaths were caused by ecstasy alone, often due to individual vulnerabilities to the drug. Anna Wood took an ecstasy pill from the same batch as four friends, but only she died, no doubt from an individual vulnerability. It was not an overdose because the science clearly shows that ecstasy overdose is in fact rare. 48% of deaths were from ecstasy being co-consumed with other legal or illegal drugs such as alcohol, amphetamines or cocaine which create deadly synergies. A further 29% were from accidents due to ecstasy/other drug intoxication, mostly car accidents.

Very few deaths from adulterants

No more than 5% of Australian ecstasy-related deaths, according to the above study, had other exotic drugs mixed with MDMA in ecstasy pills. Obviously, it is not clear at autopsy whether these other exotic drugs caused the death, or whether it was the ecstasy in the pill, but given that MDMA is responsible for the other 95% of deaths where the pill contains no other psychoactive drug, it is likely that it is the ecstasy that is responsible for most every one of the 392 deaths.

There have only been three 'bad batch' deaths in Australia between 2000 and 2018, the study period.

Very few deaths from other party drugs

Drug Free Australia has identified a handful of MDMA-related deaths that lie outside of the years 2000 to 2018, with 6 PMA deaths in South Australia in the mid-1990s.

Again, there are a handful of deaths from party drugs other than ecstasy, with a number of NBOMe deaths identified by Google search between 2012 and 2016, where evidence indicates the deceased users knew what they were taking. Notably, three Melbourne deaths in January 2017 were caused by pills containing 25c-NBOMe and 4-FA but it is questionable whether these drugs would have been delineated by the Bruker Alphas used for the Canberra pill testing trials simply because this mobile equipment often fails in identification where there are multiple drugs in a pill (written advice from SA toxicologist Dr Andrew Leibie).

But pill testing greenlights ecstasy

With at least 95% of Australian deaths caused or co-caused by ecstasy itself, pill testing fails to address the causes of most every Australian MDMA-related death.

This greenlighting of MDMA by pill testing outfits worldwide is made abundantly clear by Pill Testing Australia's first evaluation where it red-cards any

substance it deems to be, in their own words, "associated with increased harm/multiple overdoses/ death." The fact that their evaluations confirm that unadulterated MDMA is white-carded if found in a pill explicity clarifies that MDMA is greenlighted.

Diagram 3: Classification and reporting of detected substances

WHITE:	Where a substance was analysed, and was the same as what the patron anticipated that it might be
YELLOW:	Where a substance was analysed, and there was a significant disparity between the result and what the patron anticipated that it was
RED:	Where a substance was analysed, and revealed the presence of a substance known to be associated with increased harm / multiple overdoses/ death Where a substance was analysed and returned an ambivalent result, or functional groups known to be associated with significant harm

Causes of MDMA-related deaths

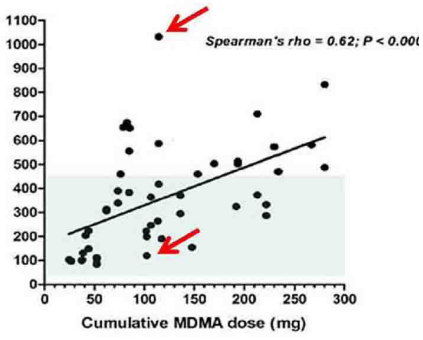
- Individual vulnerabilities to MDMA - Pill testing cannot test for individual vulnerabilities
- MDMA used with alcohol, cocaine etc - Pill testing tests pills, not user blood samples
- Accidents, mostly car accidents - Pill testing cannot determine who will have an accident while intoxicated

Pill testing might prevent the 3 out of 392 deaths that have been caused by bad batches in Australia, but very good evidence from the second Canberra pill-testing trial indicates that it would do nothing to stop the other 99.25% of deaths. Worse, pill testing increases the likelihood that the drug responsible for almost all Australian party pill deaths will be taken by those who have purchased it.

Pill testing can't advise an appropriate dose

Pill Testing Australia is now calling for governments to buy them new equipment that can measure the purity and dose of MDMA in an ecstasy pill, saying they need to advise users on how to more safely moderate their doses.

Given that every person metabolises the MDMA in their ecstasy pill differently there will be blood concentrations which will differ tenfold for roughly the same amount of MDMA taken. The graph below from this South Australian study shows the blood MDMA concentrations for 49 ecstasy users, NONE of which died in the study, against the amount of carefully measured MDMA they ingested.



The light grey shaded area in the previous graph shows the blood concentration range for 196 of the 392 MDMA-related Australian deaths (the lower 50%) between 2001 and 2018 (30 - 450 ng/ml – see this and the Roxburgh study previously detailed above for the range). As can be clearly seen, even small doses of MDMA (80-90 mgs) yield blood concentrations well ABOVE the levels which caused 50% of our Australian ecstasy deaths.

Notice that ingestion of just 100-115 mg of ecstasy gives blood levels ranging tenfold from 120 – 1040 ng/ml. When it is considered that 125 – 150 mg of MDMA in a pill can be routinely used for experimental PTSD research with no ethics approval problems, such individual differences against toxic levels makes advice on dose absurd.

Festivals do not need pill testers advising on dose. All that is needed is a large photo of a decedent at each festival captioned – "this ecstasy user died after taking ¼ of a pill". Messages on what to look for when someone is hyperthermic or toxically affected by ecstasy can be delivered via all sorts of social media and by screens at festivals. No need for pill testing at all.

Users MORE likely to take ecstasy once tested

The Australian National University evaluation of the 2019 Canberra pill testing trial confirms that the methods used by Pill Testing Australia to classify identified substances is actually increasing the likelihood the user will take that substance.

When pill testing identifies a substance to be what the user thought they had purchased, the substance is given an "all-clear" white card which is displayed on a noticeboard in the pill testing tent, declaring it to not contain substances "associated with increased harm / multiple overdoses / death" (see p 11). If a 'dangerous' drug is identified, it is given a red card.

Yet while the evaluation stated that "most of the patrons had a generally accurate perception of the contents" of their pills before testing, it also states that "those who received a test result confirming the substance to be what they thought it was were likely to take as much or more than originally intended" and "concordance between expectation and identification is associated with stable or increased intention to take a substance."

When it is considered that 90% of the 158 pills presented in the 2019 Canberra trial contained ecstasy, the drug found in Dr Amanda Roxburgh's study to be responsible for almost all of the 392 MDMA-related

deaths in Australia between 2000 and 2018, the symbolics of a white card rather than the red card it deserves makes it clear why a user would be more likely to use it after the pill has been tested.

Pill testing clearly sends all the wrong messages which will only increase party drug deaths in Australia.

Pill testing counselling failed to deter use

The same evaluation as described above also confirms that only seven pills were discarded by users after pills were tested, each containing N-ethylpentylone, which would likely come from a batch or batches of 200 or more pills each somewhere in Canberra or Australia which otherwise caused no hospitalisations or deaths.

Pill Testing Australia claims that they tell users of the dangers of ecstasy but there was no evidence of counsellors dissuading any user from taking their tested pill, with not one ecstasy user recorded discarding their pills, evidencing zero behaviour change.

Drug Free Australia asserts that it is too late to be telling ecstasy users that their substance is dangerous given the horse has bolted once they have spent $100 purchasing it. The real need is government-funded social media campaigns telling the truth about ecstasy before they make the cash outlay.

Pill testing a failure in England/Wales

Statistics from England and Wales show that the introduction of pill testing did not produce any reduction in deaths as promised, nor did it appear to change the behaviour of users by getting some to quit using ecstasy, as also forecast by its advocates. While European countries have poor to non-existent statistics on ecstasy deaths, the UK keeps up-to-date figures. Pill testing operated by “the Loop” began in 2013 and by 2016 began expanding into 12 music festivals with government assent. In 2013 ecstasy was used by 1.2% of the population, rising significantly to 1.7% by 2017/18 (see Table 1.02). In 2013 there were 43 ecstasy deaths, more than doubling to 92 deaths in 2018 (more recent figures are confounded by the COVID epidemic).

Harm Reduction Australia’s specious campaign to establish an intervention that provides little to no protective effect for ecstasy users will continue to mislead young Australians, broaden the pool of novice users and lead to more needless deaths.

Decriminalisation of illicit drug use

Decriminalisation and increased mortality

Portugal was the world's first country to decriminalise the use of all illicit drugs in July of 2001. Its new drug policy was one it titled 'dissuasion' where the money previously targeted for policing of illicit drug use would now go towards treatment and counselling to dissuade all problem users from drug use.

Drug use in Portugal increased 59% by 2016 (their latest survey) and use by high school minors went up by 80% by 2011, settling back to 24% higher by 2019. Decriminalisation is associated with increased use worldwide. Increased use creates increased harm.

Overdose deaths in Portugal were 111% above the 2002 figure by 2019. Clearly decriminalisation's dissuasion did not work, and increased mortality the price.

The truth on Portugal's decriminalisation

Portugal decriminalised all illicit drug use as of July 2001 and since that time drug decriminalisation/ legalisation activists have inundated politicians and the media with glowing reports of Portugal's touted 'success'.

But below is the graphic reality, using their own official data and graphs sent to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the same statistics used for the yearly United Nations World Drug Report drug-use tables.

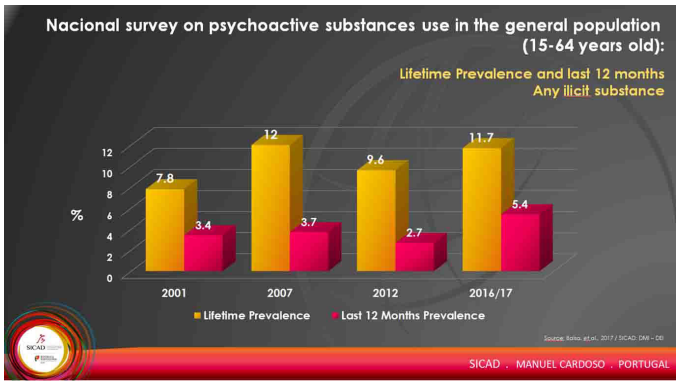
By 2016 drug use was 59% higher than in 2001

The figures for overall illicit drug use in Portugal for their last survey in 2016 indicated a 59% increase in use of all illicit drugs. Results of their scheduled 2021 population survey have never been released, but if wastewater reports on Portugal, as compared to the rest of Europe are any indicator, Portugal may have something to hide. For four of the five drugs studied in European wastewater reporting - cocaine, ecstasy, ketamine and cannabis - Portugal's cities rated amongst the top three to four across European countries.

From their survey data:

Use in the last 12 months

2001	3.4%
2007	3.7%
2012	2.7%
2016	5.4%

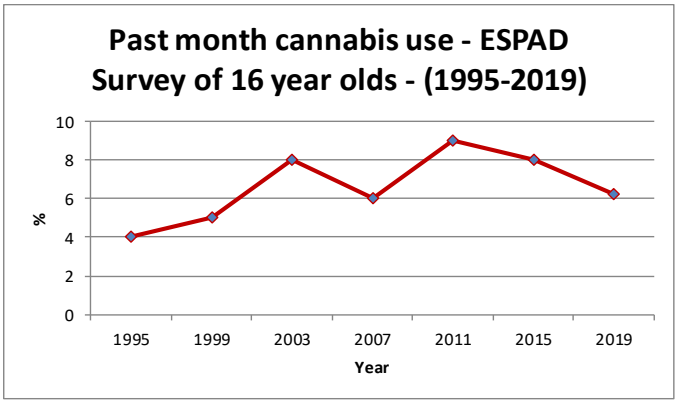


The 59% increase above use in 2001 indicates that Portugal's decriminalised policy of dissuasion does not work. Given that the underlying premise of dissuasion is that drug use is harmful, where recovery is better than continued use, success would be seen via a decrease in drug use. This is not the case.

Portugal's decriminalisation model includes more treatment, accompanied by increased treatment expenditures. Despite the extra treatment, the model has failed.

High School drug use 80% then 24% higher

The ESPAD survey of cannabis use (last 30 days before survey) for 16 year old high-school students shows



increases in use of the drug from 1999, a couple of years before decriminalisation, through to 2019. The increases were by 2011 very substantial with an 80% increase, moving down to a 60% increase above 1999 by 2015.

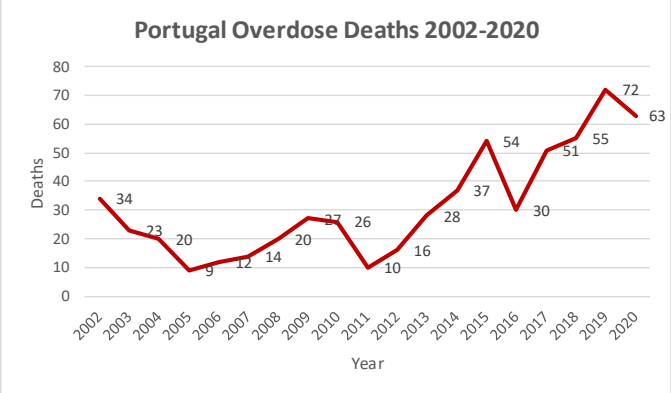
In the latest ESPAD report available, high school minors were still 24% above pre-decriminalisation levels.

Drug deaths in Portugal 111% higher by 2019

There have been significant increases in overdose-related deaths in Portugal since decriminalisation. The claim by Harm Reductionists that there were significant decreases in drug-related deaths since decriminalisation are based on two errors.

First, false claims that there were more than 75 drug-related deaths in 2001 which more than halved to 34 deaths in 2002 use a figure for 2001 for which there is no substantiation. Official drug-related deaths for Portugal, taken from the latest 2023 EMCDDA Statistical Bulletin are charted below.

Second, there is no way of knowing what the real number of drug related deaths before 2002 was. Up until 2009 Portugal counted all deaths where any illicit drug was detected, whether the death was caused by that illicit drug or not. Portugal later changed its definition for Selection B drug-induced deaths to only those that were caused by overdose or poisoning, and in 2009 reanalysed their data back to 2002. This leaves no comparison to the years before decriminalisation. The official figures yield the following graph.

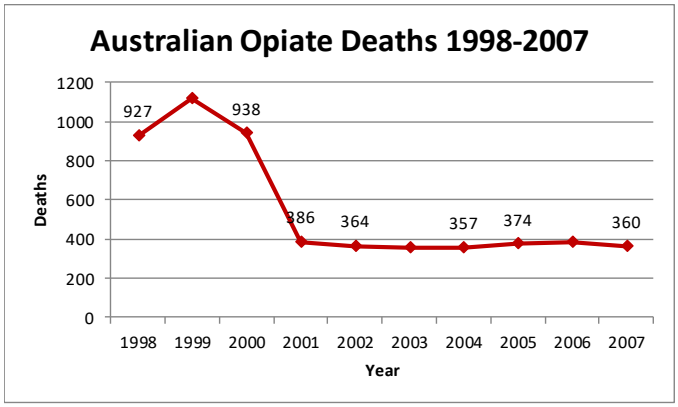


Early decreases in deaths between 2002 and 2005 are part of the same decreasing trend in opiate use which was already substantially decreasing from 0.9% in 1998, to 0.7% in 2000, the year before decriminalisation. These decreases were not due to decriminalisation because they were not a part of it. Decriminalisation was introduced July 2001 and appears to be the beneficiary of whatever dynamic was driving opiate use and deaths down.

However these early decreases in deaths are matched by an increasing trend between 2005 and 2010, which is followed by sharper rises in drug deaths from 2011 to 2019 and 2020, the latest year for which data is currently available.

Compare Tough on Drugs deaths to Portugal's

Portugal's overdose mortality graph should be compared with Australia's Tough on Drugs results below.



While Australia maintained criminal penalties for use of most drugs, it saw sharply decreased drug deaths that were then maintained at those lower levels throughout the tenure of Tough on Drugs as explained in our first chapter.

Portugal's lower opioid mortality counts are due to a population half the size of Australia's and also to low rates of opiate injection, which contrasts with Australia's high rates of opioid injection. In Portugal heroin has also historically been predominantly smoked rather than injected, reducing overdose risk.

INCREASED USE ELSEWHERE

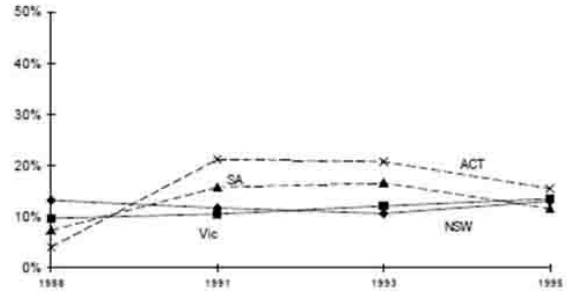
Portugal's experience replicates that of other jurisdictions which had decriminalised cannabis in the decades preceding their liberalisation experiment.

Decriminalisation is thereby associated with increased drug use. Increased drug use automatically implies increased harm and deaths, a recognition implicitly acknowledged by the concept of Harm Reduction, i.e. if illicit drugs did not cause unacceptable harm and mortality there would never have been a need for Harm Reduction programming.

Decriminalisation accelerated Australian use

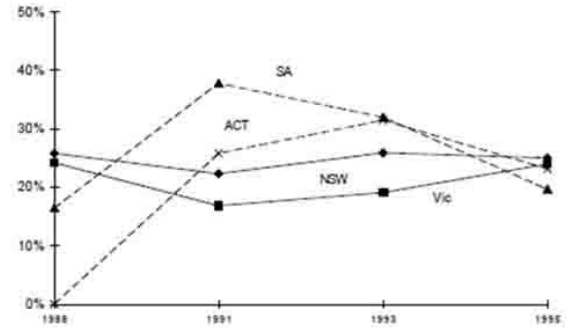
South Australia decriminalised cannabis in 1987, followed by the ACT in 1992. The following graphs from NDS Household Surveys show sharp rises in cannabis use for both jurisdictions, up from negligible use in each, before equalling the use of NSW and Victoria, States with previously entrenched cannabis problems.

Figure 4.1: Used in the past 12 months for four jurisdictions



Source: NDS 1988, 1991, 1993, 1995

Figure 4.2: Use marijuana monthly or more often for four jurisdictions, 1988–1996



Source: NDS 1988, 1991, 1993, 1995; those who have never tried marijuana are excluded

SA offences went from 6,231 in '87/'88 to 17,425 in '93/'94 and when researchers asked users about the increases, many said "We thought cannabis was now legal."

Decriminalisation in the USA increased use

- Alaska legalised cannabis in 1975. A study in 1988 found that 72% of year 12 students had tried it. They recriminalised shortly thereafter.
- California decriminalised cannabis on January 1, 1975. 10 months after cannabis use by 18 - 29 year olds was up 15%.
- Oregon decriminalised cannabis in 1973. 12 months after cannabis use by 18 - 29 year olds was up 12%.

If tobacco smoking rose by 12-15% in 12 months for young people in this country, we would be horrified.

By contrast, increases in US cannabis use overall from 1973-76 were negligible, as per the US Household Surveys (at the base of this column). We note that the reducing use from the US 1980s 'Just Say No' campaign is also evident in the same survey results, something drug law reformers try to deny.

Increased use = increased deaths in Oregon

Decriminalisation in Oregon has had very measurable harms with a 341% increase in opiate mortality since decriminalising all drugs in mid-2021. Within 10 months overdose deaths had increased from 280 to 607 deaths. By the end of 2022 there were 956 deaths. In 2023 deaths were on track for 1,250 for he year, or a 446% increase.

Oregon has recently recriminalised all illicits drugs, the legacy of their eye-opening decriminalisation experiment.

This 'Harm Reduction' measure can thereby reliably be expected to increase drug harms and deaths wherever implemented.

Table 2.1. Trends in Prevalence of Lifetime and Last Year Marijuana Use by Age[1] (NHSDA 1974-1996)

	1974	1976	1977	1979	1982	1985	1988	1990	1991	1992	1993	1994	1995	1996
	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Lifetime														
12-17 years	23.0	22.4	28.0	26.7	23.2	20.1	15.0	12.7	11.1	9.1	9.9	13.6	16.2	16.8
18-25 years	52.7	52.9	59.9	66.1	61.3	57.6	54.6	50.4	48.8	46.6	45.7	41.9	41.4	44.0
26-34 years	-	-	-	45.0	51.5	54.1	57.6	56.5	55.2	54.3	54.9	52.7	51.8	50.5
26 + years	9.9	12.9	15.3	-	-	-	-	-	-	-	-	-	-	-
35 + years	-	-	-	9.0	10.4	13.9	17.6	19.6	21.1	22.2	23.8	25.4	25.3	27.0
Last Year														
12-17 years	18.5	18.4	22.3	21.3	17.7	16.7	10.7	9.6	8.5	6.9	8.5	11.4	14.2	13.0
18-25 years	34.2	35.0	38.7	44.2	37.4	34.0	26.1	23.0	22.9	21.2	21.4	21.4	21.8	23.8
26-34 years	-	-	-	20.5	21.4	20.2	14.2	14.4	11.6	11.5	11.1	11.5	11.8	11.3
26+ years	3.8	5.4	6.4	-	-	-	-	-	-	-	-	-	-	-
35 + years	-	-	-	4.3	6.2	4.3	3.7	4.2	4.6	3.8	4.6	4.1	3.4	3.8

Cannabis legalisation

State data shows increased deaths

Colorado, along with Washington State, was the first US State to legalise recreational use of cannabis. Now that legalisation is being touted as a Harm Reduction measure, stretching all definitions of drug harm beyond all recognition, real-time data from Colorado demonstrates that legalisation of illicit substances only *multiplies* harms and deaths.

CASE STUDY - USA

The legalisation of cannabis for recreational use in the USA commenced in mid-2013 when Colorado and Washington State put changed drug policy legislation into effect.

This chapter will examine the increased use and cannabis-related hospitalisations, road deaths and suicides in Colorado, where the statistics have been closely monitored, treating them as normative for other US States and indeed for any other country that wants to replicate these policies.

2009 Colorado commercialises medical cannabis

In 2009 Colorado commercialised medicinal cannabis, making it very easy for citizens within that State to be able to obtain a prescription for cannabis, resulting in burgeoning use and harms from that year on.

The number of cardholders ballooned in 2009 from the 4,800 prior to that year to more than 41,000, with 250 medical dispensaries operative. By mid-2010 there were over 900 unlicensed cannabis dispensaries.

Colorado legalises recreational use in 2013

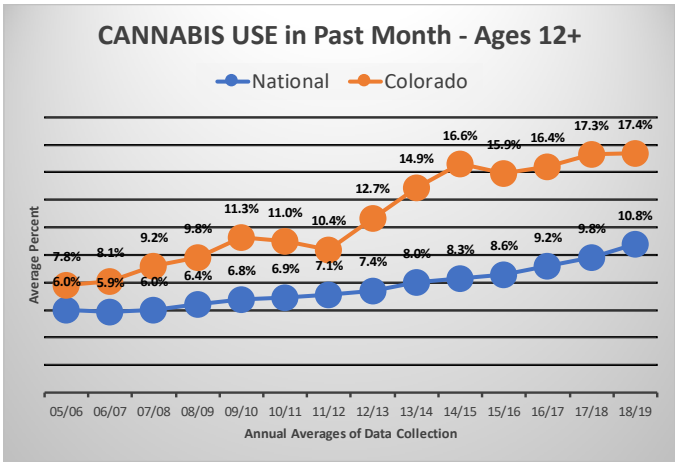
Medicinal commercialisation was a precursor to the legalisation of recreational cannabis use which effectively commenced mid-2013.

An acceleration of harm

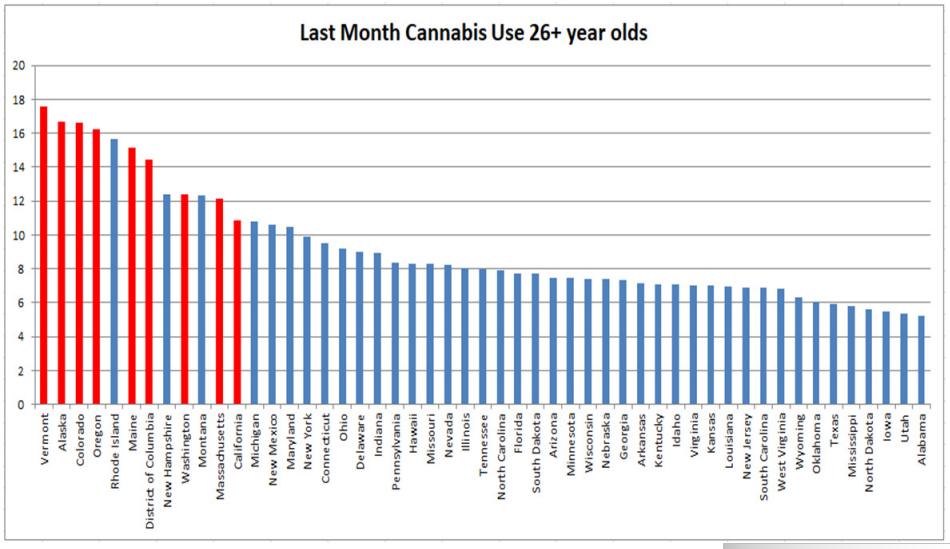
Thus significant increases in use, hospitalisations, road deaths and suicides are seen from 2009 on, and most indicators accelerating from 2013 on. This can be observed in the graphs which will be seen following.

Cannabis use in past month

Use of cannabis in the month before survey indicates an acceleration in the year that Coloradans voted for the measure (2012), a trend that is seen in other jurisdictions that have liberalised drug laws (red bars on graph below). That acceleration moderated by 2016, but increases were nevertheless maintained.



Note that the very modest increases of cannabis use for the entire US - the blue data line above - began to also accelerate as other States joined Colorado and Washington. This effect can be seen with the cannabis legalisation States from the year 2016. States that had then legalised cannabis are identified by the red bars in the bar graph following:

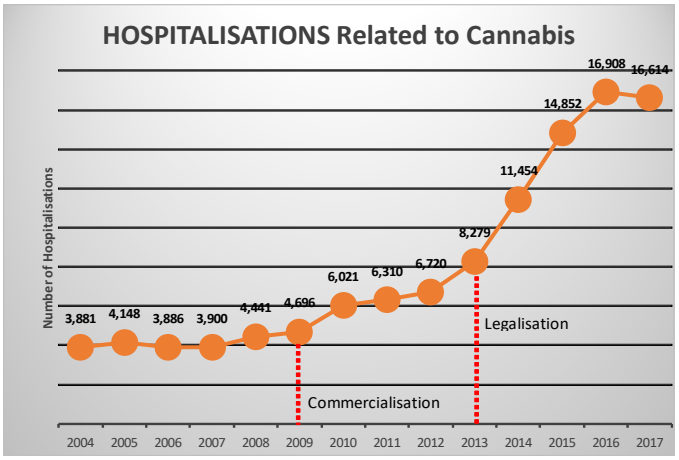


Colorado, which had previously led all other US States for cannabis use, had by 2016 slipped to number 3 as other US States Vermont and Alaska introduced recreational cannabis legalisation.

Use by adults over the age of 25 doubled in the first 2 years of legalisation, with increases in use by those 17 years or younger and by college-age adults being somewhat more modest.

Hospitalisations related to cannabis up 360%

The accelerations in use by the various age categories in Colorado were matched by increases in hospitalisations related to cannabis as per the graph below.



From commercialisation of medical cannabis in 2009 through to a peak in hospitalisations in 2016 there was a 360% increase, which represents substantial levels of harm as a result.

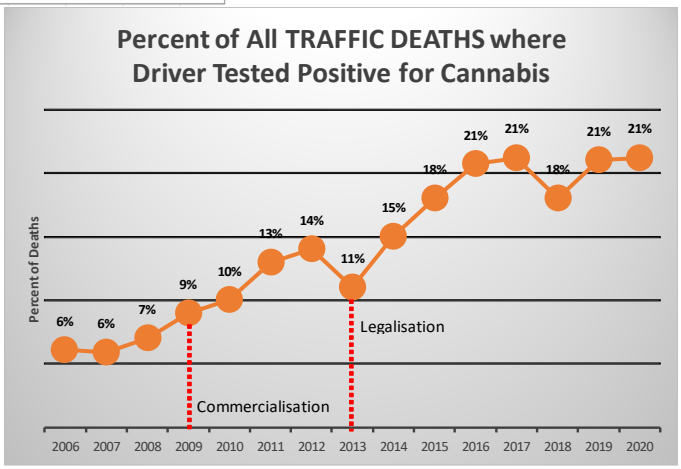
We note the above figures are not population adjusted, where population increased 16% from 2009 through 2020.

Cannabis-related traffic deaths up 230%

Traffic deaths where the driver tested positive for cannabis likewise saw very significant increases, up 230% by 2020.

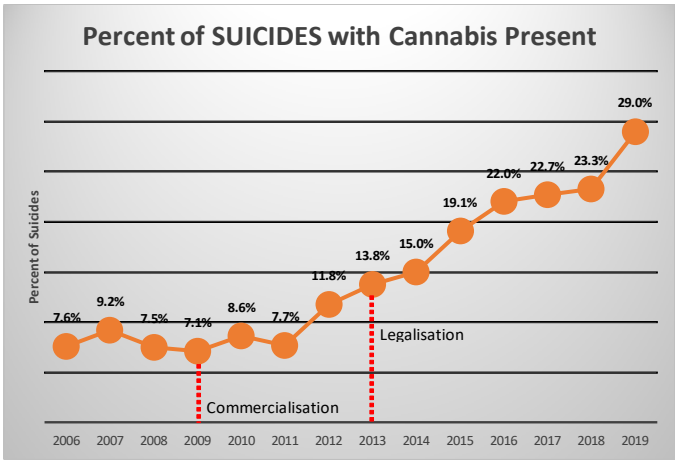
From 2013 and its introduction of legalised recreational use there was a 138% increase in traffic deaths involving cannabis use by the driver against a 29% increase in traffic deaths overall for Colorado.

This represents significant community harm, where traffic deaths are the result of cannabis intoxication, with many likely to have been caused by the synergistic intoxication effect of cannabis co-used with alcohol.



Cannabis-related suicides up 410%

Suicides in which cannabis was present increased substantially, representing a 410% increase from commercialisation through to 2019. It must be noted that there is a very well-evidenced literature describing a relationship between cannabis and suicide.



Loose medical cannabis laws like full legalisation

US statistics show how recreational users have been able to use medical cannabis availability for self-reported 'pain' to feed their recreational use. For

instance, 90% of medical cannabis patients in Arizona claim pain as their malady, while 4% use it for cancer. In Colorado, it is 94% for pain and 3% for cancer, while in Oregon 94% claim to use it for pain. Only 2% of patients across 7 US states in 2014 used cannabis for verifiable illnesses such as AIDS wasting or MS.

Drug Free Australia notes that there are no laboratory tests for pain, which makes it a prime candidate for ruse and deception due to its subjective nature and the impossibility of objectively verifying or disproving it.

There are well established profiles for patients of chronic pain across all Western countries, where patients are more predominantly women and those aged 60 and above. For instance, a 2001 study by Sydney University's Pain Management Research Centre found 54% of patients were women, with men suffering in their sixties and women in their eighties.

Yet the profile for medical cannabis pain patients in the USA is very different. A 2007 study of 4,000 medical cannabis patients in California found that their average age was 32, three quarters were male and 90% had started using cannabis while teenagers, an identical age and gender profile to that of recreational users across the US.

This discordant profile means that medical cannabis in the various States of the US has mainly amounted to a quasi-legalisation strategy for recreational use of cannabis via subterfuge and ruse.

Cannabis black market still exploded

Colorado's legislative House Bill 1221 was introduced in 2017 to address a 380% rise in arrests for black market 'grows' between 2014 and 2016. Legalisation, rather than discouraging black market criminals, rather encourages criminal grows under the laxer legislative frameworks governing cannabis use.

Legalisation MULTIPLIES harm and deaths

The conclusion that must be drawn from this newly imagined Harm Reduction measure - where legalisation is legislated to release drug users from the non-physical and newly minted 'harm' of a criminal record - is that legalisation of illicit substances does not merely *add* to the harms already affecting drug users, but rather *multiplies* harm.

Calculating harm in Australia

Harm reduction multiplied individual harms

As previously discussed in this document, harm reduction policies saw increases in Australian heroin use, peaking at 112,000 dependent users by 1999 - (dependent heroin user numbers are calculated from the methodology used to officially calculate numbers for 1997-1998). As Tough on Drugs prevention methods were implemented, dependent user numbers had shrunk to 36,000 by 2002, a level maintained through 2007.

By 2020 harm reduction policies teamed with inadequate prevention measures, saw another 104,000 new opiate users added to the Australian population. Thus harm reduction policies TRIPLED the number of drug users and likewise tripled the gross level of harm inflicted on those individuals and their community. Add to that the constellation of people harmed around each individual user.

The false economy of harm reduction

Taking the previous drug policy eras:

1985-1998 - opiate users number 112,000
1998-2007 - opiate users **down** to 36,000
2007-2020 - opiate users **up** numbering 141,000

In 2007 there were 36,000 opiate users susceptible because of their drug use to HCV, HIV, opiate related mortality, criminality and poor state of health. Under the harm minimisation policies from 2007 the number suseptible to these unacceptable harms was by 2020 141,000, adding a significant burden to all health care facility.

If harm reduction increases overall drug use and associated harms, then the obviously increased nett harms outweigh any supposed benefit. This leads to a situation where Harm Reduction gives with one hand and takes with two others. Thus Harm Reduction is a false economy that increases overall the very harms it claims to alleviate.

Disinterested in the harm inflicted on others

The afore-cited IHRA statement reflects that Harm Reduction has no interest in, or even understanding of the harm inflicted on the whole constellation of people around a given drug user. It rather pretends that the harms of illicit drugs are private, contained to the individual user alone. Looking with tunnel vision at the self-inflicted harms of the user and funneling out the harms on those around each individual, harm reduction wilfully ignores the societal impact of drug use.

1 million less families affected by cannabis

Going back to the Australian success of Tough on Drugs, 17.9% of the population was using cannabis in 1998, reducing under the prevention approach to 9.1% by 2007. There were approximately 1.1 million less cannabis users due to Tough on Drugs, and potentially 1 million less families affected.

The harms of cannabis summarised

Gone are days when cannabis could be characterised as relatively harmless. In 2024 the science on cannabis has advanced to a point where the most sensible harm reduction measure is to not use cannabis at all.

The current science drawn from multiple medical journal studies show that cannabis is:

- causal in 33 cancer types, double that of tobacco - 14
- casual in 70% of pediatric cancer types
- causal in 89 of 95 birth defects
- prematurely ageing users at 30 years by 30%
- causal in psychosis, violence, suicide

- passes mutations epigenetically on to 3 or 4 generations of a user's progeny

Harm reduction is named as such because it seeks to eliminate unacceptable harms caused by illicit drugs. All of the above are unacceptable harms. Prevention of cannabis use will shield millions from these harmful impacts.

Prevention - 1 in 4 Australians saved the grief

Given a conservative 5 people in the constellation of harm around each cannabis user, around 5 million Australians were saved the grief of the effects of cannabis use, or one in every 4 Australians by 2007 according to population figures.

By contrast, harm reduction policies had presided over an ever-increasing use of cannabis which went from 12.7% in 1993 to 17.9% in 1998. Tough on Drugs intervened while the trajectory was still steeply moving upwards. As with previous use of the similarly dangerous tobacco in the 1960s, where 70% of the male population were willing users, the upper limit for cannabis could have been significantly higher than in 1998 and many more Australians drawn into the vortex of harm.

Prevention is thereby demonstrated to have heavily impacted the harm production seen with Harm Reduction policies.

Australia must move to fully discard all Harm Reduction ideologies and interventions if it genuinely cares for users' lives and families.

The next chapter describes what we know exactly to work.

We know exactly what works

SUCCESSFUL INTERVENTIONS

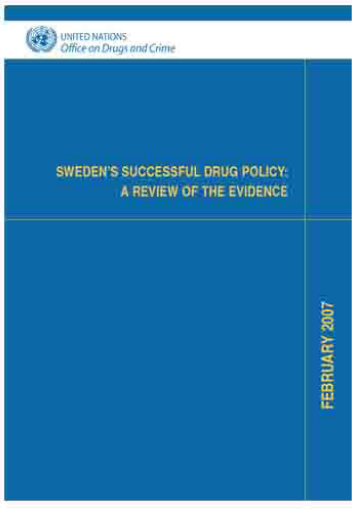
Governments must follow Sweden's success

In 2007 the United Nations Office on Drugs and Crime (UNODC) produced a booklet titled Sweden's Successful Drug Policy – A Review of the Evidence.

On pages 14 and 15, the UN document spells out the aim of Swedish drug policy.

The goal of society's efforts is to create a drug-free society. This goal has been established by Parliament and has strong support among citizens' organizations, political parties, youth organizations and other popular movements." The bill encouraged people to play an active role, stating that "everybody who comes in contact with the problem must be engaged, the authorities can never relieve [individuals] from personal responsibility and participation. Efforts by parents, family, friends are especially important. Also schools and non-governmental organizations are important instruments in the struggle against drugs.

This vision of a drug-free society still remains the overriding vision. The ultimate aim is a society in which drug abuse remains socially unacceptable and drug abuse remains a marginal phenomenon. In this visionary aim, drug-free treatment is the preferred measure in case of addiction and prosecution and criminal sanctions are the usual outcome for drug-related crime."



The Swedish drug policy has had the support of 96% of Swedes. The priorities are:

- Coerced rehabilitation
- Education
- Thoughtful and caring policing while maintaining criminal sanctions

This means that decriminalisation of drug use is seen as an impediment to seeking a drug-free society.

Following are graphs from the UN report showing the percentage of Swedish high school age young people (aged 15-16) and Swedish conscripts (aged 18-19) that have ever experimented with illicit drugs. Sharp decreases in illicit drug experimentation are evident in the 80's when the Swedes heavily funded their restrictive program, and then increased in the 90's once they relaxed funding for their drug program due to a poorer economy. ***In 2004, the Swedish government admitted it had become too relaxed about illicit drug use, and increased funding again***. High school student

Figure 5: Life-time prevalence of drug use among 15-16 year old students in Sweden, 1971-2006

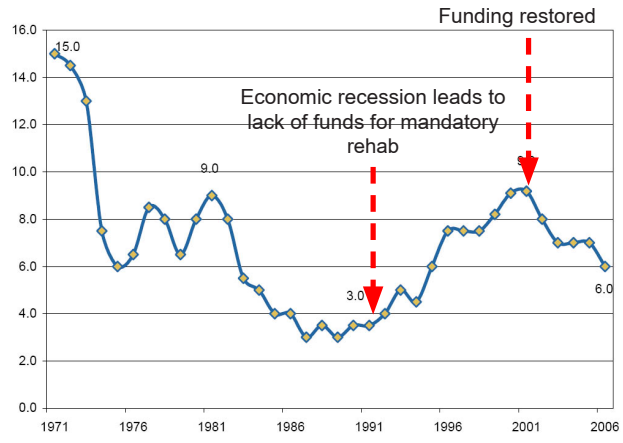
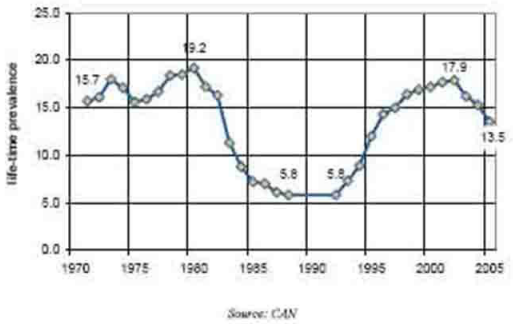


Figure 6: Life-time prevalence of drug use among military recruits in Sweden, 1971-2005



Source: CAN

lifetime prevalence for illicit drug use was back to 6% in 2006.

A comparison of EMCDDA 2000 lifetime prevalence percentages for high school age young people between Sweden and the Netherlands is instructive. (The Netherlands claimed that its soft drug policies would keep their drug use down).

Note that the Netherlands did not reach Sweden's initial levels of drug use until the 80's. Many other European countries did not equal Sweden's 1971 levels until the 90's.

Netherlands	15%*	(1980's)	31.7%	(1999)
Sweden	15%	(1971)	7.7%	(1998)

* *This figure is for cannabis alone (typically other drugs add 1-2% for most European countries)*

These low percentages of lifetime prevalence for young people translate to very low levels of Last 12 Months illicit drug use for surveyed Swedish respondents, as compared to the Netherlands and reflect dramatically different outcomes for each country.

Iceland shows what kind of education works

A resilience-based approach to drug prevention was very successfully trialled in Iceland, as reported in the journal, Substance Abuse, Treatment, Prevention and Policy 2008, 3:12. Adolescent cannabis use was reduced by 65% as per documentation at Appendix D.

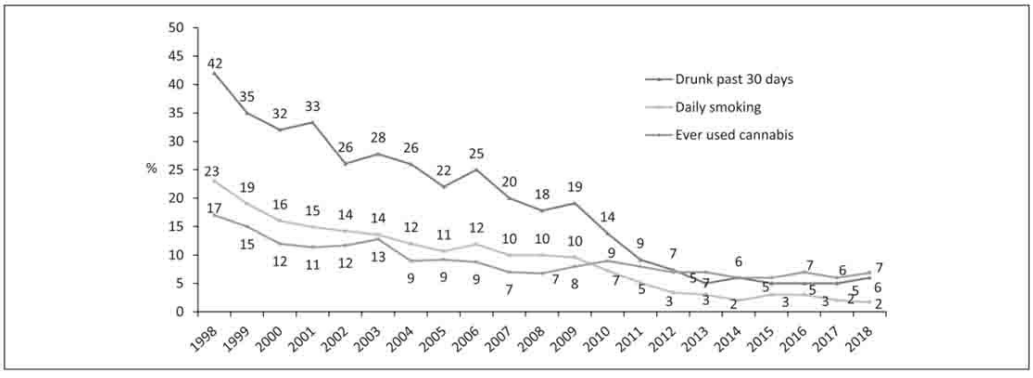


FIGURE 2 Annual Percentage of Self-Reported Substance Use Among Icelandic Adolescents, 1998-2018
SOURCE: Kristjansson et al. (2016).

Drug Free Australia has communicated with Jón Sigfússon, a Director of the Icelandic Centre for Social Research and Analysis, Reykjavik University, and he has identified the following elements in terms of their success: He writes,

For those of you who have less time I take the liberty to quote a few lines from the paper:

... The results from the Icelandic national surveys were used to develop an effective prevention approach with a broad-scale and systematic assessment of the risk and the protective factors that predicted adolescent substance use in Iceland. The key components of this prevention approach included:

• Educating parents about the importance of emotional support, reasonable monitoring, and increasing the time (we don't have an emphasis on this...) they spend with their adolescent children.

• Encouraging youth to participate in organized recreational and extracurricular activities and sports.

• Working with local schools in order to strengthen the supportive network between relevant agencies in the local community.

The research underlined the importance of the adolescent-parent relationship, the powerful influence of the peer group, and a commitment to facilitate the participation of adolescents in guided recreational and extracurricular activities, such as sports and organized youth work. The research helped to conceptualize the prevention effort as one that sought both to reduce the potentially-modifiable risk factors for substance use while at the same time strengthening community-level protective factors. Thus, the approach focused not only on reducing risk factors, but also on mobilizing society to foster responsible guardianship, community attachment, and informal social control, all on the local community level. This effort has come to be known as the Icelandic Model of Adolescent Substance Use Prevention. It is important to demonstrate that this approach is not merely a "program" in the conventional sense with a given time frame, but rather a long-term effort to alter society on behalf of young people in Iceland in order to decrease the likelihood of adolescent substance abuse...

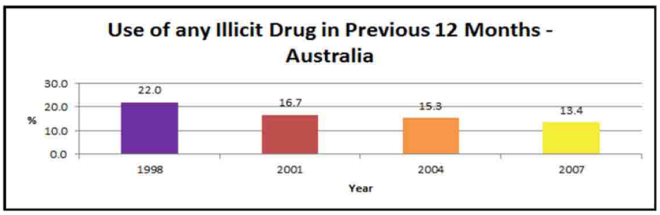
Tough on Drugs – reductions of 39%

Australia's Federal Government introduced Tough on Drugs in 1998, with Drug Free Australia's current President, Major Brian Watters as Prime Minister John Howard's chief advisor on drug issues. By 2007 the drug policy had reduced illicit drug use by 39% and had drawn the attention of the United Nations - a document that more fully explains the elements of Tough on Drugs.

Television advertising such as this and this was used to put Australia's drug problem, which was then the highest in the developed world, front and centre with the Australian public. Every household with children in Australia was posted a booklet on how parents should talk to their children about drugs.

Overall illicit drug use reduced 39% - cannabis use was down 50%, heroin use by 75% and amphetamine use by 46%.

Since Tough on Drugs was discontinued in 2008, illicit drug use had increased 34% by 2022.



A proven pathway to less drug use

With Sweden, Iceland and previous Australian policies demonstrating a proven pathway to much lower drug use, Australia has the opportunity to pursue drug policies that work.

Australians want less drugs, not more

The Australian Government's Australian Institute of Health and Welfare (AIHW) conducts the National Drug Strategy Household Survey every three years, commonly surveying close to 25,000 Australians each time. This enormous sample gives the surveys a great deal of accuracy and validity.

The last survey was in 2022, and Table 11.7 (at the bottom of this page) from its statistical data indicates Australian approval (or lack thereof) of the regular use of various illicit drugs.

With 95-99% of all Australians not giving their approval to the use of heroin, cocaine, speed/ice and ecstasy, and 77% not giving their approval to the regular use of cannabis, **there is solid evidence that Australians want less drug use, not more**.

Harm Reduction as a philosophy and a praxis has delivered exactly what Australians do not want:

- ineffective government programs
- more drug use
- more drug-related harm
- increasing drug-related deaths

Australians will look to their political leaders to act not in the interests of deep-pocketed major political donors but rather in the interests of their constituencies.

In that context, Harm Reduction can no longer have any place in Australia.

Table 11.7: Personal approval[a] of the regular use by an adult of selected drugs, people aged 14 and over, by gender, 2007 to 2022–2023 (per cent)

Proportion

	Males						Females						Persons
Drug	2007	2010	2013	2016	2019	2022–2023	2007	2010	2013	2016	2019	2022–2023	2022–2023
Alcohol	51.7	51.5	51.7	52.4	50.8	50.8	38.9	38.9	38.6	39.8	40.1	41.3	45.8
Tobacco	15.8	17.4	17.3	18.1	17.7	17.5	12.9	13.3	12.2	13.2	13.1	13.6	15.5
Kava	n.a.	5.9	6.8	7.6	8.7	11.5#	n.a.	2.6	2.9	3.3	4.1	5.9#	8.6#
Illicit drugs (excluding pharmaceuticals)													
Marijuana/cannabis	8.7	11.0	12.6	17.8	23.6	26.9#	4.6	5.3	7.0	11.2	15.6	19.9#	23.4#
Ecstasy	2.5	3.0	3.3	3.9	5.3	6.7#	1.5	1.7	1.6	1.8	2.3	3.0#	4.8#
Methamphetamine or amphetamine[b]	1.5	1.5	1.6	1.6	1.6	1.8	0.9	0.9	1.1	0.8	0.9	1.1	1.5
Cocaine/crack	1.8	2.2	1.9	2.0	3.0	3.4	1.0	1.2	1.3	1.4	1.7	2.2	2.8#
Hallucinogens	2.1	3.2	4.5	5.1	8.0	12.0#	1.2	1.6	1.7	2.4	3.2	7.1#	9.5#
Inhalants	1.0	1.3	0.9	0.9	1.2	1.4	0.7	0.8	1.0	1.0	0.8	0.9	1.2
Heroin	1.3	1.5	1.3	1.3	1.5	1.5	0.7	1.0	1.1	1.0	0.8	1.1	1.3
Ketamine	1.1	1.6	1.8	2.1	3.3	4.6#	0.8	0.9	1.1	1.1	1.5	2.2#	3.4#
GHB, GBL or 1,4-BD	0.8	1.3	1.3	1.5	1.8	2.3	0.7	0.8	1.0	0.8	0.8	0.8	1.5
Pharmaceuticals													
Prescription pain-killers/pain-relievers[c]	n.a.	13.4	13.0	13.2	13.3	13.7	n.a.	12.6	12.2	12.1	11.5	12.4	13.0
Tranquillisers, sleeping pills[c]	4.8	7.2	9.5	10.1	10.1	10.2	3.4	5.7	6.8	8.5	8.5	8.9	9.5
Steroids[c]	2.3	3.0	3.0	3.0	3.1	4.9#	0.9	1.4	1.5	1.8	1.6	2.2#	3.5#
Methadone or buprenorphine[c]	1.1	1.5	1.3	1.6	1.8	2.0	1.0	1.0	1.2	1.1	1.2	1.1	1.6

Appendices

LIST OF APPENDICES

Appendix A

Observations on the 2017 Cochrane Collaboration review of OST and NSP - Dr R.M. Colquhoun

Appendix B

Letter in Lancet exposing either fraud or inept research regarding Vancouver injecting room study

Appendix C

Letter to Lancet by Police Commander John McKay confirming police numbers were tripled around the new Vancouver injecting room in 2003, and remained at those numbers through to 2011 and beyond, explicitly contradicting the false statements made by the Lancet study authors

Appendix D

Summary of both injecting rooms in Melbourne and Sydney, with statistics and qualitative data demonstrating both failed against all their stated objectives, while sharply increasing policing loads

Appendix E

Iceland success documentation

Observations on the 2017 Cochrane Collaboration review of OST and NSP

Dr R. M. Colquhoun

The aim of this paper is to critically analyse the claims by Platt and colleagues that: "Among people who inject drugs (PWID), sharing needle/syringes is the main risk factor for infection with HIV and HCV" and "that NSPs reduce HIV transmission among PWID by 48% (95% confidence interval (CI) 3% to 72%), with strong evidence that OST reduces HIV transmission by 54%. Further, that "As a treatment for opioid dependence, OST has been shown to reduce the frequency of injection and unsafe injecting practices."

In the Platt paper no evidence is provided to substantiate the effectiveness of OST and NSP programs in reducing the transmission of HIV, and the cited studies do not support their claims.

The Aspinal (2014) study suggests there is evidence to support the effectiveness of NSP in reducing HIV transmission, although the quality of this evidence was graded as low and that an earlier review of reviews (ROR) concluded that there was "only tentative evidence to support the effectiveness of NSP in reducing HIV" and that only a minority of studies support this claim.

The other study they cite to support their claim "showed that opiate substitution treatment was associated with a substantial reduction in risk of HIV infection among people who inject drugs" (MacArthur, 2012). In the review of the evidence for reduction of HCV infection among IDUs they state that "the evidence is considered as low quality because it was derived from observational studies with serious risk of bias and that "Meta-analysis of five observational studies pooling adjusted estimates from 3530 anti-HCV negative participants show low quality evidence that high NSP exposure does not reduce the risk of HCV acquisition."

Contrary to the assertion that "There is good evidence for the effectiveness of NSP and OST in reducing injecting risk behaviour and increasing evidence for the effectiveness of OST and NSP in reducing HIV acquisition risk" and HCV infection (Platt et al,. 2017, Mattick, 2009a) the evidence indicates the opposite is true.

After many years of strongly advocating OST and NSP programs the authors concede that " the evidence on the effectiveness of NSP and OST for preventing HCV acquisition is weak" and in fact is non-existent given the lack of RCTs and the reliance on poor quality observational studies. Mattick and colleagues state that "As well as reducing heroin use and crime, methadone maintenance treatment is expected to be effective is in the reduction of HIV infection among heroin users" as HIV infection is most often transmitted among injecting drug users as a result of sharing needles. However, a fair evaluation of the assumptions that underpin these programs show that the evidence indicates that OST and NSP programs have been abject failures.

They have created an expectation that use of clean needles will prevent and HCV and HIV transmission and are likely to have had the effect of encouraging those who had never injected drugs to do so. After the initial claim that OST programs would allow IDUs to withdraw from opiate addiction this has been shown to do the opposite - those who transition to opiate substitutes stay addicted to these drugs for many more years than they would if they had stayed with heroin - thus increasing the risk of infection and mortality.

Moreover, Governments have wasted millions of dollars on these programs that could have been used in prevention strategies, thus saving many from developing an addiction and saving many lives.

Most damning is the fact that the premises or assumptions that encouraged these false assertions of the effectiveness of these programs are false, thus rendering the very slim evidence of their effectiveness to also be valueless.

It has been established for many years that:

- injecting drug use has minimal if any impact on HIV infection rates,
- while HCV is almost exclusively transmitted by unsafe drug injecting,
- that sexual contact has had very little, if any, impact on transmission rates,
- that many using OST are already infected with HCV before they commence OST and that they continue to inject drugs: amphetamine (62%) and heroin

(61%). Over half of the sample (62%) continued to use contaminated needles and injecting paraphernalia (O'Brien, 2007).

- Further, HR advocates state that "methadone maintenance is effective in reducing HIV infection"…and ..."this may not be the case for HCV as HCV is more readily transmitted than HIV" with infection rates of between 50% and 95% (Mattick, 2009a, p. 123).

The research of Guy et al. (2007) found that the most frequent route of HIV exposure was male-to-male sex, accounting for 70% of diagnoses while heterosexual contact accounted for 18% of cases, with just over half of these people born in or having a sexual partner from a high-prevalence country and that transmission by injecting drug use was infrequent. It is accepted that even when an argument is valid, when premises are false then the conclusions are not sound and are false.

Indeed, as the premises are false it means any attempt to draw a conclusion or to prove the contrary is doomed from the beginning. However, advocates for OST and NSP seem not to understand this basic principle of logic or else deliberately ignore it in their advocacy of OST and NSP programs.

The arguments and assumptions for the research and conclusions regarding HCV and HIV infections and the effectiveness of OST and SNP programs are:

Argument A

Premise (1) That needle sharing is a major cause of HIV transmission;
Premise (2) That OST has the effect of reducing injecting drug behaviour;
Conclusion: OST and NSPs reduce HIV transmission rates.

Argument B

Premise (1) That HCV infection rates among IDUs are very high:
Premise (2) That OST and SNPs result in reductions in rates of injecting drugs;
Premise (3) IDUs will use of clean injecting equipment at high rates;
Conclusion: OST and SNPs result in significantly lower rates of HCV infection among IDUs.

While these arguments are logically valid neither of the conclusions are sound as the premises on which they are based are not true. That is, HIV is very rarely transmitted by injecting drugs making OST and SNPs irrelevant and HCV infections are already at high rates when IDUs enter treatment with the prevalence and incidence of hepatitis C virus (HCV) among Australian injecting drug users (IDUs), around 50 to 60 percent and 15 percent respectively and that they continue to inject drugs and fail to exclusively use clean injecting equipment (O'Brien, 2007), with some seventy six (76) percent of IDUs accessing OST and SNPs having hepatitis C which renders NSPs insignificant in reducing HCV infection rates.

These programs fall far short of eliminating or significantly lowering the use of contaminated equipment and fail to lower HCV infection rates and are irrelevant in reducing HIV infection rates.

The review of the studies on NSPs and OSTs and HCV and HIV show that there are high rates of HCV among IDUs when they commence treatment, that IDUs continue to inject drugs and do not use clean equipment each time they inject and continue to be infected or reinfected and that the 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 harm reduction (HR) continue to claim that the evidence is "substantial" (MacArthur, 2014) that needle syringe programmes are effective and cost-effective even when no conclusive evidence is cited and that "it is effective in reducing heroin use, crime, drug related mortality and HIV" (Mattick, 2009a, p133) despite a Cochrane review of methadone research finding that it is no more effective than no treatment on rates of crime or mortality or on HIV transmission (Mattick, 2009b). The gap between the assumptions and the very meagre research evidence and the conclusions of the effectiveness claimed by advocates of OST and SNPs is breath-taking and borders on academic fraud.

The introduction of methadone was an attempt to reduce the harm associated with heroin addiction and to facilitate withdrawal from the drug while IDUs stabilised their lives. 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.

Observational research has purported to show 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 (Mattick, 2009b). No trials have shown any improvement in health outcomes or reduction in HIV transmissions.

Moreover, people dependent on methadone and other substitute agonist medications 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 (the principal agonist drug prescribed) does not have any proven effect other than to retain people in treatment or reduce injecting drug use in the short term (Mattick, 2009b). And yet in Australia thousands are hopelessly addicted to this dangerous drug that costs the community in the region of $150m each year.

After many failed attempts to help addicts escape their addiction by inducting them onto OSTs it is apparent that it is also more addictive than heroin and much harder to withdraw from 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 and inject other drugs (O'Brien, 2007). 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 life-choices are 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 before relapsing to heroin.

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 40 years or more and a black market in methadone and fentanyl thriving, meaning that these drugs are often more accessible than heroin.

As reported by Mattick and colleagues, "a consistent finding in the studies of methadone-assisted heroin detoxification is the high rates of relapse to heroin use following cessation of methadone doses" (Mattick, 2009a, p 65). Despite this admission the same authors state that "Methadone assisted withdrawal has shown to be safe, effective and acceptable" (Mattick, 2009a, p85).

What is most disturbing is the fact that health authorities have no idea how to get people off methadone once its usefulness, if any, has been exhausted. Detoxification rates for buprenorphine are similarly poor, although some claim it is marginally more effective in the short term (Mattick, 2009a).

At present in Australia, according to the Australian Institute of Health and Welfare, as at April, 2023, there were around 55,700 people receiving agonist maintenance treatment across Australia on any given day, which is approximately the same number who were on OSTs in 2009.

Moreover it directly cost our community some $150m each year at an estimate of $4500 to maintain each person on methadone. It is the most prescribed drug in Australia with 61% of all prescriptions being for this substitute opioid (AIHW, 2023).

While it is claimed that methadone maintenance remains "the most researched treatment for this problem," there are very few studies that are cited and despite the widespread use of methadone maintenance treatment for opioid dependence in many countries, its effectiveness has been disputed for good reasons. Its purported benefits have never been proven and research shows that these claims are not supported and yet advocates continue to promote its use (Mattick, 2009a; Platt, 2017).

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 HCV 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 those few injecting drug users who are HCV negative stop sharing needles. To prevent needle sharing sterile needles have been provided at a cost of some $40m each year for the little benefit.

The research indicates that 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 only reduces sharing by some 15%. However, the research shows that up to 70% of injecting drug users who are accessing needle exchange facilities and methadone clinics are testing HCV positive, while injecting drugs is only responsible for 3-4% of HIV transmissions. Most new cases of HIV result from unsafe and multiple-partner sex, particularly among homosexual men, and is associated with high rates of other sexually transmitted diseases (O'Brien, 2007).

These statistics (facts) mean that even if methadone was effective in reducing injecting rates and needle sharing, it could not reduce HCV infection rates, which are often at saturation levels among IDUs while it would 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 (OSTs)_and NSPs is required.

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.

The current statistics indicate the failure of the OST programs, which were touted as a major plank in the harm minimisation policy. In 2000 there were approximately 50,000 people receiving OST. In 2022 there were approximately 49,000. As most people tend to stay on these substitute opioids for many years as it is much harder to withdraw from than opiates like morphine and heroin, it is likely that few people have commenced this treatment over the last 20 years or more, as shown that over the past 10 years the average age of OST recipients has increased from 38 in 2011 to 45 years in 2022. This is despite the fact that over this period there has been an increase in the number of people using illicit opiates and an increase in overdose deaths from a low of 316 in the early 2000s after the introduction of the Tough on Drugs program to 1123 opioid induced deaths in 2022 (AIHW).

Instead of reducing harm Australia has seen an enormous increase in the number people using opioids for illicit or non-medical purposes to approximately 715,000, while in 2000 there were an estimated 73,000 Australians who were misusing opioids (AIHW).

While HM has not been at all successful in reducing illicit opioid misuse use and the harm associated with it, it has also seen a significant increase in meth or ICE use. Among other harm, the risky behaviour it causes has resulted in a very large increase in STDs. For example: In 2000, the number of sexually transmitted diseases (STDs) reported in Australia included: Chlamydia: 27,792 cases; Gonorrhoea: 7,347 cases; and Syphilis: 1,309 cases. In 2022, the reported STD cases in Australia were: Chlamydia: 93,777 cases; Gonorrhoea: 32,877 cases, and; Infectious Syphilis: 6,036 cases. These figures reflect a significant increase in STI cases over the two decades. (RACGP). The increase in drug use, especially 'chemsex' is a potent driver of this health crisis.

Policies that have been effective have been neglected while harm reduction policies, driven by a political agenda that shows no demonstrable impact on HIV and HCV rates, has been promoted in the last 40 years or more.

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